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EDITORIAL

Narratives of Essentialism and Exceptionalism: The Challenges and Possibilities of Using Human Rights to Improve Access to Safe Abortion

ALICIA ELY YAMIN AND PAOLA BERGALLO

Context

As this special section of *Health and Human Rights* goes to press, women's access to sexual and reproductive health, including safe and legal abortion, faces both old and new threats in many corners of the world. Among other things, the US government under Donald Trump decided to defund the United Nations Population Fund and to reinstate and expand the so-called Global Gag Rule that prevents any non-US, nongovernmental organization from receiving funds from the United States if they provide not just abortion services but any information regarding abortion, even with other donors' funds.[1] USAID is the largest donor in the world for family planning services, and grantees will lose funding unless they agree to these conditions.[2] As many as 50 European and other governments, including Canada, stepped in to try to make up at least in part for the loss in funding. Now that it has been announced that all US global health assistance funding for international health programs, such as for HIV/AIDS, maternal and child health, malaria, global health security, and family planning and reproductive health will be affected, the losses may be as much as US$9 billion.[3]

The funding crisis provoked by the new administration in the United States is but one facet of the challenges that the rapid ascendancy of conservative populist nationalism has created in relation to sexual and reproductive health and rights (SRHR), and abortion rights in particular. That is, the funding changes reflect the extreme degree to which ideology underpins policy in this area, domestically and globally, which advocates have long known. But after years of progressives using international forums to advance SRHR,

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Disclaimer: All opinions expressed are personal and do not necessarily reflect those of the Independent Accountability Panel for the UN Secretary's General's Global Strategy for Women's, Children's, and Adolescents' Health.

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including but not just abortion access, conservative actors have appropriated many of the same strategies based on an agenda that construes SRHR and "gender ideology" as fundamental threats to the traditional patriarchal family. These conservative actors seek not only to limit progressive advances in international law but also to undermine the legitimacy of the international institutions themselves and the norms that emanate from them. In the last couple of years, and especially the last year, the extent to which these conservative forces have consolidated transnational advocacy networks, and political blocs in international spaces, has become dramatically apparent, as evidenced by activity at United Nations (UN) forums as well as some of the transmissions of ideas across national contexts. Further, the de-legitimization of international institutions is mirrored at the national level with assaults on institutions of democratic governance, from the media to the courts, as shown by the actions of Trump (United States), Putin (Russia), Erdogan (Turkey), Orbán (Hungary), and others. SRHR are almost always among the first targets of these conservative populists, including abortion and extending to issues such as the traditional "family."

At both the international and national levels, in parliaments and legislatures, there is increasingly little room for dialogue on issues relating to SRHR, including abortion. The impacts of this absence of dialogue are evidenced by, for example, limited, inconsistent, and regressive outcome documents and resolutions—from the Commission on the Status of Women to the Commission on Population and Development, from the UN General Assembly to the Human Rights Council. In this political landscape, we seem to have gone back to a time when human rights are universal only to the extent that they can be universally agreed on by member states. The construction of limited abortion rights under positive international law depended greatly on a normative scaffolding that now appears dangerously precarious.

The possibility of any meaningful collective deliberation regarding what is a contested issue in virtually every country of the world is further exacerbated by an all-out assault on scientific truth. The pseudo-science and alternative facts that are peddled cynically by opponents of choice—whether they relate to "fetal pain" or future suicide risks in women post-abortion—have proven remarkably influential over legislatures and courts in any number of countries. As the US Supreme Court found in 2016 in *Whole Women's Health v. Hellerstedt*, the arguments used to support the "targeted regulation of abortion providers," which called for requiring admitting privileges and "ambulatory surgical center" standards for abortion providers (requirements that, at the time, had been passed by more than a dozen US states), are also based on specious arguments.[4]

Not all is bleak in this picture, and increasingly the dynamics of different regions need to be considered separately to better understand how to move forward, as well as how to hold firmly onto what we have achieved. The Montevideo Consensus on Population and Development in Latin America, developed in 2013 as part of the International Conference on Population and Development (ICPD) plus 20 events, for example, stands out as a progressive beacon on issues of SRHR amidst a decidedly conservative global backdrop.[5] Moreover, the African Commission on Human and Peoples' Rights called for the decriminalization of abortion across Africa in both 2016 and 2017, in line with the Maputo Protocol to the African Charter on Human and People's Rights.[6]

In any case, it is an especially apt time for scholars and practitioners across disciplines and geographic divides to collectively reflect on where we are in relation to using human rights discourse, tools, and framing to advance access to safe abortion as a right, and how we got here. The pieces in this special section of *Health and Human Rights*, which speak with multiple voices and perspectives on these complex struggles, are an important step in that direction.

Starting points

In the 1970s and 1980s, women's rights activists around the world formed international and regional networks and developed feminist understandings

of what began to be called "reproductive rights," of which safe pregnancy and safe abortion were key elements. In the 1990s, women's rights activists and scholars began appropriating international human rights forums and mechanisms to advance many issues in SRHR, including abortion rights, as well as other issues relating to gender equality, such as gender-based violence. The fall of the Berlin Wall and the subsequent erosion of rigid dichotomies between the West's promotion of civil and political rights and the former Soviet bloc's promotion of economic, social, and cultural rights seemed to signal an opening in international human rights law: the traditional dichotomies between the political and economic, and between the public and private realms in the traditional liberal state were challenged with new understandings of well-enshrined legal rights, and in turn rights-holders, as well as the nature of state obligations to them. International forums offered spaces to set standards and create consensuses that could not be achieved within the closed spaces of national legislatures and judicial systems.

A year after the World Conference on Human Rights in Vienna paved the way for women's rights to be seen as human rights, the ICPD that was held in Cairo in 1994 was the culmination of years of activism and work on the part of women's health and rights communities, together with LGBTQ and other communities. The Programme of Action that emerged from Cairo was a watershed, bringing into being a new paradigm of development based on women's choices and reproductive rights. But we should not forget that "it was not all peace, love, rainbows and unicorns at Cairo."[7] Compromises were made, including around abortion. It was not just that pragmatism led to fissures among sexual and reproductive rights advocates but also that there were differing perspectives from women's groups in the North and South, which would play out over the coming two decades.

At the time, many activists thought optimistically that ICPD meant that women's movements had finally gotten a seat at the table, and that pushing further at the Fourth World Conference on Women in Beijing a year later in 1995—and across the intersectoral UN conferences of the 1990s—would allow more unified progress. In retrospect, the struggle had just begun, and the backlash against Cairo and Beijing, and SRHR, from right-wing governments, the Conference of Islamic States, the Vatican, and conservative evangelicals was still taking shape. Further, the identification of reproductive rights with autonomy in a vacuum in some countries, disconnected from the broader conditions in women's lives, had consequences on the way alternative voices and movements for "reproductive justice" grew among women of color in the United States and elsewhere, for example.

The truth is that abortion was and is necessarily about reproductive, gender, and social justice, and was recognized as such from early on in many countries, especially in the "global South". It was and is about women and girls being fully human and therefore able to have control over their sexual and reproductive lives. And in many countries, SRHR activists recognized from the beginning of using rights paradigms for advocacy that decisional autonomy always required freedoms in the private sphere and access to social and economic endowments and entitlements in the public sphere.

At the end of the 1990s, despite the promise of "people-centered development" in the Millennium Declaration of 2000, the Millennium Development Goals (MDGs) returned to an essentialist view of women's role in reproduction, including only one goal (MDG 5) on reproductive health relating to the reduction of maternal mortality (and in 2007 adding target 5B on access to "family planning"). Setbacks in certain regions after the fall of the Berlin Wall—such as in Eastern Europe, where there was a resurgence of Catholic conservatism—also created obstacles to women's SRHR, and abortion in particular, in the 1990s. Indeed, it is often alleged that Poland was where the concept of "gender ideology" as a threat to the traditional family was initiated.

But legal mobilization for abortion and other SRHR moved ahead through the use of supranational tribunals and standard-setting, as well as at the national level. New generations of feminist lawyers availed themselves of advances in regional and international arenas, as well as structural innovations at the national level, such as constitutional

blocs in domestic constitutional law in Latin America. Transnational advocacy networks created new geographies of knowledge, and the internet made the sharing of ideas and strategies among lawyers and activists in different regions infinitely easier. Lawyers worked with physicians and others to bridge gaps between normative victories and the effective enjoyment of rights in practice.

Today, it is clear that there is no one path forward, no one-size-fits-all strategy for achieving access to safe and legal abortion. Indeed, the articles in this issue, representing disciplines from the medical, social sciences, and legal fields, and a wide variety of geographical contexts, present a nuanced picture of struggles for abortion access using rights tools and frameworks. They also suggest, among other things, that we would do well to move beyond some of the standard debates in international human rights law in relation to abortion; promote more systematic intersectoral collaboration; focus on systems (both legal and health); and situate struggles within national and global political economies, and especially neoliberalism. The remainder of this editorial reviews the mobilizations and countermobilizations in different countries and across borders; sets out how a comprehensive and robust human rights-based approach (HRBA) would change conceptions of governmental responsibility and decisions within health systems; and, finally, notes the neoliberal economic context in which the regulation of women's bodies and these debates are occurring.

Beyond the "legalism v. anti-legalism" debate in human rights scholarship

The topic of abortion ineluctably illustrates the hollowness of debates between legalism and anti-legalism in human rights scholarship, as well as epistemic dissonances between fields. Legalistic approaches to human rights and constitutional rights are often described as holding that ethical relations between people and, in the case of international law, states, are guided by rules which exist and are followed. With regard to abortion, many advocates would no doubt agree from an empirical perspective with Marge Berer that "the plethora of convoluted laws and restrictions surrounding abortion do not make any legal or public health sense. What makes abortion safe is simple and irrefutable—when it is available on the woman's request and is universally affordable and accessible." Yet in reality, exceptionalism and essentialism are the Scylla and Charybdis through which abortion reforms must be navigated. Law, of course, is not merely a set of rules but a reflection and refraction of negotiated social practices, and the validity of law is dependent on the process through which it is adopted. This is one of the things that makes abortion so contentious: it is notoriously impervious to forms of public deliberation, based on a shared understanding of empirical fact, which we expect from most of our lawmaking processes. This exceptionalism in lawmaking is coupled with widespread social norms that reflect and reinforce essentialism regarding women's reproductive and caretaking roles in society.

A rigid legalism, which tends to see positive international law as well as domestic constitutions and legislation in formalistic terms, is justifiably critiqued as naïve by human rights scholars "[b]ecause rules do not, and cannot, constrain self-interested political actors."[8] And, of course, laws do far more than set rules. Regarding abortion, it is especially clear that laws orient social norms and discourses, as well as reflect and reproduce gender relations.

In international law, the portrayal of a linear march of progress in a formalistic vision fails to consider the recursive relationship between international and domestic law, as well as considerations of normative and social legitimacy. As Johanna Fine, Katherine Mayall, and Lilian Sepúlveda's paper shows, international and national human rights norms have interacted to create new interpretations of well-enshrined norms and to foster recognition of the denial of abortion care as a violation of women's and girls' fundamental human rights.

At the domestic level, too, there is no one-size-fits-all law reform or strategy for legal mobilization, as most of the papers show. A fundamental aspect of law that is well illustrated by this issue is that norms as written mean different things in different contexts, and a given law's validity is contextual and

the product of historical trajectories. In Chile, legal mobilization in favor of permitting abortion in case of fatal fetal anomalies (as well as on grounds of risk to life and health, and sexual assault) may today be the most strategic human rights move, as argued by Lidia Casas and Lieta Vivaldi, given the dynamics and history of Chile. In other countries, other strategies are required to ensure that rights are effectively enjoyed in practice at subnational levels, as Barbara Baird notes regarding Australia.

Across contexts, many of the authors implicitly or explicitly note the gap between normative symbolism and the "effective enjoyment of rights." For example, Claire Pierson and Fiona Bloomer point to the limits of making effective change by framing abortion in terms of human rights recognized under international law in the context of Northern Ireland. They note that this strategy has not affected the macro-political level, where decision making takes place. Although in the Northern Irish context, rights have had high resonance in response to mainstream political conflict, they seem to be disregarded when it comes to liberalization of the abortion law.

Indeed, much legal mobilization now often incorporates an understanding of how de facto power relations structure the opportunities for women to avail themselves of abortion when it is legal. This important change in legal mobilization is illustrated by Ana Cristina González Vélez and Isabel Cristina Jaramillo in their documentation of the important work of Colombian women's nongovernmental organizations seeking to shape the meaning of law through the development of legal expertise and pedagogical strategies to persuade health providers. Marta Rodriguez de Assis Machado and Débora Alves Maciel also recognize the significance of understanding power relations in the struggle for abortion reform in Brazil. In their paper, the authors trace the historical movement and countermovements deployed in different arenas, including the legislature, courts, and health authorities, since 1995, showing how legal progress is neither linear nor able to be understood without regard for the political context.

Lynn Morgan's piece further underscores the importance of tracing conservative actors' movements and the transnational networks they create, as well as the effects of conservative discourses. Morgan's study of the Dublin Declaration on Maternal Healthcare and its deployment in abortion politics in El Salvador and Chile points to the array of conservative tactics faced by domestic advocates seeking legal reform or fighting arbitrary criminal law systems. Similarly, Julieta Lemaitre and Rachel Sieder explore how "legal mobilization before international human rights courts moderates social movement claims," arguing that the international legal forum influences and alters the arguments of the actors before it, leading to moderated arguments by both feminist and conservative actors.

If Morgan's and Lemaitre and Sieder's pieces stress the transnational effects of advocacy, many of the articles describe how regulations have had differential impacts across countries, suggesting a need to develop strategies that go beyond national legislation and policies and work at the subnational level. This seems particularly clear in the articles about Australia, Thailand, and Nepal. As Ronli Sifris and Suzanne Belton's work on Australia shows, in order for decriminalization to have a practical effect on women's lives, the regulation of medical procedures and financial resources and the removal of legal and practical barriers are required at the subnational level to allow women to enjoy their rights. At the same time, in Thailand, where more moderate liberalizing interpretations of abortion law have been put forward, Grady Arnott, Grace Sheehy, Orawee Chinthakanan, and Angel Foster found variations in implementation conditions that have generated significant subnational disparities, with women from ethnic minorities in a border area receiving far more limited access to care.

Legal mobilization around abortion cannot be disconnected from the social contestation that occurs in other forums, beyond legislatures, courts, and administrative bodies, because this "societal legal mobilization" helps shape broader public understanding of the relationship between abortion and human rights. In her case study on Peru, Camila Gianella explores this "societal legal mobilization" in Peru's two leading newspapers. Gianella observes

legal mobilization and countermobilization through content analyses and thus captures the powerful narratives deployed in framing key concepts, such as conception, autonomy, vulnerability, and the social responsibility to protect.

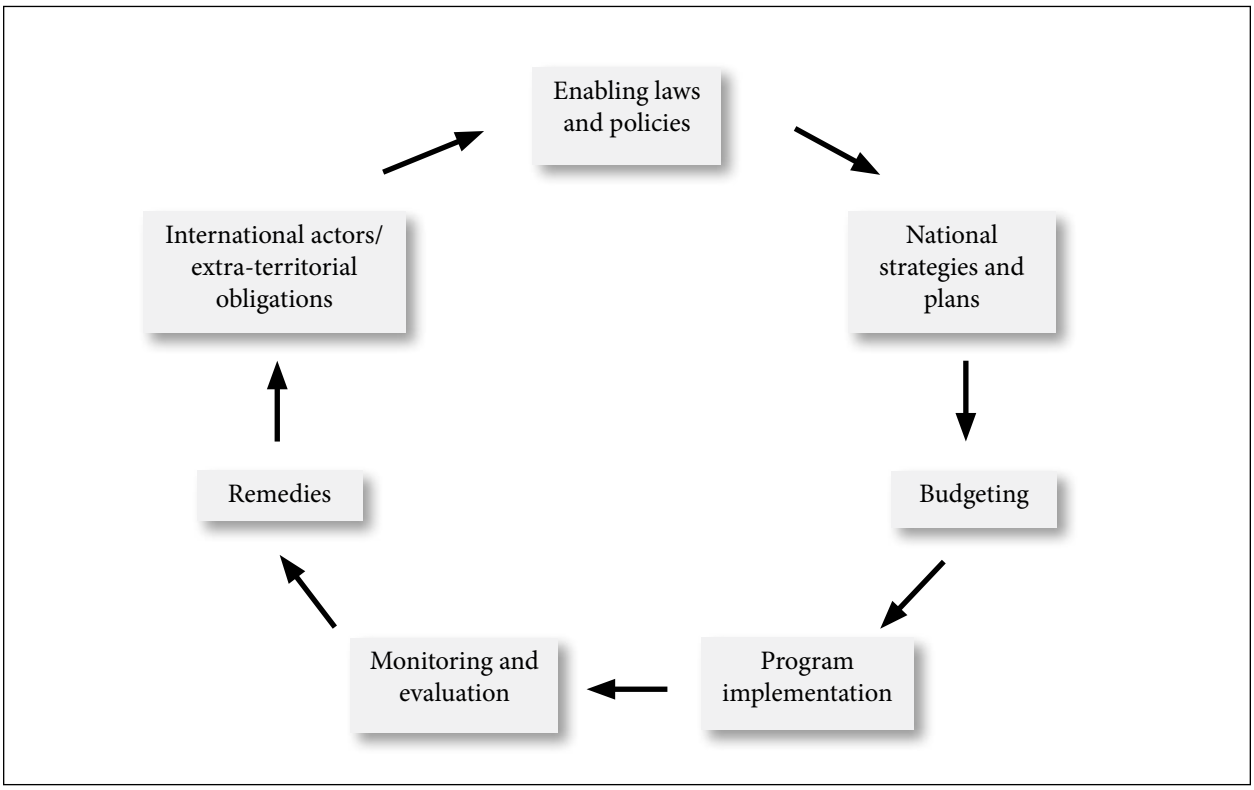
Finally, there are cautions regarding the proliferation of norms and inconsistent use of legal tools in reproductive health. Jocelyn Viterna's article on the process that led to defining abortion as aggravated homicide in El Salvador's judicial system exemplifies the huge costs suffered most often by marginalized women and the abuse of the criminal law to regulate reproduction. Yet at the same time, we have seen a recent proliferation of obstetric-violence legislation in Latin America, which in the name of "protecting" women from abuses and mistreatment presents risks of drawing criminal law back into the reproductive health arena.[9]

Changing conceptions and decisions: Adopting human rights-based approaches more systematically in health systems

As noted above, the articles in this issue speak explicitly and implicitly to the need to go beyond law reform and litigation. The question is, how might HRBAs help us change the conceptualization of government actions and responsibility, as well as provide tools for advocacy around decision making at different stages of the health policy cycle, and beyond?

First, the way in which Zika was initially addressed in Latin America offers an example of how HRBAs might change thinking about state responsibilities. Zika is a disease of the poor, where standing water and inadequate housing create breeding grounds for mosquitoes. Zika was declared a public health emergency by the World Health Organization in 2016; and links between

FIGURE 1. Circle of accountability



Source: Derived from Office of the High Commissioner for Human Rights, *Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, UN Doc. A/HRC/21/22 (2012); for full diagram and explanation, see A. E. Yamin, *Power, suffering and the struggle for dignity* (Philadelphia: University of Pennsylvania Press, 2015).

contracting Zika during pregnancy and serious congenital defects in the infant, including microcephaly, were established.[10]

At the time, various governments in Latin America, including Brazil, Colombia, Ecuador, El Salvador, and Jamaica, issued recommendations to women to postpone pregnancy for six months to "indefinitely."[11] From a human rights perspective, one problem with those official recommendations is that 56% of pregnancies in Latin America and the Caribbean are unplanned.[12] Further, there is frequently inadequate or nonexistent comprehensive sexuality education; girls and women have little access to contraception; there is a very high incidence of sexual violence across the region; and there are cultural barriers to negotiating the use of condoms with male partners.[13] Finally, many of the countries where these recommendations were made have partial or even total prohibitions on abortion.[14] Thus, the way Zika was addressed, at least initially in some countries, exemplifies how marginalized women pay the greatest consequences for the political failures to enact public health measures or establish adequate health systems that meet the needs of poor women and girls.

How does that change in thinking translate into action? Applying a systematic HRBA would change decisions (and advocacy opportunities around decision making) at every stage of the health policy cycle, as outlined in the UN's 2012 technical guidance on a human rights-based approach to the reduction of preventable maternal mortality and morbidity (see Figure 1).[15] This guidance was the first intergovernmentally approved document for a rights-based approach to any health issue—and one which is relevant to abortion at every stage.[16]

First, ensuring enabling legal and policy frameworks based on international human rights is only the beginning of a longer process. Fine, Mayall, and Sepúlveda's piece traces the influences of international and regional human rights norms "in lobbying and influencing legislatures to liberalize abortion laws and establish policies to ensure access to safe and legal abortion services." Such legal and policy frameworks must, at a minimum, allow for restrictions on the criminalization of abortion when women's lives and health are at risk, in cases of rape and sexual abuse, and where fetal congenital anomalies are inconsistent with life.[17] As noted above, decriminalization is not the end of the battle; that battle requires many steps to change practices in invariably complex and often underfunded, decentralized, fragmented, and sometimes dysfunctional public health systems. The existence of private abortion clinics and providers in these circumstances, which ensure safe services for those with the money to pay for them, may serve to reduce an important source of public pressure to change the situation for those living in remote and poor urban and rural areas.

Joanna Erdman's analysis of the different dimensions of time in abortion law argues that human rights law requires that limitations on abortion be "transparent, rational, and proportionate" and that a woman's moral judgment to seek a later abortion be trusted. She argues that "international human rights law sets standards of legitimacy for abortion law as health regulation" and that laws should be "evidence-based to counter the stigma of late abortion." She also convincingly argues that "there will always be a need for abortion services later in pregnancy" and that justice—and thus an HRBA—demands that structural limitations on women's capacity to make earlier decisions on abortion be addressed. The paper by Casas and Vivaldi, about facing a diagnosis of fatal fetal anomaly in a setting where the law compels women to carry the pregnancy to term, offers an especially poignant example of the stark violation of women's human rights and the difficulties faced by health professionals who can do little to ease women's experience of loss and suffering in these circumstances.

Second, the effective enjoyment of all rights, including those related to safe abortion, requires multisectoral planning, and "linkages between sexual and reproductive health and related policies, including education and nutritional policy, should be drawn explicitly."[18] Arguably, planning should also include the regulatory approval of harm reduction strategies within and beyond health systems, even when many forms of abortion are illegal. And as Wan-Ju Wu, Sheela Maru, Kiran Regmi, and

Indira Basnett note in relation to Nepal, to promote equitable access and safeguard abortion as a fundamental right, "policymakers must begin by including abortion as a part of the package of basic health care services and integrating safe abortion services into the continuum of reproductive health care."

Third, budgets need to reflect these multisectoral plans and training for the providers involved across sectors. For example, Sifris and Belton explain that in Australia, the supply of public health facilities cannot meet the demand for services, thereby forcing women to seek services in the private sector. As a result, "there is a gradient of socio-economic access to reproductive health services that is inequitable." This is common, even where abortion restrictions have been eased. Basnett also refers to the underfunding of abortions in Nepal. As the UN's technical guidance explains, "The budget should ensure that financing is not borne disproportionately by the poor. Out-of-pocket costs cannot impede accessibility of care, irrespective of whether services are provided by public or private facilities."[19]

Fourth, the implementation of programs, including regimes based on exceptions, requires the regulation of and protocols for provision and referral, and continuous training. For instance, the authorization of conscientious objection among health care providers when abortion is legal, and even more so when abortion is legally restricted, can be the source of important variations in women's access to services. Wendy Chavkin, Laurel Swerdlow, and Jocelyn Fifield's research outlines the necessary components

> *for a functional health system that permits provider [conscientious objection] and yet assures access to abortion … : clarity about who can object and to which components of care; ready access into the system by mandating referral or establishing direct entry; and assurance of a functioning abortion service through direct provision or by contracting services to other abortion providers.*

But the authors also make clear through an in-depth look at several countries that it is only in a few instances that this sufficiently protects women's rights in practice.

Fifth, implementing an HRBA requires alignment between national policies and regulations and those of subnational states or provinces. Wu, Maru, Regmi, and Basnett argue that applying a human rights framework in Nepal would imply the need to "prioritize the decentralization of services and increase the number of health posts and sub-health posts with the capacity to provide first-trimester medical abortions," invest "in technical support for providers in rural areas and referral networks to tertiary centers as needed," and "safely expand the provision of second-trimester abortions." Moreover, the importance of training pharmacy workers in Nepal and in other Asian countries with comparable conditions for the provision of medical abortion, such as Bangladesh, stretches the list of primary and community-based providers in the same way that contraceptive service provision has done.[20]

Sixth, the monitoring of abortion provision and post-abortion complications is extremely difficult where abortion is legally restricted. Nevertheless, monitoring that might enable evidence-based policies on abortion (or post-abortion care), assessment of legal compliance and institutional capacity, and status of conscientious objection, confidentiality, and the like—should be documented. Sifris and Belton discuss how the failure to collect and analyze health data "stymies the making of evidence-based clinical guidelines or health policies regarding elective abortion."

Seventh, as discussed throughout the papers in this special section, remedies and litigation to transform legal regimes and to create new narratives of women as fully equal members of society are critical to protect this fundamental aspect of women's dignity. Just as legalism alone is inadequate, simplistic anti-legalism does not reflect the advances made through a combination of national and supranational mobilizations, which have constructed normative understandings, exploited opportunity structures, and provided bulwarks against conservative political interests over time.

Finally, the context in which donors and development agendas shape what interventions are prioritized, as well as how services are organized and delivered, has enormous effects on abortion

provision, especially in highly aid-dependent countries, as suggested by the discussion of funding at the opening of this editorial.

In short, a comprehensive HRBA in turn calls for a much greater interdisciplinary collaboration between the health and legal fields, as well as among scholars and activists in the social sciences. No one field alone can achieve normative victories and translate them into the "immanent regularity of practices," as Pierre Bourdieu calls them, within health systems and larger cultures.[21] And feminists should equally strive for men and providers to become allies in a broader social struggle for equal dignity in the communities and societies in which they live, which moves beyond both exceptionalism and essentialism.

Situating struggles for abortion and gender equality in a neoliberal world

It is very clear from the contributions to this special section that discourses at the global, regional, and national levels have an impact on the discourse and parameters for abortion advocacy. On one level, the Sustainable Development Goals (SDGs) are an enormous advance over the MDGs because they acknowledge the need for a universal framework—for rich and poor countries alike—and the need to look at inequalities within and between countries; and they also connect issues of SRHR with gender equality (and gender-based violence) and other pillars of development. For example, in the SDG framework, Target 3.7 ("universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs") is interdependent with "rights" under Target 5.6 ("universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences").[22] Yet abortion did not make it to the indicators that will be used to measure achievements on these targets, and thus will likely fall through the proverbial cracks.

Further, it is clear from the diverse papers in this collection that achieving abortion access requires challenging not just ideological views of women as instruments of reproduction and caretakers of children but also views of women as anything less than full human beings with equal dignity and rights. It also requires subverting neoliberal fundamentalisms that increasingly control our collective imaginations.

The maintenance of the neoliberal status quo at the national and international levels is not compatible with a global system that recognizes and guarantees the effective enjoyment of substantive equality and social rights, including sexual and reproductive health rights. Market values influence all spheres of life in neoliberal economies, including how health systems are constructed and the very concept of health as a consumer good as opposed to a right or a tool for building a life of dignity. Liiri Oja's research on Estonia discusses how although Estonia has a "good abortion law" that guarantees women timely and safe access to abortion, it is grounded in neoliberalism and therefore "important pillars supporting a steadfast reproductive rights protection remain missing," particularly a "meaningful commitment to women's reproductive rights and gender equality that protects women from shaming, micro-aggressions, and harmful stereotypes." Baird's paper on Australia exposes how the neoliberal environment characterizing the private supply of abortions in Australia explains the important subnational variations in access. Baird writes:

> *In the current neoliberal policy environment and in the context of continuing moral conservatism in Australia, [equitable access to abortion services] will only happen [when public health departments take responsibility and] under pressure of ongoing activism—and even then there are no guarantees.*

Without effective regulation or public health care supply, the market delivers the illusion of freedom—the freedom of the consumer—while creating a reality of exclusion and degradation.

A number of the contributions in this special

issue demonstrate the dangers of neoliberalism's hegemonic grasp on development paradigms and social policies, which has had and will likely continue to have a disproportionately dramatic effect on women, who do not have the same access to education or paid work as men, and who depend on public health systems to a much greater extent. Further, the deep linkages between neoliberalism and the very plutocrats and nationalists that cynically decry it are related to other ideological and biomedical fundamentalisms that regulate women's bodies. It is women who invariably experience the greatest marginalizing effects of neoliberalism, as well as the religious ideologies and biomedical hierarchies. The three tend to overlap when women are in contact with the health system due to socially constructed roles as caretakers, as well as their sexual and reproductive needs. Advocacy to emancipate women from one fundamentalism should draw links to others as well.

Concluding reflections

The most fundamental dilemma in promoting SRHR has been the tension between the need to protect women against violence (whether in the home or in war and crisis settings) and the need to empower them as autonomous agents with rights. The creation of binding norms and standards in SRHR is the product of years of work that recognizes that autonomy alone is not sufficient to guarantee substantive and material equality. Women require realization of the full spectrum of rights, including benefits to education, employment, and equal protection in addition to access to health care. Women require these freedoms and rights to be able to undertake their life projects and participate as full members of the communities and societies in which they live and to which they contribute.[23]

The infiltration of fundamentalist religious sects in representative politics around the world poses extraordinary risks to the realization of women's rights when deliberative democracy functions in ways that impede impartial discussion of issues such as abortion and emergency contraception. But the pieces in this volume suggest that women face multiple fundamentalisms—which are connected. The fundamentalist religiosity is often allied with conservative nationalism that denies scientific truth. At the same time, neoliberalism commodifies women's bodies, as well as access to care, in increasingly marketized societies. Indeed, the "de-defining" of the public and private realms—where women and girls voluntarily commodify themselves on social media spaces that are widely viewed but privately owned—and its impacts on women's sexual and reproductive rights call for greater understanding.

Notwithstanding the progress that has been made, the issue of abortion may indicate most dramatically how deeply rooted and normalized patriarchy remains in our institutions and in our collective psychology. The autonomy to exercise control over our bodies—to have sexual relations when and with whom we want, without having to procreate—evokes discourses of uncontrolled selfishness and immoral hedonism about women.[24] Until all women—poor and rich, disabled and able-bodied, young and old, of all classes, races, and ethnicities, and of all gender expressions and sexual orientations—are understood to have rights to sexual pleasure, which men take for granted, we will always be fighting defensively against restrictions that regulate our bodies, our desires, and in many cases our lives.

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Abstract

The aim of this paper is to provide a panoramic view of laws and policies on abortion around the world, giving a range of country-based examples. It shows that the plethora of convoluted laws and restrictions surrounding abortion do not make any legal or public health sense. What makes abortion safe is simple and irrefutable—when it is available on the woman's request and is universally affordable and accessible. From this perspective, few existing laws are fit for purpose. However, the road to law reform is long and difficult. In order to achieve the right to safe abortion, advocates will need to study the political, health system, legal, juridical, and socio-cultural realities surrounding existing law and policy in their countries, and decide what kind of law they want (if any). The biggest challenge is to determine what is possible to achieve, build a critical mass of support, and work together with legal experts, parliamentarians, health professionals, and women themselves to change the law—so that everyone with an unwanted pregnancy who seeks an abortion can have it, as early as possible and as late as necessary.

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Toward a definition of decriminalization of abortion

In simple terms, the decriminalization of abortion means removing specific criminal sanctions against abortion from the law, and changing the law and related policies and regulations to achieve the following:

- not punishing anyone for providing safe abortion,
- not punishing anyone for having an abortion,
- not involving the police in investigating or prosecuting safe abortion provision or practice,
- not involving the courts in deciding whether to allow an abortion, and
- treating abortion like every other form of health care—that is, using best practice in service delivery, the training of providers, and the development and application of evidence-based guidelines, and applying existing law to deal with any dangerous or negligent practices.

Some history

Abortion was legally restricted in almost every country by the end of the nineteenth century. The most important sources of such laws were the imperial countries of Europe—Britain, France, Portugal, Spain, and Italy—who imposed their own laws forbidding abortion on their colonies.

According to the United Nations Population Division's comprehensive website on abortion laws, legal systems under which abortion is legally restricted fall into three main categories, developed mostly during the period of colonialism from the sixteenth century onward:

- common law: the UK and most of its former colonies—Australia, Bangladesh, Canada, India, Ireland, Malaysia, New Zealand, Pakistan, Singapore, the United States, and the Anglophone countries of Africa, the Caribbean, and Oceania;
- civil law: most of the rest of Europe, including Belgium, France, Portugal, Spain, and their former colonies, Turkey and Japan, most of Latin America, non-Anglophone sub-Saharan Africa, and the former Soviet republics of Central and Western Asia. In addition, the laws of several North African and Middle Eastern countries have been influenced by French civil law; and
- Islamic law: the countries of North Africa and Western Asia and others with predominantly Muslim populations, and having an influence on personal law, for example, Bangladesh, Indonesia, Malaysia, and Pakistan.[1]

Historically, restrictions on abortion were introduced for three main reasons:

1. Abortion was dangerous and abortionists were killing a lot of women. Hence, the laws had a public health intention to protect women—who nevertheless sought abortions and risked their lives in doing so, as they still do today if they have no other choice.
2. Abortion was considered a sin or a form of transgression of morality, and the laws were intended to punish and act as a deterrent.
3. Abortion was restricted to protect fetal life in some or all circumstances.

Since abortion methods have become safe, laws against abortion make sense only for punitive and deterrent purposes, or to protect fetal life over that of women's lives. While some prosecutions for unsafe abortions that cause injury or death still take place, far more often existing laws are being used against those having and providing safe abortions outside the law today. Ironically, it is restrictive abortion laws—leftovers from another age—that are responsible for the deaths and millions of injuries to women who cannot afford to pay for a safe illegal abortion.

This paper provides a panoramic view of current laws and policies on abortion in order to show that, from a global perspective, few of these laws makes any legal or public health sense. The fact is that the more restrictive the law, the more it is flouted, within and across borders. Whatever has

led to the current impasse in law reform for women's benefit—whether it is called stigma, misogyny, religion, morality, or political cowardice—few, if any, existing laws on abortion are fit for purpose.

Efforts to reform abortion law and practice since 1900

The first country to reform its abortion law was the Soviet Union, spurred by feminist Alexandra Kollantai, through a decree on women's health care in October 1920.[2] Since then, progressive abortion law reform (the kind that benefits women) has been justified on public health and human rights grounds, to promote smaller families for population and environmental reasons, and because women's education and improved socioeconomic status have created alternatives to childbearing. Perhaps most importantly, controlling fertility has become both technically feasible and acceptable in almost all cultures today. Yet despite 100 years of campaigning for safe abortion, the use of contraception has been completely decriminalized while abortion has not.

Abortion is one of the safest medical procedures if done following the World Health Organization's (WHO) guidance.[3] But it is also the cause of at least one in six maternal deaths from complications when it is unsafe.[4] In 2004, research by WHO based on estimates and data from all countries showed that the broader the legal grounds for abortion, the fewer deaths there are from unsafe abortions.[5] In fact, the research found that there are only six main grounds for allowing abortion apply in most countries:

- ground 1 – risk to life
- ground 2 – rape or sexual abuse
- ground 3 – serious fetal anomaly
- ground 4 – risk to physical and sometimes mental health
- ground 5 – social and economic reasons
- ground 6 – on request

With each additional ground, moving from ground 1 to 6, the findings show that the number of deaths falls. Countries with almost no deaths from unsafe abortion are those that allow abortion on request without restriction.

This is proof that that the best way to consign unsafe abortion to history is by removing all legal restrictions and providing universal access to safe abortion. But the question remains, how do we get from where things are now to where they could (and should) be?

Attempts to move from almost total criminalization to partial (let alone total) decriminalization of abortion have been slow and fraught with difficulties. Why? Because the best way to control women's lives is through (the risk of) pregnancy. The traditional belief that women should accept "all the children God gives," the recent glorification of the fetus as having more value than the woman it is dependent on, and male-dominated culture are all used extremely effectively to justify criminal restrictions. Nevertheless, the need for abortion is one of the defining experiences of having a uterus.

Globally, 25% of pregnancies ended in induced abortion in 2010–2014, including in countries with high rates of contraceptive prevalence.[6] Increasingly, thanks to years of effective campaigning, more and more women are defending the need for abortion, as well as the *right* to a safe abortion—and access to it if and when they need it. Moreover, a growing number of governments, in both the Global North and more recently the Global South, have begun to acknowledge that preventing unsafe abortions is part of their commitment to reducing avoidable maternal deaths and their obligations under international human rights law.

While some people still wish that this could be achieved through a higher prevalence of contraceptive use or post-abortion care alone, the facts are against it. Those facts include both the occurrence of contraceptive failure among those who do use a method and the failure to use contraception, both of which are common events and sexual behaviors.

The role of international human rights bodies in calling for law reform

A new layer of involvement in advocacy for safe

abortion, based on an analysis of how existing laws affect women and girls and whether they meet international human rights standards, has emerged in recent years. United Nations human rights bodies—including the Human Rights Committee, the Committee on the Elimination of Discrimination against Women, the Committee on Economic, Social and Political Rights, the Working Group on discrimination against women in law and practice, and the Special Rapporteurs on the right to the highest attainable standard of health, the rights of women in Africa, and torture—have played an increasingly visible role in calling for progressive abortion law reform.[7]

Regional bodies such as the Inter-American Court of Human Rights, the European Court of Human Rights, and the African Commission on Human and Peoples' Rights (ACHPR) have been very active in this regard as well. The ACHPR called in January 2016 for the decriminalization of abortion across Africa, in line with the Maputo Protocol, and renewed that call in January 2017, making waves across the region.[8]

Legalize or decriminalize: What's in a word?

Interestingly, no human rights body has gone so far as to call for abortion to be permitted at the request of the woman, yet many have called for abortion to be decriminalized. This raises the question of what is understood in different quarters by the term "decriminalization."

For many years, the abortion rights movement internationally has called for "safe, legal abortion." More recently, calls for the "decriminalization of abortion" have also emerged. Do these mean the same thing? In simplistic terms, they might be differentiated like this: legalizing abortion means keeping abortion in the law in some form by identifying the grounds on which it is allowed, while decriminalizing abortion means removing criminal sanctions against abortion altogether.

In that sense, abortion is legal on one or more grounds (mostly as exceptions to the law) in all but a few countries today, while Canada stands out as the only country to date that, through a Supreme Court decision in 1988, effectively decriminalized abortion altogether.[9] No other country, no matter how liberal its law reform, has been willing to take abortion completely out of the law that delimits it.

However, this distinction is often not what is meant. Instead, the two terms are used interchangeably—that is, abortion may be legalized *or* decriminalized on some *or* all grounds. No one is likely to be able to change this lack of differentiation in terminology. Nevertheless, it is crucial when recommending abortion law reform to be clear what exactly is and is not intended. I will come back to this later in the paper, after exploring the complexity of the changes being called for, no matter which of the two terms is used.

The law on abortion in countries today

Criminal restrictions on the practice of abortion are contained in statute law—in other words, laws passed by legislatures, sometimes as part of criminal or penal codes, which consolidate a group of criminal statutes. In the UK, for example, abortion was criminalized in sections 58 and 59 of the Offences against the Person Act of 1861, with one aspect further defined in the Infant Life Preservation Act of 1929, and then allowed on certain grounds and conditions in Great Britain (but not Northern Ireland) in the 1967 Abortion Act, which was then amended further in the Human Fertilisation and Embryology Act of 1990. In the 1967 Abortion Act, legal grounds for abortion are set out as exceptions to the criminal law, yet the 1861 act is still in force and still being used to prosecute illegal abortions today.[10]

Ireland, formerly a part of the UK, was also subject to the 1861 Offences against the Person Act and revoked sections 58–59 only in the Protection of Life during Pregnancy Act of 2013, which imposed its own almost total criminalization of abortion.[11] Sierra Leone, a former British colony, also revoked the 1861 Offences against the Person Act in the Safe Abortion Act, passed in December 2015 and again a second time unanimously in February 2016. That act allows abortion on request during the first 12 weeks of pregnancy, and until week 24 in cases of rape,

incest, or risk to health of the fetus or the woman or girl, but it was not finally signed into law.[12]

At the end of the twentieth century, abortion was legally permitted to save the life of the woman in 98% of the world's countries.[13] The proportion of countries allowing abortion on other grounds was as follows: to preserve the woman's physical health (63%); to preserve the woman's mental health (62%); in case of rape, sexual abuse, or incest (43%); fetal anomaly or impairment (39%); economic or social reasons (33%); and on request (27%).

The number of countries in 2002 that permitted each of these grounds varied greatly by region. Thus, abortion was permitted upon request in 65% of developed countries but only 14% of developing countries, and for economic and social reasons in 75% of developed countries but only 19% of developing countries.[14] Some countries permit additional grounds for abortion, such as if the woman has HIV, is under the age of 16 or over the age of 40, is not married, or has many children. A few also allow it to protect existing children or because of contraceptive failure.[15]

These percentages, published in 2002, are out of date, but they have not changed dramatically. In late 2017, research updating the world's laws on abortion and adding new information about related policies, conducted under the aegis of the Department of Reproductive Health and Research/Human Reproductive Programme at WHO, will be incorporated into the United Nations Population Division's website.[16]

Regulating abortion

There is much more to this story, however. In addition to statute law, other ways to liberalize, restrict, or regulate access to abortion, which also have legal standing, include the following:

- national constitutions in at least 20 countries, such as the Eighth Amendment to the Constitution (1983) in Ireland;
- supreme court decisions, such as in the United States (1973, 2016), Canada (1988), Colombia (2006), and Brazil (2012), as well as higher court decisions, such as in India (2016, 2017) allowing individual women abortions beyond the 20-week upper limit;
- customary or religious law, such as interpretations of Muslim law that allow abortion up to 120 days in Tunisia and the United Arab Emirates but do not allow abortion at all in other majority Muslim countries;
- regulations that require confidentiality on the part of health professionals on the one hand, but on the other hand require health professionals to report a criminal act they may learn of, for example, while providing treatment for complications of unsafe abortion;
- medical ethical codes, which, for example, allow or disallow conscientious objection; and
- clinical and other regulatory standards and guidelines governing the provision of abortion, such as reporting guidelines, disciplinary procedures, parental or spousal consent, and restrictions on which health professionals may provide abortions and where, who may approve an abortion, and which methods may be used—as adjuncts to (though not always formally part of) the law.

Reed Boland has found that the distinction between laws and regulations governing abortion is not always clear and that some countries, usually those where abortion laws are highly restrictive, have issued no regulations at all. In the most complex cases, there are multiple texts over many years which may contain conflicting provisions and obscure and outdated language. The upshot may be that no one is sure when abortion is actually allowed and when it isn't, which may serve to stop it being provided safely and openly at all.[17]

Uganda is a case in point. According to a recently published paper by Amanda Cleeve et al., Uganda's Constitution and Penal Code conflict with each other, leading to ambiguous interpretations and lack of awareness of the fact that abortion *is* legal to protect women's health and life. Moreover, while Uganda has a national reproductive health policy, it is not supported in law and is not

being implemented. In 2015, in order to clarify this situation, the minister of health and other stakeholders developed *Standards and Evidence-based Guidelines on the Prevention of Unsafe Abortion*. These included details of who can provide abortions, and where and how, and assigned health service responsibilities, such as level of care and post-abortion care. However, the guidelines were withdrawn in January 2016 due to religious and political opposition.[18]

Post-abortion care to treat the consequences of unsafe abortions has been instituted since it was approved in the International Conference on Population and Development's Programme of Action in 1994, in countries where there was little or no prospect of law reform, as a stopgap measure, to save lives. But this has not been a success in African countries such as Tanzania, where, under the 1981 Revised Penal Code, it remains unclear whether abortion is legal to preserve a woman's physical or mental health or her life, and where 16% of maternal deaths are still due to unsafe abortions.[19] Although the government has tried to expand the availability of post-abortion care, a 2015 study found that "significant gaps still existed and most women were not receiving the care they needed."[20] In early 2016, according to a CCTV-Africa report, the newly appointed prime minister, in tandem with the president, threatened to dismiss and possibly imprison doctors performing illegal abortions following recent reports of doctors in both public and private hospitals accepting payments for doing abortions and a reported increase in cases of complications.[21]

Sometimes, other laws unrelated to abortion create barriers. In Morocco, the abortion law was established in 1920 when Morocco was a French protectorate. In May 2015, following a public debate arising from reports of women's deaths from unsafe abortion, a reform process to expand legal protections was initiated by a directive of the king. According to the Moroccan Family Planning Association, despite a consensus that abortion should be permitted within the first three months if the woman's physical and mental health is in danger, and in cases of rape, incest, or congenital malformation, unmarried women would be excluded because it is illegal to have sex outside marriage.[22]

In India, a very liberal abortion law for its day was passed in 1971, but it has been poorly and unevenly implemented, such that high rates of morbidity and mortality persist to this day.[23] Even 15 years ago, the process for clinic registration as an approved abortion provider was arduous, limiting the number of clinics.[24] Moreover, two other laws have led to restrictions on abortion access: the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, which forbids ultrasound for purposes of sex determination and has led to restrictions on all second-trimester abortion provision, and the Protection of Children from Sexual Offences Act, which requires reporting of underage sex, so that minors who become pregnant cannot feel safe if they seek an abortion.[25]

Restricting abortion without changing the law

Decent laws and policies can be sabotaged and access to abortion can be restricted without amending the law itself, but instead through policies pressuring women to have more children, public denunciation of abortion by political and religious leaders, or restricting access to services. Bureaucratic obstacles may be placed in women's paths, such as requiring unnecessary medical tests, counselling even if women feel no need for it, having to get one or more doctors' signatures, having to wait between making an appointment and having an abortion, or having to obtain consent from a partner, parent(s) or guardian, or even a judge.

In Turkey, for example, in 1983, in response to population growth, the government passed a law allowing fertility regulation, termination of pregnancy on request up to 10 weeks after conception, and sterilization. A married woman seeking an abortion was required only to obtain her husband's permission or submit a formal statement of assumption of all responsibility prior to the procedure.[26] In recent years, however, President Erdogan has taken a pronatalist stance and urged Turkish couples to have at least three children. Since 2012, he has been calling abortion murder, expressing opposition to

the provision of abortion services and threatening to restrict the law. Women protested against these threats in such large numbers in 2012 that to date there have been no changes to the law itself. But administrative changes were made in order to make the procedure for booking an appointment for an abortion—which is still primarily provided by gynecologists in hospitals—more difficult.

These changes have made it nearly impossible to obtain an abortion in a state hospital; indeed, some state hospitals have stopped providing abortions altogether. Although comparative data are not available, a 2016 study found that of 431 state hospitals with departments of obstetrics and gynecology, only 7.8% provided abortions without restriction as to reason, 78% provided abortions only if there was a medical necessity, and 11.8% did not provide abortions at all. Of the 58 teaching and research hospitals with departments of obstetrics and gynecology, only 17.3% provided abortion services without restriction as to reason, 71.1% only if there was a medical necessity, and 11.4% not at all. Overall, 53 of 81 provinces in Turkey did not have a state hospital that provided abortions without restriction as to reason, although this is permitted under the law.[27]

Thus, the availability of safe abortion depends not only on permissive legislation but also on a permissive environment, political support, and the ability and willingness of health services and health professionals to make abortion available. In contrast to Turkey, Ethiopia is an example of the success of that support.

Law reform for the better—slowly but surely

In 2005, Ethiopia liberalized its abortion law. Previously, abortion was allowed only to save the life of the woman or protect her physical health. The current law allows abortion in cases of rape, incest, or fetal impairment, as well as if the life or physical health of the woman is in danger, if she has a physical or mental disability, or if she is a minor who is physically or mentally unprepared for childbirth.[28] This is a liberal law for sub-Saharan Africa, but for a long time, little was known about the extent of its implementation. In 2006, the government published national standards and guidelines on safe abortion that permitted the use of misoprostol, with or without mifepristone, in accordance with WHO guidance. A nationwide study in 2008 by the Guttmacher Institute estimated that within a few years, 27% of abortions were legal, though most abortions were still unsafe.

A 2011 study by Jemila Abdi and Mulugeta Gebremariam found that Ethiopian health care providers' reasons for not providing abortions were mainly personal or due to lack of permission from an employer or the unavailability of services at their facility. Only 27% felt comfortable working at a site where abortion was provided. Reasons for not being comfortable were mainly religious, but also included personal values and a lack of training. Although 29% thought it should be a woman's choice to have an abortion, 55% disagreed. The study also uncovered a lack of medical equipment and trained personnel, and bureaucratic problems at clinical sites.[29]

Even so, major efforts were and are still being made to improve access at the primary level by constructing more health centers and training more mid-level providers. Between 2008 and 2014, the proportion of abortions provided in health facilities almost doubled. In 2014, almost three-fourths of facilities that could potentially provide abortions or post-abortion care did so, including 67% of the 2,600 public health centers nationwide, 80% of the 1,300 private or nongovernmental facilities, and 98% of the 120 public hospitals. The proportion of all abortion-related services provided by mid-level health workers increased from 48% in 2008 to 83% in 2014. While a substantial number of abortions continue to occur outside of health facilities, the proportion is falling, showing that change is possible but also that it takes time.[30]

In recent decades in Latin America, a combination of legal reforms, court rulings, and public health guidelines have improved access to safe abortion for women.[31] These include allowing abortion on request in the first trimester of pregnancy, as in Mexico City (since 2007), and in Uruguay (since 2012). In Argentina, Bolivia, Brazil, Colombia, and

Costa Rica, higher courts have been instrumental in interpreting the constitutionality and scope of specific grounds for abortion, though their judgments are not always implemented. In countries such as Peru, guidelines issued by hospitals or by governments at federal or state levels govern the enforcement of permitted grounds.[32] Additional steps needed constitute a huge task, as Ethiopia has shown—training providers and ensuring that services provide legal abortions, as well as informing women that these changes are taking place and that services are available.

Self-use of medical abortion in the absence of law and policy reform

In other Latin American countries, abortion laws have remained highly restrictive in spite of campaigns for women's sexual and reproductive rights and human rights for more than 30 years. As a result, and thanks to the advent of new technology, women have begun to take matters into their own hands. An uncounted number of women, probably in the millions, has been obtaining and using misoprostol to self-induce abortion (widely available for gastric ulcers) from a range of sources—pharmacies, websites, black market—since its abortifacient effectiveness was first discovered in the late 1980s. This practice, begun in Brazil, has spread to many other countries and regions. In response, legal restrictions and regulations on access to medical abortion pills have been imposed by countries such as Brazil and Egypt in an effort to stop the unstoppable.

Moreover, in the past decade, feminist groups have set up safe abortion information hotlines in at least 20 countries, and health professionals are providing information and access to abortion pills via telemedicine, including Women Help Women, Women on Web, safe2choose, the Tabbot Foundation in Australia, and TelAbortion in the United States.[33]

In Uruguay, which has hospital-based outpatient abortion care, Lilian Abracinskas, executive director of Mujer y Salud en Uruguay, said in a recent interview, "*In Uruguay, we don't have doctors who do abortions. Abortion with pills is the only way and it isn't possible to choose another method, such as manual vacuum aspiration. Health professionals are willing to be involved before and after, but not in the abortion.*"[34] Thus, abortion service delivery has been reduced to providing information, prescribing pills, and conducting a follow-up appointment if the woman has concerns. It can be that simple (although it does restrict access to aspiration and surgical methods).

Abortion law as a political football and a weapon against women

While the overall trend globally is toward more progressive laws, some countries where the right-wing has taken power have gone backward. In Chile, from 1931 to 1989, the law allowed abortion on therapeutic grounds, described in the Penal Code as "termination of a pregnancy before the fetus becomes viable for the purpose of saving the mother's life or safeguarding her health." Pinochet, the dictator who overthrew the Allende government, banned abortion in 1989 as he left office, leaving no legal grounds at all.[35] It took until 2016 for Michelle Bachelet's government, during her second term in office, to introduce a bill permitting three grounds for legal abortion—to save the woman's life, in cases of rape or sexual abuse, and in cases of fatal fetal anomaly—which are more narrow than what was in place between 1931 and 1989 but are the best that its supporters think they can achieve today.[36]

In Russia, the law has gone back and forth between permissive and restrictive with every change of political head of state. Stalin made abortion illegal when he took over from Lenin, and then after 1945, abortion was again permitted on broad grounds across the Soviet Union and in its satellite countries in Eastern Europe and West Asia, while under Vladimir Putin a long list of restrictions has been imposed, greatly reducing the number of grounds on which abortion is permitted. In January 2016, a bill aiming to "rule out the uncontrolled use of pharmaceutical drugs destined for termination of pregnancy" was tabled in parliament. It would have banned retail sales and limited the list of organizations permitted to buy medical abortion pills wholesale. It would also have banned abor-

tions in private clinics and removed payment for them from state insurance policies. And it would not have allowed abortions to be covered by state health care unless the pregnancy threatened the woman's life. The bill was withdrawn after strong public protest that was coordinated by the Russian Association for Population and Development; however, attempts at further restriction are likely to continue.[37]

In a number of Central and Eastern European countries, the backlash against communist rule and the increasing influence of conservative religious figures has led to regular attempts to undermine permissive abortion laws. Poland has had the worst of it. In 1993, a liberal law was replaced by a very restrictive law that removed "difficult living conditions" as a legal ground for abortion, leaving only three grounds: serious threat to the life or health of the pregnant woman, as attested by two physicians; cases of rape or incest if confirmed by a prosecutor; and cases in which antenatal tests, confirmed by two physicians, demonstrated that the fetus was seriously and irreversibly damaged.[38] This law, in spite of an attempt to ban all abortions in 2016, remains in place due to months of national action by women's groups, including a national women's strike on October 3, 2016. However, in November 2016, the government approved a regulation offering pregnant women carrying a seriously disabled or unviable fetus a one-time payment of €1,000 to carry the pregnancy to term, even if the baby would be born dead or die soon after delivery. The package includes access to hospice and medical care, psychological counselling, baptism or a blessing and burial, and a person who will act as an "assistant to the family" and coordinate the support. The purported aim was to reduce the number of legal abortions on grounds of fetal anomaly.[39] This horrendous proposal, nasty anti-abortion propaganda, and systematic pressure on hospitals in Poland to stop doing abortions on medical grounds exemplify the right-wing extremism of the anti-abortion movement today, whose epicenter is in the United States and whose war on women sometimes feels relentless.[40]

But this is not stopping women from having abortions.

Keeping laws and policies that benefit women in clear sight

Cuba was the first country in Latin America and the Caribbean to reform its abortion law in favor of women, with a law that remains unique. Since 1965, abortion has been available on request up to the tenth week of pregnancy through the national health system. The Penal Code, adopted in 1979, says that an abortion is considered illegal only if it is without the consent of the pregnant woman, is unsafe, or is provided for profit.[41]

In Japan, the law allowing abortion, enacted in 1948, was initially based on eugenics but was a liberal law in practice. Under this law, abortion became the primary mode of birth control in the country. The law was reformed in 1996 to omit all references to eugenics. Abortion is now permitted to protect health, which includes socioeconomic reasons, and in cases of sexual offenses. Abortion was and remains the main form of fertility control. The great majority of abortions fall under the health protection indication. Nearly all abortions are in the first trimester.[42]

In recent years in some countries, laws to legalize abortion are found in public health statutes, court decisions, and policies and regulations on sexual and reproductive health care, rather than as part of the criminal law. Uruguay's 2012 law is an example of public health legislation that sets out procedures and health care standards for the provision of abortion services.[43]

In December 2014, the parliament of Luxembourg voted to remove abortion from the Penal Code up to 12 weeks of pregnancy and said that the woman no longer had to show she was "in distress" due to her pregnancy. Regulations on who can provide abortions were also revised.[44] In France, in 2014, 2015, and 2016, the 1975 Veil Law was reformed to increase access to abortion and reduce barriers. Women no longer have to be in a "state of distress" in France either, but need only request an abortion. The required seven-day "reflection period" between the request for an abortion and the abortion itself was also dropped. Most recently, midwives are now permitted to provide medical abortion, and the costs for all abortions are now reimbursed.[45]

Sweden's law is among the most liberal,

though abortion is not entirely decriminalized. The Swedish law was amended in 1938, 1946, 1963, 1975, 1995, 2007, and 2008. Abortion is available on request up to 18 weeks. After that, permission from the National Board of Health and Welfare is required and may not be granted if the fetus is viable. Appeal is not permitted. Regulations govern who provides abortions and where. Any person not authorized to practice medicine who performs an abortion on another person can be fined or imprisoned for up to a year. Abortion is subsidized by the government; 95% of abortions take place before 12 weeks, and almost none after 18 weeks. Most are medical abortions.[46]

In Australia, each state and the Capital Territory have a different law, ranging from very liberal to very restrictive; several are in the process of change.[47] In the United States in 1973, the Supreme Court held that criminalizing abortion violated a woman's right to privacy and said that abortion should be a decision between a woman and her doctor. However, the court also held that US states have an interest in ensuring the safety and well-being of pregnant women, as well as the potential of human life. This opened a door to restrictions that become greater as pregnancy progresses, opening a Pandora's box for states to impose restrictions that are tying up state and federal courts to this day:

- first trimester: a state cannot regulate abortion beyond requiring that the procedure be performed by a licensed doctor in medically safe conditions;
- second trimester: a state may regulate abortion if the regulations are reasonably related to the health of the pregnant woman; and
- third trimester: the state's interest in protecting the potential human life outweighs the woman's right to privacy, and the state may prohibit abortions unless abortion is necessary to save her life or health.[48]

It is impossible not to think that no law is the best law when it comes to abortion, which brings us back to Canada, where abortion has not been restricted since 1988 and is available on request with no stipulations as to who must provide it or where.[49] Although abortion is not easily accessible in remote areas, and Canada was exceedingly slow to approve mifepristone,[50] opposition to abortion has never developed a foothold. The benefits for women of having no law are crystal clear.[51]

Legalization or decriminalization: Closing the circle

Although recent calls for the decriminalization of abortion by human rights bodies, politicians, and some feminist groups aim to decriminalize only certain grounds and conditions related to abortion, these are far better than nothing. Thus, in Chile, El Salvador, Honduras, and Peru, where abortion is severely legally restricted, calls to "decriminalize abortion" include only three to four grounds—to protect the life and health of the woman, in cases of severe or fatal fetal anomalies, and as a result of rape or sexual abuse. While the great majority of abortions are not for these reasons, they are the only grounds that stand a chance of achieving majority approval through law reform in settings where "everything" is simply not in the cards.

In Africa, the Maputo Protocol is legally binding on the 49 states that have ratified it. The 2016 call by the ACHPR for the decriminalization of abortion across Africa is based on the Maputo Protocol, which calls for safe abortion to be authorized by states "in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus."[52] However, in January 2017, at the African Leaders' Summit on Safe and Legal Abortion, the ACHPR went further, calling for safe, legal abortion as a human right, which by any definition surely exceeds the Maputo Protocol's boundaries.[53]

At bottom, the extent of decriminalization aimed for is a choice between the ideal and the practicable, and reflects the extent to which abortion is seen as a bona fide form of health care—not just by advocates for the right to safe abortion but also by politicians, health professionals, the media, and the public. The fact that abortion *is* still

legally restricted in almost all countries is not just a historical legacy but indicative of the continuing ambivalence and negativity about abortion in most societies, no matter how old or where the law originally came from.

Some abortion rights supporters seem to have an underlying fear that without leaving *something* in the criminal law, "bad things" may start to happen. Canada proves this is not the case. Granted, not everywhere is Canada. But there are general criminal laws that allow the punishment of wrongdoing—such as forcing a woman to have an abortion against her will, giving her medical abortion pills without her knowledge, or causing injury or death through a dangerous procedure. These are laws against grievous bodily harm, assault, or manslaughter, which can be applied without the need for a criminal statute on abortion.

Changing the law to benefit women

Successfully changing the law on abortion is the work of years. Advocates do not get a lot of chances to change the law and need to decide what they want to end up with before campaigning for it, with the confidence that whatever they propose has a chance of being implemented. Another chance may not come again soon.

Allies are crucial. Most important are parliamentarians, health professionals, legal experts, women's groups and organizations, human rights groups, family planning supporters—and above all, women themselves. Achieving a critical mass of support among all these groups is key to successful law reform, as is defeating the opposition, which can have an influence beyond its numbers.

Those unable to contemplate no law at all must confront the fact that each legal ground for abortion may be interpreted liberally or narrowly, and thereby implemented differently in different settings, or may not be implemented at all. The challenge is to define which abortions should remain criminal and what the punishment should be. Even if only some grounds would be considered acceptable, the question of who decides and on what basis remains when reforming existing law.

Wording becomes critical to supporting good practice. For example, grounds which are based on risk are particularly tricky. The definition of "risk" is itself complex, and the extent of risk may be hedged with uncertainty. Risk to the woman's life, health, or mental health and risk of serious fetal anomaly have been subjected to challenge and disagreement among professionals. As Christian Fiala, head of the Gynmed Ambulatorium in Austria, has noted, "There is only one way to be sure a woman's life is at risk, that is—after she dies."[54]

Reed Boland explores the importance of wording in depth with regard to the health ground for abortion:

> *The wording of [the health] indication varies greatly from country to country, particularly given the range of languages and legal traditions involved. Sometimes … there must be a risk to health. Great Britain's law, for example … allows abortion where "continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman …" Sometimes … there must be a danger to health. Burkina Faso's Penal Code permits abortions when "continuation of the pregnancy … endangers the health of the woman …" And in some countries there must only be medical or health reasons. In Vanuatu, there must be "good medical reasons", in Djibouti "therapeutic reasons", and in Pakistan a requirement of "necessary treatment". These concepts are not necessarily the same.*[55]

Legislating on second-trimester abortions presents particular difficulties. Many laws say little or nothing about second-trimester abortions, which has a proscriptive effect. Second-trimester abortions constitute an estimated 10–15% of abortions globally, but as many as 25% in India and South Africa due to poor access to services. When they are unsafe, they account for a large proportion of hospital admissions for treatment of complications and are responsible for a disproportionate number of deaths. Hence, the law should protect second-trimester abortions assiduously. Yet social disapproval of these abortions can run high, and laws tend to be increasingly restrictive as pregnancy progresses, even laws that are liberal with regard to the first tri-

mester. The mistaken belief that second-trimester abortions can be legislated away persists, despite the facts.[56]

Restrictive abortion laws are being broken on a daily basis by millions of women and numerous abortion providers. Even in countries where the law is less restrictive, research shows that the letter of the law is being stretched in all sorts of ways to accommodate women's needs. Yet opposition and a stubborn unwillingness to act continue to hamper efforts to meet women's need for abortion without restrictions.

Conclusions

It should be clear that the plethora of convoluted laws and restrictions on abortion do not make any legal or public health sense. What makes abortion safe is simple and irrefutable—when it is available on the woman's request and universally affordable and accessible. From this perspective, few existing laws are fit for purpose but merely repeat every possible permutation of the self-same restrictions.

The aim of this paper was not to provide answers or roadmaps, because in every country prevailing conditions must be taken into account. The aim was to motivate transformative thinking about whether any criminal law on abortion is necessary. Treating abortion as essential health care is a major step forward, and where the national setting insists on some sort of law, advocates could draft the simplest, most supportive law possible, placing first-trimester abortion care at the primary and community level, ensuring second-trimester services, involving mid-level providers, increasing women's awareness of services and the law, aiming for universal access, integrating WHO-approved methods, and addressing social attitudes to reduce opposition. Space did not permit me to raise the issues of cost and public versus private services, but they are two major aspects that deserve priority consideration.

If it were up to me, all criminal sanctions against abortion would be revoked, making abortion available at the request of the only person who counts—the one who is pregnant. And as with all pregnancy care, abortion would be free at the point of care and universally accessible from very early on in pregnancy.

Canada has proved that no criminal law is feasible and acceptable. Sweden has proved that abortions after 18 weeks can effectively disappear with very good services, and WHO has shown that first-trimester abortions can be provided safely and effectively at the primary and community level by trained mid-level providers and provision of medical abortion pills by trained pharmacy workers. Finally, web- and phone-based telemedicine services are showing that clinic-based services are not required to provide medical abortion pills safely and effectively.

But to achieve these goals, or something close to them, it takes a strong and active national coalition, a critical mass of support, and—with luck and knowing what the goalposts are—less than 100 years of campaigning to make change happen on the ground.

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Theorizing Time in Abortion Law and Human Rights

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Abstract

The legal regulation of abortion by gestational age, or length of pregnancy, is a relatively undertheorized dimension of abortion and human rights. Yet struggles over time in abortion law, and its competing representations and meanings, are ultimately struggles over ethical and political values, authority and power, the very stakes that human rights on abortion engage. This article focuses on three struggles over time in abortion and human rights law: those related to morality, health, and justice. With respect to morality, the article concludes that collective faith and trust should be placed in the moral judgment of those most affected by the passage of time in pregnancy and by later abortion—pregnant women. With respect to health, abortion law as health regulation should be evidence-based to counter the stigma of later abortion, which leads to overregulation and access barriers. With respect to justice, in recognizing that there will always be a need for abortion services later in pregnancy, such services should be safe, legal, and accessible without hardship or risk. At the same time, justice must address the structural conditions of women's capacity to make timely decisions about abortion, and to access abortion services early in pregnancy.

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Introduction

Temporal categories such as trimesters, temporal measurements such as gestational age, and temporal concepts such as viability figure prominently in the legal regulation of abortion. Yet time is a relatively undertheorized dimension of abortion and human rights.[1] The World Health Organization's (WHO) guidance on safe abortion describes gestational limits and mandatory wait times as access barriers, and thus, human rights concerns.[2] International human rights law also generally recognizes timeliness as a component of access and imposes state obligations to protect against unnecessary administrative delays.[3] Time in abortion law, however, is a dimension of many human rights controversies beyond access. Among the most pressing is the criminal prosecution of women for abortion, often self-induced, later in pregnancy. These cases test the line between abortion and homicide, where fetal remains become key evidentiary artifacts in courts of law and public opinion.[4]

In his article on time as a dimension of medical law, John Harrington explores time as social, plural, and rhetorical.[5] All of these dimensions are relevant to time in abortion law. First, time is not a neutral referent against which pregnancy proceeds; rather, time and its passage in pregnancy is known and marked by different social practices. Time is marked by the clock or calendar, where its passage is official, uniform and linear. Time is experienced by the body, where its passage is marked in measurement and scale, perceived by hand and eye, but also sensed in movement, pain, and pressure.[6] Time is also experienced in the mind, more subjective and qualitative in its experience. Most women view their pregnancy differently as it progresses, those who want their pregnancies and those who wish to end them. Ann Furedi of the British Pregnancy Advisory Service notes that the language used by women to describe their pregnancy changes with time: "They start by saying they have missed a period, they then say they are pregnant, then that they are going to have a baby."[7]

Second, time in abortion is plural because these social practices of telling time are specific to different contexts, used in different ways and to different ends. In a medical context, the calendar sets routine prenatal clinic visits, each carrying the potential to frustrate best-laid plans with a diagnosis of a health risk or fetal anomaly. In a cultural context, the calendar may separate an act of responsible family planning, contraception, from an immoral selfish act, abortion. In a religious context, the calendar can mark the moment of ensoulment, the possession of a soul believed to confer the status of personhood with full moral rights.[8] While in a legal context, the calendar may decide who will receive safe and lawful care, and who must survive exploitation or abandonment. Abortion law captures and holds these diverse temporalities because abortion itself is a boundary object, shared across multiple social worlds, and assuming different meaning in each of these worlds.[9] Abortion is a resource and a stake in struggles of religion, crime, politics, health, freedom, equality, and power.[10] This makes time, in Harrington's third dimension, also rhetorical. The struggles over time in abortion law, its competing representations and meanings, are ultimately struggles over ethical and political values, authority and power—the very stakes that human rights on abortion engage.

This article focuses on three struggles over time in abortion and human rights law: struggles in morality, health, and justice. The article focuses on the passage of time in pregnancy and thus legal regulation by gestational age. It offers a more complex understanding of what these struggles over time mean for morality, health, and justice, which underlie human rights protections in abortion law and policy.

In morality, the article emphasizes that while international human rights law accepts the protection of morals as a legitimate aim of abortion law sufficient to set some limits on access, it requires that those limits be transparent, rational, and proportionate. Human rights law does not accept the claim that moral ends justify all means of restriction. Absolute moral positions are rejected in favor of regulatory approaches that evidence a respect for competing moral values, women's rights, and freedoms among them. In the end, there is a human rights argument that collective faith and trust

should be placed in the moral judgment of those most affected by later abortion—pregnant women.

In health, the article explores how international human rights law sets standards of legitimacy for abortion law as health regulation, welcoming gestational limits to the extent they are necessary to ensure safe and quality abortion services as a health intervention. Human rights thus call for abortion laws to be evidence-based to counter the stigma of later abortion, which leads to over-regulation and access barriers, but can also shape informed consent practices in harmful ways, denying women's rights to make free and informed decisions and to have those decisions respected.

In justice, the article recognizes that there will always be a need for abortion services later in pregnancy, and thus international human rights law must specifically require states to ensure such services are safe and lawful if women are to survive pregnancy. This requires safe and supportive environments for providers of later abortion care, as well as structural conditions for women to make timely decisions about abortion, and to access desperately needed services without devastating hardship and risk.

While the article draws heavily on abortion law and practice in the Global North, periodic models of regulation that allow abortion on request early in pregnancy continue to be introduced into liberalizing contexts in the Global South, at the same as new restrictions are proposed and debated for abortion later in pregnancy. The human rights struggles of time in abortion law may thus reveal some universal character, or may alternatively find unique expression in diverse contexts.

The temporality of morality in abortion, law, and human rights

One of the complexities of abortion law is that it often serves and is justified by multiple objectives, including the protection of women's health and rights, but also, protection of prenatal life.[11] The latter objective may be informed by religious or secular ideas, and prenatal life may be protected as an independent right or a state interest against the general denigration of human life.[12] The law labels the destruction of an embryo and/or fetus an ethically or morally significant act, which gives reason to regulate abortion as something more than a personal decision or medical procedure, but as a social act. It is for this reason that abortion remains regulated in many states under penal or criminal law, often classified as a moral offense. International human rights law does not contest this objective of abortion law, but rather acknowledges that abortion laws may serve a legitimate aim in the protection of morals, of which the right to life of the unborn or the sanctity of life as a public interest may be an aspect.[13]

The ethical dilemmas of abortion are most pronounced, philosophically and publicly, later in pregnancy. Yet these ethical stakes also figure at the start of pregnancy, especially in the endeavored categorical distinction between contraception and abortion, and its moral undertones in advocacy for expanded access to emergency contraception but also medical abortion.[14] Many women themselves regard or experience abortion early in pregnancy as a categorically different act. For example, they may prefer early medical abortion precisely because they can "normalize" it as an act of menstrual regulation rather than a "real" abortion.[15] To terminate a pregnancy when there is a high risk of miscarriage, when there is an embryo rather than a fetus, or when one does not feel or look pregnant may help a woman distance herself ethically from abortion: a moral comfort in acting before the clock starts.

Many abortion laws, largely in their judicial interpretation, reject the idea of conception as the ethically decisive moment in pregnancy, but nonetheless commit to some stage of gestation when prenatal life attains a status that is ethically significant enough to limit the freedom of women in pregnancy. Later abortion, for example, has long troubled the distinctions between crimes of abortion, child destruction (willfully causing the death of a child capable of being born alive), and homicide.[16] In ethics and morality, if not in law, late or later abortion, a colloquial term applied to abortion in a seemingly widening span of gestational age, "straddles … [a] no-man's land between abortion and murder."[17]

Temporal restrictions on access to abortion negotiate this uncertain terrain. The trimester framework, as enunciated by the U.S. Supreme Court in *Roe v. Wade* and widely adopted transnationally, is premised on a growing countervailing state interest in prenatal life, insufficient in the first trimester to govern the legal treatment of abortion (weeks 1 to 12), but controlling by the third semester (weeks 29 to 40).[18] Temporal restrictions are common, even dominant, in abortion laws worldwide. Even when not explicitly written into the law, gestational restrictions may be set at the policy or implementation level. Zambia has one of the most liberal abortion laws in Sub-Saharan Africa, for example, with no explicit reference to gestational limitations, yet a Ministry of Health regulation limits legal authorization for abortion to viability, set at 28 weeks.[19] In periodic models of regulation, abortion is often allowed on request, often until the 12th to 14th week and sometimes further into the second trimester. Time or gestational age, however, is rarely the sole determinant of access. More often, time limitations are combined with indications.[20] In the first trimester, for example, abortion may be available on request or on socio-economic grounds. It may be permitted later in pregnancy or with no time limits in cases of risk to the woman's life or health; when pregnancy results from a sexual or other crime; and in cases of fetal impairment. Even laws with only indications-based access set time limits on their application. In 2015, for example, the High Court of Northern Ireland declared that human rights law requires lawful abortion in cases where pregnancy results from sexual crime.[21] The Court qualified the ruling, however, with a time limitation. Once a pregnancy is viable, the Court explained, "There is a sufficient counterweight in the protection of unborn life … such that the prohibition can no longer be claimed disproportionate."[22] The Supreme Court in India, by contrast, ruled to extend a formal 20-week time limit in the abortion law in a morally compelling case involving a minor survivor of sexual violence.[23] Since the Supreme Court handed down this decision, High Courts have authorized termination post-20 weeks in these narrow circumstances, yet they have also requested expert medical opinion on the safety of or need for termination, leading to additional delay and denied access.[24]

Proportionality is the logic of most contemporary abortion laws, but also the logic of many human rights challenges to and justifications for these laws.[25] Absolute positions are rejected in light of competing values and interests, and abortion laws assume the task of calibrating, mediating, and ultimately balancing these interests. This balance is achieved through a combination of weighting by time and reason: the interest in prenatal life grows weightier with time, while the rights and interests of women in life, health, autonomy, and equality are each assigned a different moral weight in the balance.

The problem in such balancing is calibration. Rarely do abortion laws spell out how gestational age is to be measured, or what relative weight is to be assigned to different values under the law. There is great variation, for example, in how gestational age is measured: from conception or last menstrual period (LMP), by calendar or developmental age, by uterine size.[26] There are algorithms that account for menstrual regularity, the race or age of the pregnant woman, and whether this is her first or a subsequent pregnancy. Then there is the question of measurement, and by what means: ultrasound imaging, physical exam, or a woman's recollection of her LMP. Measurements of gestational age are at best professional estimates, and are routinely off by one or two weeks, especially later in pregnancy. This means the law ultimately leaves measurement to the discretion of individual physicians, resulting in great variations in access.

Gestational age, in other words, proves an arbitrary means of regulating access to abortion and thereby runs afoul of human rights protection against arbitrary laws. This arbitrariness is an entirely predictable outcome of boundary crossing in abortion law: the repurposing of clinical practices to serve as moral regulation. Boundary crossing is common in abortion law, where concepts originating in social spheres beyond law, most often medicine, are incorporated into law and its argumentation.[27]

Such boundary crossing, however, presents

significant problems for women's access to care and for the legitimacy of the law in regulating access, insofar as it masks moral judgment in medical discretion. Rather than eliminate the moral and ethical questions of later abortion, the law reassigns them to physicians in the guise of professional judgment. Under the British abortion law, for example, the therapeutic indication carries a 24-week limitation, but in practice, access becomes more difficult in the weeks approaching this limitation, especially after 20 weeks. This is because physicians set their own conditions on the rule, which merely allows abortion until the 24th week, but does not require its availability.[28] In practice, physicians assess, question, and decline requests in later weeks of pregnancy on any number and variety of considerations.[29] It is a subjective calculus. Although abortion is legal, it may be available only for women with a fetal diagnosis and not those without medical reason, unless the women are severely marginalized by age or financial constraint. A thousand biases are bundled into individual assessments, and access is a negotiated exercise of discretion.[30]

Partly in answer to this arbitrariness, the moral significance of gestational age is increasingly grounded in a more objective, evidence-based practice. This is not an entirely new convention. In the 19th century common law, abortion was discouraged after quickening (fetal movement), which was taken as empirical evidence of fetal life. Today, prenatal life is also defined and measured empirically, and anchored scientifically. The favored though not exclusive marker is viability, defined as the point at which the fetus is capable of sustained life outside the uterus, with or without artificial aid. With neonatal technological advances, viability has now entered the second trimester. Viability again presents a blurring of boundaries, where the ethical or moral significance of abortion is derived from scientific or medical knowledge and then encoded into law.[31] In 1990, for example, Britain reformed its abortion law to introduce a lower 24-week limit on viability on the basis of what was described as scientific medical grounds, a limit reassessed but ultimately maintained in 2007 by recommendation of a Parliamentary Science and Technology Committee.[32] Even short of viability, scientific-medical practices in the visualization of embryonic and fetal development, and the detection of fetal pain, are also used in moral-based arguments for lowered limits.

There are two main critiques to viability and these other empirical markers as the line of moral acceptability in abortion. The first critique challenges the scientific soundness of the markers.[33] There is no standard definition or mode of measurement of viability, for example, nor any standard of what probability of survival is enough.[34] Viability varies with each pregnancy, and the quality of neonatal care available. As scholar Nan D. Hunter observes, "viability cannot be thought of as a bright line … it is hardly a line at all."[35] As a moral marker, viability thus proves no more or less objective than any of its determinative elements: fetal weight, gestational age, etc. The second critique of viability is a philosophical challenge. Viability is a claim about what action can be taken in the present based on an anticipated future that is never to be. Viability is a measurement only sensible as applied to a neonate post-birth, but it is used to define the status of a fetus in utero. Moral arguments from viability thus treat pre- and post-birth as though they were equivalent states, when the very argument is that they are not.

In the end, rather than seek moral absolutism where there is none, the only legitimate answer in law is to embrace individual moral judgment on its fairest terms. There is a human rights argument that the judgment of those most affected, pregnant women themselves, should matter most, and it is thus their moral judgment about later abortions in which collective faith and trust should be placed.[36] This is the sentiment driving popular Trust Women abortion movements. Gestational time limits thus implicate human rights of more than access to services, but of women's freedom in conscience, equality, and liberty. These freedoms prove especially important in countering a troubling trend related to post-viability abortion, in which the claimed moral conflict of abortion is resolved by compelling interventions intended to result in a live birth (for example, caesarean delivery).[37] These interventions are justified by the argument that re-

spect for a woman's right to terminate a pregnancy does not entitle her to destroy prenatal life.

Coerced birth is a profound infringement of human rights, not only as an affront to physical integrity in the performance of a medical intervention without consent, but also in the violation of reproductive freedom, which is understood to encompass body and mind: the freedom to decide one's life course. Under the European Convention on Human Rights, the European Court recognizes that the regulation of abortion—and more broadly, the decision to become a parent or not—engages a woman's right to respect for private and family life.[38] This broader framing of the right, capturing the social dimension of motherhood, may be critical to understanding the morality of women's decision-making in later abortion.

The temporality of health in abortion, law, and human rights

Many, if not most, abortion laws serve and are justified by the state's more general interest in protecting health, safety, and welfare. These interests are evidenced not only in indications for lawful abortion, but by regulation of where, how, and by whom abortions may be performed to ensure safe and effective practice. Abortion laws in this respect treat and regulate abortion as a health care intervention, where health, safety, and welfare are the measures of the law's legitimacy.

The regulation of providers, facilities, and methods by gestational age may be entirely valid, even welcomed, to the extent that such regulation reflects real differences in the effectiveness, risks, service delivery, and resource needs of abortion throughout pregnancy, as well as differences in the experience of abortion among women and providers. Abortion, however, is often targeted for excessive regulation due to falsehoods about its inherent risks or dangerousness, a function of abortion stigma. The over-regulation of abortion throughout pregnancy on grounds of medical need or safety is another instance of boundary crossing, where moral and material hazards merge. Abortion receives more scrutiny than it warrants and more regulation than it needs as a medical intervention. Abortion restrictions, in other words, overstay their evidence, demanding training, infrastructure and protocols that are unnecessary for or even counterproductive to safe delivery and access.

Arbitrary restrictions on abortion methods by gestational age often result from imperfect abortion categories themselves, such as trimesters. The most appropriate methods used for or the experience of abortion at weeks 13 and 14, for example, may be more similar to weeks 8 and 9 than weeks 18 and 19. WHO guidance on safe abortion notes that

> *some countries offer outpatient abortion services only up to 8 weeks gestation when they could be safely provided even after 12–14 weeks gestation … some countries offer vacuum aspiration only up to 6 or 8 weeks, when it can be safely provided to 12–14 weeks gestation by trained health-care personnel.*[39]

Excessive time restrictions on the indicated use of mifepristone and misoprostol in medical abortion similarly limit access. Early FDA standards in the US, for example, approved these medications for use up to 49 days of pregnancy, required that the provider be able to assess pregnancy duration accurately, and that the patient certify they understand the duration of their pregnancy.[40] The FDA has since revised some of its stringent standards, extending indicated use to 70 days of pregnancy on strong evidence of efficacy and acceptability.[41] Nonetheless extreme caution continues to influence restrictive standards and practice-based barriers around the introduction of medical abortion in other jurisdictions.[42] Moreover the unthinking application of legal regulation designed for surgical abortion to medical abortion, despite these restrictions that limit its use to very early pregnancy, again lead to arbitrary access restrictions.[43] Laws governing the treatment of pregnancy remains or fetal tissue, for example, may require women who elect medical abortion to remain in the facility to expel the tissue, or after expelling the tissue at home, to bring it back to the health facility for examination.[44] In illustration of a human rights approach, by contrast, the

UK Human Tissue Authority's guidance on the disposal of pregnancy remains following termination places paramount importance on respecting and acting upon the informed wishes of the woman.[45] Overregulation of medical abortion reduces its threat, or alternatively its promise, to expand service access, especially in resource-constrained settings where public sector physicians may not be skilled in dilation and evacuation or be willing to provide abortion services.[46]

Excessive access restrictions also come from the interpretation of laws rather than their formal decree. The chilling effect of abortion laws carrying criminal or other severe penalties often results in their over-application. With no certainty and little security in measuring gestational age, physicians are understandably cautious in their assessments, but also thereby more likely to restrict access to services unnecessarily. A recent US study found a statistical correlation between laws forbidding late-term abortions and the reduction of not only late-term but also "near-late-term" abortions (that is, abortions within one month of the limitation).[47] It is for this reason that international human rights law calls for abortion laws to first and foremost ensure clarity in their prohibitions and permissions, but this is an impossible task where the standards of the law itself borrow measures or concepts of inherent uncertainty, such as gestational age or viability.[48]

Beyond unnecessary and unfair restrictions on access, the excessive safety regulation of abortion practice also shapes access to abortion in harmful ways. Absolute gestational cutoffs, for example, adversely impact the human right to free and informed decision making in health care. The prospect of being cut off from access may create unnecessary urgency in decision making, when further investigation, consultation, and monitoring may be desired or needed. Human rights law evidences concern for delays in access, including mandatory waiting periods, but rarely considers the harm of being rushed by legal limits. In Victoria, Australia, a 2008 review of abortion practice undertaken for law reform described how public hospitals allowed for post-viability abortion exclusively in cases of fetal abnormality, despite no formal limitation in law.[49] Later abortions for psychosocial reasons were available only through one private clinic in the state. The public hospitals referred all requests for abortions after certain gestations to review panels, setting cutoffs for referrals in weeks 23 and 24. This gestational limitation led to rushed requests by women to ensure eligibility, and to inconsistent decisions across hastily convened panels.

Even when lawful and accessible, the stigma of abortion as an immoral or socially undesirable act may lead to the adoption of non-evidence-based practices around informed consent in the clinical setting. In the case of second trimester medical abortion, for example, many physicians think it is important that women know about and consent to certain aspects of the procedure—for example, that they may see the products of conception, or may experience a kind of mini-labor likened to childbirth. Communicating this information prepares the patient and may support them during an experience that is qualitatively different, both medically and emotionally, from early term abortion. Yet this information may also communicate something of the moral significance of the act they will undertake. Informed consent thereby becomes a means by which to compel women to reckon with the moral significance of the act, and to take moral responsibility for it.[50] Using informed consent procedures for this purpose is coercive and potentially runs afoul of the rights to freedom of conscience and freedom from degrading treatment.

The temporality of justice in abortion, law, and human rights

Later abortion and its regulation raise a number of questions about justice. The most common justice claim is the recognition that there will always be a need for abortion throughout pregnancy.[51] If women are to survive pregnancy and avoid life-threatening clandestine abortions, international human rights law must require that states specifically ensure legal, safe, and accessible abortion in the second trimester and beyond.[52] Yet second trimester and

later abortion often lack professional and public support, resulting in limited human resources, inadequate training and guidance on medical management, and heavily restricted public sector availability and access.[53]

Safe and lawful abortion care later in pregnancy is a refuge for many women, but it can impose a heavy burden on those who provide it. Many physicians, nurses, and midwives are reticent to talk about or to otherwise share their everyday experiences of this stigmatized and stigmatizing work, including its highly emotional dimensions.[54] This leaves them professionally marginalized and socially isolated even in the spatial organization of their work, which is often performed in hidden or unmarked clinical spaces. Private sector clinics, operating without public support, for example, assume the burden of later abortion provision in many settings. This not only creates economic barriers of access for women, but also marks these providers with a suspect profit motive, making them more vulnerable to politically motivated harassment, prosecution, and violence.[55]

Whether because of stigma or formal illegality, health providers may adopt professional practices to hide and thereby to protect the abortion-related services they provide later in pregnancy, and the patients who receive them. Higher rates of complications and hospital presentation for post-abortion care (PAC) in the second trimester make these services especially critical to the human rights of women in health and survival.[56] A common practice in PAC is "protective" record-keeping on the treatment of women who present with fetal demise, ruptured membranes, retained placenta, hemorrhage, or infection late in pregnancy. Health providers administering PAC in a hospital may obscure suspected cases of abortion in medical records by using terminology that does not differentiate between abortion and miscarriage, or that omits data about the length or other suspect characteristics of the pregnancy.[57] These practices allow women suspected of having undergone an abortion to receive treatment and leave the hospital without notice by criminal justice authorities.

Providers may follow similar administrative 'disappearing' practices for the abortion service itself, recording it as PAC, or as premature birth or labor induction, and thus falling outside a criminal abortion prohibition.[58] Second trimester abortion deaths are also obscured on death certificates as simple maternal death from obstetric causes.[59] Thus, as discursive practices of provision and experience, abortion early in pregnancy folds into post-coital contraception or menstrual management, while abortion later in pregnancy shades into miscarriage or stillbirth. All of these terms describe a pregnancy that does not result in a live birth, but each carries a distinct social meaning and legal consequence.[60] This is another instance of boundary crossing, albeit where health providers use concepts originating in medicine to undermine restrictive abortion laws and to facilitate access to safe and compassionate care.

The silence of abortion providers and the invisibility of abortion provision, while understandable as efforts of protection and harm reduction, nonetheless complicate accurate or reliable measures of abortion prevalence in the second trimester and beyond, perpetuating perceptions of later abortion as a rare if not deviant act.[61] This further contributes to the public marginalization of later abortion, making it vulnerable to political trade-offs and symbolic legal sanction. The missing deaths and suffering of women denied access to safe and lawful abortion later in pregnancy is itself a human rights issue.[62] The first and most basic entitlement of human rights law is the right to be acknowledged as a person whose health and life matters.

The reasons why women seek and need later abortion raise a second and distinct justice claim, where they reveal scope for public policy interventions to address underlying needs that create delay. Women seek or are required to access later abortion for different reasons.[63] Some learn of fetal diagnosis or indications, others experience the onset or worsening of a health condition for which termination is medically indicated, and others still experience a life change that compels a shift in priorities. There are also systemic barriers that delay

access to care, such as financial and geographic barriers, delayed referrals, and lack of information, which tend to impose a disproportionate burden on socially vulnerable and marginalized women. Caution is warranted, however, in drawing too strict a distinction between service- or structure-related barriers and women-related reasons for delay, such as fetal diagnosis and maternal health conditions, but also women's failure to recognize pregnancy symptoms, denial of the possibility of pregnancy, ambivalence about the decision, and changes in life circumstances. Before attributing cause or responsibility for delay to women themselves, it is worth asking what these reasons for delay reflect about the environment in which women seek abortion-related information, make decisions, and access resources.[64] For example, the range of available tests, scans, and screening procedures has fundamentally changed women's relationships to their pregnancies. In *R.R. v. Poland*, the European Court of Human Rights recognized the rights of women to timely, full, and reliable information on the health of their pregnancy, including that of the fetus, as a prerequisite to lawful abortion.[65] Other women-related reasons for delay may reveal needed policy measures in comprehensive sexuality education, in securing safe homes and work, and in shifting cultural norms and stereotypes about responsible mothering. Human rights in later abortion thus entail government obligations not merely of restraint, but of positive obligations to address structural conditions of women's vulnerability and capacity for meaningful decision-making.

A third justice claim concerns the consequences of delay, and what happens to women who find themselves beyond gestational age limits, whether set by law or practice. Many women travel to find legal services at great financial, health, and personal hardship.[66] International human rights law has generally failed to adequately capture the last of these hardships: the significant work that a woman must undertake, the unwavering commitment she must have, and the substantial resources she must draw on to access services.[67] The 2016 decision of the Human Rights Committee against Ireland is an exception, having acknowledged the hardships of a woman required to travel to another country to terminate a pregnancy, at personal expense, separated from family support, and denied the care of health professionals whom she knew and trusted.[68] If women cannot travel, they are forced into more precarious practice without legal protection. Prosecutions for self-use often involve later abortions. There is thus a human rights project in harm reduction to reduce the risk of prosecution. Abortion should not cost a woman her life, by death or imprisonment.

Conclusion

To theorize about time in abortion law and human rights is ultimately to spend time with, to seek to understand, and ultimately to support women who seek later terminations of pregnancy. Human rights law cannot answer the question of why it is moral, healthy, or just to deny a woman an abortion at 24 weeks, 22 weeks, 18 weeks, or 12 weeks. Rather, the imperative of human rights law should be to impose no greater distress and no further burdens on women, but to realize the truest compassion of law in the hardest of times, when morality, health, and justice make their strongest demands.

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The Dublin Declaration on Maternal Health Care and Anti-Abortion Activism: Examples from Latin America

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Abstract

The Dublin Declaration on Maternal Healthcare—issued by self-declared pro-life activists in Ireland in 2012—states unequivocally that abortion is never medically necessary, even to save the life of a pregnant woman. This article examines the influence of the Dublin Declaration on abortion politics in Latin America, especially El Salvador and Chile, where it has recently been used in pro-life organizing to cast doubt on the notion that legalizing abortion will reduce maternal mortality. Its framers argue that legalizing abortion will not improve maternal mortality rates, but reproductive rights advocates respond that the Dublin Declaration is junk science designed to preserve the world's most restrictive abortion laws. Analyzing the strategy and impact of the Dublin Declaration brings to light one of the tactics used in anti-abortion organizing.

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I learned about the Dublin Declaration in 2014 while living in Santiago, Chile. Abortion has been completely prohibited in Chile since 1989, with obvious consequences: clandestine abortions are widespread despite the ban, and the burden of illegality falls most heavily on low-income women. Some of the ban's effects, however, are less apparent. I did not previously realize, for example, that the field of genetic counseling is virtually non-existent in Chile because, without the possibility of abortion for genetic anomalies, there is no point.[1] I was also surprised to hear some pro-life Chileans deny that the word "abortion" should apply to certain intentional medical terminations of pregnancy. This is precisely what then president Sebastián Piñera meant in 2012 when he explained that an operation to end a pregnancy is not technically an abortion if it is performed to save a woman's life. "If the mother opts for a treatment that will save her life but not that of her child," he said, "we would not be facing a case of abortion. In the same way, if she decides to opt for the life of her child while risking or sacrificing her own—a decision that must be respected—she would not be committing suicide."[2] The first part of his statement was baffling enough, but that the president of a country—in which abortion is *never* authorized—would suggest that a woman might prefer to die rather than have a life-saving abortion struck me as outrageous. How could a president be so cavalier about the endangered life of a pregnant woman? How could he suggest that the deliberate termination of a pregnancy would not be "a case of abortion"? It was in trying to understand Piñera's reasoning that I stumbled across the Dublin Declaration.

The Dublin Declaration on Maternal Healthcare was issued on September 8, 2012, by a group of self-described pro-life clinicians and researchers attending the International Symposium on Excellence in Maternal Health. It states that "direct abortion—the purposeful destruction of the unborn child—is not medically necessary to save the life of a woman."[3] This simple, unequivocal declaration was designed to cloud one of the most compelling claims made by reproductive rights advocates—namely, that the option of safe, legal, therapeutic abortion is essential to protecting women's lives and reducing maternal mortality. As I dug deeper, it became clear that the Dublin Declaration was the latest salvo in a well-orchestrated campaign to spread disinformation about abortion. The overall strategy is not new; anti-abortion activists have long made dubious claims (about the existence of "post-abortion stress syndrome," for example, or the link between abortion and breast cancer) that they continue to promote despite being discredited by the scientific community.[4] Increasingly, they try to get their research published in reputable scientific journals, which enhances their professional credibility and political clout. By inserting scientifically framed anti-abortion claims into the mainstream scholarly literature, they aim to derail the reproductive rights movement.

The Dublin Declaration is a global initiative designed to keep abortion bans in place by undercutting arguments about the need to offer therapeutic and medically necessary abortions. It offers authorities an excuse to deny requests for abortion based on medical necessity. It also provides moral camouflage for pro-life doctors who must occasionally end a pregnancy to save the endangered life of a pregnant woman. Its effects are especially insidious in Latin America, where five countries now ban abortion completely: Chile (since 1989), Dominican Republic (2009 and 2012), El Salvador (1998), Honduras (1997), and Nicaragua (2006). Authorities in these countries rely on the Dublin Declaration to justify intervening when a woman's life is threatened by pregnancy, without admitting that they allow "abortion." The goal of this article is to expose the Dublin Declaration as a strategy designed to sow doubt and spread disinformation about the medical necessity for abortion by showing how it was deployed in two high-profile cases, one in El Salvador and another in Chile.

Before delving into the analysis, I offer a word about why this matters. The Dublin Declaration is little known outside of pro-life circles. When I presented this paper at an abortion conference in Belfast, one Irish listener was astonished: "What? Are you talking about *our* Dublin? I had no idea!" This is not surprising; abortion politics are so intensely polarized that each side routinely ignores

the other's arguments until some outlandish claim gains enough legitimacy or notoriety to become the basis of a precedent-setting legal case, heart-wrenching bedside battle, or political scandal. Some readers will undoubtedly dismiss the Dublin Declaration as yet another iteration of the junk science that anti-abortion zealots churn out and refuse to let die. They might wonder why we should care, especially when "the opposition" already receives an outsized share of media attention.

As a feminist medical anthropologist studying the backlash against sexual and reproductive rights movements in Latin America, I argue that we should analyze the Dublin Declaration for two reasons. First, where pregnant women's lives are at stake, the Dublin Declaration offers politicians and clinicians a treacherous justification to withhold life-saving medical care. Second, it is important to understand the logic and legal strategies used by our adversaries, especially when their ideas move swiftly across national borders and language barriers. Many Latin American social scientists (far more than I can cite here) are working to identify, theorize, and challenge the strategies used by pro-life and pro-family activists. They have shown how religious ideologies are strategically translated into the secular discourses of biomedicine, bioethics, and human rights, and how conservative religious activism is promulgated through the expansion of sectarian private education, infiltration of government ministries and legislatures, and proliferation of anti-choice and pro-family nongovernmental organizations.[5] This work matters; understanding the history, philosophy, social networks, and conditions for political and legal legitimacy of these movements allows us both to appreciate the moral integrity of those with whom we disagree and to challenge them more effectively.

Background

The Dublin Declaration is based on a centuries-old Catholic moral premise known as the "doctrine of double effect," which emphasizes that the *outcome* of an action may be judged by the actor's *intention*. This idea has been used by Catholic moral theologians "to explain the permissibility of an action that causes a serious harm, such as the death of a human being, as a side effect of promoting some good end."[6] An abhorrent act may be pardonable depending on the perpetrator's intent; hence the right to use reasonable force for the purpose of self-defense.

The Dublin Declaration holds that "direct abortion" is never permissible. This logic is predicated on the difference between intent and outcome. "In Christian morality," according to one Catholic news source, there is a difference "between a direct abortion, and the unintended though foreseen death of the child as a secondary consequence of certain treatments."[7] The same logic is manifested in the *Ethical and Religious Directives for Catholic Health Care Services*, which states, "Abortion (that is, *the directly intended* termination of pregnancy before viability or the *directly intended* destruction of a viable fetus) is never permitted" (emphasis added).[8] If, however, fetal death results from a medical intervention that is required to cure "a proportionately serious pathological condition of a pregnant woman" and it "cannot be safely postponed until the unborn child is viable," then the clinician and the pregnant woman may be absolved of culpability because the fetal death was unintended.[9]

This idea has been applied to the abortion debate for at least 50 years. A 1967 critique by British philosopher Philippa Foot said, "As used in the abortion argument this doctrine [of double effect] has often seemed to non-Catholics to be a piece of complete sophistry."[10] Abortion rights supporters view the doctrine of double effect as a disingenuous attempt to deceive, while abortion opponents view it as a moral guide in life-or-death situations. The Dublin Declaration provides an escape clause for pro-life clinicians and their political allies who can use it to justify terminating a pregnancy when faced with events—such as ectopic pregnancy—that threaten a pregnant woman's life, by defining the treatment as something other than abortion. They reason that "the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women." The doctrine of double effect can protect a pregnant woman from being

held liable for an action—such as an accident—that unintentionally causes the death of her fetus. Why, we might ask, would the framers want to re-package this antiquated notion in 2012?

The Dublin Declaration coincides with the global expansion and consolidation of Catholic health care facilities. Catholic hospitals generally refuse to allow the termination of pregnancies as long as a fetal heartbeat can be detected.[11] The coordinated expansion of the doctrine of double effect seems designed to counteract the argument that maternal mortality rates can decline significantly only where therapeutic abortion is legal, safe, and accessible. It aims to preserve abortion bans while shielding medical personnel from criminal and moral culpability when treatments to preserve a pregnant woman's health inadvertently cause the death of a fetus. (If legally codified, it would also smuggle the Catholic moral precept of double effect into secular law.) In 2012, Ireland was in the midst of a debate over the relationship between abortion laws and maternal mortality rates. Abortion opponents cited low Irish maternal mortality rates as evidence that women are not harmed by the abortion ban, while critics charged that a combination of undercounting and travel to other countries for abortion could explain the "myth of low maternal mortality in Ireland".[12] A 2012 inter-agency governmental assessment recommended sweeping changes in maternal mortality reporting. Ireland was also under increasing pressure from the European Court of Human Rights to ease its almost-complete ban on abortion, especially for reasons of medical necessity. The central question was the following: is access to legal abortion necessary to save women's lives?

The politicization of maternal mortality

Since the 1980s, the global health community has agreed that maternal mortality rates need to be controlled and that the means for doing so are within reach. In the 1990s, the international health community created "a broader sexual and reproductive health and (reproductive) rights paradigm," in which maternal mortality would be addressed holistically, using a human rights-based approach, along with HIV/AIDS, gender-based violence, access to safe childbirth and safe abortion, and the like.[13] When the Millennium Development Goals (MDGs) were formulated in 2000, however, they focused narrowly on maternal mortality reduction. Only one of the MDGs mentioned sexual or reproductive health; MDG5 "called for improvement in maternal health and set a target of a 75% reduction in maternal mortality ratios (MMRs) from 1990 levels by 2015."[14] Many women's health advocates lauded the effort to hold "governments accountable for their failure to provide the required services to prevent maternal deaths."[15] Others felt that by skirting the issue of abortion, the MDG framers managed to shift the abortion conversation into the realm of maternal mortality.[16] Maternal mortality became politicized; an issue that had been considered a settled matter turned into a proxy for the struggle to legalize abortion. This led abortion-rights supporters such as the Center for Reproductive Rights to redirect some of their advocacy toward maternal mortality reduction.[17] Researchers at the World Health Organization prepared a study showing that approximately 13% of maternal deaths worldwide are attributable to unsafe abortion,[18] and women's health advocates began to argue that abortion restrictions must be loosened to safeguard women's lives and reduce maternal mortality rates.

Conservative religious activists from both Catholic and evangelical churches across Latin America pressured political leaders, including leftist presidents, to resist sexual and reproductive rights movements.[19] Among other things, they claimed that the movement to liberalize abortion laws "comes in the guise of reducing maternal mortality."[20] It was at this point that the Dublin Declaration arrived on the scene to attack the claim that abortion is medically necessary. Writing with reference to the United States, political scientist Daniel Skinner says, "Those pro-choice actors who turned to the medical necessity frame were surely hoping that the lack of choice implied by necessity would serve as a backstop capable of securing access to abortion."[21] Skinner believes this assumption was misguided because advocates did not anticipate the backlash from pro-life physicians and their allies.

Certainly this was the case in Latin America, where pro-life scientists concocted an argument showing that maternal mortality rates were falling dramatically, even in countries that banned abortion. Hence, they said, there was no need to liberalize abortion laws.[22]

One of these scientists was Elard Koch, a Chilean co-author of the Dublin Declaration and renowned abortion opponent. In 2012, he and his colleagues at the MELISA (Molecular Epidemiology in Life Sciences Accountability) Institute in Chile published an epidemiological study showing that maternal mortality rates *declined* in places that banned abortion, including some regions of Mexico as well as in Chile during the "natural experiment" created by the prohibition of therapeutic abortion in 1989. The authors attributed the decline to better education among women, access to modern medical care, and improvements in sanitation and hygiene. Their take-home message was that abortion restrictions lead to *lower* maternal mortality. Legalizing abortion would not reduce maternal mortality, the authors argued, nor would prohibiting abortion increase maternal mortality: "only marginal or practically null effects would be expected from abortion legalization or abortion prohibition on overall maternal mortality rates in [Mexico]."[23] Koch called the argument for therapeutic abortion "anachronistic."[24]

The fact that Koch's study was published in the English-language mega-journal *PLoS One* allowed it to cross from the pseudoscientific fringe into the realm of scientific legitimacy. This infuriated some abortion supporters. In Belfast, one senior scientist railed that the article "never should have been published." Yet the study did not go unchallenged. The Gutt-macher Institute issued two detailed rebuttals of work by Koch and his team.[25] The rebuttals showed that low maternal mortality rates in Chile could be attributed to factors that Koch and his team had not considered, including the increased availability of modern contraceptives, widespread use of misoprostol (medical abortion) as an alternative to surgical abortion, and good hospital protocols for post-abortion care.[26] The authors noted that maternal mortality is low in some other countries that restrict abortion—such as Ireland, Malta, and Poland—because women travel to neighboring countries for the procedure.

Some abortion rights advocates were annoyed by the authors' obvious political motivations. Joyce H. Arthur, director of the Abortion Rights Coalition of Canada, charged that "an anti-abortion bias had infected the study's methodology and conclusion. This bias must be addressed, despite the authors' efforts to take sanctuary under the mantle of scientific objectivity." Arthur noted that Koch and colleagues

> *are members of the group We Care [World Expert Consortium for Abortion Research and Education], a group of anti-abortion researchers and doctors that formed around 2011 to publish their own research in mainstream venues, in an apparent effort to put a gloss of scientific respectability on their anti-abortion stance … [and] to create a false picture of scientific confusion and conflicting data in the abortion field.*[27]

Breaking into the mainstream scientific journals was certainly a victory for Koch and his team, because it gave them the imprimatur of scientific legitimacy. Not all of the scholarship on the "myth of maternal mortality" was as well placed; other venues for this argument include *The Linacre Quarterly* (journal of the Catholic Medical Association) and *Issues in Law and Medicine*, a journal co-sponsored by the Watson Bowes Research Institute of the American Association of Pro-Life Obstetricians and Gynecologists.[28]

The message promulgated by Koch and colleagues was clear: maternal mortality is not a justification for decriminalizing abortion. Their goal was to undermine global reproductive rights advocates who saw the MDGs as integral to relaxing the bans on abortion. "The aim of this study," according to Koch et al., "was to assess the main factors related to maternal mortality reduction in large time series available in Chile in context of the United Nations' Millennium Development Goals (MDGs)."[29] The competing claims allowed the media to depict the controversy as a dispute between two equal sides rather than an attempt by a small group of religiously motivated ideologues to derail

the scientific consensus.[30] The Dublin Declaration became the focal point for a North-South alliance of pro-life organizations (Personhood USA, VIFAC [Vida y Familia A. C. de Guadalajara], Alliance Defending Freedom, Construye A.C., and the Committee for Excellence in Maternal Healthcare) that prepared a short report entitled "Policy-Making to Reduce Maternal Mortality: A Holistic Approach to Maternal Care" for a presentation to the United Nations Commission on the Status of Women. Their press release said:

> *In accordance with Millennium Development Goal 5, delegates to the [United Nations Commission on the Status of Women] often discuss policies for reducing world-wide maternal mortality. Unfortunately, the International Planned Parenthood Federation and sympathetic delegations often use this admirable goal as a vehicle to advance resolutions which promote abortion in developing nations.*[31]

The report emphasized that "education, not abortion" was the key to lowering maternal mortality in Chile and elsewhere. Crusaders set out to spread the message: new medical technologies such as early detection, hospital-based Caesarean birth, fetal surgery, and neonatal intensive care units make it easier to save women's lives *as well as* those of the fetuses ("pre-born children") they carry. Choosing one life over the other, they said, is no longer necessary. Skinner writes that "anti-choice actors are shrewd for taking this tactical route," because it puts pro-choice groups on the defensive by requiring them to prove that any particular abortion is medically justified and by questioning the motives of doctors who plead medical necessity.[32] Shifting abortion politics into the realm of maternal mortality practically guaranteed that opposing forces would square off during a hospital bedside crisis, with a woman's life hanging in the balance.

News of the tragic death of Savita Halappanavar in Ireland came in October 2012, just a month after the Dublin Declaration was issued. Halappanavar was a pregnant 31-year-old dentist who had been admitted to a hospital in Galway with ruptured membranes and a miscarriage in progress. Doctors hamstrung by the Irish abortion ban declined to perform a uterine evacuation because they could still detect a fetal heartbeat, even though at 17 weeks' gestation the fetus had no chance of surviving. They were hampered by the Eighth Amendment to the Irish Constitution, which made "the life of a pregnant woman … equal to the life of the foetus she is carrying."[33] As a result, Irish hospitals had a policy of refusing to perform elective or scheduled abortions (such as in cases of cancer or fatal fetal abnormality), in which case the woman usually went abroad for the procedure. Dr. Peadar O'Grady told me that until the law changed in 2014, medical emergencies were routinely handled but "denied as being abortions by arguing double effect."[34] When Halappanavar died of sepsis, people disagreed about whether her death was the result of medical malpractice or Ireland's Catholic "doctrine of double effect" banning abortion.[35] Some cited the Dublin Declaration as evidence that Halappanavar's life could have been saved, while others cited it as evidence of why she died. Maeve Taylor of the Irish Family Planning Association explained that the law essentially forced doctors to do nothing while Halappanavar's health deteriorated to the point that she *might* die—which meant in this case that she did die.[36] Doctors were put in the untenable position of needing to decide "exactly how endangered her life had to be" before they could legally terminate the pregnancy.[37] Similar tragic circumstances were reported elsewhere.[38] Valentina Milluzzo was a 32-year-old Italian woman who was pregnant with twins when she went into early labor and died in 2016; her family charges that doctors claimed "conscientious objector" status as their reason for not terminating the pregnancy while her condition deteriorated. Such deaths put a human face on maternal mortality and show it to be the direct result of religiously inflected state policy. To reproductive rights supporters, these deaths are a tragic repudiation of Dublin Declaration claims.

Pressuring politicians

Even after Halappanavar's death, pro-life lobbyists continue to argue that abortion bans can remain in place without jeopardizing women's lives. The

Dublin Declaration website offers the document in 18 languages and is widely circulated through pro-life Catholic and evangelical circles. In the United States, it is promoted by Live Action, a self-pronounced "new media nonprofit dedicated to ending abortion and building a culture of life." Live Action is perhaps best known for distributing the heavily edited "sting videos" in 2015 that purported to show sales of fetal tissue at US Planned Parenthood clinics. Its director, Lila Rose, takes every opportunity to claim that abortion is never medically necessary; her Twitter website banner reads, "Love them both." In 2014, she openly criticized Wisconsin Governor Scott Walker—at the time a Republican presidential candidate—for being "wimpy" on abortion; the following year, Walker signed a 20-week abortion ban and said during a televised debate that an "unborn child can be protected and there are many other alternatives that will also protect the life of that mother." In response to his comment, Rose tweeted, "Abortion is never medically necessary."[39]

El Salvador

The impact of the Dublin Declaration has been felt in Latin America, where women's health and reproductive rights activists are fighting to overturn complete abortion bans. Abortion has been completely prohibited in El Salvador since 1998, and authorities remain steadfastly opposed to making exceptions for rape, incest, fetal anomalies incompatible with life, or mortal threats to pregnant women's lives.[40] The Salvadoran abortion ban captured the world's attention in 2013, when a pregnant 22-year-old woman called "Beatriz" (a pseudonym) was denied an abortion by the Salvadoran Supreme Court, even though the fetus had anencephaly and full-term anencephalic infants rarely survive for more than a few hours after birth. Beatriz also suffered from lupus, a condition exacerbated by her pregnancy. When she requested an abortion, authorities stalled for several months, perhaps in an effort to enable the fetus to achieve the age of viability. Even with Halappanavar's death fresh in advocates' minds, the Archbishop of San Salvador asserted that Beatriz represented a "strategy" that consisted of "finding an emblematic case to secure the legalization of abortion." The bishop said, "What it tries to do is open the door to abortions in El Salvador. It is a strategy they have used in other countries."[41] The hospital acted only after the Inter-American Court of Human Rights ordered the Salvadoran government to provide Beatriz with access to life-saving medical care. Rather than providing an "abortion," however, doctors performed what they termed a "premature induction of birth" via hysterotomy (a surgical incision into the womb similar to a Caesarean section) at 27 weeks' gestation. To justify their logic, doctors arbitrarily defined 20 weeks' gestation as the dividing line between an "abortion" and a "premature birth." They reasoned that El Salvador's restrictive abortion law would permit them to deliver a fetus after 20 weeks without labeling the procedure an abortion, even though they knew in this case that the fetus would not survive. The intent of an abortion, they said, was to kill a baby, whereas the intent of an induction was to save a pregnant woman's life.[42] This form of "preterm parturition" allowed authorities to claim that they were upholding the law and protecting Beatriz's life, while doing everything possible to save the child's life.[43]

The child died; Beatriz lived. Anti-abortion forces nevertheless claimed victory, saying the Beatriz case proved that abortion is unnecessary to save a woman's life imperiled by pregnancy. The Catholic news agency ACI Prensa ran a headline reading, "'Beatriz' Case Proves that Abortion Is Not Needed to Save the Life of the Mother."[44] From Virginia, Lila Rose of Live Action issued a press release touting the Dublin Declaration: "Salvadoran Supreme Court Protects Lives of Both Mother and Child: Historic Decision from Pro-Life Latin American Nation." She wrote:

> *El Salvador has shown what true medical compassion looks like, all while keeping in line with medical science and plain common sense. Hundreds of doctors in Ireland, another pro-life country, recently published the Dublin Declaration, which states unequivocally that abortion is never needed to save a woman's life. These doctors have agreed that we*

> *don't have to pit the mother's life against the child: we can strive to protect them both.*[45]

The implication was clear; "pro-life countries" will refuse to perform abortions, even when a woman's life is threatened. If doctors do end a pregnancy to save a pregnant woman's life, they will call it something other than abortion. Several English-language news sources accepted this framing uncritically, and in El Salvador a newspaper headline read, "Court Protects Life of Beatriz and Her Child."[46]

The fundamental premise of the Dublin Declaration is the notion that the fetus and the pregnant women share an "equal moral status."[47] Women's health advocates disagree, citing contradictory statements in Catholic doctrine. Witness, for example, this statement from the United States Conference of Catholic Bishops' Committee on Doctrine: "the risk to a woman's life is entirely irrelevant, insofar as any intervention that can be classed as direct abortion would be impermissible regardless of the degree of risk to the woman."[48] In practice, doctors guided by the doctrine of double effect have made pregnant women wait before initiating life-saving cancer treatments. They have also subjected women to invasive medical procedures (such as Caesarean sections, hysterotomies, and salpingostomies) that would otherwise have been unnecessary, thus multiplying the risks to their health.[49] The American College of Obstetricians and Gynecologists issued a statement opposing the Dublin Declaration in October 2012:

> *Abortions are necessary in a number of circumstances to save the life of a woman or to preserve her health. Unfortunately, pregnancy is not a risk-free life event, particularly for many women with chronic medical conditions. Despite all of our medical advances, more than 600 women die each year from pregnancy and childbirth-related reasons right here in the US. In fact, many more women would die each year if they did not have access to abortion to protect their health or to save their lives.*[50]

Meanwhile, the Dublin Declaration is evidence that claims of medical necessity are being attacked with "greater degrees of nuance and scientific sophistication."[51] In both El Salvador and Chile, authorities have justified their complete bans on abortion by claiming that "direct abortion" is never medically necessary.

Chile

In Chile, General Augusto Pinochet banned the practice of abortion in 1989, just prior to relinquishing power after 16 years. When Michelle Bachelet was elected president in 2014, she promised to legalize abortion for women whose lives were endangered by pregnancies, as well as in cases of rape or of serious fetal anomalies incompatible with life outside the womb. During the presidential campaign leading up to her election, the media was filled with news of Belén, an 11-year-old girl who became pregnant as a result of repeated rape by her stepfather. The case became a "bargaining chip" in the electoral campaign.[52] No one denied the circumstances, but the political situation was messy. Belén's mother said the sex between her 11-year-old daughter and her partner was "consensual" and that his arrest was "an injustice against my partner."[53] Doctors said that Belén's life was in danger as a result of her age; they recommended an abortion. When reporters located Belén, however, she told them that she planned to love her baby despite the rape; "It's going to be like a doll I'll hold in my arms. I'm going to love it a lot even though it comes from the man who did me harm, but I'm going to love it anyway." Then president Sebastián Piñera went before the cameras to announce that abortion would not be necessary for Belén and that medical personnel were ready to induce a "premature birth" if they determined that the pregnancy endangered her life.

Piñera's logic was rooted in the doctrine of double effect, just like the Dublin Declaration. This doctrine is promoted in Chile by a number of anti-abortion scholars, including Universidad de Los Andes Professor of Legal Philosophy and Natural Law Alejandro Miranda Montecinos, who wrote that the doctrine of double effect provides a "better and more consistent" framework than its alternatives and should be taken up in Latin American law, including with regard to abortion.[54] Miranda Montecinos is on record opposing induced abortion

in Chile. He signed a public letter urging the state to protect "both innocent children" in Belén's case by offering medical and psychological help, prosecuting the rapist, and improving socioeconomic conditions to prevent "overcrowding, poverty, inequality, lack of education, and violence against women and children."[55] His logic was clear: if the doctrine of double effect were incorporated into secular law, Chile would be able to retain its legal ban on abortion while offering legal protection to the medical personnel who act to save pregnant women's lives at the expense of fetal lives.

Sowing doubt

The most pernicious effect of the Dublin Declaration has been to sow doubts about the medical necessity for abortion. Deliberately deceiving the public is a strategy that has been used by the tobacco, coal, pharmaceutical, and sugar industries, vaccine opponents, and climate change deniers.[56] According to Robert Proctor, the goal of such strategies is to produce public ignorance by intentionally generating contradictory statements that will mislead the public for commercial, political, or ideological purposes.[57] The strategy is especially effective, he explains, when the topic is technically (scientifically or statistically) complex, as is the case with the relationship between abortion and maternal mortality. The success of the strategy depends on publicity that will take the message to the highest levels of policymaking.

In Latin America, a history of coercive international population control programs unfortunately makes it easy to impugn the motives of reproductive rights advocates.[58] In Nicaragua, for example, where abortion has been totally banned since 2006, abortion opponents inflamed anti-imperialist sentiment by charging that so-called *organizaciones abortistas* (abortionist organizations) received financing from European governments that did not want more Third World babies, as well as from the pharmaceutical and medical industries that profited from abortion.[59] Reverberations of the Dublin Declaration were evident in an anonymous Nicaraguan op-ed titled, "Abortion to Save the Life of the Woman?," in which the writer upbraided any naïve soul who was taken in by the "echo chamber of those who manipulate our human sensibilities with the hypothetical situation in which a mother is sentenced to die if she can't get an abortion—a situation that never happens."[60]

Reproductive rights advocates who are aware of the Dublin Declaration can respond by exposing the strategy and correcting disinformation. This is what liberal legislators in the United States did in the 2000s, after then president George W. Bush funded "pregnancy crisis centers" that spread misinformation about the effects of abortion.[61] More recently, the French government banned "misleading" anti-abortion websites.[62] Respected health authorities have gone on record in support of the need for abortion to reduce maternal mortality; these include the World Health Organization, European Board and College of Obstetrics and Gynaecology, American College of Obstetricians and Gynecologists, and International Federation of Gynecology and Obstetrics.

Conclusion

A revolutionary feminist wave is sweeping across Latin America.[63] Latin American reproductive rights are advancing at national, transnational, and international levels. Activists are organized and mobilized like never before, standing up for people's rights to necessary medical services and to make their own decisions about reproductive and sexual matters. Increasingly, they are winning. Over the past 20 years, many Latin American countries have passed gender equity protections and seven have liberalized their abortion laws, with other initiatives pending. Momentum is building as activists appeal to international human rights bodies, invoke anti-discrimination laws and treaties, file judicial injunctions to protect fundamental rights, work to revise penal codes, and rewrite hospital protocols.[64] Successes of this magnitude do not, of course, go unchallenged. Abortion opponents in Latin America are active, too, with strategies that include constitutional reforms, creating new rights claimants (such as fathers, fetuses, and families),

expanding conscientious objection provisions, promoting religious liberty protections and national sovereignty, producing propaganda, and attacking international courts and agencies that support reproductive rights.[65] The Dublin Declaration can be seen as part of an ideologically driven attempt to influence national debates, create confusion and competing truth claims, and keep abortion criminalized in places like Ireland, Chile, Nicaragua, and El Salvador. History is not on their side, though, as momentum builds to overturn these bans.

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Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study

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Abstract

Since abortion laws were liberalized in Western Europe, conscientious objection (CO) to abortion has become increasingly contentious. We investigated the efficacy and acceptability of laws and policies that permit CO and ensure access to legal abortion services. This is a comparative multiple-case study, which triangulates multiple data sources, including interviews with key stakeholders from all sides of the debate in England, Italy, Norway, and Portugal. While the laws in all four countries have similarities, we found that implementation varied. In this sample, the ingredients that appear necessary for a functional health system that guarantees access to abortion while still permitting CO include clarity about who can object and to which components of care; ready access by mandating referral or establishing direct entry; and assurance of a functioning abortion service through direct provision or by contracting services. Social attitudes toward both objection and abortion, and the prevalence of CO, additionally influence the degree to which CO policies are effectively implemented in these cases. England, Norway, and Portugal illustrate that it is possible to accommodate individuals who object to providing abortion, while still assuring that women have access to legal health care services.

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Introduction

Abortion laws were liberalized in many countries throughout Western Europe from the 1960s onward, with first-trimester abortion becoming functionally available upon a woman's request within varied legal structures and requirements. Out of political compromise or pragmatic necessity, clauses allowing medical practitioners to refuse to perform abortions on grounds of conscience were inserted into many of these laws. Since then, conscientious objection (CO) has become increasingly politically contentious. Some argue that the loss of staff willing to perform abortions—on account of their invoking CO—has effectively limited access for women seeking legal abortions in certain jurisdictions, while others stress the importance of respecting individual conscience.

CO has been defined as "the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs."[1] Although CO to abortion is reportedly widespread, a limited number of countries have laws or policies that regulate its practice. In 2013, Wendy Chavkin et al. conducted a scan of national laws and policies that regulate CO to abortion, finding that most of those countries with regulations permit CO but circumscribe the practice in order to protect women's access to care.[2] A similar review from 2015 found only 22 countries that explicitly regulate CO to abortion, most of which are in Europe and have legally permissible abortion and national health care systems.[3] Many of these countries stipulate who is eligible to object and restrict the circumstances in which CO is authorized. However, a few countries, primarily in Scandinavia and Eastern Europe, do not discuss CO in their abortion laws, which has been interpreted to mean that providers lack a legal right to object.[4]

We embarked on this exploratory multiple-case study of four countries whose abortion laws contain CO clauses in order to assess the efficacy and acceptability of national policies that regulate CO to abortion—that is, do their regulations effectively permit CO while still ensuring that women have access to abortion care? We restricted our inquiry to those countries that have CO clauses in statute, legally permissible abortion, and publicly funded health care provision in which the state has an obligation to provide an agreed-on bundle of health care services to its citizens. The selection of countries was also based on the feasibility of stakeholder interviews and the extent to which in-person interviews would expand our understanding of a regulation's perceived impact on abortion access. The four countries meeting these requirements are all high-income Western European countries with liberal abortion regimes. Lawmakers seeking to liberalize national abortion policies must consider a wide variety of legal, social, economic, and cultural factors that influence access to abortion, of which CO is only one. We hope that these case studies can inform stakeholders about the varied experiences of countries which purport to regulate CO in a manner that enables both objection and abortion access.

Each of these four countries has ratified the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the European Convention on Human Rights, and the European Social Charter. Article 18(1) of the International Covenant on Civil and Political Rights guarantees the right to freedom of thought, conscience, and religion, while Article 18(3) explicitly authorizes restrictions on exercise of conscience when necessary to protect public safety, order, health, or morals, or the fundamental rights and freedoms of others. Article 12 of the International Covenant on Economic, Social and Cultural Rights enshrines the right to health, and Articles 16(e) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women affirm the reproductive rights of women and access to family planning care, respectively. International and regional human rights bodies charged with interpreting these treaties and supervising the compliance of states have determined that the freedom to manifest religion or beliefs can be subjected to restrictions. Specific findings by such bodies include the requirements that laws and pol-

icies permitting CO must pertain to individuals, not institutions; must require objecting physicians to refer women to alternate accessible and willing providers; and must ensure that sufficient numbers of non-objecting providers are available. The professional ethical guidelines of many countries' medical, nursing, and midwifery societies support the option of CO but require objecting providers to be forthright about their objection, to provide referrals, and to provide treatment in medically urgent situations (see Table 1).

Methods

We employed an exploratory, multiple-case study design because it is well suited to analyzing the nuances of complex phenomena and relies on multiple data sources to enhance rigor and strengthen the credibility of the theories generated.[5] Prior to commencing fieldwork, we surveyed each country's health system and legal landscape as they relate to abortion and CO, using research templates to ensure the uniform collection of background information. This included a review, in collaboration with legal colleagues, of each country's constitution, relevant laws, and regulations. These data, along with other data sources—including medical codes of ethics and professional guidelines, government and regional agency reports, press clippings, scholarly publications, archival documents, and interviews with key stakeholders—were catalogued in online folders shared among the research team.

In each country, we interviewed 11–16 stakeholders from all sides of the debate, including at least one lawmaker, legal expert, health system official, medical association representative, reproductive health advocate, academic, bioethicist, anti-abortion advocate, and religious freedom advocate. In total, 54 stakeholders participated in semi-structured interviews across our four cases. Background research and key informants in each country helped identify relevant participants, and we conducted a preliminary investigation of the public stances of each interviewee in order to ensure that the sample included those with a range of attitudes toward abortion and CO. Most interviews were conducted in English, with some in Italian and Portuguese, which were subsequently translated into English for analysis. Interviews were digitally transcribed. Through an iterative process, the research team agreed on a set of descriptive analytical themes across cases. To increase rigor, case summaries were reviewed by several interviewees from each country.

Case summaries

England

In 1967, the UK Parliament passed the Abortion Act, establishing legal exceptions to the Offenses Against the Person Act of 1861 and to the Scots common law offense of abortion. Under the 1967 law, an abortion may be lawfully provided if two physicians concur that the continuance of the preg-

Table 1. Professional standards of care regarding conscientious objection to abortion

Providers have a right to conscientious objection and to not suffer discrimination on the basis of their beliefs
The primary conscientious duty of health care providers is to treat (i.e., provide benefit and prevent harm to) patients; conscientious objection is secondary to this primary duty
Moreover, the following safeguards must be in place in order to ensure access to services without discrimination or undue delays: • Providers have a professional duty to follow scientifically and professionally determined definitions of reproductive health services, and to not misrepresent them on the basis of personal beliefs • Patients have the right to be referred to practitioners who do not object to procedures medically indicated for their care • Health care providers must provide patients with timely access to medical services, including giving information about the medically indicated options of procedures for care, even if they object to these options on the basis of conscience • Providers must provide timely care to their patients when referral to other providers is not possible and delay would jeopardize patients' health • In emergency situations, providers must provide the medically indicated care, regardless of their own personal beliefs

Sources: International Federation of Gynecology and Obstetrics, Ethical issues in obstetrics and gynecology (London: FIGO, 2012); World Health Organization, Safe abortion: Technical and policy guidance for health systems (Geneva: WHO, 2012)

nancy would involve greater risk to the physical or mental health of the pregnant woman or her existing children than would termination before 24 weeks of gestation, or at any time in the pregnancy if there would be substantial risk of serious disability in the resulting child or serious risk to the life or health of the pregnant woman.[6] The Abortion Act applies in England, Scotland, and Wales, but not in Northern Ireland or the Isle of Man; for the purposes of this study, we analyzed the situation only in England. The National Health Service (NHS) pays for almost all abortions for resident women and contracts with the nongovernmental charitable sector, primarily Marie Stopes International and the British Pregnancy Advisory Service, to provide the majority (about two-thirds) of these services.[7] As of 2015, medication abortions (also known as medical abortions) accounted for 55% of all abortions provided in England.[8]

Section 4 of the Abortion Act states that "no person shall be under any duty, whether by contract or by any statutory or other legal requirement to participate in any treatment authorized by this Act to which he has a conscientious objection."[9] There is no formal system for CO declaration. Since the law's passage, two court cases have clarified that conscientious objection to abortion is limited to those directly participating in treatment and that they can object only to services directly related to abortion care.[10] Professional medical organizations consider it important to protect their members' exercise of conscience and to simultaneously emphasize providers' duty of care to patients, as well as their obligation to prevent their private beliefs from impeding patients' access to information and services.[11] Both professional guidance and common law require objectors to refer patients to another provider, locating this responsibility to refer under the rubric of the duty to care.[12] Women can "self-refer," which means bypassing the usual gatekeeper—a general practitioner—by obtaining the two required physician signatures under the Abortion Act at the site providing the abortion.[13] It is permissible for employers to require a willingness to provide abortion services as part of job descriptions.[14] In our interviews with anti-abortion respondents, some found this practice discriminatory and thought it could dissuade medical students from entering into associated specialties; most of the stakeholders we interviewed, however, stressed its functional necessity.

Clinical commissioning groups (CCGs) are responsible for determining the health needs of the local population and commissioning health services accordingly (in this case, for example, from the NHS hospital and/or British Pregnancy Advisory Service or Marie Stopes International).[15] In order to determine met and unmet need, they use established benchmarks for the proportion of women who obtain abortions under 10 weeks, and they require abortion services to be provided within a specified period of time following a request.[16] A CCG monitors compliance with its contracts; if an institution were to fail to provide the procedure, the CCG would deem the institution in breach of contract and would reassign the contract. Respondents reported that budget cuts to the NHS and the devolution of many responsibilities from the NHS to CCGs have led to low reimbursement rates for abortion and to competition between family planning and other locally needed services. They added that this aggravates generalized demoralization among NHS clinicians and makes many reluctant to add abortion (or intrauterine device provision) to an increasingly overburdened workload.

Several interviewees discussed developments since the passage of the law, which they believed had consequences both for CO and for practice. They reported that the advent of medication abortion had lessened the burden for some objectors by making them feel less complicit if the woman self-administers the medications, whereas it confused boundaries for others. Moreover, the relocation of most abortion provision to the independent sector has decreased in-hospital training opportunities and has effectively separated abortion care from mainstream medicine.[17]

Most expressed the view that CO did not significantly impede access to abortion. In addition to the reasons just described, many pointed to the fact that objectors constitute a small minority. While the law does not allow abortion on request,

interviewees reported that in practice most women experience ready access and are reportedly unaware that abortion remains in the Criminal Code. Nonetheless, respondents additionally reported that one group of advocates has launched a campaign to remove all criminal restrictions on abortion. Several study participants who favor abortion access disputed the necessity to do so, voicing concern that it might prove politically risky.

While the Church of England is the official state religion, one respondent characterized England as "a country with a very depleted religious tradition." Other interviewees highlighted that England is a "multi-faith, multi-ethnic, multi-cultural society" committed to honoring diversity while also ensuring that differing views do not intrude on one another.

Italy

Enacted in 1978, Italian Law No. 194 "on the social protection of motherhood and the voluntary termination of pregnancy" legalizes abortion during the first 90 days of pregnancy for economic, family, health, or personal reasons, and allows abortion before 24 weeks' gestation when the pregnancy entails a serious threat to the woman's life or when fetal abnormalities constitute a serious threat to the woman's physical or mental health.[18] Women seeking abortion must first undergo an exam and "options counseling" in order to obtain a certificate confirming qualification for the procedure; then they must wait seven days, unless there is urgent need for termination.[19] Law No. 194 emphasizes that the purpose of counseling prior to abortion is to make women aware of available welfare services and to help them "overcome the factors which might lead the woman to have her pregnancy terminated." Additionally, the law states that the "father of the conceptus" should be included in counseling, with the woman's permission.[20] In practice, the provision allowing second-trimester abortions to protect the mental health of the woman is rarely utilized, and women seeking services after 12 weeks often travel abroad for care.[21] Italy's national health system, the Servizio Sanitario Nazionale (SSN), is required to fund all abortion services provided in the country, which it does mostly in public hospitals, with a small minority in approved private clinics. Only obstetrician/gynecologists may be certified as abortion providers. As of 2013, 93.5% of abortions in Italy were performed in SSN hospitals as opposed to private clinics, and 86.2% of the procedures were surgical.[22]

Article 9 of the law legalizes and regulates the practice of conscientious objection, which is permitted unless the immediate termination of pregnancy is essential in order to save the pregnant woman's life. While the law requires objectors to submit a declaration of objection to the provincial medical officer, interviewees consistently explained that objectors usually notify just their medical supervisors. Even then, participants noted, a declaration of objection is moot in cases where objectors are employed at a Catholic hospital, work at a hospital where the medical directors are themselves objectors, or work in one of the many hospitals where nobody provides abortions and where there is thus no such service.

Respondents reported that it is the hospital's responsibility to ensure that the patient receives all necessary services. Regional health departments are responsible for monitoring hospital compliance, and they hold an explicit right to move personnel if necessary.[23] However, interviewees misunderstand this and consistently asserted that listing abortion provision in a job posting is considered discriminatory, which limits regional health departments' ability to effectively redistribute the provider workforce. As a result, participants explained, many hospitals are staffed only by objectors and thus offer no functional abortion services. Despite the clarity of the law regarding the scope of permissible objection, many respondents were unaware of the legal requirements relating to who can object and to which components of care. All interviewees opposed to abortion expressed discontent with any constraints on CO.

Unlike in the other countries, CO in Italy is widespread, with estimates of prevalence among gynecologists in Rome and the surrounding region ranging from 81.9% (according to the Department of Health) to 91.3% (according to the Free Associ-

ation of Italian Gynecologists for the Application of Law 194).[24] Only 60% of Italian hospitals offer abortion services.[25] Several interviewees who favor abortion access explained that Article 9 had made sense when the law was initially passed in 1978, since it would have been unrealistic to force providers to suddenly comply with a new requirement to provide abortion services. However, in their view, the way the law has been implemented has resulted in an inversion of the initial intent to allow an exception to the norm of providing care. Instead, they explained, objection has become the norm and abortion provision the exception. Interviewees from all sides of the debate noted that abortion providers in Italy experience discrimination, increased workloads, and limited career trajectories. Many said that some clinicians registered as conscientious objectors in order to avoid these burdens, rather than for moral or religious reasons, and referred to this as "convenient" objection.

Article 15 of Law 194 requires that health personnel be trained in and make use of "more modern techniques of pregnancy termination which are physically and mentally less damaging to the woman and are less hazardous," illustrating impressive foresight on behalf of the drafters, who had anticipated technological developments.[26] However, several interviewees consider the paucity of medication abortion to be in direct contradiction to this provision. Medication abortion accounted for only 13.8% of abortions in Italy in 2013, and access varies dramatically based on regional restrictions.[27]

In 2012, the International Planned Parenthood Federation European Network filed a complaint before the European Committee of Social Rights asserting that access to safe abortion was limited in Italy due to widespread conscientious objection, and a similar complaint was filed a year later by the Italian General Confederation of Labour.[28] The committee issued decisions on these complaints in 2014 and 2016, respectively, finding that women do encounter substantial barriers and discrimination when seeking access to abortion and that affected hospitals do not adequately compensate for service gaps due to CO.[29] The committee held that this violates the right to health and the right to nondiscrimination as enshrined in the European Social Charter.

Interviewees emphasized the social and political influence of the Vatican, despite the fact that only 30% of Italians regularly attend mass.[30] Many publicly funded hospitals are affiliated with the Catholic Church and do not provide abortion services even though some employees may be willing. Interviewees who favor abortion access reported that, in their view, the Catholic Church's overt opposition to abortion has contributed to the stigma associated with the procedure in Italy.

Notably, interviewees across the board remarked that the law in Italy is well written but not applied. Those opposed to abortion felt that counseling clinics do not adequately fulfill their duty to dissuade women from having abortions. Conversely, those who favor abortion access described the SSN's inadequate performance in maintaining access to abortion services in the face of widespread individual objection. As one respondent put it, "I really think that the question is not conscientious objection but a well-organized health system, which recognizes abortion as a health procedure."

Norway

Passed in 1975, Norway's Act No. 50 "concerning the termination of pregnancy" allows abortion on request before the 12th week of pregnancy. It also permits abortion through 18 weeks' gestation if a board determines that continuing the pregnancy would put a significant mental or physical strain on the woman, that the resulting child might suffer from severe medical complications, that the woman's pregnancy is the result of rape or incest, or that the woman suffers from a severe mental illness.[31] After the 18th week of pregnancy, terminations are authorized only under exceptional circumstances. As in England, interviewees in Norway explained that the policy in practice enables women to bypass the usual gatekeepers—general practitioners—and self-refer for the procedure. Public hospitals are required by law to provide abortion services; the Norwegian National Health System finances all abortions which take place in public hospitals, with a few pilot programs providing abortions in

non-hospital clinics.[32] Often, obstetrician/gynecologist registrars (physicians in specialty training) perform abortions. In 2015, 86.4% of terminations were medication abortions.[33]

The 1975 law allows health care professionals who are directly involved in providing or assisting abortions to object to participating. Clinicians may not invoke CO if the life of the pregnant woman is in danger.[34] While the law specifies that objectors should provide written notification to their administrative chiefs, interviewees held conflicting views regarding whether such a declaration was mandatory; nonetheless, respondents concurred that objectors usually notify their supervisors informally and that this functions well.[35]

Most interviewees, regardless of their stance on abortion, agreed that women should not experience provider disapproval when seeking abortion and that it was the health care authority's responsibility to ensure that women receive legal care. To illustrate fulfillment of this duty, respondents reported instances where physicians had been sanctioned or dismissed for objecting to providing intrauterine devices. Municipalities are charged with organizing abortion services in such a way that women are able to obtain care even where CO exists, and most interviewees therefore agreed that it would be permissible to include abortion provision as a required duty in job descriptions.[36] Some nurse and midwife interviewees working in hospitals described feeling overburdened when many of their colleagues were objectors and reported sites where it had been necessary to cap the number of objectors and to require willingness to provide abortions as a hiring prerequisite. Most physician interviewees had not experienced such situations. The majority of respondents in Norway did not feel that CO hindered access to abortion services, although some reported that thinly populated and staffed rural areas might experience occasional staff shortages, which could lead to delays.

In 2011, the Norwegian Ministry of Health and Care Services issued a circular clarifying that general practitioners could not object to providing women with referrals to abortion services.[37] However, in 2014, the health minister attempted to widen the scope of conscientious objection by allowing general practitioners to refuse to provide women with abortion referrals. This led to popular protest, with 10,000 people demonstrating against it at the March 8th Women's Day celebration in Oslo. The proposed changes were withdrawn, physicians' obligation to help women seeking abortion was underscored in subsequent regulations, and women were allowed to self-refer for abortion services in addition to prohibiting general practitioners' refusal to refer.[38] Nonetheless, despite this recent debate, interviewees consistently reported that general practitioners who are objectors constitute a very small minority.

While the Evangelical Lutheran Church is the established Church of Norway, the Constitution provides for the free exercise of religion and stipulates that all religious and belief communities shall be supported equally.[39] According to one anti-abortion respondent, this church has no official guidance on CO to abortion, and others reported that most Norwegians are not religiously observant. Almost all Norwegian interviewees, despite their differing views on abortion and on the desirable scope of CO, concurred that the regulation of CO should accommodate the competing interests of stakeholders and that women must be able to readily obtain non-judgmental services. As one interviewee who favors expanding the scope of CO explained, "I think it's important to take care of both sides. We have the law and I can say I don't agree with this law, but that's the democratic minority. I don't agree with abortion but we have the law, and I have to take care of the doctors and nurses who don't want [to perform abortions] in the same way I also have to take care of the women, because they have a right in the law [too]."

Portugal

In 1984, Portugal amended its Penal Code to permit abortion in cases of rape and in cases where the pregnancy poses a danger to the health of the woman or fetus.[40] After much social protest that led to a referendum in 2007, another exception was added to the Penal Code whereby abortion is permitted upon a woman's request within the first 10 weeks of

pregnancy.[41] Women seeking an abortion must first undergo a physical exam and options counseling in order to obtain a certificate confirming their qualification for the procedure, which is followed by a mandatory three-day waiting period.[42] The Portuguese national health system, Serviço Nacional de Saude (SNS), is obligated to provide free abortion care within five days of a patient's request and provides care largely through its own public hospitals (around two-thirds of abortions), which almost exclusively provide medication abortion.[43] The onus lies on the hospital to ensure access. In areas with provider shortages, the SNS dispatches traveling teams of willing physicians, pays for patients to travel and receive SNS-funded care elsewhere, or contracts with the independent sector. Unlike SNS facilities, independent contractor clinics provide primarily surgical abortion procedures.[44]

Interviewees explained that because advocates who championed the 2007 effort to further decriminalize abortion had been aware that CO would be a point of contention, they did not dispute the inclusion of a CO clause. This clause stipulates that only those involved in the direct provision of abortion may object and that objectors must submit a written declaration to their hospital director. This declaration must affirm that the objector will provide an abortion if necessary to save the health of the pregnant woman, will refer the patient to a willing clinician, will not participate in options counseling, and will identify the specific legal exceptions to which they object.[45] This "partial objection" is unique to Portugal among our cases, and it was endorsed by many anti-abortion interviewees and by some of those in favor of abortion who believe that the declaration process should reflect a nuanced gradation of objection. Those respondents opposed to abortion considered the exclusion of objectors from counseling to be discriminatory, whereas others assumed it provides relief for those uncomfortable with abortion and protects women from negative encounters.

Overall, study participants reported that Portugal's system successfully ensures women's access to abortion. They raised concerns about provider burnout in light of the fact that clinicians working in areas with provider shortages report an excessive abortion-related workload, and consequently a limited range of practice; they consider budget cuts to the SNS to have exacerbated this problem. Interviewees mentioned that some hospitals reserve certain positions for non-objectors in order to increase women's access to abortion services.

In addition to federal regulations, the Order of Doctors' code of ethics requires doctors to report to the Order of Doctors all services (including those unrelated to abortion) to which one conscientiously objects and to immediately inform patients of their objection.[46] However, many of our clinician respondents, including those from the Order of Doctors, were unaware of these dual reporting requirements. They indicated that few complied with either and that informal adjustments suffice. As in the other cases, this irregular compliance with reporting means that rigorous data on the prevalence of objection are not available.

Several interviewees discussed the impact of Portugal's small size on access to abortion, saying that it is fairly easy for patients in locales with many objectors to travel for services, although this might entail delays. Several respondents reported that while roughly 80% of the population identifies as Catholic, only 20% regularly attend mass, leading one interviewee to characterize Portugal as a "soft Catholic country."[47]

While interviewees in the other countries frequently complained that their laws are outdated, Portuguese informants were less well versed in the intricacies of the country's abortion law, possibly because it is more complex or because it is still in its infancy. Nonetheless, the law has already withstood a challenge by anti-abortion members of Parliament, whose 2015 attempt to impose cost sharing and mandatory psychological counseling on women seeking abortion was later revoked.[48]

Discussion

Public sector commitment to providing legal care

While the approaches to regulating CO in all four countries have similarities (see Table 2), stakehold-

Table 2. National laws and policies related to abortion and conscientious objection

	England	Italy	Norway	Portugal
Year of liberalization*	1967	1978	1975	2007

Grounds for legal abortion	• Before 24 weeks if two physicians concur that continuance of pregnancy involves greater risk to the physical or mental health of the pregnant woman or her existing children than termination
	• At any time if substantial risk of serious disability in the resulting child or serious risk to life or health of the woman
		• During first 90 days if continuation of pregnancy, childbirth, or motherhood would seriously endanger the woman's physical or mental health, in view of her health, economic, social, and family circumstances, the circumstances in which conception occurred, or probability of child's abnormalities or malformations
		• After 90 days if pregnancy or childbirth seriously threatens the woman's life or physical or mental health, including in cases associated with the diagnosis of serious abnormalities or malformations of the fetus
			• On demand before 12 weeks
			• Through 18 weeks if a board determines any one of the following:
			  • the pregnancy, childbirth, or care of the child may result in unreasonable strain on the physical or mental health of the woman or place her in a difficult life situation
			  • the resulting child might suffer from a serious disease
			  • the woman's pregnancy is the result of rape or incest
			  • the woman suffers from a severe mental illness
			  • After 18 weeks, under exceptional circumstances
				• On demand before 10 weeks
				• Until 12 weeks, to avoid danger from death or serious, long-lasting lesions or to the physical or psychological health of woman
				• Until 16 weeks if the pregnancy is the result of a crime against freedom and sexual self-determination
				• Until 24 weeks if the resulting child will suffer from an incurable serious illness or congenital malformation

Referral process	General practitioner referral or self-referral	Consultation required for abortion certificate	General practitioner referral or self-referral	Consultation required for abortion certificate
Waiting period	None	7 days	None	3 days
Abortion provision: percentage national health care system versus independent sector	33% public facilities 67% independent sector	Vast majority provided in public hospitals; a small minority provided in independent sector	Almost all provided in public hospitals, with a few pilot programs providing abortions in non-hospital clinics	67% public facilities 33% independent sector
Percentage medical abortion	55%	Nominal	86%	65%
Are objectors prohibited from providing options counseling?	No, but self-referral limits such encounters	Depends on region	No, but self-referral limits such encounters	Yes
Who can object?	Only those involved in direct provision	Only those involved in direct provision (with regional variations with regard to counseling)	Only those involved in direct provision	Only those involved in direct provision
To whom do providers declare objection?	To medical supervisor	To regional authority (under law), to medical supervisor (in practice)	No declaration necessary	To medical supervisor (in practice) and professional association (under law)
Who ensures the woman receives care?	Clinical commissioning group	Regional authority	Regional authority	Hospital (within 5 days)
Is it acceptable for an employer to list abortion-related work as a job requirement?	Yes, but it is not necessary in the independent sector	Regional variation	Yes	Yes

*Citations for the data in this table can be found within the article text.

ers reported varying degrees of implementation. National health systems in the four countries are obligated to assure the provision of free, timely, and appropriate abortion care, a task for which they rely on regional health authorities and hospital managers. The duty to provide abortion services therefore rests at the organizational level as opposed to an individual one, a distinction which anchors our discussion of the specific ways in which this commitment is carried out in each country—whether by subcontract or by direct provision, with supplementation as necessary. It is worth noting that while opponents of abortion were not at peace with legally permissible abortion, they did not contest the duty of the national health system to provide publicly funded care.

In this sample, the ingredients that appear necessary for a functional health system that permits provider CO and yet assures access to abortion include the following: clarity about who can object and to which components of care; ready access into the system by mandating referrals or establishing direct entry; and assurance of a functioning abortion service through direct provision or by contracting services to other abortion providers. Surprisingly, written declaration by objectors does not appear to be essential. Although all countries but England technically require written declarations from objectors, many interviewees were not aware of this, and it seemed to be often practiced in the breach. Interviewees agreed that supervisors have to know who objects in order to design work schedules and assignments. Many considered informal on-site notification to suffice and referenced instances of cooperation among objectors and abortion providers in order to ensure the delivery of care. Respondents highlighted that this lack of consistent reporting means that there are scant or spotty regional and national data on the prevalence and characteristics of objection, which generally limits the national health system's ability to monitor implementation and intervene as needed. The English system for monitoring the provision of care is linked to contract review—because providers are on contract with the NHS, regional authorities continually review data relating to the provision of abortion in order to ensure contract compliance, a process that doubles as a method for monitoring providers' legal compliance.

All four countries stipulate that only those involved in the direct provision of abortion are eligible for objector status, and that objectors and primary care physicians are obligated to refer women seeking abortion to the appropriate provider. In all four, this has been upheld by national legislation, administrative rule making, and case law. Interestingly, England and Norway have adopted a belt-and-braces approach, allowing women to self-refer by skipping the usually required first stop at the gatekeeper general practitioner and proceeding directly to the abortion provider. Interviewees in England and Norway reported that CO restrictions were least concerning to obstetrician/gynecologists and most disturbing to general practitioners, nurses, and midwives: the obligation to provide referrals and care prior to the procedure is most likely to affect general practitioners, and the requirement to provide post-procedure care is most likely to disturb objector nurses and midwives, who may have to administer second doses of medications or assist with post-procedure bleeding, pain management, and so forth, especially after a procedure initiated on a previous shift.

Despite the four countries' legal and legislative clarity on the fact that ancillary, managerial, and supervisory tasks fall outside the scope of legal objection, respondents in each country reported that some clinicians had illegally invoked CO to the provision of emergency contraception, intrauterine devices, and post-abortion care. While interviewees in all countries reported instances when clinicians had been sanctioned or prosecuted for failure to comply with the law, they also described uneven and incomplete monitoring of compliance. Participants reported ongoing debate in their respective countries over excluding objectors from counseling, as is done in Portugal. While anti-abortion interviewees in Portugal and Italy saw such exclusion as unfair to both objectors and women, their counterparts in Norway said that they approved of protecting women from exposure to disapproving clinicians.

Whether the national health system provides abortion itself or subcontracts the procedure out to third parties can affect its ability to permit objection and ensure women's access. In Italy, interviewees said that SSN insistence that care be provided at its own facilities despite the lack of willing clinicians has stifled the emergence of an independent sector and constrained access to the procedure. However, in England, where ready access is assured because the independent sector provides the majority of abortions in stand-alone clinics, interviewees said that obstetrician/gynecologist trainees within the NHS often lack sufficient opportunity for training in abortion care. They anticipate that this technical competence gap could prove increasingly problematic, since the need for hospital-based abortion care for women with medical complications may increase if England's obesity and diabetes epidemics persist. Norway avoids this problem by relying on obstetrician/gynecologists-in-training to provide most in-hospital abortions.

In contrast to their counterparts in England, Portugal, and Norway, interviewees in Italy consistently reported that access to abortion is compromised in areas with a high prevalence of objection and that the government has not compensated for the paucity of willing providers. Interviewees from all four countries queried whether increased salaries or other positive incentives might attract more clinicians to abortion provision and simultaneously reduce stigma. They also reported that clinicians might be more willing to provide medication abortion than surgical abortion. Lastly, they speculated that the health system could increase the pipeline of willing providers by routinely incorporating training on the clinical and legal aspects of reproductive health care. The Norwegian law stipulates only that abortions must be performed by medical practitioners and in facilities approved by the medical officer, which widens the pool of eligible providers and settings.

Societal attitudes toward objection and abortion

Interviewees in each country conveyed a range of attitudes toward both objection and abortion that appear to affect the efficacy of policy implementation in that country. Interestingly, the majority of interviewees who are advocates for abortion expressed a widespread acceptance of CO, for various reasons. Many of them justified their perspective on the grounds of respect for self-determination and integrity, which they consider applicable not only to women who decide to terminate pregnancies but also to clinicians who decide that their moral beliefs preclude them from performing abortions. Pragmatically, many in this group also articulated a wish to protect women seeking abortions from disapproval and from receiving care from individuals uncomfortable with providing it. A similar desire to shield women from exposure to those with negative attitudes toward abortion underlay their rejection of requiring proof of sincerity of objection, along with their opinion that doing so would be impracticable and smack of policing. This group of interviewees also pointed to the earlier era of "silent objection"—when some objecting staff would discourage or delay patients—as confirming the utility of permitting CO, since the overt practice can then be subject to regulatory constraints.

However, this type of pragmatism was not uniform. A few interviewees in each country advocated the prohibition of CO altogether, considering it incompatible with clinicians' duty to patients and arguing that objectors should choose other lines of work if they are unable to fulfill all of their responsibilities. Women's rights advocates in Portugal, England, and Norway highlighted a refusal to cede ground gained for women's position over recent decades. On the opposite side of the spectrum, aside from participants in Norway, anti-abortion respondents could not reconcile their opposition to abortion with a toleration of permissive laws, nor with constraints on CO.

Interviewees consistently noted that the stigmatization of both objection and abortion provision complicates policy in practice. Those opposed to abortion access argued that objector stigma is a reason why more providers do not object to providing abortion whereas, conversely, those supportive of abortion linked abortion-provider stigma with provider shortages, burnout, and "convenient" objection. Moreover, while all four countries have

mechanisms for patients to complain about health service provision, many interviewees reported that women seeking abortion are unlikely to complain because of shame or stigma associated with the procedure, thus limiting a country's ability to monitor the implementation of CO policies. In fact, because Italian abortion advocates reported that they could not identify a woman willing to step forward with a formal complaint or legal challenge, nongovernmental organizations had to initiate the two complaints brought before the European Committee of Social Rights.

The limitations of our approach preclude us from generalizing our findings. This was an exploratory study of four liberal Western European countries with national health care systems and abortions provided without patient fees. We interviewed a non-representative sample of participants who were chosen because of their organizational roles. We did not systematically investigate the experiences of women seeking abortion nor of practicing clinicians (although many of the physicians, nurses, and midwives interviewed because of their institutional roles were also practitioners and relayed their own observations from the frontlines), and we cannot report whether these groups substantiate the observations here. Therefore, we lack the empirical grounding to make recommendations for countries without specific laws, with less robust health sectors, or with a higher prevalence of CO. Nonetheless, there are strengths in our study approach that support confidence in the findings. The use of multiple cases integrating legal analysis, offical documents, and interviews of experts permits a comparison of patterns across similar countries, the provision of granular detail about the translation of CO policy into practice, and the preliminary identification of factors that enable robust access to abortion by the public sector in the context of CO.

Conclusion

CO to abortion presents a challenge to governments charged with negotiating competing belief systems. Non-theocratic governments with commitments to pluralism have to resolve tensions between contending rights and obligations, particularly when the conflicts involve governmental services or requirements. This balancing act becomes especially fraught when the domain is socially contentious and the line between religiously based conscience and political position is blurred. This is certainly the case regarding reproductive health care, where political and religious opposition have been closely allied and often indistinguishable. Legally permissible CO to legally sanctioned health care highlights the competing interests of objectors, willing providers, patients, and societies committed to delivering a democratically agreed-on set of services by a national health care system.

Regional and international human rights bodies concur that states must provide abortion services and can limit the expression of CO in order to do so. According to our interviewees, England, Norway, and Portugal comply with their national laws that permit individuals to exercise CO to abortion, while still fulfilling their obligations to provide and fund access to abortion care. They do so by imposing constraints on objectors and by assuring ready access into a functioning system. These "best case" studies illustrate that it is possible to permit CO to abortion and still ensure that women have access to care.

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The Role of International Human Rights Norms in the Liberalization of Abortion Laws Globally

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Abstract

International and regional human rights norms have evolved significantly to recognize that the denial of abortion care in a range of circumstances violates women's and girls' fundamental human rights. These increasingly progressive standards have played a critical role in transforming national-level abortion laws by both influencing domestic high court decisions on abortion and serving as a critical resource in advancing law and policy reform. Courts in countries such as Argentina, Bolivia, Brazil, Colombia, and Nepal have directly incorporated these standards into groundbreaking cases liberalizing abortion laws and increasing women's access to safe abortion services, demonstrating the influence of these human rights standards in advancing women's reproductive freedom. These norms have also underpinned national-level abortion law and policy reform, including in countries such as Spain, Rwanda, Uruguay, and Peru. As these human rights norms further evolve and increasingly recognize abortion as a human rights imperative, these standards have the potential to bolster transformative jurisprudence and law and policy reform advancing women's and girls' full reproductive autonomy.

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Introduction

The evolution of international and regional human rights norms to recognize safe abortion as a human rights imperative has significantly influenced judicial and legislative developments on this issue across the globe. These increasingly progressive standards have played a critical role in liberalizing national-level abortion laws by both influencing domestic high court decisions to recognize access to abortion as a constitutional guarantee and by serving as an important resource in advancing law and policy reform. As these standards continue to evolve to create stronger protections for abortion as a fundamental human right, they can further influence the development of transformative national-level jurisprudence and law and policy reform in recognition of women's reproductive autonomy.

This article examines key developments in United Nations (UN) and regional human rights bodies toward the recognition of abortion as a human right and the significant influence of these norms in high court decisions and legislative measures affirming and advancing women's right to access abortion services at the national level. The authority of such normative developments at the national level is often overlooked in critiques of international and regional human rights bodies, despite the profound impact of these developments on women's ability to exercise reproductive autonomy. Instead of providing an exhaustive list of these developments, this article explores particularly notable examples and concludes by discussing critical recent normative developments that may further advance reproductive autonomy.

Importantly, these normative advancements and their integration at the national level do not occur in a vacuum—they result from sustained efforts by lawyers, advocates, and activists to hold states to account for their human rights obligations, demonstrate the harmful impact of restrictive abortion laws, and destigmatize abortion. Furthermore, formal legal recognition of these rights is only a first step toward enabling women to access abortion care; the complex task of fully implementing such laws is essential for guaranteeing women's and girls' ability to exercise their reproductive rights. While this article focuses on concrete legal gains that have been made through the translation of these norms from the supra-national to the national level, the role of civil society in catalyzing these developments and the importance of the full implementation of these legal guarantees must not be overlooked.

Development of international human rights norms on abortion

Over the past two decades, international human rights norms have evolved significantly to recognize the denial of safe abortion services as a human rights violation. The 1994 International Conference on Population and Development's (ICPD) Programme of Action largely underpinned these developments as the first international consensus document wherein states recognized reproductive rights as human rights that are already enshrined in domestic and international law. Its call to governments to strengthen their commitment to women's health by addressing unsafe abortion, to ensure access to abortion when legal, and to guarantee all women quality post-abortion care established an important entry point to address unsafe abortion and promote abortion access as a human rights imperative.[1] Yet the ICPD Programme of Action's directives on abortion are relatively narrow and contradictory, as they do not recognize the need for states to reform their laws and policies to permit abortion—despite clear evidence that this is essential for reducing unsafe abortion and resulting maternal mortality and morbidity—or recognize the linkages between lack of access to abortion and gender discrimination.[2]

One year after the ICPD Programme of Action, the Beijing Platform for Action further called on governments to "[review] laws containing punitive measures against women who have undergone illegal abortions," and at ICPD's five-year review, governments recognized that "in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible."[3]

International and regional human rights bodies have gone beyond these consensus documents in recognizing abortion as a human rights imperative and acknowledging the range of human rights violations that stem from restrictive abortion laws and lack of access to safe abortion services. Through a series of individual communications, UN treaty monitoring bodies, which oversee and provide authoritative interpretations of states' obligations under UN human rights treaties, have clearly established that when abortion is legal under domestic law, it must be accessible in practice, and that denials of access to legal abortion services can amount to violations of the rights to health, privacy, non-discrimination, and freedom from cruel, inhuman, and degrading treatment.

Furthermore, through their general comments, general recommendations, and concluding observations, treaty bodies have affirmed that states must ensure that legal abortion services are available, accessible (including affordable), acceptable, and of good quality.[4] They have urged states to abolish procedural barriers to abortion services, such as third-party authorization requirements, mandatory waiting periods, and biased counseling.[5] To ensure access to abortion, states should adopt relevant legal and policy measures, including enacting clear guidelines outlining the conditions under which abortion is legal, and should provide financial support for those who cannot afford abortion services.[6] States should also guarantee the availability of skilled health care providers who can offer safe abortion services and ensure that provider refusals on the grounds of religion or conscience do not interfere with women's access to services.[7] States must also ensure that women receive confidential and adequate post-abortion care, which must not be conditioned upon admissions by women that will be used to prosecute them for undergoing abortions illegally, as this may amount to cruel, inhuman, and degrading treatment.[8]

Moreover, treaty bodies have regularly and explicitly called on states to decriminalize and ensure access to safe abortion services and have repeatedly recognized the connection between restrictive abortion laws, high rates of unsafe abortion, and maternal mortality.[9] They have condemned absolute bans on abortion as being incompatible with international human rights norms and have urged states to eliminate punitive measures for women and girls who undergo abortions and for health care providers who deliver abortion services.[10] Moreover, they have called on states to decriminalize abortion, at a minimum, when the pregnancy poses a risk to the woman's life or health, when the pregnancy results from rape or incest, and in cases of severe fetal abnormality.[11] Furthermore, in the landmark case of *L.C. v. Peru*, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) explicitly instructed a state party to decriminalize abortion in cases of rape, marking the first instance in which a human rights body has explicitly directed a state to liberalize its abortion law as a result of an individual communication.[12] Additionally, treaty monitoring bodies have urged states to interpret exceptions to restrictive abortion laws broadly to incorporate, for example, mental health conditions as a threat to women's health.[13]

Recently, these bodies have moved beyond articulating the specific grounds under which abortion should be legal and have urged states to generally ensure women's access to safe abortion services in connection with states' obligation to guarantee comprehensive reproductive health services. This shift demonstrates a growing recognition that narrow exceptions to abortion bans do not adequately protect women's reproductive rights or enable women to exercise reproductive autonomy.[14] Notably, the Committee on the Rights of the Child has urged states to "decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services" and "ensure access to safe abortion and post-abortion care services, irrespective of whether abortion itself is legal."[15] Additionally, the CEDAW Committee has directed states to "ensure that sexual and reproductive health care includes access to … safe abortion services," without qualification as to the legality of abortion. It has also framed abortion as an aspect of women's autonomy.[16] Finally, as further analyzed below, the Human Rights Committee recently issued a groundbreaking decision in the case of

Mellet v. Ireland, recognizing that the prohibition and criminalization of abortion contravene international human rights law.[17]

In addition to the treaty monitoring bodies, the Special Procedures of the United Nations Human Rights Council have also recognized abortion as a human rights concern. For example, Anand Grover, when he was Special Rapporteur on the right to health, noted that laws criminalizing abortion lead to higher numbers of maternal deaths, and poor mental and physical health outcomes while "infring[ing upon] women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health."[18] Also, the current Special Rapporteur on the right to health has called on states to decriminalize abortion and adopt measures to ensure access to legal and safe abortion services.[19] Similarly, the Special Rapporteur on torture has recognized that "states have an affirmative obligation to reform restrictive abortion legislation that perpetuates torture and ill-treatment by denying women safe access and care."[20]

Regional human rights bodies have also recognized abortion as a human rights concern. For example, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) explicitly recognizes that states must ensure women's right to abortion, at a minimum, in instances of "sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."[21] In a recent general comment, the African Commission on Human and Peoples' Rights further recognized that inadequate access to safe abortion and post-abortion care can result in violations of the rights to privacy, confidentiality, and freedom from discrimination and cruel, inhuman, or degrading treatment.[22]

Furthermore, through a series of cases, the European Court of Human Rights has affirmed that states must ensure that where abortion is legal, it is accessible in practice, finding that the denial of legal abortion services can amount to violations of the rights to private life and to be free from inhuman and degrading treatment.[23] Additionally, the Parliamentary Assembly of the Council of Europe has recognized women's right to physical integrity and to control their own bodies, indicating that the decision of whether to carry a pregnancy to term must be decided by the woman herself, and has called on states to ensure women's access to abortion and to eliminate barriers to safe abortion.[24]

Finally, the Inter-American Commission on Human Rights issued precautionary measures where a woman was denied cancer treatment on the basis that it could harm her pregnancy, calling on the state to guarantee the woman's access to medical treatment for her cancer and to ensure that such measures are adopted in agreement with the woman.[25] It also brokered a friendly settlement with the government of Mexico in connection with the case of a 13-year-old girl who became pregnant as a result of rape and was denied access to legal abortion services.[26] Additionally, the Inter-American Court of Human Rights issued provisional measures ordering a state to take all necessary steps to preserve the life of a woman whose pregnancy placed her life in grave danger, which under those circumstances required termination of the pregnancy.[27]

Influence of human rights norms on national-level abortion jurisprudence and law reform

The evolution of strong international and regional human rights standards recognizing abortion as a human rights imperative has significantly influenced jurisprudence and law reform at the national level. High courts have increasingly relied on international human rights standards in determining whether their countries' laws and practices adequately secure women's reproductive autonomy. These normative developments laid the groundwork for numerous national landmark decisions that have affirmed women's right to abortion in a range of circumstances and have solidified the state's obligation to ensure access to legal abortion services in practice.

Notably, since 1994, more than 35 countries

have liberalized their abortion laws, expanding the grounds under which women can legally access abortion services. While the development of progressive jurisprudence, laws, and policies is just one aspect of states' compliance with their human rights obligations, enshrining these rights within law is a critical step toward the full realization of such rights and can increase accountability when laws are violated or not implemented.

Jurisprudence

Colombia. In 2006, the Colombian Constitutional Court issued a groundbreaking decision overturning the criminalization of abortion under all circumstances and finding that, in order to protect women's human rights, abortion must be permitted—at a minimum—when pregnancy poses a risk to the woman's life or physical or mental health; when it results from rape, incest, or unwanted impregnation; or when the fetus has an impairment incompatible with life.[28]

In reaching its decision, the court carefully examined the meaning and exercise of women's human rights as enshrined in the Colombian Constitution and international and regional human rights instruments, emphasizing the prominence that women's rights had attained in international conferences, such as ICPD and Beijing, and their outcome documents.[29] It further looked extensively at the right to health under international human rights law, recognizing that states must "offer a wide range of high quality and accessible health services, which must include sexual and reproductive health services" and that "the right to freely decide the number of children is directly linked to women's right to life when there are highly restrictive or prohibitive abortion laws that result in high maternal mortality rates."[30]

Furthermore, the court evaluated Colombia's absolute prohibition on abortion alongside the Human Rights Committee's decision in *K.L. v. Peru*, which established that the denial of abortion services in cases of fatal fetal impairments could amount to cruel, inhuman, and degrading treatment.[31] The court recognized that numerous UN treaty monitoring bodies had called on states to repeal absolute bans on abortion.[32] Notably, at the time, *K.L. v. Peru* was the only authoritative precedent from a regional or UN human rights body specifically addressing protections for women's right to abortion services, yet the court went far beyond this precedent in expanding the legality of abortion in Colombia. While the court's ultimate decision also relied largely on limitations on legislative discretion in applying the criminal law, examining the proportionality and reasonability of the relevant Penal Code provisions, the court's extensive consideration of and reliance on international human rights norms provides an important backdrop and context for its judgment.

Argentina. In 2012, Argentina's Supreme Court of Justice issued a decision providing an authoritative interpretation of the Penal Code's rape exception, which was unclear as written into law.[33] Argentina's Penal Code explicitly authorizes abortion under certain circumstances, namely where the woman's life or health is at risk and where "the pregnancy results from rape or indecent assault of a woman [with an intellectual or psychosocial disability]."[34] A growing body of jurisprudence from the provinces, protocols, and national health regulations had interpreted the latter provision to permit abortion in all cases of rape, given the lack of clarity in the provision's statutory construction.[35]

Importantly, ensuring Argentina's compliance with its international obligations was a key factor in the court's decision to hear this case. In rejecting arguments that the case was moot since the petitioner had already accessed abortion care, the court reasoned, in part, that the failure to issue a decision "may compromise Argentina's state responsibility before the supranational legal system."[36]

In ruling that the clause on rape and indecent assault should be read broadly, the court noted that UN human rights bodies had condemned restrictive interpretations of countries' abortion laws.[37] It remarked that the Human Rights Committee had established that abortion should be permitted in instances of rape and, in particular, had expressed

concern about restrictive interpretations of Argentina's abortion law.[38] Therefore, the court determined that *all* women and girls who become pregnant as a result of rape can access legal abortion services. Furthermore, the court clarified that these women and girls are not required to provide evidence of the rape or to receive judicial authorization before procuring an abortion. To this end, the court invoked UN treaty body standards reprimanding Argentina for failing to guarantee timely access to legal abortion services and for the judiciary's "interference" with such access.[39]

Brazil. In 2012, Brazil's Supreme Court authorized abortion in cases of anencephaly—a fatal condition wherein parts of the fetus's brain and skull do not develop during pregnancy.[40] At the time, Brazil's Penal Code permitted abortion only in instances of rape and where the pregnancy posed a risk to the woman's life. In adding an exception for anencephaly, the court recalled the World Health Organization's definition of health as "a state of complete physical, mental and social wellbeing, and not only the absence of disease or infirmity," and recognized that anencephalic pregnancies can pose enhanced risks to the pregnant woman's life and health. The court further noted the ICPD Programme of Action's recognition of reproductive rights as human rights and examined the precedent set by the Human Rights Committee in K.L. v. Peru, which recognized that compelling an individual to carry to term an anencephalic pregnancy can amount to cruel, inhuman, and degrading treatment and violate the right to privacy.[41] Ultimately, the court determined that it would be unconstitutional to interpret the Penal Code as criminalizing abortion in cases of anencephaly.[42]

Nepal. International and regional standards have also had a profound effect on high court decisions concerning the accessibility of abortion services.[43] In 2009, the Supreme Court of Nepal issued a decision in Lakshmi Dhikta v. Nepal establishing inadequate access to safe and legal abortion as a human rights violation. Although Nepal had liberalized its highly restrictive abortion law seven years earlier, permitting abortion without restriction as to reason during the first 12 weeks of pregnancy, access to safe abortion services remained limited, especially for poor and non-urban women.[44] The petitioner in this case was a pregnant woman with five children who was denied abortion services because she could not afford the fee.

In interpreting the Interim Constitution's protection of the right to reproductive health, the court recognized the linkages between reproductive health, as defined in the ICPD Programme of Action, and reproductive rights. Furthermore, it looked to the International Covenant on Economic, Social and Cultural Rights in interpreting the right to health, recognizing the importance of affordability, accessibility, and availability, including the need to guarantee equitability in payment schemes and in the distribution of health care providers.[45]

Notably, in recognizing the state's duty to provide appropriate remedies, including compensation and the enactment of laws as a measure of non-repetition, the court looked to several cases from regional human rights bodies.[46] For example, it referenced the European Court of Human Rights' decision in *Tysiąc v. Poland* ordering policy reforms to ensure women's access to timely abortion services, as well as monetary compensation to the petitioner.[47] Further, the court examined the friendly settlement in *Paulina Ramirez v. Mexico* from the Inter-American Commission on Human Rights, wherein the Mexican government agreed to provide financial reparations, cover particular educational expenses, and issue guidelines on access to abortion services.[48]

Bolivia. In 2014, Bolivia's Constitutional Tribunal issued a decision in a challenge to several articles of the Penal Code, including the restrictive abortion law.[49] Bolivia's Penal Code authorized abortion only where the pregnancy poses a risk to the woman's health and in cases of rape or incest, and required judicial authorization for abortion in the latter instances. The petition alleged that the Constitution's protection of reproductive rights must allow wom-

en to voluntarily terminate a pregnancy and that abortion should be regulated in the sphere of public health, as opposed to the Penal Code.

Although the Constitutional Tribunal failed to overturn the restrictive abortion law, it recognized that requiring women to obtain judicial authorization for abortion services violated their rights and impeded their access to these services.[50] In reaching this conclusion, the court explicitly looked to the International Covenant on Civil and Political Rights' recognition of states' positive obligations to guarantee that women, particularly girls, who are victims of rape or incest have access to sexual and reproductive health services.[51] It further grounded its decision in the CEDAW Committee's and Committee Against Torture's concluding observations on Bolivia, which recognized judicial authorization as a barrier to abortion services and urged the state to eliminate this requirement and guarantee abortion access for women and girls who become pregnant as a result of rape or incest.[52] Although the court fell short in recognizing women's right to decide whether to carry a pregnancy to term as a fundamental aspect of reproductive autonomy, the removal of the judicial authorization requirement was a significant step forward.

Law and policy reform

International and regional human rights norms have also been a key tool in lobbying and influencing legislatures to liberalize abortion laws and establish policies to ensure access to safe and legal abortion services. For example, in 2010, Spain enacted a sexual and reproductive health law authorizing abortion without restriction as to reason. The law itself indicates that it seeks to bring Spain in line with the "international consensus" on reproductive rights. It explicitly looks to CEDAW's recognition of the unique impact of pregnancy and childbearing on women and considers the Convention on the Rights of Persons with Disabilities' reproductive rights protections.[53] It further recognizes that the European Court of Human Rights has criticized the lack of legal certainty stemming from restrictive abortion laws and that the Parliamentary Assembly of the Council of Europe has urged states to decriminalize abortion and guarantee women freedom to control their bodies.[54]

Additionally, in 2012, Rwanda amended its Penal Code, including the relevant provisions on abortion, and brought its abortion law in line with the grounds for abortion set forth in the Maputo Protocol. It simultaneously lifted a reservation to the Maputo Protocol that it had entered on the provision addressing abortion.[55] Thus, Rwanda now permits abortion when a woman becomes pregnant as a result of rape, incest, or forced marriage, or if the continuation of the pregnancy jeopardizes the health of the woman or the fetus.[56] Previously, abortion was permitted only to preserve the woman's health.[57]

Furthermore, in 2014, Peru adopted national guidelines providing clarity for physicians and patients on the provision of legal abortion services.[58] The CEDAW Committee recommended the adoption of these guidelines in its decision in *L.C. v. Peru*, in which it held Peru accountable for denying the petitioner access to legal abortion services.[59] In addition to recognizing CEDAW as one of the legal bases for their promulgation, the guidelines were adopted on the eve of Peru's periodic review of its compliance with CEDAW, suggesting that the pressure mounted by the committee's decision and the impending review influenced the government to take steps to ensure women's access to legal abortion services.[60]

Indisputably, extensive advocacy on behalf of civil society has been essential for translating these gains from the international arena to the national level. Notably, in the case of Peru, several years lapsed between the issuance of the CEDAW Committee's decision in *L.C.*—and even more from the Human Rights Committee's 2008 decision in *K.L.*—and the promulgation of the national guidelines on abortion provision. During this time, civil society actors were essential to persuading the government to take concrete measures to increase access to abortion care. Indeed, strong advocacy coalitions are critical for holding governments to account for their human rights obligations and

ensuring compliance with and adoption of these normative frameworks.

Catalyzing reproductive autonomy for women: Importance of future normative developments

As demonstrated above, international and regional human rights norms have underpinned national-level jurisprudence, laws, and policies liberalizing restrictive abortion laws and securing access to legal abortion services in practice. While these norms firmly and importantly recognize states' obligations to ensure access to legal abortion services and to decriminalize abortion—at a minimum—on certain grounds, they still fail to fully recognize women's right to decide whether to carry a pregnancy to term as a fundamental aspect of women's equality, autonomy, and self-determination.[61] Notably, authorizing access to safe and legal abortion services only on certain grounds undermines women's autonomy and decision making by forcing them to carry to term pregnancies against their will, stigmatizes women who seek abortions for other reasons, perpetuates entrenched discriminatory norms about women's roles in society, and fails to prevent women from seeking unsafe abortions.

However, recent normative developments that call on states to decriminalize abortion and guarantee access to safe abortion care are increasingly recognizing that laws denying women the ability to determine whether to carry a pregnancy to term undermine their reproductive autonomy and agency, limit their opportunities, and deny them the ability to participate as equal members of society. In the recent case of *Mellet v. Ireland*, the Human Rights Committee held that Ireland's prohibition and criminalization of abortion in nearly all circumstances subjected the petitioner to severe emotional and mental pain and suffering, amounting to violations of her rights to privacy, equality before the law, and freedom from cruel, inhuman, and degrading treatment under the International Covenant on Civil and Political Rights.[62] The petitioner was pregnant with a fetus that had a fatal impairment, and, as a result of Ireland's highly restrictive abortion law, which criminalizes abortion unless a woman's life is at risk, she was forced to travel abroad to terminate her pregnancy.[63] The Human Rights Committee called on the state to amend its law on voluntary termination of pregnancy, including the Constitution if needed, to comply with the covenant, including by ensuring effective, timely, and accessible abortion procedures in Ireland and ensuring that health care providers can deliver full information on safe abortion services without fear of criminal sanctions. This is the first decision from an international human rights body that explicitly recognizes that the prohibition and criminalization of abortion is a human rights violation in and of itself.

While the *Mellet* decision is the first of its kind, it is supplemented by the progress within other treaty bodies, such as the Committee on the Rights of the Child, to move beyond enumerating certain grounds for abortion and recognize abortion in and of itself as a human right. An important shift is underway as human rights norms progress beyond the recognition of procedural guarantees in connection with abortion to the establishment of access to abortion services as a substantive human rights obligation. This development signals the human rights imperative of law and policy reform and establishes that states with restrictive abortion laws have an obligation to make abortion legal.

This increasingly progressive jurisprudence demonstrates the significant progress toward recognizing abortion as a human right and signals the transformative potential of such norms. Undoubtedly, translating these normative gains into concrete change in countries across the globe will continue to require sustained and concerted efforts by reproductive rights advocates and civil society actors more broadly, especially in light of the extensive stigma and discrimination—as well as lack of political will—surrounding abortion in many contexts. But by continuing to establish women's and girls' right to decide whether to carry a pregnancy to term as a fundamental aspect of the realization of their human rights, human rights bodies can further support the promise of gender equality. These normative developments can have a catalytic

and transformative impact on national-level jurisprudence, laws, and policies, resulting in greater recognition globally of abortion as a fundamental aspect of women's reproductive autonomy and self-determination and ensuring women greater access to this essential reproductive health service.

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Pregnancy and the 40-Year Prison Sentence: How "Abortion Is Murder" Became Institutionalized in the Salvadoran Judicial System

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Abstract

Using the case of El Salvador, this article demonstrates how the anti-abortion catchphrase "abortion is murder" can become embedded in the legal practice of state judicial systems. In the 1990s, a powerful anti-abortion movement in El Salvador resulted in a new legal context that outlawed abortion in all circumstances, discouraged mobilization for abortion rights, and encouraged the prosecution of reproduction-related "crimes." Within this context, Salvadoran women initially charged with the crime of abortion were convicted of "aggravated homicide" and sentenced to up to 40 years in prison. Court documents suggest that many of these women had not undergone abortions, but had suffered naturally occurring stillbirths late in their pregnancies. Through analysis of newspaper articles and court cases, this article documents how El Salvador came to prosecute obstetrical emergencies as "murder," and concludes that activism on behalf of abortion rights is central to protecting poor pregnant women from prosecution for reproduction-related "crimes."

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Introduction

Most forms of abortion have always been illegal in El Salvador, but historically, Salvadoran women were not prosecuted. However, after a successful anti-abortion mobilization in the 1990s culminated in an absolute abortion ban in 1997, and a constitutional amendment defining life as beginning at the moment of conception in 1999, the Salvadoran state began to prosecute women for abortion for the first time in recent history. Moreover, our data demonstrate that between 1999 and the present, at least 34 women, many of whom were initially charged with the crime of abortion, were eventually convicted for the "aggravated homicide" of their newborns and sentenced to 4–40 years in prison. Many of these women suffered naturally-occurring stillbirths.

How did the Salvadoran judicial system transform from a state that largely ignored the crime of abortion to an aggressive prosecutor of women's reproductive lives? How did poor women who suffered obstetrical emergencies come to be legally understood as criminals who "murdered" their own children? Analyzing 25 years (1989-2014) of newspaper articles from the largest daily Salvadoran newspaper, *El Diario de Hoy*; six interviews with key informants (activists and legislators); complete court documents from 16 women sentenced to prison for the "aggravated homicide" of a newborn; and sentencing documents from 53 abortion or newborn homicide cases uncovered through a review of judicial records in 12 of El Salvador's 21 sentencing districts; this article examines how the familiar mobilizing cry of anti-abortion movements—"abortion is murder"—became deeply embedded within the Salvadoran legal and judicial process.

El Salvador is not the only nation to imprison pregnant women for reproduction-related "crimes."[1] However, its corresponding penalties are among the most extreme in the world. Analyzing this extreme case allows scholars to better understand the conditions under which the idea that abortion is murder can become integrated into the written legal code, and the institutionalized judicial processes, of a nation.

In the following pages, we first review information from the court cases of three Salvadoran women wrongfully charged with the "homicide" of their fetus or newborn to illustrate the judicial overreach currently occurring in El Salvador. Second, we present newspaper and interview data to provide an historical account of how anti-abortion discourses pressured the Salvadoran judicial system into adopting such aggressive prosecution tactics. Third, we demonstrate how these aggressive prosecution tactics permeate every level of the judicial process, from the doctors who attend the women during their obstetrical emergencies, to the police who arrest them, to the judges who condemn them for murder. Finally, we conclude that activism on behalf of women's reproductive health is a key element in preventing states from prosecuting women for reproduction-related "crimes."

Three examples illustrating how naturally occurring obstetrical emergencies became "murder" in El Salvador

Mirna, charged with attempted aggravated homicide

In May 2002, Mirna was 34 years old, seven months pregnant, and poor. Although she had married at age 19, she and her husband still had no children due to a history of difficulties conceiving, miscarriages, and one premature birth of a child who died at four months old. This pregnancy again appeared problematic; Mirna suffered back pains and significant vaginal bleeding throughout. Feeling the urge to defecate, Mirna went to the pit latrine behind her house, only to accidentally birth her daughter into the latrine. Three neighbors quickly helped retrieve the child. The premature baby—a girl—was taken to the hospital, where she was diagnosed with sepsis and intrauterine growth restriction, but survived.

According to doctors consulted for this paper, the medical factors associated with intrauterine growth restriction are also factors commonly associated with premature or precipitous births. Yet when the police arrived at Mirna's house to take her and her baby to the hospital, they also captured Mirna for suspected abortion. By the time the case reached the courts, Mirna was charged with

"attempted aggravated homicide." The judge who found her guilty concluded, "This tribunal has no doubt that the defendant's behavior was intentional, because who doesn't know that throwing a newborn baby into a latrine could cause its death." Mirna was sentenced to, and served, 12 ½ years in prison. Her daughter is now 16 years old.

Carmen, charged with aggravated homicide

In October 2007, 18-year-old Carmen was working as a live-in domestic in El Salvador, making $80 per month. She was pregnant as the result of a violent sexual assault. Carmen went into labor on a Sunday, and self-delivered a small baby that did not move or cry. The next day, Carmen worked a full day despite continuing to bleed heavily. By the time her employer took her to the hospital, she was regularly losing consciousness from blood loss. The employers claimed to have not known Carmen had been pregnant although Carmen reports that the employers both knew she was pregnant, and also knew that the baby had died. The medical staff who attended Carmen realized she had given birth and reported her for suspected abortion. Like Mirna, the abortion charge was upgraded to aggravated homicide through the course of the trial.

The autopsy of Carmen's baby found "no external or internal evidence of trauma" on the body, and listed the cause of death as "undetermined," noting that "with the available studies completed, it is not possible to determine the cause of death." The autopsy also reported several abnormalities in the body, including incongruent height, weight, and foot measurements; vascular congestion in the heart; and the wrong number of veins in the umbilical cord. Despite clear medical evidence suggesting a stillbirth, and no evidence of a crime, the autopsy nevertheless classified the type of death as "violent." At no point in the court documents did the forensic analyst provide any justification for this "violent" classification. The judge found Carmen guilty of aggravated homicide and sentenced her to 30 years in jail. In his written statement, the judge admitted frankly that there was no direct evidence of a crime, but said he was able to come to his decision through "the force of reason."

Maria Teresa, charged with aggravated homicide

In November 2011, 28-year-old Maria Teresa lived with her six-year-old son and his paternal grandparents in a shack of corrugated metal located in a poor, gang-ridden suburb of San Salvador. Her son's father had abandoned them years earlier, but she continued to live with and care for his elderly parents. She worked in a factory during the day, and supplemented her day job with house cleaning on evenings and weekends. Maria Teresa did not know she was pregnant, as she had been bleeding heavily throughout the pregnancy, and her stomach did not grow. In fact, she reports visiting the doctor twice during the pregnancy, once with pains in her lower abdomen, and another time with sharp pains in her back. The doctors diagnosed her with a bladder infection; even they did not suspect pregnancy.

Maria Teresa woke one night with a strong thirst. While getting a drink of water, she suddenly felt an urge to defecate. She went to the pit latrine outside their home, and was horrified to feel what felt like a "little ball" fall out of her body. She cried out for her mother-in-law before passing out in a pool of blood. Her mother-in-law called an ambulance, and Maria Teresa arrived at the hospital in hypovolemic shock. The doctors, realizing she had given birth, reported Maria Teresa to the police for abortion. The state's attorney upgraded the charge to aggravated homicide. Although the autopsy data indicated that the fetus likely died in utero and was then expelled, the judge nevertheless found Maria Teresa guilty and sentenced her to 40 years in prison. In his statement, he wrote that Maria Teresa must have known she was pregnant, so she therefore must have "decided to carry out her criminal plan within the area of her household, looking for a moment during which there weren't any other persons around to carry out this homicide."

The cases of Mirna, Carmen, and Maria Teresa illustrate a transformation in Salvadoran judicial practice. After 1999, poor Salvadoran women who appear to have suffered naturally occurring obstetrical emergencies began to be prosecuted for the "aggravated homicide" of their newborns. To investigate the events accompanying this judicial

transformation, we analyze 25 years of national-level political developments, as reported through the *Diario de Hoy* newspaper, and as recalled by local activists and politicians.

The birth of the anti-abortion movement in El Salvador

In the early 1990s, El Salvador was in the process of negotiating a peace treaty to end 12 years of civil conflict between the socialist-inspired FMLN (Frente Farabundo Martí para la Liberación Nacional) guerrillas and the Salvadoran state. At this time, Salvadoran law only allowed legal abortions in three circumstances—when the life of the mother was at risk, when the pregnancy was the result of rape, or when the fetus had deformities incompatible with extrauterine life. Nevertheless, illegal abortion clinics operated relatively openly and without fear of prosecution. Although there was much political turmoil and debate at the time, changing abortion laws or increasing the enforcement of those laws, was not on the public agenda. From 1989 to the end of 1992, there was not a single reference to local-level abortion issues or activism in *El Diario de Hoy*. *El Diario* did regularly report on Pope John Paul II's anti-abortion speeches while touring other parts of the world, but the reporters would mention the topic of abortion only in passing, focusing instead on colorful accounts of the city where the Pope was speaking.

In 1992, the Salvadoran state signed peace accords with the FMLN guerrillas, and the FMLN was conferred formal status as a political party. It was also in 1992 that the first anti-abortion editorials and articles began appearing in *El Diario*. Yet it wasn't until 1994 that the abortion agenda won significant attention from Salvadoran politicians. This was the year of the first post-peace accord elections, and the first time the new FMLN party could contend for formal political power. This was also the year that the United Nations planned its Population Conference in Cairo. *El Diario* reported on Pope John Paul II's claims that the Cairo conference was the First World's attempt to force abortion on poor countries in order to control their population. The anti-abortion movement in El Salvador quickly adopted the Pope's discourse as their own. It was also at this moment that the local Catholic Church in El Salvador became a major player in the pro-life movement, bringing with it the ability to quickly mobilize thousands of individuals in the course of a weekend by making announcements to parishioners during mass. And Salvadoran politicians from two political parties on the right, ARENA (Alianza Republicana Nacionalista) and the PCN (Partido de Conciliación Nacional), began proposing that El Salvador could protect its sovereignty—and the lives of unborn Salvadorans—from UN incursion by passing stronger anti-abortion legislation.

The Truth Commission created by the 1992 Peace Accords recommended a revision of the country's existing criminal code. In 1997, the Foundation Yes to Life presented a formal request to the legislative assembly to ensure that the new criminal code did not allow any exceptions to abortion—even for the life or health of the pregnant woman. It further launched a powerful media campaign, and *El Diario de Hoy* published numerous graphic editorials promoting the "abortion is murder" meme. Articles with titles like "The horrors of abortion" erroneously detailed how "abortionists" cause "babies" torturous pain in their mother's womb by tearing them apart, limb by limb, even in the earliest weeks of pregnancy.[2] (The current consensus in the medical community is that a fetus cannot feel pain prior to the 24th week of gestation.)[3] The Archbishop of San Salvador, Fernando Saénz LaCalle, publicly compared abortion to the "Nazi death camps."[4] The Catholic Church mobilized thousands of school children from parochial schools and bussed them to the legislative assembly to rally for the total abortion ban.[5] Professional organizations like doctors' unions issued statements in favor of the total ban.[6] The new minister of health claimed that regardless of what law was eventually passed, he and his doctors would not practice abortions.[7]

Resistance and resignation

Despite powerful anti-abortion mobilization, the newly created FMLN political party initially stood

firm in its support for maintaining the legality of abortion when a woman's life was in danger, when a woman was raped, or when the fetus had deformities that would not allow it to survive outside the womb. The party called on the Salvadoran government to prevent abortion, not prohibit it, and they sought to turn the discussion to the economic dimensions underlying unwanted pregnancies. Prominent feminist organizations supported the FMLN position by speaking out against the total abortion ban, and providing scientific and social evidence supporting abortion rights to the legislative assembly.[8] In 1997, the FMLN voted as a party against the total abortion ban, but they had insufficient votes to prevent its passage.

The new criminal code eliminated all legal options for abortion, and extended the criminal sentence for women who consent to abortion to two to eight years in prison. The new criminal code also introduced a new crime: abortion accomplice. Specifically, the law states that anyone who induces a woman or facilitates with economic or other means the ability to have an abortion in El Salvador can be sanctioned with two to five years in prison. Importantly, although it outlaws both "abortion" and "facilitating abortion," the criminal code provides no legal definition for either term.

Immediately after the total abortion ban was passed, Archbishop Lacalle sent a letter to the legislative assembly stating that it was not sufficient to outlaw abortion in the criminal code; a constitutional amendment defining life as beginning from "the very moment of conception" was also needed.[9] The right-wing party ARENA responded immediately, using its legislative majority to push the first of two required votes to amend the constitution to recognize fetal personhood. The FMLN again voted as a party against the reform, but again did not have enough votes to block its passage.

Despite their professed concern to protect unborn life, ARENA deputies waited two years before putting the second constitutional amendment vote on the agenda. Their strategy was clear: they waited to introduce the issue until immediately before the next election cycle, so that the FMLN would again be forced to defend abortion publicly during a critical campaign moment. Public opinion in El Salvador appeared strongly in favor of the amendment. *El Diario* reported that activists collected a remarkable 600,000 signatures and mobilized tens of thousands of protestors to support the amendment.

In the wake of this powerful organizing, the FMLN decided to allow its deputies to vote their conscience, and to no longer promote a party line supporting limited abortion rights. Feminists, who had supported the FMLN position throughout the debate, were disappointed. The personhood amendment passed with the majority of FMLN members casting positive votes, and a minority abstaining. After the vote, several FMLN leaders also made public statements celebrating the constitutional protection of fetal life.

This vote marked a change in FMLN strategy that had profound implications for the abortion rights movement in El Salvador. Not only did the FMLN disengage with the issue of abortion, but some deputies also urged their feminist allies to drop their public support of abortion. With a few important exceptions, feminist organizations concurred. Salvadoran feminists interviewed described the next eight years as a period of "self-censorship." They continued to mobilize around other women's reproductive issues, including access to contraception, sex education, rape prevention, and legal protections from gender-based violence. But with few exceptions, they no longer discussed the issue of abortion publicly. This decision, reported to me by activists from three separate feminist organizations, is also evidenced in the newspaper review. Whereas articles reporting on feminist abortion rights activism were relatively regular up until 1999, they became nearly nonexistent between 1999 and 2007.

Feminists offer two reasons for reducing public support of abortion rights. First, they noted that it was important to maintain the FMLN as allies in the legislative assembly if they were to achieve any of their multifaceted goals for women's rights. Second, feminists feared that speaking out in favor of abortion could have powerful, negative ramifications for their nascent post-war organizations. Anti-abortion activists had proven themselves able to mobilize significant financial and political

resources to counter anyone who spoke in favor of abortion rights. Moreover, because the new criminal code outlawed facilitating abortion, feminists worried that any abortion rights mobilization could result in potential jail time for activists.

Anti-abortion discourse finds a new target

After their legislative victories in 1997 and 1999, anti-abortion discourse in El Salvador appears to have turned its attention toward a new target: mothers who would "murder" their babies. A 2001 article in *El Diario de Hoy*, titled "Crimes without punishment" begins,

> *The numbers of newborns being thrown into latrines, trash receptacles, or vacant lots by their own mothers is alarming. Very few children are able to survive this misfortune. The authorities need to capture these women red-handed to process them for aggravated homicide, but to the contrary, these crimes never come to light and are given complete immunity.*"[10]

Another 2001 article, "Stories of hearts of stone," states: "They are human beings who only lived the nine months that they were in their mothers' wombs. Upon birth, they await the sweet hands of a mother, but what they find instead are the talons of soulless women."[11]

Although *El Diario de Hoy* had long published articles equating abortion with "murder" more generally, by 2001 the attorney general's office began to conflate abortion and "homicide" in its statements referencing specific judicial cases. To illustrate: a university student allegedly showed up at the hospital hemorrhaging, saying she had just suffered a miscarriage. The doctors suspected her of provoking an abortion, and reported her to the police. The attorney general's office told a reporter that although the young woman was initially being charged with abortion, if they could find the deceased baby, they could potentially upgrade the charge to "aggravated homicide" depending on whether the fetus had breathed upon exiting the womb.[12]

El Diario articles also suggest that state agents were feeling increased pressure to prosecute women for abortions and "homicides." One 2003 article reports on a press conference in which the nation's top prosecutor and the director of the national police sought to defend their respective institutions regarding why they had not been more successful in shutting down El Salvador's clandestine abortion industry. They professed that they were limited legally because the current law only criminalizes actual abortions. If the abortion laws were strengthened to criminalize "intention to abort," they argued, they would have the legal power they needed to prosecute abortion. The article concludes with a representative of the ombudsman for human rights stating, "In this country, we still don't have clear and efficient policies that allow us to protect the lives of the unborn." She also said that the state needed to go further to fight the situations "that we've seen, where women throw away their own children as if they were any old thing [13]

Social mobilization requires an adversary. The Salvadoran anti-abortion movement initially framed itself in opposition to the FMLN and the feminists who would permit (albeit limited) legal abortion in El Salvador. However, when both the FMLN and local feminist organizations reduced their public engagement with the issue of abortion, then it no longer made sense for abortion opponents to target them. Why mobilize in defense of El Salvador's new anti-abortion laws when there was no threat to those laws in the first place? The newspaper articles reviewed above suggest that, in the face of quiescence from the abortion rights movement, the anti-abortion movement identified a new enemy: the "perverse mother" who was guilty of "murdering" her own innocent child.

A sharp increase in the number of prosecutions

To estimate the number of convictions for abortion and newborn homicide in El Salvador, we combined information from four separate data collection processes. First, author Guardado Bautista reviewed every legal case from 1997 to 2014 as tried in 12 of the 21 judicial sentencing districts in El Salvador. He recorded all abortion or "homicide

of a newborn" cases sentenced during these years, and when possible, made copies of judges' sentencing decisions. Second, to see if these prosecutions were indeed new or were a continuation of an earlier practice, we selected the 5 districts among our 12 that had had the highest number of abortion or "homicide of a newborn" cases after 1997, and we returned to these districts, this time to look through all sentencing decisions from 1989-1996. Third, we combined our data with a study completed by a local Salvadoran organization, the *Agrupación por la Depenalizacion del Aborto*. The *Agrupación* study is broader than ours, as it reviewed all court cases in all of El Salvador from 2000 to the first quarter of 2011.[14] However, its data cover a more limited time period, and only include counts of prosecutions and convictions; its published data does not provide details on the sentences that convicted women receive. Finally, we added to our counts six new cases publicized in the media in 2015 and 2016.

Combined, these data demonstrate that convictions for both "abortion" and the attempted or actual "aggravated homicide of a newborn" began to increase significantly in the year 2000—about the same time that anti-abortion newspaper discourses in El Salvador began targeting the "perverse mother." Prior to 1998, we found only four cases of prosecution for abortion in the sample of court documents we reviewed. In contrast, between 1998 and 2014, we discovered 74 women who were prosecuted for abortion. Of these, 23 were convicted. Although the *Agrupación* published data do not include sentencing decisions, our more limited analysis suggests that the vast majority of women found guilty of abortion were sentenced to community service, and not prison.

In stark contrast, women whose initial abortion charges were upgraded to homicide were significantly more likely to receive long prison sentences when found guilty. Prior to 1998, we only found two cases of attempted or actual "aggravated homicide" of a newborn in our 5-district sample. However, from 1998 to 2016, we discovered 75 such cases in our combined data. Of these 75 cases, 34 were found guilty. Again, the *Agrupación* data do not include information on women's sentences, but our data paint a grim story. Of the 43 cases of homicide we uncovered in our limited sample, 29 were found guilty, nine were found innocent, and five were either missing sentencing information or were still in trial. Of the 29 guilty verdicts, 24 received prison sentences of 25 years or greater, two received sentences of 12-15 years, and three received four-year sentences. The modal 30-year prison sentence for women convicted of the "aggravated homicide" of their newborns is 15 times greater than the minimum prison sentence for abortion (the crime with which these women were often initially charged). It is also two to three times longer than the prison sentences gang members receive for multiple violent murders. This is because gang murders are typically charged only with "homicide," while these women are charged with "aggravated homicide" due to the relationship between mother and child.[15]

Prosecuted for abortion, convicted of murder

The quantitative data above illustrate how, beginning in 1998, El Salvador experienced a dramatic increase in the prosecution of women's reproductive "crimes." However, they tell us little about the cases themselves. We therefore secured permission from 16 women convicted of attempted aggravated homicide or aggravated homicide of their newborns to review the entirety of their court documents, including police reports, medical files, autopsy reports, judicial correspondence, and trial documents.[16] The three women whose experiences are detailed above—Mirna, Carmen, and Maria Teresa—were among the 16. We also shared summarized case histories, plus the medical and forensic data from the cases, with Gregory Davis, a medical expert in forensics; and Christine Curry and Jodi Abbott, ob/gyns in the United States, to benefit from their specific expertise in evaluating the cases. We summarize our key findings below.

The women: These 16 Salvadoran women were overwhelmingly poor, poorly educated, and lived in situations that limited their access to medical care (for example, they lived alone in isolated rural areas, lived with physically violent or controlling

partners, lived in areas controlled by gangs where police and ambulances are loath to enter, or were domestic workers living under the surveillance of their *patron).* At least four of the 16 women were pregnant as the result of rape. The women went into labor unexpectedly and while alone. Their babies appear to have died before, during, or shortly after a complicated and unattended birth in what, had they been in the hospital, would likely have been ruled a stillbirth.

The discrimination: We documented extensive and systematic gender bias in each of the 16 cases. By systematic gender discrimination, we mean that at every stage of the judicial process, the state aggressively pursued the woman's prosecution instead of the truth. This began at the moment of arrest and culminated with sentencing. Rather than presenting actual evidence, state personnel justified their prosecution decisions by citing how the accused women violated social expectations of motherhood. For example, they argued that mothers should always know when they are pregnant; mothers should be able to tell the difference between labor pains and the urge to defecate; mothers should know when it is necessary to seek medical care to protect their unborn babies; and mothers should act to protect their unborn or newborn babies even when suffering a severe medical crisis and losing consciousness.

Sites of discrimination: We found evidence of the aggressive pursuit of prosecution at every stage of the judicial process.

1. To begin, the *police* who investigated the alleged crimes only gathered evidence that would incriminate the women, and consistently failed to gather evidence that would corroborate the women's stories. In the case of Mirna, for example, police took a statement from a neighbor who told them that Mirna purposely threw the baby away because she did not want her husband to know she was pregnant. However, they did not at that time travel to the husband's work place to ask whether he knew Mirna was pregnant. (He later stated vehemently that he did).
2. *Doctors* who treated these women postpartum routinely failed to investigate likely birth complications. In eight of the 16 cases, the most basic medical information, such as the women's blood pressure and estimated blood loss, was not reported on the women's medical charts. Even in cases where these data exist, the medical staff regularly failed to interpret the data for the courts (nor did the attorney general ask for an interpretation). For example, doctors failed to note when a woman's excessive bleeding at the time of birth would have resulted in her acting dazed, confused, and incoherent—a physiological consequence of insufficient oxygen reaching the brain. Such incoherent actions have been used to incriminate most of the 16. In none of the 16 cases did medical staff analyze women's past or present medical conditions, evaluate the placenta, or check for maternal infections, diseases, or chromosomal abnormalities. Of the eight women for whom there are limited data, all were anemic, and some severely so—a pregnancy complication that could be indicative of miscarriage or stillbirth. More concrete actions also demonstrated the doctors' assumptions of guilt. In several cases, doctors testified against the accused women in court, making erroneous claims to support incrimination. For example, Mirna's doctor testified that there was no way that a woman could possibly mistake labor pains for the urge to defecate and the intrauterine growth restriction in her daughter was not caused by a genetic or physiological abnormality, but rather was evidence of the fact that Mirna "did not want the baby." In another case, medical personnel wrote, "patient apparently threw away her baby" on the woman's medical chart.
3. *Forensic analysts* also appear consistently biased toward incrimination. Analysts regularly found that infants were full term, but provided little information to support that conclusion. In Maria Teresa's case, the analyst concluded that the infant was full term, but failed to list the body weight because, he writes, "there was no scale." In another case, the analyst concluded that the

baby was "full term" after listing its length at 51 cm long and its weight at only 700 grams, two measures that are practically impossible to find in the same infant. Forensic analysts also failed to discuss possible breaks in the chain of evidence. In at least nine of the 16 cases, the scene of the alleged crime was contaminated by multiple people prior to the arrival of the police. In one case, the infant's body was cleaned, dressed, and then prayed over all night before a neighbor suspected malfeasance and called the police the following morning. Yet not a single forensic analyst noted whether and how these breaks in the evidence chain could contaminate forensic findings. Perhaps most centrally, in eight cases medical forensics used a "lung flotation test" to "prove" live birth, and to conclude that the cause of death was likely homicide. This line of reasoning is highly problematic for two reasons. First, establishing that a baby was born alive is a necessary, but not sufficient, condition to prove homicide. An infant could be born alive and breathe for a few minutes before dying a natural death. Yet judges regularly only referenced the fact that a baby had supposedly been born alive to determine that "killing" had occurred. Second, leading forensic experts have rejected the lung flotation test for more than a century because it is known to provide false positives.[17]

4. *Judges* were among the most biased actors in the judicial process. Judges frequently admitted only the evidence that supported a guilty verdict, and systematically excluded evidence that supported the women's testimony. For example, judges admitted testimonies from neighbors who condemned the women (even when the data in their testimonies was highly suspect), but refused to admit testimony from neighbors who supported the women's telling of the events. In other cases, the autopsies concluded that the cause of infant death was undetermined and may have been due to natural causes, but the judges nevertheless claim that there is sufficient circumstantial evidence to warrant a conviction. To illustrate, Maria, who had already suffered a documented stillbirth several years earlier, told the courts that her most recent pregnancy also ended in stillbirth. She delivered the baby while home alone, without assistance, and after suffering from three days of high fever. The autopsy was unable to confirm live birth, and specifically stated that the cause of death was "undetermined." Yet the judge writes his conclusion as if live birth and criminal death had been clearly established: "(The defendant) injured the legal life of a newborn, which by the fact of being born alive, had the right to exist and to be protected from its birth, especially by its mother." Moreover, the judge seems to argue that the young woman was guilty only because she hid her pregnancy: "No legal motive exists to justify a mother killing her child, much less a defenseless newborn, the evidence in this process demonstrates that the only motive that the defendant had was avoiding public criticism and the rejection by her parents."

In still other cases, the judges seem to acknowledge that the infant death was due to natural causes, but they nevertheless condemn women of aggravated homicide because, as mothers, they should have done more. In one case, a judge wrote: "Such is the case that (the defendant) has two other children, and therefore knows what it means to give birth, and knows the care that she should take with a newborn." In another case: "The conduct and attitude shown by the defendant is characterized by an omission which manifested at the moment of the birth; this same lack of timely assistance, and not wanting to cooperate by going to a health care center, were the causes leading to the death of the child."

Importantly, social expectations of motherhood are a central theme in many of the judges' rulings. One ruling reads: "(the Court) could not reach any other conclusion than that, if the child was dead and his death had been produced violently, then the author of this action couldn't be any other person but the mother." Another reads:

> *since the first person called to protect the life of a newborn is the mother, because she is the person in whom nature has deposited the procreation of*

> *life, and the care to conserve this life, ultimately assuring that this life flourishes; the complete opposite occurred in this case, given that it was the mother herself who, despite being the first obliged to protect this life, was the one who destroyed it with her actions.*

Explaining new forms of prosecution in El Salvador

"Abortion is murder" is a common rallying cry for anti-abortion activists around the globe. But in El Salvador, it has done far more than rally adherents—it has transformed how the state's judicial system prosecutes pregnant women. Why? Although complex questions like this defy simple causal explanations, the brief historical review above offers important insight.

First, the anti-abortion movement in El Salvador took root in a period of what Swidler calls "unsettled times."[18] Such moments provide a unique opportunity for powerful groups to promote cultural change based on their preferred ideologies.[19] In 1992 El Salvador, warring factions had just signed a peace treaty. The conservative ARENA party had spent the better part of the 20th century defending with violence a traditional political and economic system that maintained power in the hands of the landed aristocracy. Now they were required to share the legislative assembly with the very "communist insurgents" they had tried to eliminate. ARENA had long argued that FMLN "communists" were anti-free market, anti-family, and anti-religion. Attacking the FMLN for its defense of (limited) abortion rights was (a) remarkably consistent with ARENA's historical ideology, (b) well-suited to gaining political power in the new arena of political contestation, and (c) supported by Pope John Paul II's recognition of ARENA leaders in protecting the unborn at the Cairo convention.

Second, the language of El Salvador's new anti-abortion legislation is particularly likely to result in increased prosecutions. As noted above, Salvadoran law has institutionalized legal uncertainty about in utero "deaths." If life begins at conception, and abortion is undefined, then why aren't miscarriages or stillbirths legally equivalent to manslaughter, or even aggravated homicide? Moreover, the Salvadoran law is unique in that it penalizes not just abortion, but also "facilitating" abortion, an additional threat that may have encouraged doctors to report suspected abortion, and discouraged the mobilization of abortion rights advocates.

Third, the abortion rights movement made a collective decision to exit the formal political debate for eight years (1999-2007). During this time, the powerful anti-abortion movement no longer had a political opponent with which to engage. Anti-abortion advocates responded to this vacuum by creating a folk devil to attack—the "perverse mother," or "soulless woman," who would callously "throw away" her own child. It was shortly after the abortion rights voices disappeared that references to perverse women began appearing, and that women who suffered obstetrical emergencies began going to jail with increased frequency.

Fourth, the high rates of criminal violence in El Salvador put extraordinary pressure on the judicial system, and this may encourage the prosecution of women for obstetrical emergencies. A source inside the El Salvador attorney general's office reports that it is not uncommon for prosecuting attorneys in the homicide division to have 500 cases on their desk at any one moment. These attorneys also face quotas dictating how many cases they must move forward each month. Because prosecuting alleged gang murderers may open prosecutors to threats of violence from gang affiliates hoping to influence the outcome of the trial, it is not surprising that prosecutors choose to try cases like Mirna, Carmen, and Maria Teresa—poor women who have no money for defense attorneys, no plans to execute violence against their prosecutors, and who are easily detained while in the hospital recovering from their obstetrical emergencies.

Rebirth of the abortion rights movement in El Salvador

In 2006, the *New York Times Magazine* published an in-depth analysis by author Jack Hitt on the total abortion ban in El Salvador.[20] Hitt examined

the case of a young woman named Karina who, he reported, was serving a 30-year prison sentence for "abortion." When the article was published, anti-abortion activists in El Salvador and elsewhere criticized Hitt. Karina was serving 30 years for aggravated homicide, they argued, not for abortion, and Hitt's error reflected his abortion rights motives in writing the article. What we recognize today as a clear prosecutorial pattern illuminates the reason behind Hitt's mistake—the young woman was initially charged with abortion, and only later was the charge upgraded to aggravated homicide. After serving seven years in prison, Karina was released when a new trial found no evidence of homicide.[21]

Hitt's controversial article had a powerful, if largely unintended outcome. He had solicited help from local feminist activists while investigating, and it was only through working with Hitt that these activists realized that Salvadoran women were being imprisoned for the "aggravated homicide" of stillborns. The activists began meeting quietly with other feminist groups to talk about how to mount a legal defense for the young woman highlighted in the *Times* piece. And as the feminist activists uncovered additional cases, they began to re-assess their silence on abortion.

In 2009, the FMLN won control of the executive office, and fear of prosecution for "facilitating" abortion lessened. The feminist activists who had already been quietly defending women imprisoned for stillbirths decided to organize formally, creating the *Agrupación Ciudadana por la Despenalización del Aborto*. Through their activism and provision of free legal representation, this small group of determined feminists has secured the release of five women imprisoned for the aggravated homicide of their newborns. Carmen was pardoned, and Karina and Maria Teresa were both awarded new trials where they were found "not guilty."[22]

The Agrupación's defense of women imprisoned for "homicide" brought new international attention and resources to the abortion rights cause in El Salvador, and has proven to others that mobilizing on behalf of abortion rights does not carry the extreme political costs once imagined. Most centrally, the FMLN has responded to the renewed abortion rights activism by introducing a new bill that would re-insert the original "exceptions" to the abortion law.

Conclusion

For the past 50 years, advocates argued for legal abortion primarily on grounds of public health and women's right to self-determination.[23] Recently, however, advocates are raising a new concern: legal restrictions on pregnant women are increasingly landing women in prison for reproduction-related "crimes."[24] In Mexico, more than 600 women were arrested for abortion between 2009 and 2011, and at least some of them appear to have suffered spontaneous miscarriages.[25] In the United States, increasing numbers of mothers considered morally suspect—typically welfare moms and drug users—are being sent to jail under "fetal harm" laws.[26]

Within this context, El Salvador is a critical case for three key reasons. First, El Salvador is to our knowledge the only place in the world where women receive decades-long sentences for suffering an obstetrical emergency. Investigation into these cases allows continued, informed pressure on the Salvadoran state that may eventually lead to the release of these wrongfully imprisoned women.

Second, the case of El Salvador provides powerful evidence for the critical role of abortion rights activism in protecting marginalized women. Even though the pre-1999 abortion rights voice was unable to change public opinion, failed to stop the passage of the total abortion ban, and failed to defeat the constitutional amendment defining life as beginning at the moment of conception, it still served a critical role. Specifically, by making itself the target of the anti-abortion movement, the abortion rights movement provided a buffer to the marginalized women most at risk for prosecution under the new law. When the abortion rights voice disappeared, poor Salvadoran women were scapegoated as "perverse mothers" and jailed for "aggravated homicide."

A final lesson from El Salvador is that the rallying cry "abortion is murder," typically studied for its importance in mobilizing activists, must

also be studied for its ability to reshape judicial systems. Judicial systems are comprised of individuals—doctors, police officers, attorneys, judges, legislators, and bureaucrats—whose behavior is motivated not only by legislation and regulation, but also by the cultural lens with which they see the world. As demonstrated above, after the explosion of anti-abortion mobilization in the 1990s, the words "abortion" and "homicide" were regularly used interchangeably in El Salvador, not only by the anti-abortion activists themselves, but also by mainstream news reporters, and high-ranking legal officials. It is thus not surprising that this same blurring of abortion and homicide in cultural discourse became institutionalized in the policies and practices of the Salvadoran judicial system. When "life begins at conception" and "abortion is murder," then logically, any loss of life within the uterus—provoked or naturally occurring—warrants investigation. And because provoked abortions are often medically indistinguishable from naturally occurring miscarriages, judges will be asked to determine a woman's responsibility for a "failed" pregnancy, likely by evaluating whether the woman upholds the appropriate cultural standards of mothers. As the case of El Salvador makes clear, women who are poor, poorly educated, and victimized by violence will be the most vulnerable to prosecution.

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Pregnancies and Fetal Anomalies Incompatible with Life in Chile: Arguments and Experiences in Advocating for Legal Reform

LIDIA CASAS AND LIETA VIVALDI

Abstract

Chile allows abortion under no circumstances. Whether it's fetal anomaly incompatible with life or congenital malformation resulting in little or no life expectancy, all Chilean women are expected to carry their pregnancies to term. In this context, in January 2015 the Chilean Congress began debating a bill to legalize abortion on three grounds, including fatal congenital malformation. The medical community, including midwives, has presented its views for and against, especially on how the law may affect clinical practices; in addition, women, many of whom have experienced a fatal congenital malformation diagnosis, have weighed in. This qualitative study draws on 22 semi-structured interviews with nine certified nurse-midwives, one neonatologist, nine obstetrician-gynecologists, one psychiatrist, one psychologist, and one sociologist who provide care during gestation, pregnancy, delivery, and post-delivery in the public and private sectors, plus three interviews with two women and the former partner of a woman who underwent the experience. These interviews starkly illustrate the plight facing women carrying nonviable fetuses, including women's shock upon receiving the diagnosis, their feelings of bereavement and loss, and the clinical practices used in an attempt to ease their suffering under the weight of exceedingly difficult legal restrictions. These interviews confirmed that compelling women to carry nonviable fetuses to term violates their human rights. They also show that the chances of legislative change are real and that such change will present new challenges to the Chilean health care system.

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Introduction

Chile bans abortion even in cases of congenital malformation with little or no life expectancy. As a result, all Chilean women are forced to carry their pregnancies to term. Their only choices are safe termination abroad or safe or unsafe illegal abortion at home. In this context, in January 2015 the Chilean Congress began debating a government bill to legalize abortion on three grounds, including fatal congenital malformation. Since 1999, Chile has been prompted numerous times by United Nations human rights bodies to improve its abortion laws.[1]

This article documents the experience of carrying and delivering fetuses with congenital anomalies incompatible with life and reviews the actions of providers who care for these women during gestation, pregnancy, delivery, and post-delivery. In Chile, published studies on pregnancy termination in this context are few. The plight facing women with a severe fetal congenital anomaly diagnosis differs from that of those who want to terminate a pregnancy in that the former are generally wanted pregnancies and the sense of loss is highly distinct.[2] The literature notes that for women, the autonomy to decide whether to terminate or continue a pregnancy with fetal anomaly is of critical importance, and governments must provide counseling and care tailored to their needs.[3]

The Chilean medical community has taken active part in the legislative debate, speaking out for and against President Michelle Bachelet's proposed bill. They have provided mostly technical opinions, save for midwives who also contributed the experiences of pregnant women. Women for and against the bill who have experienced such pregnancies have provided testimony in Congress and to the media. This article tries to provide a nuanced portrait of women's suffering and of the difficulties confronted by clinicians dealing with fetal malformation diagnoses in a country with an absolute abortion ban.

We draw on interviews with public and private health care providers. To illustrate women's plight, we also interviewed two women and the former male partner of a woman who underwent this experience. While we contacted more women, the vast majority did not wish to be interviewed. Due to these constraints, most insights on women's experiences were provided by their health care providers. These interviews confirmed that forcing women to carry a nonviable fetus to term violates their human rights.

Methods

Our investigation used mixed qualitative methods involving compilation and systemization of information from primary sources (statistical registers) and secondary sources, including a literature review and unpublished reports about women's experiences and overall treatment received. Although not the original intent, this study captures primarily the experiences of health care providers, since most of the women we contacted did not wish to be interviewed.

From July through September 2015, we conducted 22 semi-structured interviews with one psychiatrist, one psychologist, nine certified nurse-midwives, one neonatologist, nine obstetrician-gynecologists, and one sociologist in public and private practice in the cities of Santiago, Valparaíso, and Valdivia. One interview was part of a group session with a multidisciplinary clinical research team that relayed the results of an unpublished study based on a clinical history review and interviews with nonviable pregnancy patients in the Aconcagua and Valparaíso-Quillota public health services. We also interviewed two women and the former partner of a woman who lived through the experience. Questions posed to health care providers centered on medical and personal experiences and on their views on the decriminalization of abortion on fatal fetal anomaly grounds. We asked them when, by whom, and how affected women were told; what overall medical treatment was provided; what the women's reactions were; whether the women requested pregnancy interruption; and what course of action was followed for women who sought abortions. We also queried them on their views on liberalization of the law and its potential effects on clinical practice. The two women and the former partner, for their part,

were asked about medical treatment received, options given during gestation, whether they sought or thought about pregnancy termination, and their views on the decriminalization of abortion on fatal fetal anomaly grounds, as there is evidence that at least some women are given the option of terminating the pregnancy or inducing early labor.[4]

Interviewees were contacted personally or through the snowball technique.[5] We contacted antenatal care professionals who provided names of obstetrician-gynecologists and other health care providers, as well as contacts with the College of Nurse-Midwives. The women were identified with assistance from health care providers and personal contacts. In the case of the male partner, his former wife was not willing to participate. Locating women who had had nonviable pregnancies and were willing to talk was not an easy proposition. Interviews were done in person, digitally recorded, and transcribed for analysis. The research was reviewed and approved by the Diego Portales University Ethics Committee. All participants were fully apprised of the contents, potential risks, and benefits; were assured anonymity and confidentiality; and gave their consent.

Context

On January 31, 2015, the government of President Michelle Bachelet submitted a bill to decriminalize abortion on three grounds: danger to the woman's life, fetal anomaly incompatible with life, and rape. At present, Chile does not allow abortion under any circumstances. In March 2016, the bill passed in the Chamber of Deputies, not before the fetal anomaly clause was reframed as "a pregnancy may be terminated when … the embryo or fetus suffers a lethal congenital or genetic structural impairment." All polls conducted since January 2015 have shown widespread support for decriminalization in cases of severe fetal abnormality. An October 2016 poll by the nongovernmental organization Humanas showed that 75% of female respondents agreed with the fetal anomaly exception. The lowest level of support in any poll stood at 67% for both men and women.

There is no cut-and-dried definition of "fetal anomaly incompatible with life" or a definitive understanding or list of fatal malformations. For the purposes of the congressional debate, local experts proposed one: most fetal anomalies involve fetal or neonatal death.[6] This definition is phrased to avoid tension with organizations of persons with disabilities and the misperception that severe fetal anomalies include Down syndrome. Carmen Astete and Blanca Román note that a fatal prognosis may result from a combination of pathologies.[7] A literature review presented by one of the local experts found a number of recognized fatal pathologies, including bilateral renal agenesis, Potter syndrome, acrania/anencephaly, skeletal dysplasia, trisomy 13 or 18, and alobar holoprosencephaly.[8] Local experts, in fact, went by the inventory in the UK's Fetal Anomaly Screening Program.[9] Hernán Muñoz et al. report that 20% of 23,446 infant deaths in Chile in 2013 involved fetal anomalies.[10] Overall, Chilean infant mortality has fallen, while the number of malformations has remained constant, perhaps due to late and teen pregnancies and alcohol and drug abuse.[11] For 2012, Chile's National Statistics Institute noted a total of 8.6 fetal anomalies per 1,000 live births.[12]

Malformations incompatible with life can be diagnosed at various stages. The Chilean public health system advises ultrasound testing at weeks 11–14, 20–24, and 30–32.[13] Muñoz et al.'s meta-analysis review shows that 51% of anomalies can be diagnosed at weeks 11–14 and 65.7% in the second trimester.[14] All clinicians interviewed agreed that severe malformations, such as anencephaly, become immediately evident at the first ultrasound; if in doubt, further tests can confirm. Other malformations may be detected at later stages.

In the Chilean public health system, biotechnology techniques and a multidisciplinary approach have ensured timelier, more accurate diagnoses. Despite suboptimal infrastructure and a specialist shortage, 68% of fetal anomalies and up to 88% of fatal anomalies are diagnosed prenatally.[15] Muñoz et al. confirm that 80% of all fatal malformations and up to 100% of some fatal anomalies are diagnosed prenatally in Chile.[16]

Findings

Diagnosis and pregnancy

Initial reaction. How and when a diagnosis is reported is key. Women's reactions will vary depending on whether the pregnancy was planned, if they had previously contemplated abortion, if they have a support network, and whether they have other children.

In the public health system, women often hear the results from sonographers or attending physicians. Midwives noted that because of their rapport with patients and their ability to use less technical language, it often falls to them to provide details and explain the pathology. Depending on protocols, women may also be referred to secondary care facilities for confirmation by a geneticist and an opinion on fetal survival.

Data from two public health services in Santiago show that few babies born with a fetal anomaly incompatible with life survive beyond one week.[17] Health care providers noted that most mothers report uncertainty as a key driver of distress. One obstetrician-gynecologist recommended being highly specific with women or couples about fetal death, birth, and survival rates beyond one week. To facilitate informed decision making, he thought legal reform ought to mandate full information and counseling.

In the public health system, information and emotional support is provided at specialist perinatal centers. In the private sector, diagnoses often come from the attending physician or the sonographer. Sometimes doctors disagree on a diagnosis, as the former partner noted, which can lead to either hopes for a positive outcome or further anxiety over the uncertainty surrounding the pregnancy. Disagreement among doctors is in fact a moot point, as abortion is not a legal option and the primary focus for clinicians is to find out whether the fetus can receive antenatal care that could improve its chances of survival.

There was consensus among medical respondents that most affected women experience shock and disbelief. As a female midwife said, it is news no one expects to hear: "'Maybe you're wrong. Maybe I didn't understand right. Miracles happen.'" A woman treated at a private clinic said that she was shocked, yet had only a general idea of the diagnosis. Her gynecologist provided details only a month later. The former partner said:

> *The news was devastating. I was stunned; my ex cried, but stayed strong. I recall making an appointment for a test; they took some amniotic fluid and we got the results three weeks later. But this wasn't the attending; our gynecologist thought the baby was fine, that it was healthy … I breathed easier. I believed him, I was relieved.*

Case management by health care providers after first diagnosis. A confirmed diagnosis triggers a range of feelings that may vary over time but are best described as "a sense of overflowing bereavement," as one of the women interviewed put it. In practical terms, it is the start of a lengthy, uncertain process in which many practitioners interact with varying degrees of coordination. The former partner, whose wife was treated at one of Chile's best private clinics, said it was four weeks between first diagnosis and confirmation, similar to other private clinics. For women in the public system, the process is lengthier due to a shortage of specialists.

Multidisciplinary teams making group decisions, including on fatal malformation cases, have recently started forming across Chile's public health service. In the private sector, cases continue to be handled on an individual basis. One private sector obstetrician-gynecologist said that dealing with these cases is a very personal affair. When faced with a difficult situation, he asks colleagues for a second opinion, but there is no comprehensive approach.

Since specialist maternal and fetal health centers are not available in most of Chile, patients are referred to the University of Chile and the Pontifical Catholic University teaching hospitals and some regional hospitals or private clinics. The aim is to secure a clear-cut diagnosis and determine possible antenatal care, not pregnancy termination. Many respondents agreed that more such centers are needed, as women who live far away have it much

harder: in addition to the expense and emotional toll, they must also travel.

All health professionals noted that the absence of protocols that standardize concepts, processes, and action means that women depend on the judgment, responsiveness, and willingness of the attending team.

One female nurse-midwife felt that the criminalization of therapeutic abortion explains the lack of protocols:

> *Since therapeutic abortion is illegal, there is no training and no protocols. There is merely creativity and instinct by the multidisciplinary team responsible … We have no specially trained people to follow up on cases.*

Living with pregnancy after diagnosis. The sense of disbelief that follows a malformation diagnosis is often followed by feelings of unfitness to be a wife and mother. Women experience denial and self-blame or downplay the situation. As a group of female midwives noted, feelings of guilt, incompetence, and shame are all channeled toward family and partners: "'Why wasn't I able to carry a healthy baby? Why me?'" This, in turn, can lead to searching for clues in one's own or the partner's family. Guilt takes the form of relentless questioning. The psychiatrist said:

> *Many mothers wonder why this happened. They took good care of themselves, yet some people who are into drugs or alcohol have no issues. They even think "it must have been something I ate … maybe that sushi did this to me."*

The psychologist argued that a severely impaired fetus is in itself a traumatic event:

> *There is guilt, self-reproach, dejection, depression, etc. Motherhood is so idealized that we tend to believe the idea of the "super mom." This is a sensitive issue, because there is a sense of grief and self-flagellation that is very persistent over time … "Here is the failed mother."*

The psychiatrist noted that her patients expressed a range of feelings. While there is anguish at not knowing when the fetus will die, some are relieved that it will be spared a lifetime of pain. Others just want it removed to end its suffering or to put an end to a hopeless situation. The psychiatrist and Woman A, who had a nonviable pregnancy, agreed that there is much anxiety over whether the fetus is still moving. Woman B said, "You eat something sweet so that the fetus moves."

She described this complex process:

> *It's torture … At night I feel a lot of anguish, but ten minutes later I'll be laughing my head off, and after that, I'll start crying. It's a process. It helps to think a little bit like a mom, what type of life my baby would even have. It's a relief. If it's for the best [for it to die], OK, then that's how it should be. That calms you down, it helps. It's not that you are happy that your baby isn't OK, but knowing that its life would have been awful, that's a relief. Every sorrow is one's own and one is not more important than another, but if you were to give birth thinking everything was normal and then to have it die, that would be worse. That also makes me feel a little better. I have these months—that can also be torture—to brace for it … We can all die any time, but this is a death foretold. And that is also a relief. When the uncertainty passes, you have peace. I cry a lot, it's hard to get up in the morning, it's hard to fall asleep, it's hard to go to work, but deep down I am at peace.*

Faith and God figure constantly, albeit ambiguously. There is always hope for a miracle, that the diagnosis was wrong, or that God will intervene. But there is also the wrathful God. Interviews with midwives and the psychiatrist, and the results of an unpublished study conducted by another research team, showed that women with unplanned pregnancies who contemplated abortion before finding out that their fetus had an abnormality experienced the most guilt, as they felt it to be the wrath of God. The man interviewed said that his former partner, a devout Catholic, turned to mysticism as a coping mechanism.

Health risks. Almost all health care providers interviewed saw no health risks for the mother in continuing the pregnancy, save for conditions such as a partial molar pregnancy or excess amniotic

fluid. The former can cause a choriocarcinoma—a type of tumor—while the latter can cause placental abruption and increase the risk of post-partum bleeding. Risk to life is considered rare. As some obstetrician-gynecologists suggested, medical practice allows for some form of treatment, and if pregnancy termination occurs, it is the consequence, not the goal.

However, all agreed that the heaviest impact is on mental health. Pregnancy brings exposure, compliments, and questions in public, at work, from relatives, and even from unaware health care workers. Some women turned to Chile Crece Contigo (Chile Grows with You), a nationwide social program for parents and family members that, for these specific cases, offers support and counseling designed to ease guilt and prevent pathological grief.[18]

The psychiatrist said:

> *Only psychiatrists can grant sick leave to mothers dealing with anxiety or anguish, but getting insurers to cover this is hard. They have cut rest periods down from a month to 15 days. A woman carrying a nonviable fetus shouldn't have to go to work because she will inevitably be asked about the baby, with catastrophic results for her mental health. I know of a terrible case of an anencephalic baby who survived for nearly three months. The mother, who was over 40, fully expected it to live and camped out at the hospital. When it died she went into pathological grief. When she had first found out that the fetus was malformed she had threatened to jump in front of the subway if we didn't abort it.*

A public health midwife said that women

> *feel that somehow they have failed; that they are just unable to have healthy children. They dread a new pregnancy and many opt for tubal ligation … Unresolved grief leads to depression but many can't get time off work for therapy. A common result is post-partum depression becoming chronic. While pregnant they have nightmares about carrying a monster, like in the movies. After birth, many don't want to see the malformed baby.*

Her colleagues agreed that after an experience like this, many couples break up. Some have known of men who avoid sex in order to prevent another pregnancy.

Mental health issues are compounded by poorly trained medical practitioners. Female patients in the private health system pay out of pocket for counseling, and costs are steep. A woman related her experience at an expensive private clinic:

> *The doctor said that we needed counseling, and he went on to offer—practically handing out brochures—the services of the clinic's excellent psychologists. I found this tactless and uncaring. Rather than empathy, I felt they were just trying to make money. When we were given the diagnosis we were in shock, but what he said felt almost like "Just go home" … It was very painful.*

What women are offered. Nearly all interviewees agreed that the law grossly restricts latitude; as one midwife noted, "Chile does not allow for a plan B; both therapeutic and non-therapeutic abortion are illegal." Some health professionals are at a loss when women ask to terminate a pregnancy. Most say they understand their plight, but cannot do anything. As one physician said:

> *No one offers anything … no one does [pregnancy termination], the most you can do is a karyogram [a diagram of the features of chromosomes done via an amniotic fluid, placental, or blood sample]. That said, I know for a fact that some doctors in private practice tell women about misoprostol.*

Pregnancy termination options in the public and private sectors are different. A woman seeing a doctor in private practice said that he suggested a safe out-of-country abortion, an option she declined. Although she knew that her daughter would die at birth, she chose to go through with the experience. Abroad she would have no support network, and she was uncomfortable with using an option many Chilean women can't afford. Several interviews corroborated that private clinics often suggest travel abroad, an option that patients in the public health system—who likely cannot afford it—don't often hear about. Travel to countries such as Brazil or Colombia costs at least US$500 per person, plus

living and medical expenses. Cuba or Mexico cost almost twice as much.

The former partner we interviewed said that while their doctor never suggested termination, he did note that most patients do not carry such pregnancies to term.

Among health professionals asked about women who sought an abortion, views and perceptions were mixed. Some obstetrician-gynecologists said that most do not ask. One said:

> *Everyone knows that in Chile abortion is against the law. Most patients don't ask for an abortion and most doctors, if asked, will say no. But that doesn't mean that women aren't going to do it.*

Another agreed that few women ask for an abortion: "Only one out of ten, and then in strict confidence. They don't want their medical record to show that they sought an abortion and risk others finding out."

One physician said that access to the internet and information sharing means women know about misoprostol, which is why they are no longer asking doctors about abortions. One midwife said that she knows some doctors who tell women about misoprostol. Another said, "We gave this woman a misoprostol prescription. We helped her all we could." But misoprostol safety declines with gestational age: "It is less effective because most malformations are diagnosed late, not at 6 to 8 weeks … and its use—or misuse—at that stage can cause severe bleeding, infection, uterine rupture, etc."

An obstetrician-gynecologist in the regional public and private health systems said, "Most women who decide to carry a malformed fetus to term are affluent and devout. Among the disadvantaged, most choose termination."

In Chile, "affluent and devout" are bywords for the usually well-heeled members of ultra-conservative Catholic groupings such as the Opus Dei or the Legion of Christ. But as a public hospital psychologist who specializes in fatal anomalies and treats underprivileged women said:

> *My patients aren't looking to terminate their pregnancies. I know a very specific profile: women who submit to the [gendered] social mandate and don't have the wherewithal to question it. Some want to continue their pregnancy, others don't have a choice.*

Most health care providers feel that women do not ask because they probably sense that doctors will not help them commit an illegal act, because they do not have the kind of rapport that would allow such a question, or because there is family pressure to carry on.

A midwife said that women "are pressured by sisters, mothers, partners, etc. to see things through. They all offer opinions and women feel forced to carry on. These poor women have a really hard time. They can't sleep."

But as some noted, partners or relatives can also help empower women to make their own choices. The psychiatrist observed that men escorting their partners to appointments tend to support them to do as they choose:

> *Women call the shots. There is a sort of respect on the part of these macho men, who sometimes may even be criminals, but feel that women should be able to do what they want, considering that they are the ones who suffer.*

Early induction of labor and delivery. Some medical respondents said that pregnancy termination may be discussed in meetings with department heads and ethics committees as a means to reduce suffering or health risks. However, when done without department heads signing off, early induction of labor and delivery before the fetus can be deemed to be mature or to have reached a certain gestational age can expose practitioners to sanctions.

When asked whether this procedure was performed at their medical centers, interviewees gave disparate answers. Some said no, others that it was common. A review of all interviews shows that each respondent had his or her own definition of "abortion" and of the gestational age at which early induction of labor is an option. One physician said that if a woman requested it, her opinion should prevail:

> *In pregnancies without chance of fetal survival, we support a woman's choice to terminate her pregnan-*

> *cy at weeks 30 or 32. We know the fetus is going to die anyway, so why wait until 40 weeks?*

Another said:

> *[T]he [gestational] age limit allows us to manipulate the law. Up to 15 weeks or 500 grams in weight, it's abortion. Few women ask to induce a preterm birth … Some patients have secondary pathologies; if there is a health risk, termination can be moved up to 33 weeks.*

One midwife said, "Some women ask for termination and the best you can do, if doctors are sympathetic, is ensure that they accept that she should decide, that is, wait for viability until week 34."

Health conditions are also weighed in pondering induction. A member of a multidisciplinary team noted:

> *Some women ask for induced labor, which is technically not the same as termination. … At 35 weeks some just can't take it anymore, but unfortunately the prescription is to complete rather than induce, unless strong medical reasons exist. It is rare for a woman's life to be at risk. If there's a request for induction we will take it to the ethics committee, but it usually doesn't go over well. They argue technicalities that sound more like institutional reasons. The technical aspects aren't trivial, but the real issue is why are such women allowed to get to 37 weeks … You see patients having a really hard time, and you wonder why that wasn't addressed earlier.*

There is duality when handling these situations. A physician noted that

> *one can act after 22 weeks. For example, if you have a patient with a hypertensive crisis and we're at 25 weeks, you act. If there aren't any health issues, you wait until the situation calls for action.*

Another doctor said that obstetric risk protocols are followed "until [the pregnancy] is considered viable, at 35 or 36 weeks, approximately. If you have a nonviable fetus, for example, if the fetus has acrania, we remove it a bit before."

Some argue that the private sector affords more freedom of action, but inducing labor remains a hush topic. And based on interviewees' responses, it is clearly an issue for which there is no guidance or consensual or evidence-based policy.

Delivery and post-partum. Differences in the public and private health systems become especially marked at delivery. For many women, this is a key moment since it is when, maybe for just a few minutes, they will get to see their child before it dies. In the private system, women are usually in a private room, which lets them and their loved ones live the moment in privacy. In the public system, the lack of infrastructure does not allow for a more intimate atmosphere. Caring staff will usually draw a curtain around the bed or otherwise provide some privacy, but this depends both on the particular staffers and on physical capacity. As a midwife noted:

> *Women arriving in their beds are surrounded by other women with babies in arms. You realize what's going on and draw the curtain, but still, next to her there's another mother holding a bouncing baby.*

Physicians and midwives agree that women now have more choices. They can choose delivery methods, whether to christen the baby, if they want to say their goodbyes, and so on. A woman said that holding her daughter until she died in her arms was a big help.

Respondents reported that some maternity care facilities provide areas for women and relatives to practice their beliefs, and even allow them to see or touch the baby if they wish. This helps them go through this ordeal in a more intimate, supportive environment. Yet there is a significant difference between a newborn who lives for a few minutes or hours and one who survives for months. One obstetrician-gynecologist said:

> *When someone says that these pregnancies can be ended ahead of time, some people are opposed just because fetuses can survive a month or two. But is it survival or just extended suffering? If the mother chooses to live through that, OK, that's her option. But if she doesn't, the choice should also be there.*

One midwife remembered a woman from outside Santiago whose son survived, which forced her to travel back and forth frequently because he needed

constant care. She felt that such situations are easier to deal with when the baby dies shortly after birth. When death takes its time, people become afraid of medical costs and feel guilty over wanting it to be over soon, with serious mental health consequences for all involved. One physician said:

> *The real ordeal comes when a baby survives in terrible condition. Sometimes the family has to pay for expensive surgery, and maybe look after a seriously impaired baby for the rest of its life … If you ask me, I would take trisomy 13, anencephaly or microcephaly anytime, because the baby is dead within three days. The problem is when it survives and nobody knows how or why it's still alive, or for how long.*

A midwife reflected on how difficult it is for women to deal with grief and its impact:

> *Many have other children. They don't really have the time to process their grief, because life must go on and in this macho society women are the tower of strength that must bite the bullet. If they stop working, the whole home comes tumbling down. They don't have time to grieve or find a psychologist because the kids have to go to school, have to be fed, etc. Husbands don't deal with this well. They have depressions they never deal with, which often leads to marriage breakup.*

One respondent related the emotional toll taken by holding down a job and caring for her family. The fetus she was carrying died in utero, yet she had to wait two weeks for a surgery slot to have it removed. She chose not to see it. She said that despite the pain of coming home to an empty baby room, it was a great relief knowing that it no longer suffered.

Public system professionals agree that poor follow-up with women beyond the first year is an issue, as they never know what happens with the grieving process afterward. In the private health system, based as it is on individual health risk, most insurers put caps on coverage and women must pay out of pocket for extended mental health care.

Opinions on the therapeutic abortion bill

Almost all medical staff respondents interviewed supported therapeutic abortion on grounds of fatal impairment. They played down the physical or health risks for the woman but agreed that these cases can have a major mental health impact. These firsthand accounts exposed an urgent need to legislate pregnancy termination in cases of fatal congenital malformation or imminent danger to a woman's life or health. The neonatologist noted:

> *The issue put me in a quandary ... Before I started here I was against abortion, but I've seen so much suffering in these mothers that go through nightmarish pregnancies … Those brainless patients that only breathe for three hours and then die, the poor mothers that have to carry those pregnancies to term—it's heart-rending.*

Another said:

> *Having a choice would be quite a relief, even for mothers who decide to go through with the pregnancy. It would mean that they do so because they want to, not because they are forced to.*

A midwife said that the law prevents her from providing care that is consistent with women's sexual and reproductive rights. The psychiatrist added:

> *It's abhorrent that in this country we've made so much progress in biomedicine but still think as if we were back in the Middle Ages … If we have prenatal diagnostics, if medicine has made such progress, then we ought to have therapeutic procedures that are consistent with such progress. A therapeutic abortion ban does unthinkable violence, is unethical, and contradicts the basic principles of bioethics.*

Another midwife agreed with the three grounds in the proposed bill but said that one of the objectives of decriminalization should be to promote health and safety:

> *Since all abortion is criminalized, all abortion is clandestine, and safety will hinge on income level … So it comes down to the right to adequate health care and the right not to be mutilated or die as a result.*

The psychologist commented:

> *The law doesn't merely sanction or ban abortion, it also generates a social narrative in which we are not*

> *allowed to talk about it. And for these traumas, this is a very delicate matter. That is one consequence of the ban. Even if we legislate abortion, and I hope that is the case, we would still have to wait a few generations to be able to speak freely about it.*

Some health care providers who opposed the bill said that most women were strong enough to deal with the experience. Others resorted to convoluted arguments to avoid acknowledging their opposition. One physician felt that the bill fails to take account of the opinion of medical specialists and the reality of medical practice in Chile: "Techniques are available to identify conditions incompatible with life, and the law should require that fetal-maternal specialists provide the diagnosis."

Another saw the potential for conflict with insurers:

> *If the law passes, insurance companies will favor termination, like in Germany or England. If a woman is 12 or 15 weeks along and she is carrying an anencephalic fetus, they'll suggest termination. If she disagrees, checkups, tests, delivery, ICU days—all that will cost a lot of money. So from a purely financial standpoint, insurers will press for termination.*

A midwife felt that the bill fails to offer malpractice protection, adding that if anencephalic babies can survive six or seven days—as she has seen in her practice—even that short time may be enough for some families. Her implicit opposition seems based on a concern that health care providers, especially sonographers, could be held liable for misdiagnoses.

When asked if the current abortion ban affects patient choice, an obstetrician-gynecologist working in antenatal care said:

> *Personally, I don't think so. The problem isn't the law, it's a system that doesn't deliver proper care. This [legislative debate] is a great opportunity for the country to confront the issue and do the right thing, for instance creating [specialized] centers … to deal with these patients and give them the maximum number of choices.*

The two women we interviewed and the man's ex-wife did not terminate their pregnancies. One sought termination, but her physician discouraged it; a midwife recommended another doctor, but the woman was too scared to follow through. All three interviewees agreed that women should have a choice.

Discussion

Our findings match other studies of pregnant women with a fetal anomaly diagnosis in that the primary feelings are shock and disbelief.[19] Forced motherhood in a fetal impairment context is an undue hardship on women and their partners and often leads to breakups. While some of the women in our sample (the women we directly interviewed and patients of the people we interviewed) sought to get pregnant again, fear led most to shun a future pregnancy. Some of these trends have been noted in other studies.[20]

A study that does not directly capture the views of women is admittedly limited. In this regard, we note that the task is especially challenging where abortion is banned, as women have few opportunities to ponder pregnancy termination and health care providers have few options to mitigate suffering, promote overall health, or prevent the risks associated with continuing a pregnancy. Abortion is also stigmatized through gender norms that hold women up as strong caregivers capable of dealing with the experience, as some interviewees noted. Gender issues and the stigma associated with abortion are also observed in countries where abortion is legal.[21] Our findings suggest that the criminalization of abortion reinforces a feeling of ethical or legal wrongdoing. Not all women may wish to terminate their pregnancies, even when legal.[22] The issue is not "pro-choice beliefs." Rather, as one study of mostly religious women and their partners documented, the issue is about having options.[23]

Health care staff, for their part, confront their own dilemmas. They are often untrained to handle these situations, cannot offer women other options, and must resort to circumventing the law to provide early induction of labor, suggest an illegal abortion, or prescribe misoprostol. This state of

powerlessness is a notorious stressor. In a context where abortion is absolutely banned and protocols do not exist, it is not clear whether even sympathetic health care staff know about the correct use of misoprostol in a second-trimester abortion.

In Chile, the formal training of midwives, obstetrician-gynecologists, and other practitioners does not include dealing with these difficult pregnancies. Because of legal restrictions on proper medical practice in pregnancy termination, many are unfamiliar with the technical aspects of second-trimester abortion, which results in suboptimal care. In this regard, the symbolic power of criminal law works in two ways: it steers health care workers away from assisting women and restricts proper clinical practice.

Some women can obtain a safe abortion abroad on the direct advice of their obstetrician-gynecologist. Chile is not at all unlike Ireland, where women obtain abortions abroad, in a practice known as "abortion tourism."[24] But women who lack the means are left to their own devices and must face varying degrees of safety.

In the Chilean public health system, women who seek to terminate a pregnancy after 22 weeks are dependent on medical discretion. Some doctors will perform early induction for the sake of a woman's health and integrity, knowing full well that they may be subject to disciplinary or even criminal action. Pamela Eguiguren et al. note that termination options hinge on sympathy, the views of the health care team, and whether the setting is public or private.[25]

The current legislative debate illustrates the irony of the situation and the challenges facing the Chilean health care system. A senator recently submitted an amendment to the bill requiring that even if the fatal fetal malformation is diagnosed early, the abortion will have to wait until after week 22 or when the fetus weighs above 500 grams, in order to have an early induction of labor following a two-week cooling-off period. The amendment is explicit in referring to this as early termination rather than abortion. As discussed, and all experts agree, fetal anomalies in the bill are associated with fetal or neonatal death—that is, fetuses with little or no chance of survival. The proposed gestational limit speaks to the reluctance of allowing abortion, while delaying early termination inflicts unreasonable suffering on women. Ironically, in Sweden, which allows abortion prior to 18 weeks, abortion after 21 weeks is seldom approved.[26]

The above amendment calls to mind a 2002 case that inspired an unsuccessful legislative motion to decriminalize abortion on fetal malformation grounds. A woman with a partial molar pregnancy publicly requested an abortion. The then health minister, an expert transplant pediatrician, answered that no clinician or government official could help, as abortion was illegal. After the woman underwent an emergency early induction of labor, Chile's main conservative newspaper ran a front-page headline stressing that this was pregnancy termination, not abortion.[27] In 2017, the former health minister who had reminded the affected woman that abortion was illegal signed and sponsored a paid ad opposing Bachelet's bill in the same newspaper.

The abortion ban exposes women to otherwise avoidable risks, and medical practitioners distinguish between obstetric and mental health consequences. Regarding obstetric risks, in previous research, a midwife referred to an adolescent who died as a consequence of delaying inducing labor with an anencephalic fetus.[28] But as many respondents emphasized, inasmuch as health protection is limited to its most basic physical attributes, the risks involved in ignoring the severe mental health effects of enforced pregnancy can only increase. Serious harm to psychological integrity can result in severe and chronic depression, pathological grief, and, as some respondents suggested, even suicidal ideation.

In *K.L. v. Peru*, the United Nations Human Rights Committee found that forcing women to carry a nonviable fetus to term constitutes cruel and inhuman treatment.[29] Women confronted with nonviable pregnancies have varying experiences, expectations, and needs. This should be recognized, and women—whether they choose to continue or terminate—should receive support and care, while states should guarantee appropriate conditions that

allow women to make a very difficult decision.

Failure to acknowledge this issue limits the chances for a humane response. A country that bans all abortion cannot protect the mental or physical integrity of women who choose to terminate their pregnancies, nor does it adequately shoulder the responsibility for mitigating the mental health consequences. And a system of support should seek not to persuade but to provide and organize health care that meets women's needs and rights.

The United Nations Committee on Economic, Social and Cultural Rights has asked states to remove all barriers to the full realization of sexual and reproductive rights.[30] Abortion bans make women unequal, with impacts that differ depending on economic, social, and cultural factors, including the health care available to them.

The Inter-American Court of Human Rights, in ordering provisional measures in *B. v. El Salvador*, required the state to ensure the life and integrity of B., a pregnant woman who had discoid lupus erythematosus and renal failure, compounded by an anencephalic fetus that placed her life, personal integrity, and health in imminent peril.[31] The recommended medical protocol was termination, but El Salvador bans therapeutic abortion, and the courts declined to order access. As a result, the Inter-American Court required the state to

> *adopt and guarantee, urgently, all the necessary and effective measures so that the medical team who are treating B. can take, without any interference, the medical measures they consider opportune and desirable to ensure due protection of the rights established in … the American Convention and, in this way, avoid any damage that could be irreparable to the rights to the life, personal integrity and health of B.*[32]

The paradox in allowing termination on grounds of fetal nonviability is in the language. The viability is used against the law when there is no life expectancy. Chilean midwives and obstetrician-gynecologists use second-trimester induction of labor to provide "a solution" that will not be an abortion from a medical or technical point of view. But since Chilean law does not make any such distinctions, this is still illegal.

This also raises unresolved issues. The exception works under the assumption that the fetus is not viable and that the condition requires certainties that medicine is not necessarily able to offer. While the absence of life expectancy after birth seems to remove the moral weight of allowing a decision to terminate, fear of misdiagnosis exposes the moral dilemma faced by health care providers. Clinicians who disagree with women's right to choose may cite diagnostic uncertainty in order not to apprise women fully and adequately about pregnancy termination. One interviewee suggested telling women of the probable life expectancy of the fetus, consistent with the moral stand that a life is worth living, regardless of length. But fear of liability or of being held accountable for the wrong decision obscures the basic point that women should be able to choose based on all the information science is able to provide.

Conclusions and recommendations

Whenever abortion is banned, women carrying a nonviable fetus face heightened mental anguish and risks to their moral integrity. This is compounded by the stigma and mistreatment involved in depriving women of both a voice and the chance to make an exceedingly difficult decision on their own.

While the severe fetal congenital indication in the proposed Chilean bill may be seen as a medical issue, in fact agency is the key. Women should be able to decide, yet the legislative debate has highlighted the weight of biomedical rhetoric and the medical profession's ability to impede or facilitate pregnancy termination. Accordingly, given the limitations of science and of the health care system, requiring a rock-solid diagnosis could become a barrier.

Respecting women's rights means taking into account the complexities of allowing abortion in cases with little or no chance of survival after birth. It also means supporting women by providing nondirective counseling and compassionate care throughout the whole process and beyond.

A legal regime that bans all abortion does not guarantee women's health or protect their rights to

equality, dignity, and non-discrimination.

In Chile, the legislative debate and any future law reform and policies should address the plight of these women and ensure the protection of their human rights. All women should be treated with dignity and respect and should be empowered to voluntarily choose whether to terminate or continue a pregnancy.

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Legal Knowledge as a Tool for Social Change: La Mesa por la Vida y la Salud de las Mujeres as an Expert on Colombian Abortion Law

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Abstract

In May 2006, Colombia's Constitutional Court liberalized abortion, introducing three circumstances under which the procedure would not be considered a crime: (1) rape or incest; (2) a risk to the woman's health or life; and (3) fetal malformations incompatible with life. Immediately following the court's ruling, known as Sentence C-355, members of La Mesa por la Vida y Salud de las Mujeres (hereinafter La Mesa) began to mobilize to ensure the decision's implementation, bearing in mind the limited impact that the legal framework endorsed by the court has had in other countries in the region. We argue that La Mesa's strategy is an innovative one in the field of legal mobilization insofar as it presumes that law can be shaped not just by public officials and universities but also by social actors engaged in the creation and diffusion of legal knowledge. In this regard, La Mesa has become a legal expert on abortion by accumulating knowledge about the multiple legal rules affecting the practice of abortion and about the situations in which these rules are to be applied. In addition, by becoming a legal expert, La Mesa has been able to persuade health providers that they will not risk criminal prosecution or being fired if they perform abortions. We call this effect of legal mobilization a "pedagogical effect" insofar as it involves the production of expertise and appropriation of knowledge by health professionals. We conclude by discussing La Mesa's choice to become a legal expert on abortion as opposed to recruiting academics to do this work or encouraging women to produce and disseminate this knowledge.

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Introduction

In May 2006, Colombia's Constitutional Court liberalized abortion, introducing three circumstances under which the procedure would not be considered a crime: (1) rape or incest; (2) a risk to the woman's health or life; and (3) fetal malformations incompatible with life.[1] This ruling, which came after a series of decisions on the criminalization of abortion that deferred the issue to legislators, was the result of a high-impact litigation strategy devised by Women's Link Worldwide.[2] Aware of the social and political importance of arguments favoring the criminalization of abortion, as well as the challenges faced by other Latin American countries in implementing laws liberalizing the procedure, the group of women's organizations known as La Mesa por la Vida y la Salud de las Mujeres (hereinafter La Mesa) began to mobilize to ensure the decision's implementation as soon as the decision was publicized. In this article, we describe the strategy used by La Mesa to become an expert authority on abortion and explain how this knowledge has helped increase women's access to abortion. We argue that La Mesa's strategy is an innovative one in the field of legal mobilization insofar as it presumes that law can be shaped by social actors—not just public officials and universities—through the creation and diffusion of legal knowledge.[3] We believe that the best way to pinpoint the effect of La Mesa's mobilization is by looking at its pedagogical effect regarding health providers' awareness of the grounds for abortion.

We claim that La Mesa has become a legal expert on abortion by accumulating knowledge about the multiple legal rules affecting the practice of abortion and about the situations in which these rules are to be applied. We then claim that by becoming a legal expert, La Mesa has been able to persuade health providers that they will not risk criminal prosecution or being fired if they perform abortions. We conclude with a discussion of La Mesa's choice of strategy in light of demands regarding the recognition and democratization of legal knowledge.

Expert legal knowledge

Expertise is generally defined as the ability to solve recurring problems in a given field.[4] Studies on expertise show that this ability is grounded in extensive knowledge that results in more nuanced classifications and a better understanding of conceptual relations at more abstract levels than those grasped by novices.[5] La Mesa has become a legal expert on abortion in Colombia because it has produced knowledge about the law that others lack and that is useful for solving particular problems in the realm of access to abortion. It has accumulated this knowledge in three ways: (1) by accompanying individual cases of women seeking abortion in the health system; (2) by articulating legal responses to individual cases in accordance with specific barriers that women face in the health or legal sector; and (3) by validating its own interpretations with experts in the fields of international law, constitutional law, and health law, including public officials. La Mesa has disseminated this knowledge through workshops and training sessions geared at teaching health providers about Colombia's abortion law, both as a set of freedoms for women and as a set of duties for health providers enforceable through the judicial system.[6]

It is important to say that to a large extent, the development of the legal framework concerning abortion has happened through decisions adopted by the Constitutional Court in particular cases involving women seeking abortion. Some of these cases were litigated by La Mesa, but most Constitutional Court decisions were the result of cases filed by women affected by a negative response to their health service requests. The particular writ of protections used in these cases was the *tutela,* which was introduced by the 1991 Colombian Constitution. As opposed to other constitutional writs of protection, this one is very accessible to the public and the Constitutional Court has struggled to keep it as accessible as possible: it may be presented before any judge and does not need to be technically correct in any way. In the cases of abortion, it is evident that the court has had a political will to develop and enforce legislation regarding the rights

of women because its interventions in *tutela* cases are selective and the number of abortion cases selected for review are in no way representative of the number of cases that has arrived before the Court. In general, these have been cases of aggressive selection in which the Court has sought to develop legislation and not only redress the violation of a right. During the last 10 years, La Mesa has supported at least 26 *tutela* cases and two emblematic cases reached the Constitutional Court (T-841/2011, T-532/2011).

Recognizing La Mesa as a legal expert means, on the one hand, acknowledging its power in a realm where social organizations are not frequently recognized and, on the other, making La Mesa responsible for accumulating instead of redistributing power. As we will show, the case of La Mesa challenges existing frameworks around expertise, as it represents an intentional accumulation of knowledge for the sake of increasing the power of women seeking access to abortion. In the process of becoming a legal expert, La Mesa consulted not only traditional experts and health providers but also women whose rights had been violated. This knowledge became the source of La Mesa's expertise and its opportunity to structurally change the battle over abortion.[7]

Mobilizing to produce expertise: La Mesa's pedagogical effect

La Mesa is a collective of organizations and people working on behalf of the sexual and reproductive rights of women in Colombia, particularly toward the decriminalization of abortion.[8] The collective was created in the context of Colombia's 1998 Penal Code reforms, in which conservative groups sought to create the crime of assault on the unborn person, and in the context of the forum on abortion held by the Universidad Externado de Colombia that same year.[9] La Mesa's most innovative strategy has involved its constitution as a "technical space and not just an arena for militancy" and as an expert authority on the legal regulation of abortion.[10] As explained by one of its members:

> We have also been able to become a technical referent on the issue [of abortion] for the Ministry of Health, which consults with us on how to deal with specific problems related to implementation, and we give them advice ... It is precisely La Mesa's ability to interrelate with state agencies and to be recognized as an authoritative voice on the issue. People refer to us, the ministry calls us, members of Congress call us, public entities call us, so I think that in this sense La Mesa has made an important impact.[11]

We use the notion of "pedagogical effects" to explain how La Mesa worked to gather enough relevant knowledge to claim expertise and how it has increased access to legal abortion by making this knowledge available to health providers. These effects may be related to legal mobilization insofar as they are produced through the law (specifically, legal knowledge) and for the law (particularly the application of relevant legislation on reproductive health matters).

This paper is based in a qualitative research conducted between 2014-2016 by the research team in Colombia for the project "Abortion Rights Lawfare in Latin America". The data was collected through two basic tools: semi-structured interviews (55) with various stakeholders (civil society organizations, health providers, health authorities and lawyers among others) and review of secondary sources (documents, reports, laws, statistics, etc.). Based on data gathered from current and past members of La Mesa and from allies in different government bodies, the following sections explain how La Mesa has been able to mobilize law by producing legal knowledge.

Case accompaniment as a tool for collecting information and building advocacy agendas

From the very moment that Sentence C-355 was handed down, members of La Mesa were aware of the importance of providing legal services to women interested in obtaining a legal abortion. On the one hand, they knew that other countries in the region with similar abortion regimes had been evidencing extremely low rates of legal abortions.[12] And on the other, they knew that the ruling positioned individual health providers in such a way that they could effectively block the decision's

implementation, whether due to fear of being punished or a lack of knowledge regarding their legal obligations. As a member of La Mesa pointed out in an interview:

> *I believe that the judicial strategy, both through case litigation and through strategic litigation, is a very important part of La Mesa.*[13]

> *La Mesa began to work on the implementation of the ruling. In what sense? Meeting women's demands and making sure they received care in their EPS [assigned health care provider] or in public hospitals or in university hospitals or in private hospitals … on the basis of the various exceptions provided for in Sentence C-355.*[14]

Initially, La Mesa adopted a more litigious approach to monitoring and implementation, offering a "protection-based model" to women seeking access to legal abortion. Under this model, La Mesa members who were lawyers provided counsel to women facing obstacles in the health system and frequently initiated *tutela* proceedings to get judges to order health care providers to perform the procedure. La Mesa eventually abandoned this model in favor of one oriented toward supporting women's agency and focusing on administrative claims, mainly for three reasons. First, the amount of women requiring legal counsel did not diminish but rather increased over time. As a result, litigating individual cases became too costly for La Mesa in terms of human and monetary resources. Second, individual *tutelas*, even if speedier than other judicial mechanisms, proved incapable of providing appropriate decisions in time. While the Constitutional Court was developing a strong and generous doctrine on access to abortion, getting a decision from the Court could take more than a year. At the same time, while the Constitutional Court was developing a strong and generous doctrine on access to abortion (in particular after analyzing tutelas that had been denied by judges in the lower echelon), the judges responsible for deciding on *tutelas* in the first place, were often isolated from these developments in terms of their legal theory and argumentation and thus did not always promote women's access to legal abortion. Third, many women seeking legal counsel eventually opted out of litigation, increasing frustration among La Mesa's lawyers. The new model thus focuses on providing relevant information about access to legal abortion and recommendations regarding the use of administrative procedures (such as disciplinary procedures) and is restricted to two interventions: welcoming the woman seeking legal redress and conducting a follow-up call.[15]

Although the results of La Mesa's initial litigation strategy were not as positive as expected, and the later model places decreased attention on litigation as a tool to increase access to abortion, work relating to individual cases was nonetheless crucial, and remains crucial, for La Mesa's learning process around the barriers and obstacles faced by women in the health system. Indeed, very early on, La Mesa began systematizing the types of cases it received and developed answers to these cases that integrated constitutional and international law in a way that provided firm ground to health providers faced with the decision whether to provide an abortion.[16] The facts recorded include, a description of the women´s social and economic situation, and a description of the service offered by health providers when the abortion was requested. To date the data basis of La Mesa has around 1000 entries corresponding to cases from 2006 to 2015.

The production of relevant legal knowledge regarding abortion

One of the strategic actions powered by La Mesa in coordination with other groups in Latin America, and which stands out among efforts to implement Sentence C-355, is the development of a conceptual framework for achieving a comprehensive, rights-based interpretation and application of the indications outlined by the Constitutional Court. This conceptual production aims to offer providers (mainly health providers) solutions to their legal questions that are grounded on the sophisticated integration of different types of legal knowledge. It also seeks to offer relevant organizations a comprehensive conceptual framework for enabling women's access to abortion services and driving the ruling's implementation. With this particular

strategic development of knowledge, La Mesa has become an interpreter of the law and in that role has become a central stakeholder, from the civil society side, in the process of creating law.

In particular, in 2007, La Mesa and the Alianza Nacional por el Derecho a Decidir in Mexico made the policy decision to encourage a wide and plural discussion on the scope of the health exception, whereby women's access to legal abortion services could be widened and guaranteed, at the same time that certain components could be generated to offer certainty to professionals who would apply the exception.[17]

As part of this effort, they published the report *Health Exception: Lawful Termination of Pregnancy, Ethics and Human Rights*.[18] This report proposes an extensive interpretation of the health exception that is in line with the international human rights framework, specifically the right to health and its relation to other rights.

The report, which relied on the contributions of various organizations and initiatives in Latin America, including women leaders, lawyers from regional and international organizations, health providers, and bioethicists, consists of two parts.[19] The first part comprises a position paper expressing the points of consensus reached by the organizations and experts who signed it. These ideas are based on an extensive literature review, an analysis of high court jurisprudence, and the international human rights framework.[20] The second part comprises a background document that underpins the position paper. This document includes an extensive review of decisions by national and international courts and of recommendations by human rights treaty monitoring bodies. In this way, the report addresses the health exception from a human rights perspective, the dimensions of the right to health, the principles to consider when applying the health exception, and ethical considerations.

Along with its regional allies, La Mesa has also produced documents and reports on the rape exception, gestational age limits, and conscientious objection. The report about the rape exception was published in 2011.[21] As with the health exception, La Mesa follows a strict procedure in which it identifies barriers to access through the accompaniment of cases, conducts meetings with regional experts on abortion law (both medical doctors and lawyers litigating on abortion in Latin America), and validates its findings through a virtual meeting.[22] This methodology enhances the usefulness of La Mesa's knowledge not only in Colombia but throughout the region.

Training health professionals, judges, and women's groups

La Mesa has disseminated its knowledge through trainings for health professionals, public officials, and women's organizations.[23] Between 2010 and 2014, La Mesa conducted more than 30 workshops throughout Colombia on the legal aspects of abortion.[24] The workshops were held in cities as diverse as Barranquilla, Bogotá, Cali, Manizales, Medellín, Mocoa, Neiva, Pereira, Riohacha, and Villavicencio. Participants included judicial officers, health sector workers (including personnel from secretariats of health and secretariats on women's affairs), community leaders, women's organizations, and sexual and reproductive rights organizations. In all, 1,189 participants were trained. In addition, La Mesa conducted more than 17 workshops on the health exception in different Colombian cities, including Bogotá, Cali, Cartagena, Medellín, Manizales, Mocoa, Neiva, Pereira, and Sincelejo. Participants in these sessions included lawyers, health professionals, health care providers, medical students, medical school professors, staff from secretariats on women's affairs (mainly lawyers and psychologists from equal-opportunity houses for women, known as *casas de igualdad de oportunidades*), and staff from secretariats of health.[25]

At these workshops, La Mesa also incorporated the participation of officials from public entities charged with monitoring and promoting human rights (such as the Ombudsman's Office, the Ministry of Social Protection, and district-level secretariats), with the aim of empowering them and integrating them into the chain of care.[26] These officials supported La Mesa's legal expertise by jointly convening the sessions and presenting their own views as supportive of and coordinated with

those presented by La Mesa. This deference toward La Mesa is the result of a relationship regarding knowledge that was established in 2006, when La Mesa provided the Ministry of Health with technical guidelines for the implementation of Sentence C-355 that allowed for the ministry's swift intervention on increased access to safe abortion.

Discussion: The difference that La Mesa makes

In this section, we explore the positive effects of the actions deployed by La Mesa regarding legal knowledge, arguing that the creation of expertise can be a powerful tool in supporting the application of legal frameworks that advance counterhegemonic positions, such as the feminist one. We also briefly reflect on the limits of the expertise strategy, noting that while social actors may be accepted as participants in the creation of knowledge, the lack of confrontation by intellectual peers renders conclusions unstable in the long term. Moreover, privileging international law as an authority and service providers as an audience further increases rather than reduces women's vulnerability.

Increasing access to legal abortion in Colombia

According to available data, La Mesa's work has helped increase the number of requests for legal abortion under the health exception; has assured doctors and hospitals that the protocols designed by health authorities are appropriate under current law and do not put health operators at risk; and has increased public perception of abortion as a legal procedure as opposed to an illegal one. La Mesa's legal knowledge of the other exceptions has not been as useful in expanding legal access to abortion in Colombia to date. This is partly the result of the order in which the strategy was deployed, with work on the health exception starting much earlier, and partly a consequence of tensions with other groups around the rape and fetal malformation exceptions.

Indeed, since 2009, the health exception has been increasingly invoked in requests for legal abortion and is currently the main reason for the procedure's performance in Colombia. Figures from two of the country's most important sexual and reproductive health care organizations confirm the growing use of the health exception, which reflects the dedicated work of organizations such as La Mesa in promoting its implementation.[27] At Oriéntame, a Colombian nongovernmental organization that provides comprehensive sexual and reproductive health care services, the health exception was invoked in 28% of abortion requests from 2006 (with seven being the total number of cases received), while it was invoked in 99% of the cases from 2011 and 2015 (4,066 and 8,897 cases in total, respectively). A similar situation can be seen at Profamilia, a private nonprofit organization that provides sexual and reproductive health care services throughout the country. Although Profamilia did not perform any abortions in 2006, between 2011 and 2015 the percentage of abortions performed on the basis of the health exception oscillated between 98% and 100%. In other words, when looking at all three exceptions, most legal abortions are performed under the health exception. This same tendency is confirmed by the information collected by La Mesa, whose database contains information on nearly 1,000 cases of women who have faced barriers in accessing legal abortion and who have been directly supported by La Mesa in order to overcome these obstacles and obtain the procedure. Of the women assisted by La Mesa, 74% relied on the health exception, 14% on the rape exception, and 9% on the fetal malformation exception.[28] The increased willingness among doctors and other health care providers to perform abortions as a result of La Mesa's guidance is also revealed in their adherence to organizations such as El Grupo Médico por el Derecho a Decidir, which recently joined La Mesa's activities. It is important to notice that official data on abortion is difficult to access and inconsistent and that data reported here might be biased by the nature of the providers and their explicit interest in using the health exception. Nonetheless, it is the only available data.

The success of the health exception is interesting both as evidence of the success of La Mesa's strategy and as evidence of the strategy's limitations. The fact that La Mesa initially focused its

efforts on the health indication explains in part the result of a greater impact of this strategy in the long term. But research on barriers associated with the other two exceptions—together with the debates that emerged in the construction of expertise concerning sexual violence and fetal malformations—has showed that insofar as knowledge is never merely technical, it demands either alienating potential allies or giving up on the avenues open for legal expertise. In the case of sexual violence, as some research has started to show, reproductive rights advocates are confronting radical feminists who consider filing rape cases to be a political act and for this reason the reduction or requirements to accessing an abortion by this indication, could increase difficulties to judge the perpetrator.[29] In the case of fetal malformations, tensions have risen among reproductive rights and disability rights advocates. The latter group accuses feminists of inadvertently supporting eugenics when arguing for an extension of the interpretation of viability to include "dignified life conditions."[30]

Although the number of legal abortions remains low—between 5,000 and 9,000 a year—the impact of access to these abortions as 'health exceptions' is considerable when appreciated in context.[31] The first contextual element is the strong opposition by Colombia's attorney general to the increase in legal abortions. Since his appointment in 2008, Alejandro Ordoñez has used the resources of the Attorney General's Office to investigate, prosecute, and sanction entities that perform the procedure. The second contextual element is the reluctance of public opinion to support the new legal framework, which can be seen in the difficulties faced in introducing reforms via the legislative and judicial routes, as well as in public opinion polls and media coverage.[32] Unlike in Mexico, for example, leftist movements in Colombia have not been traditional allies of the feminists, and the media has also failed to sway public opinion with cases of extreme pain and suffering.[33] The last element is the absence of a strong medical community that acts as an ally of sexual and reproductive health organizations and doctors.

The success of La Mesa's strategy in this politically hostile climate, then, may be evidence of the importance of constructing knowledge to achieve counterhegemonic effects. Nevertheless, as shown in the literature, one of the risks of putting expertise on a pedestal is that it can naturalize or reify a particular state of affairs by cloaking itself in the mantle of truth, which can end up delivering power to a new set of elites (for example, the members of La Mesa) who are not public officials who can be held accountable, for they claim a particular "scientific" or expert character.[34] In this light, La Mesa has embraced dynamics that place it closer to its base and its peers in terms of knowledge, allowing for democratic responsibility vis-à-vis the knowledge it produces, unlike strategies that seek only to change public opinion. We believe that such democratic dynamics—arising from mobilization aimed at social change—can be expanded to involve legal experts from prestigious universities in such a way that extends technical validation and the appropriation of knowledge to other levels.

The cost of expert legal knowledge

To discuss the costs of a strategy aimed at the construction of expertise, we adopt Stephen Turner's approach, which begins by characterizing such expertise in terms of the actors and texts involved. Turner expands on the traditional definition of expert knowledge by including the relationship between various types of expertise and the democratic process. On one end of the spectrum is scientific expertise—the most democratic type of expertise—which is acquired collectively, is efficacious in practice, and is validated by its audience. On the other end are experts who create their own following through the investment of large sums of money; this type of expertise is the most fragile in terms of democratic legitimacy.[35]

In the case of La Mesa, one could say that knowledge is constructed in connection with a "cultivated ignorance"—that is, against the carelessness of legal experts and the health sector in constructing a framework around the lawfulness of abortion in particular and of sexual and reproductive rights in general.[36] Instead of polarizing its audiences, La Mesa has staked out its territory by responding to the ambivalence and unawareness of

the majority. The target audience for this knowledge is service providers—whether health care providers or judicial operators—who are involved in one way or another with the legality of abortion. This is also the group that La Mesa has consulted about existing data, difficulties, and realities. Vis-à-vis this audience, La Mesa has risen as expert because it has proven itself able to amass more information than anyone else (density) and has become visible as a problem solver for service providers and bureaucrats (visibility).

To an important extent, this knowledge is created collectively: it is connected to cases of individual accompaniment, it is developed by networks of reproductive rights advocates, and it is validated by international law and constitutional law experts hired as consultants. The fact that the number of abortions has increased also reveals the usefulness of this knowledge for practitioners. But the process and results fall short of being democratic at least in three ways: (1) they do not reveal awareness of the limitations of international law as an authority at the local level, (2) they do not engage bureaucrats as equals, and (3) they do not work to level the knowledge playing field for women who are users of the legal system.

Conclusion

To date, La Mesa has invested significantly in producing and disseminating knowledge on human rights and international law with regard to abortion, filling a void among low-ranking health care providers and judicial operators. Legal experts at law schools, in fact, would not agree with many of the interpretations that La Mesa derives from legal texts. The Constitutional Court has also explained that only treaties and judicial decisions can be enforced at the local level, explicitly noting that recommendations made by any authority in the international system are just that: recommendations.

Then again, the weak bureaucracies of the health and judicial sectors do not contest the knowledge produced by La Mesa, apparently out of a sheer lack of resources as opposed to convictions relating to the status and worth of international law in these sectors' daily practices. It is crucial to note that even if some key health providers and health officials have been invited as experts to validate the knowledge produced by La Mesa, participants in the workshops are not asked to work toward the daily construction of knowledge, nor are they represented as being in charge of developing legal knowledge. In other words, the pedagogical strategy is not aimed at furthering autonomous processes or critical stances toward legal knowledge. Rather, legal knowledge is presented as a fact that is to be "absorbed" by individuals attending the workshops.

Relocating the field of legal objectivity from the local to the transnational and international has the cost of reifying and naturalizing the same meanings that might need to be challenged in the future in order to broaden current guarantees. If we have learned anything from the feminist struggle, it is that we cannot relinquish the politicization of legal knowledge, for law has been an important tool in women's oppression.[37] In this sense, even if La Mesa articulates feminist efforts in a struggle to appropriate the law by producing legal knowledge, the question remains whether the effects of this tactic will be sustained. In particular, it is crucial to understand whether feminists will be able to master their positions as experts to further legal reforms in directions not wholly supported by international law.

Finally, La Mesa's insistence on providing tools to health providers and bureaucrats seems to increase rather than decrease the legal knowledge gap between women and men. Even if women seeking abortions are counseled upon seeking La Mesa's legal advice, and even if their cases are used to build La Mesa's larger strategy, these women are neither the sources of expertise, nor the audience or validators. La Mesa has yet to devise a way to massively instruct women on how to fight for their rights when confronting street bureaucrats, such as health providers and hospital bureaucracies.

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The Battle Over Abortion Rights in Brazil's State Arenas, 1995-2006

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Abstract

This article proposes a relational approach to the study of abortion law reform in Brazil. It focuses on the interaction of pro-choice and anti-abortion movements in different state arenas and political contexts. It details the emergence of a strategic action field on abortion during the Brazilian re-democratization process and the National Constituent Assembly. We offer analysis on pro-choice and anti-abortion mobilization in state arenas—mainly in the executive and legislative powers—during the two terms of President Fernando Henrique Cardoso (FHC), 1995–1998 and 1999–2002, and the first term of President Luís Inácio Lula da Silva (Lula), 2003–2006. We then map political resources for mobilization, such as legislative bills, public policy norms, and judicial decisions, and track legal continuities and changes. Finally, we analyze anti-abortion reaction, which was consolidated through an increased conservative presence in congress after 2006, and discuss how the abortion debate has migrated from congress to the Supreme Court and the public sphere.

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Introduction

Brazil's penal code, drafted in 1940, states that abortion is a crime and provides exceptions only when there is a risk to the woman's health and in cases of rape. The political struggle for and against abortion rights dates back to the re-democratization process (1974-1985). During the transition process, the National Constitutional Assembly (1986-1987) was the first important institutional stage where pro-choice and anti-abortion social movements disputed over abortion law reform. Since then, both movements have adopted new strategies to press their message, creating organizations and public campaigns, occupying government posts, proposing bills, participating in public hearings, and filing court cases.

The literature on political conflict and abortion rights in Brazil has grown primarily over the last decade. There are many publications written by authors linked to pro-choice networks and public policies. They are descriptive, containing reports about the author's perceptions of the political context.[1] Another series of studies analyzes mobilization and/or countermobilization in specific arenas, such as elections and courts.[2] Finally, other scholars consider abortion as a case study of the relationship between religion and public debate or between political parties and churches.[3]

The article intends to bring two contributions to the research on the Brazilian case. One is analytical: we analyze abortion law reform as a political process in a more integrated, relational, and dynamic way, according to the "contentious politics" perspective.[4] We focus on social movements and counter-movements, their direct antagonists, as key collective actors to propel, or to block, political, and legal reforms.[5] As political actors, both are informal networks of relationships between organizations, groups, and individuals that are linked by political identities built around a political or cultural conflict.[6]

The pro-choice movement aims to decrease or remove institutional, constitutional, or legal restrictions imposed on abortion. The anti-abortion movement aims to defend or increase such restrictions.[7] Both are part of "strategic action fields"; that is, a socially constructed set of relations and arenas that sustain interactions of cooperation and conflict between heterogeneous actors around public agendas and problems.[8] The contentious arenas are social spaces with different political resources and level of formalization of rules and codes of action and language, such as streets, media, courts, government, and technical agencies.[9] The actors must adapt their tactics, frames, and alliances to different arenas through which they circulate. Changes of arenas occur when they perceive opportunities for progress in achieving their goals or to provoke the public reverberation of their claims.

Our analytical argument, therefore, is that the dispute over the regulation of abortion is not linear or fixed, but occurs in more or less institutionalized social spaces and involves non-state actors (feminist movements and other social movements; trade unions; religious, medical and legal organizations, and health professionals); and state actors (state bureaucracies of public policy staff, members of congress, judges, and judicial officers). Mobilization strategies and frames change according to the balance of political opportunities and restrictions, which in turn are constantly altered by the action of movements and counter-movements.[10] The emergence of opponent movements tends to create conflict that requires adaptation of strategies to neutralize the effects of the opponent's actions and push their respective agendas forward.[11]

The state is a crucial part in the conflict and can be simultaneously a target of demands and an object of dispute. Depending on the institutional structure, the political regime and context, the state with its different arenas (such as congress, administrative agencies, courts) can take place in a contentious space. This occurs when public campaigns, the typical repertoire of action of social movements, enter the state and the world of institutionalized and routine politics, which acquires the form of, for example, lobbying for proposition of bills, occupying government posts, or proposing candidates in elections. In this sense, the contentious politics occurs not only outside the state, such as in the form of outsiders' protests, but can also occur within state arenas through the connection between state and non-state actors. This

does not simply mean the institutionalization of social movements, but the activists' ability to move through various arenas.[12]

The second contribution of the article is empirical. We focus on the pro-choice and anti-abortion mobilization in the state arenas, mainly in the executive and legislative powers, during two government periods: the two terms of President Fernando Henrique Cardoso (FHC), 1995–1998 and 1999–2002, and the first term of President Luís Inácio Lula da Silva (Lula), 2003-2006. We analyze pro-choice and anti-abortion mobilization to frame their respective agendas through bills and administrative norms of public policy. We know that this is only a part of the political process that encompasses, for instance, street movements and mobilizations in court. But we argue that it is crucial to reconstruct the mobilization in the executive and legislative powers in the two above-mentioned government periods, to understand the relationship between the movements and the state in Brazil, after the conclusion of the re-democratization process, and to explain the current state of affairs regarding sexual and reproductive rights today.

The article shows how the FHC and Lula governments were permeable to the national and international pro-choice agenda. However, the balance of political opportunities and restrictions for the movement and the counter-movement had faced variations according to two key factors: the permeability of the government to the pro-choice movement and the political context as a whole. The close alliance between pro-choice groups and the executive branch during Lula's administration, along with the political crisis, generated as backlash a new conservative reaction formed upon a close relationship between congress and the anti-abortion movement's network.

In the first section, we show briefly the emergence of a contentious field on abortion related to the end of the Brazilian re-democratization process that resulted in the installation of a National Constituent Assembly. In the second section, we compare the battle over abortion in FHC's and Lula's governments. In the third section, we analyze the conservative reaction.

Creating the abortion battleground in Brazil

At the end of the 1970s, the Brazilian feminist movement developed close ties with the domestic political opposition groups fighting against the military regime (led by left-wing activists and progressive sectors within the Catholic Church), and with international groups that had female autonomy as a main piece of their political agenda.[13] Pro-choice mobilizations, although they did occur during Brazil's political transition to democracy, were infrequent. Abortion was rejected not only by the church, but by left-wing activists who opposed liberal and individual evocation of autonomy and freedom of choice for women. Government agencies resisted including abortion in their political agendas, and Catholics mobilized in protest whenever abortion became part of the national debate.[14]

The process of creating the new democratic constitution caused open disagreement between pro-choice activists and the church. The Brazilian National Constitutional Assembly (1986-1987) opened the national political arena to groups and movements mobilized during re-democratization under the broad umbrella of the anti-military regime movement. In 1985, the first civilian president was elected, and the Constitutional Assembly, a year after, represented a unique political opportunity for groups and movements to focus their specific agendas and to claim normative and public legitimacy for them. Drafting the new constitution became a battleground for divergent interests among various groups and movements.[15]

The polarizing topic of abortion was heavily discussed.[16] Feminist leadership sent the "*Carta das Mulheres*" (Women's Letter) to congress, outlining demands for items to be declared in the new constitution, including the right to interrupt pregnancy. The counter-movement, led by the National Conference of Bishops of Brazil (CNBB) with the support of evangelical members of congress, pressed for the new constitution to include protection and right to life since conception.[17] Amidst a clash with the Catholic Church, the feminists' strategy was to at least prevent the inclusion of the protection of life since conception in the final wording of the Federal

Constitution of 1988, and they succeeded in that.[18] Without winners in the constitutional battle, the dispute was directed to the infra-constitutional regulation, signaling congress as a strategic space to promote political and legal changes.

The constitutional definition of fundamental and social rights, especially the right to health, created a new legal, moral, and political vocabulary that expanded the penal rhetoric that had governed the policies and laws on abortion in Brazil. The new constitution also expanded the formal access of different interests to state arenas. In addition to free elections, councils were created in the executive sphere, and in the judiciary branch, new procedural instruments were put in place for the defense of rights.

On the international front, the UN world conferences and its parallel forums became spaces for the formation of coalitions in transnational networks of feminist and human rights organizations.[19] In the early 90s, feminist activists were intensely mobilized in the preparatory activities to the conferences. In September 1993, Brazilian activists held the National Meeting of Women and the Population, Our Rights for Cairo '94. The "*Carta de Brasília*" (Letter from Brasilia), resulted in discussion, included feminist demands related to non-coercion, women's comprehensive health, and sexual and reproductive rights. Official delegations were also integrated by professionalized and globally connected organizations, such as CFEMEA (Centro Feminista de Estudos, e Assessoria) and CEPIA (Cidadania, Estudo, Pesquisa, Informação, e Ação).[20] The UN Conference on People and Development, which took place in Cairo in 1994, and the Fourth World Conference on Women, in Beijing in 1995, fueled the national pro-choice discourse framed in terms of human rights and the right to health.[21]

The national pro-choice movement maintained two agendas: one more radical (claiming the decriminalization of abortion) and another more moderate (claiming the increase in instances of legal abortion). The second gained more force in the institutional battles, as it was more open to negotiations with governments and political elites. The national mobilization was supported by the formation, in 1991, of the *Rede Nacional Feminista de Saúde e Direitos Reprodutivos* (National Feminist Network on Health and Reproductive Rights) for the "defense of comprehensive health for women and their sexual and reproductive rights" and for a public unified health system, "universal and of good quality, accessible to all women."[22]

The movement internalized the international framing of abortion as a public health issue, connecting movement, state, and global institutions.[23] Feminist leaders joined or aligned themselves with parties, thereby connecting the movement to institutional spaces. From the mid-1990s on, the pro-choice movement found its channels and access to the national executive branch during the FHC and Lula administrations. Both administrations were linked to political parties that had opposed the military regime and allowed female leaders to build alliances since the beginning of re-democratization. Both governments signed and ratified international treaties, established National Human Rights Plans (PNDH), created state bureaucracy specifically for women's politics, and furthermore, placed feminist leaders in government positions. In this way, the executive branch in the 1990s and 2000s was transformed into a political working arena for the pro-choice movement.

The anti-abortion movement also renewed the social bases of activism. During the 1970s and 1980s, CNBB led the formation of groups and movements, recruiting from its network of Catholic dioceses. Pro-life groups were created as far back as the late 1980s, but from the 1990s onward, the movement acquired its own structure connecting local groups to national and international networks. The first National Meeting of Pro-Life Movements took place in Brazil in 1992 with the support of Human Life International, an American organization of transnational anti-abortion activism, with particular focus on Latin America. In 1993, the National Pro-Life and Pro-Family Association was created, with the mission to defend "human life from conception to natural death, without exceptions" and "the moral and ethical values of the family."

Movements and counter-movements in the national state arenas (1995-2006)

In the national state arenas, the battle over abortion from 1995 to 2006 took place mainly in the legislative branch (through bills) and in the executive branch (through administrative norms for public policy). Although there are reports of litigation in individual cases beginning to be used in the 1990s in Brazil, the mobilization toward the judiciary in the dispute during the analyzed period was residual. A legal strategy was built only in 2004 in the initial action that brought to the Supreme Court a case involving the interruption of pregnancy of an anencephalic fetus.[24] Later, two contentious public hearings took place in the Federal Supreme Court (STF), one in 2007 on a biosafety law and another in 2008 on the case involving the interruption of pregnancy of an anencephalic fetus.[25]

When social organizations, groups, and movements adopt a strategy to move a dispute from the public sphere to institutional arenas, they must often rely on alliances with different state actors (such as members of congress, public defenders, or prosecutors). Mobilization in state arenas depends, therefore, on how receptive such actors are to social claims. Also, the political resources available for mobilization in institutional arenas—bills, administrative norms, and judicial decisions—are not identical, because of varying degrees of coercive compliance and stability to consolidate political and legal changes.

Different regulatory compositions can be activated depending on the institution, issue, and context of political opportunities. In the composition of norms governing a certain subject, there is a structural definition of what can be regulated by what kind of norm, and the limits of these rules are also regulated. For example, altering the penal code to create the possibility for legal abortion should occur through a legislative amendment or a Supreme Court decision that can invalidate or interpret a piece of federal legislation. Technical norms, issued by the federal, state, or municipal executives, standardize and streamline operational aspects of health care equipment. These norms have weaker binding effect, and courts do not require compliance, but they may have significant impact on accessing health services. For example, one of the major issues regarding access to legal abortion in cases of rape refers to the hospitals requiring a police report; a technical norm issued by the Ministry of Health regulated the dismissal of this requirement.

Technical norms, decisions, and bills represent a political and legal resource, as well as a tactic for framing public issues. Although constrained by rules of enunciation within the state bureaucracy, these official documents are taken here as formal translations of the political dispute, supported by state alliances and negotiations and framed by moral, scientific, and legal arguments.

To map the legal battle between movement and counter-movement in the state arenas, we created two databases: one populated with administrative actions of the federal executive branch (including decrees, ordinances, resolutions, technical norms, plans, and internalization of international documents), and another populated with actions taken by political parties and members of Congress inside the federal legislative branch (bills of law and constitutional amendments with their respective justifications). Although the collected data covers the period between 1989 and 2015, we refer in this text only to 50 bills, which were presented between 1995–2006.

FHC government (1995–2002)

During FHC's government (1995–2002), the Ministry of Health began to produce technical norms for regulation of legal abortion services in the public health system. While the 1940 penal law formally provided for legal abortion, there were many difficulties for people accessing it, especially for those relying on the public health system. In the absence of a federal norm, the provision of abortion services depended on the regulation of each hospital or state and municipal ordinances. [26]

The mobilization to implement legal abortion services in the public health system occurred in a fa-

vorable alliance between feminists and progressive doctors, allocated especially in the Brazilian Federation of Gynecology and Obstetrics (FEBRASGO).[27] In 1998, the Technical Norm for the Prevention and Treatment of Injuries Resulting from Sexual Violence against Women and Adolescents was published. This was the first time the Ministry of Health regulated legal abortion in the nationwide public system. The regulation of the provision of legal abortion services in public hospitals was part of a broader package of measures for female victims of violence. This strategy of regulating access to legal abortion due to rape indication finally made it possible to implement legal abortion services.

At the end of the 1990s, only eight hospitals were performing legal abortion; in the 2000s, there were 44.[28] This was far below demand, not even considering unequal regional distribution (hospitals were highly concentrated in southeast Brazil), but the creation of technical norms represented a victory for the movement. In reaction, anti-abortion groups began to pressure professionals in the Technical Area for Women's Health to repeal the norm, on the grounds that the norm would facilitate access to abortion for women who were not victims of violence.[29] After the publication of the technical norm, Congressman Severino Cavalcanti, author of two proposals for anti-abortion constitutional amendments, presented a bill aiming to block its application.

Indeed, in this period we observed an increase in congressional opposition to abortion. Between 1989–1994, eight anti-abortion bills were proposed, as opposed to 14 pro-choice bills. Between 1995 and 2003, anti-abortion bills outweighed the pro-choice projects, with a total of 13 anti-abortion projects and 6 pro-choice projects.

The pro-choice movement sought to expand its support base focusing on the implementation of legal abortion.[30] The battle for broad decriminalization of abortion was central to the pro-choice agenda during the Constitutional Assembly and the years following it, but this strategy became less important in the 1990s. Between 1989 and 1994, there were six pro-choice bills opposing criminalization. From 1995 to 2002, five pro-choice bills advocated broadening the specific cases of legal abortion or its regulations, while only one was directed at decriminalization. This relationship worsened in the following years.

Among the anti-abortion bills in this period, other regulatory strategies besides criminalization and increasing punishment start to appear. Of the 13 anti-abortion bills presented between 1995 and 2002, four were related to the increase of criminalization or punishment, four aimed at broadening the rights of the fetus, and three proposed the prohibition of research on embryos. One bill sought to broaden doctors' right to refuse to perform legal abortion, and another created a symbolic date, a day of homage to the "unborn child".

The end of the FHC government was highlighted by two actions by the pro-choice movement within the institutional field, aiming to extend the right to abortion. The first involved a draft of a penal code revision. Thanks to parliamentary allies, the Penal Code Review Commission forwarded to the Ministry of Justice a document outlining broadened permissions for abortion if the fetus had "serious and irreversible abnormalities." The then Justice Minister Jose Carlos Dias was in favor of revising the penal code, the reform did not advance. Secondly, pro-choice activists succeeded with the Second National Plan for Human Rights (PNDH II), approved in 2002, with the mention of the need for "extensions for permission to the practice of legal abortion in accordance with the commitments undertaken by the Brazilian government, in the framework of the Beijing platform of action." This demand, however, would depend on legislative changes. Although there was intense mobilization in the legislative arena, the pro-choice and anti-abortion advocates were deadlocked, and most bills never became the legal standard.

The alliance movement and government: Lula's first presidential term (2003-2006)

Lula's government reshaped the way social movements interact with the state. A closer and more organic relation was created through the implementation of national conferences and policy councils, boards of mixed composition (state actors

and civil society), with a fundamental role in the formulation of strategies and proposals for the implementation of public policies.[31] In the field of sexual and reproductive policies, it expanded the reach of the pro-choice movement within the state bureaucracy itself: in 2003, the Special Secretary for Women appointed Maria José de Oliveira Araújo to oversee women's health within the Ministry of Health. At that time, she was already a key pro-choice activist, having helped found the *Coletivo Feminista Sexualidade e Saúde* (Feminist Collective of Health and Sexuality), the National Feminist Network for Health and Sexual and Reproductive Rights, and the drafting of the Program for Integrated Women's Health Care (Paism).[32]

In this environment, the pro-choice movement increased activity between its own networks and state structures, benefiting from its ability to employ people in government positions rather than just alliances.

Comparing the institutional mobilization in the legislative and executive branches during FHC's two terms and Lula's first term, there is a general increase in state mobilization addressing abortion, particularly in the executive branch: there were 27 bills proposed and five acts of the executive branch under FHC, and 35 bills and 16 acts of the executive branch in Lula's first term.

The Ministry of Health, from 2004 on, made a concentrated effort to implement a national policy of assistance for women's health, which would involve care for domestic and sexual violence, consequences resulting from illegal abortion, and implementation of legal abortion services.[33] In 2004, the technical area for women's health of the Ministry of Health published two documents: the National Policy for Comprehensive Women's Health Care: Principles and Guidelines and the National Policy for Comprehensive Women's Health Care: Action Plan 2004–2007. These include an assessment of the (low) implementation of care services to women in situations of violence and the provision of strategies to intervene, such as increasing the number of clinics offering legal abortion; revising technical norms for legal abortion; training; and policies for humanized care for women suffering the consequences of unsafe abortions. As part of this national policy, increased distribution of the "morning after pill" generated intense public debate, which was accompanied by the initiative of counter groups to stop the distribution of this pill via legislative bills.

In 2005, the Ministry of Health issued other technical norms that advanced implementation of the right to legal abortion. Among the pro-choice victories, these norms revoked the requirement that a hospital be given a police report before providing abortion in case of rape, and created an obligation for the National Health System to perform legal abortions in such instances.[34] Removing the police report requirement was one of the most controversial issues; it raised so much opposition that even a Supreme Court justice publicly advised doctors not to follow the administrative regulations.

Meanwhile, the *Rede Feminista de Saúde* (Feminist Health Network) in 2004 launched the campaign *Jornadas Brasileiras pelo Aborto Legal e Seguro* (Brazilian Efforts for Legal and Safe Abortion), which culminated in the organized participation of the movement in the First National Conference on Women's Policies, convened by the federal government. The National Policy Plan for Women was prepared at this conference, and expressed the need to "review the legislation dealing with abortion."

Based on the conference resolution and on the National Policy Plan for Women, the federal government drove the abortion agenda in the legislature. In 2005, the special secretary for women's policies established a tripartite commission, with representatives from the executive branch, civil society, and the legislative branch itself in order to revise abortion legislation. The commission sent congress a bill decriminalizing abortion up to the twelfth week of pregnancy.[35] This was arguably the moment that decriminalization came closest to approval. But in Lula's second term, after a religious offensive, the executive branch removed their support and the project was halted in the House of Representatives.

Between 2004 and 2005, pro-choice members of congress proposed four bills aiming to broaden specific permissions for abortion. The bills rein-

forced the legislative strategy of the movement to invest more in projects that expand or regulate the cases of legal abortion, to the detriment of those cases decriminalizing abortion more broadly. This was already the goal of pro-choice legislative disputes: pro-choice legal frames in the FHC era involved only one bill aiming at decriminalization/reduction of punishment, while five bills focused on increasing indications and regulating legal abortion access.

On the other hand, the high number of anti-abortion bills in the first Lula government shows that the countermobilization intensified in response to the pro-choice movement's increased influence in the executive branch. For example, as a direct response to the Ministry of Health technical norm regulating distribution of the "morning-after pill," a bill was proposed that prohibited its distribution.

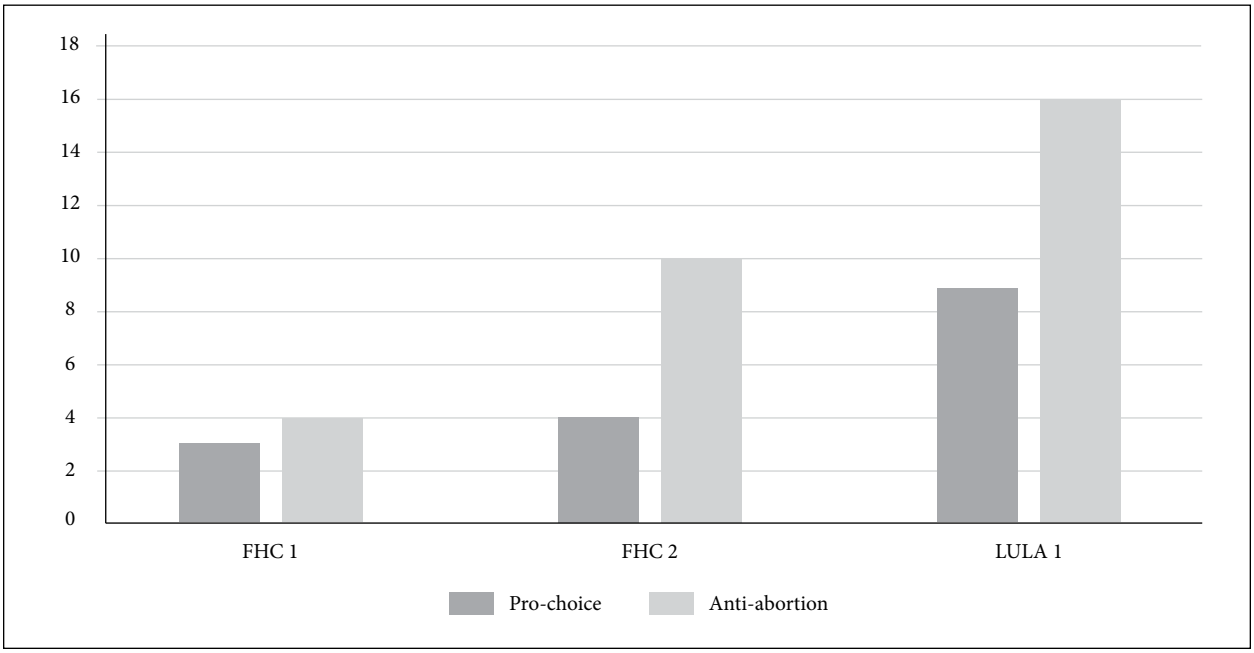
Number of pro-choice and anti-abortion bills, 1995-2006

The anti-abortion bills during Lula's first administration did not just surpass the number introduced during the FHC years; they also had diversified legal frameworks (See Table 1 and Figure 1). They sought to keep and even expand criminalization (for example, with the proposal to ban any kind of right to abortion, including in exceptional cases) but state control of the woman's body took other forms. For example, some bills proposed the creation of a hotline to report abortion cases to the police, and a mandatory pregnancy registration. More proposals sought to expand the rights of the fetus. The rhetoric of protection, which the anti-abortion movement was already using to frame the protection of the fetus, was then used also to protect women through bills ranging from abortion prevention programs to social assistance programs for women wishing to proceed with a pregnancy resulting from rape. Although these proposals focused on women wishing to keep their pregnancies, the anti-abortion movement began to dispute with the pro-choice movement the defense of the interests of women.

Anti-abortion legal frames in the legislative bills

The pro-choice and anti-abortion battle inside the state arenas led to some moderation in the framing

Figure 1. Number of pro-choice and anti-abortion bills, 1995-2006



processes on both sides. On the pro-choice side, the most radical agenda for decriminalization of abortion gave way to a more moderate agenda for abortion regulations, as outlined by the Brazilian legislation via public policies on women health and sexual violence, or through the expansion of specific legal cases. On the anti-abortion side, the language of social and human rights was incorporated selectively into its agenda: going beyond repression, this tactic aimed at proactive solutions of state policies for women deciding not to undergo abortion. This shift in the conservative activism tending to frame their discourse in the language of rights, public policy and protection of women is recognized as a tendency in Latin America and is also an example of the dynamics between movement and counter-movement as a game of reaction, neutralization, and adaptation of strategies.[36]

Conservative reaction, political crisis, and broken alliances

The last two years of Lula's first term changed the opportunities and restrictions for movement and counter-movement. Among the legislative proposals between 2003 and 2006, a sharp reversal occurred in 2005. While legislative proposals favorable to the pro-choice agenda prevailed until 2004, anti-abortion proposals dominated from 2005. This reversal began with the report of an alleged political corruption scheme involving vote-buying of congressional members. The political scandal, known as *Mensalão*, led to a government crisis in 2005 and 2006, undermining the government's congressional support and lowering the president's popularity. It also contributed to a retreat in pro-choice policies, which gained wide public attention and generated opposition in the public opinion.

The weakening of the government, combined with the approach of the 2006 presidential and congressional elections, generated oppositional impact in regard to the abortion agenda. Facing political and electoral damage due to this agenda, Lula's government stepped back from pro-choice initiatives and sought support from the CNBB, a traditional basis of the Workers' Party (PT) political support, and evangelical representatives in Congress.

The bill created in the 2005 tripartite commission, which proposed the decriminalization of abortion and its legalization through regulatory compliance in the public health system, sparked the formation of *I Frente Parlamentar em Defesa da Vida: Contra o Aborto* (First Parliamentary Front for Defense of Life: Against Abortion). The group promoted the First National Seminar on Defense of Life in 2005, which orchestrated meetings among local pro-life groups.[37] The countermobilization that began in congress resulted in the formation of the *Movimento Nacional da Cidadania pela Vida: Brasil sem Aborto* (National Movement of Citizenship

Table 1. Anti-abortion legal frames in the legislative bills

Legal frame	FHC (1995-2002)	Lula (2003-2006)
Increase criminalization/punishment	4	7
Increase choice for doctors	1	0
Institution of symbolic day	1	0
Protection of life since conception/increased rights of fetus	4	3
Prohibit embryo research	3	0
Broaden women's rights	0	3
Increase control over women's bodies	0	2
Prohibit emergency contraception	0	2

for Life: Brazil without Abortion) in 2006, which convened state committees that brought together previously disparate organizations and movements.[38]

The simultaneous launch of the movement through the *Manifesto à Nação* (Manifesto to the Nation) and the *Campanha Nacional em Defesa da Vida* (National Campaign in Defense of Life), connected, for the first time in Brazil, congress and the anti-abortion movement's network. In the 2006 elections, marches occurred throughout the country, with slogans such as "For a congress in defense of life," "Decide for life: vote for candidates who are against abortion," and "Yes life. Abortion never!"[39]

The conservative reaction to the abortion agenda was consolidated with the increased evangelical presence in congress after 2006. The "evangelical caucus" led pressure for the revision of technical standards and proposed projects seeking to impede or prohibit access to legal abortion. One key proposal was for the "statute of the unborn child," which sought to revoke the cases of legal abortion already in the penal code.

In a context of anti-abortion political pressure towards law enforcement agents, police departments and prosecutors' offices launched an offensive against clinics performing clandestine abortions. Most strikingly, a medical clinic in Campo Grande, Mato Grosso do Sul, was forced to close in 2007, and police investigated all clinic patients and medical staff. More than 10,000 women had their medical records confiscated and privacy invaded. At least 25 women were charged and served time in prison for the crime of abortion.[40] In 2009, a case involving the legal abortion to be performed on a 9-year-old victim of sexual abuse also received great attention from the media. After pressure from anti-abortion groups, especially the Catholic Church, the hospital and doctors refused to perform a legal abortion, which was only possible after the intervention of the Federal Secretariat for Women and the Public Prosecutor Office.[41]

Meanwhile, a battle occurred in the Supreme Court with two public hearings, one on biosecurity and the other on the anencephalic fetus.

The wave of institutional pro-choice activities culminated in the approval of the biosafety law in 2005 that allowed and regulated embryo research. The battle continued as a constitutional challenge of the law in the federal Supreme Court, proposed by the state attorney general, on the grounds that the law would contradict the principle of inviolability of the right to life that, according to his argument, exists since the moment of fertilization. In April 2007, a public hearing was installed by the Supreme Court, gathering two sides in opposing: pro-life movement versus scientists' pro-embryo research together with pro-choice activists. The pro-life judicial claim was dismissed in May 2008, again preventing the protection of life since conception to enter the Brazilian regulatory framework, this time through a Supreme Court interpretation of the constitutional right to life.

The anencephalic fetus case was proposed by the pro-choice movement in 2004 (after a first attempt in 2003). In July 2004, the Supreme Court granted a preliminary injunction allowing the procedure to be performed until the merits of the case were judged. The full court revoked the injunction months later, and the case was shelved until 2008, when a public hearing gave greater public visibility to the movement and counter-movement battle, the greatest since the constituent assembly. In 2008, the Supreme Court held four sessions of public hearings on the anencephalic fetus case involving 27 participants to defend views for or against the request. Participants included religious organizations, feminist organizations, professional associations, government representatives, and individual actors (such as doctors and members of congress). The tense nature of the ethical-moral conflict and the mobilization around the issue itself attracted media coverage and public interest. The trial was delayed four more years, but the Supreme Court finally recognized the claim in 2012.

While these two judicial decisions showed a context of positive political opportunities for the pro-choice movement in the Supreme Court, the alliance of feminists with the Workers' Party (PT) government ended with their definitive political and public retreat from the issue. In 2009, following political pressure, the Secretary for Human Rights removed public commitment to decrim-

inalize abortion from the Third National Human Rights Plan.[42] In the 2010 election campaign, abortion was again a central issue. Dilma Rousseff, who had throughout her political career supported legalizing abortion, pledged in her "Open Letter to the People of God" not to take measures toward legalizing abortion if she were elected, a pledge that she fulfilled during her two terms (2011–2014 and 2015–2016).

Conclusion

This article proposes a relational approach to the study of abortion law reform in Brazil. We focus on the interaction of pro-choice and anti-abortion movements between different state arenas and political contexts. To analyze the disputes in the state areas, and the strategies used by the two movements, one has to consider that battles over abortion regulation are formalized through legislative bills, norms of public policies issued by the executive branch, and judicial decisions. They are different political resources for mobilization, with different degrees of authoritative force, which also impacts strategies. Technical norms serve as guidelines for public policy and are not binding, but legitimize and strengthen the decisions of public officials. However, they are limited political resources, unstable and susceptible to revisions by the government when faced with pressure from opposition groups. From the moment those technical norms become law, however, they are no longer subject to the inclinations of the public administrator and, in addition, courts can require compliance. This helps to explain why disputes in the legislative arena were responsive to government regulation. In this sense, although the executive branch as an ally was key to implement public policies by increasing access to legal abortion, the legislative arena was crucial for the pro-choice movement to solidify it and for the counter-movement to block it. A Supreme Court decision, in turn, although limited to formal frameworks and requirements of access, has the authoritative force to remove a piece of legislation or interpret it in an innovative way due to claims based on unconstitutionality. Although allies from the pro-choice and anti-abortion movements have proposed many bills in congress, they haven't advanced to change the prohibition standard. The only change in the prohibitions framework since 1940 came from the Federal Supreme Court, in its decision on the case regarding the anencephalic fetus in 2012, which allowed for termination of pregnancy in these cases.

Retracing the political process on abortion in Brazil, we showed that the movement and counter-movement dynamics between the executive and the legislative branches during two governments that progressively opened space to the pro-choice movement, FHC (1995–2002) and Lula's first term (2003–2006), is key to understanding the backlash against the pro-choice agenda after 2006.

The first generation of Brazilian pro-choice activists advanced strategies in the occupation of the state. Political opportunity seized by the two governments intensified the connections between pro-choice movement and the state, resulting in advances in the regulation of access to legal abortion services. Offensives launched by the existing pro-choice agenda were decisive in terms of creating a perception of threat to the anti-abortion movement: pro-choice regulations were issued within the Ministry of Health, the legislative branch regulated embryo research (2005), and a bill decriminalizing abortion advanced with the support of the executive branch, with strong participation from the pro-choice movement.

The counter-movement responded by increasing activity in congress and mobilizing in the public sphere. To understand how abortion came to be a key issue to the anti-abortion movement in the electoral campaigns, it is important to mention that abortion rights policies traditionally raise opposition in the public sphere, led by the Catholic Church and pro-life groups, and public opinion is often divided. Recent research shows that most Brazilians approve legalizing abortion in cases of rape, risk to the life of the mother, and non-viability of the fetus, but the majority does not support complete legalization.[43]

Our analysis shows that the political context in the FHC and Lula eras is key to understanding

the migration of the dispute to the Supreme Court and the public arenas in the ensuing years.

Part of the pro-choice movement explored the Constitutional Court as an escape route to legislative disputes. Three positive decisions for the pro-choice movement (the biosafety law case in 2008, the anencephalic fetus case in 2012, and the concession in 2016 of a habeas corpus considering unconstitutional the pre-trial prison of two doctors accused of abortion) showed political opportunities for the pro-choice agenda in the court. Two cases are still pending there: the Zika infection case from 2016 (demanding authorization to proceed to abortion in case of microcephaly of the fetus) and the most recent one, filed in March 2017, finally addressing decriminalization until 12 weeks. After the political backlash, the Supreme Court appears to be the sole institutional arena still receptive to the pro-choice movement.

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Abortion Rights Legal Mobilization in the Peruvian Media, 1990–2015

CAMILA GIANELLA

Abstract

State and non-state actors engaged in disputes to expand and limit abortion rights have engaged in legal mobilization—in other words, strategies using rights and law as a central tool for advancing contested political goals. Peru, like other Latin American countries, has experienced an increase in abortion rights legal mobilization in recent years, including litigation before national and international courts. This paper centers on societal legal mobilization, or the legal mobilization that occurs outside the legislative and judicial branches and that includes strategies promoted by the executive branch, political actors, and non-partisan organizations and individuals. It presents an analysis of op-ed articles published in two national newspapers, *El Comercio* and *La República*, between 1990 and 2015. The paper argues that the media is also an arena where legal mobilization takes place and is not just a space influenced by legal mobilization. Rather, the media's agenda operates independently of legal mobilization in the legislature and the courts, and it determines whether certain issues receive coverage and the way these issues are framed.

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Introduction

Access to legal abortion in Latin America has been highly controversial, with various actors adopting diverse strategies to sway policy agendas and social attitudes on abortion, both in favor of and against abortion rights. These struggles around abortion can be traced back to the 1970s, although the 1990s marked a particularly unique era of abortion rights battles in Latin America.[1] Institutional reforms, such as the adoption of new constitutions in many Latin American countries in the late 1980s and early 1990s, created or strengthened high courts' ability to act independently of other branches of government and made the courts readily accessible to ordinary citizens. These reforms must be understood within a regional context in which the promotion of the rule of law was perceived as a necessary step toward democratization and in which judicial reforms were perceived as central to overall democratic reforms. However, the rule of law was also seen as essential for the adoption of free-market economic policies aimed at strengthening private investment, which led to important international support for judicial reforms in the region. International agencies—including the World Bank, the Inter-American Development Bank, the United Nations Development Program, governmental agencies, and nongovernmental institutions—invested nearly US$1 billion in judicial reform programs in the decade starting in the mid-1990s.[2]

In parallel, at the International Conference on Population and Development, which took place in Cairo, Egypt, in 1994, and the World Conference on Women, held in Beijing, China, in 1995, the international community recognized the importance of addressing unsafe abortion and the serious public health risk it represents for women's lives.

Meanwhile, at the regional level, several Latin American countries adopted the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (*Belém do Para*) in 1994 and supported the implementation of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women in 1999.

The adoption of these mechanisms and conventions encouraged the implementation of sexual and reproductive health programs across Latin America, as well as measures to reduce maternal deaths. For example, according to CLADEM, over the last 20 years, many Latin American countries have promulgated formal regulations protecting the right to sexual and reproductive health and have included this right in their constitutions.[3] However, at the same time, across the region, abortion rights have seen "either limited progress or even reversals."[4] Chile, El Salvador, and Nicaragua are among the five countries in the world that prohibit abortion under all circumstances; their abortion bans were introduced in 1989, 1998, and 2006, respectively. Legal abortion upon request during the first 12 weeks of pregnancy is available only in Cuba (since 1965), Mexico (Mexico City only, since 2007), and Uruguay (since 2012). Other Latin American countries allow abortion on some grounds, such as when the pregnancy constitutes a serious risk to the woman's life (this is the case in Argentina, Brazil, Colombia, Honduras, Panama, Paraguay, and Peru), when the pregnancy is the result of sexual abuse (Argentina, Brazil, Bolivia, Colombia, Ecuador, and Panama), and when fetal malformations make life outside the womb impossible (Colombia and Panama; Brazil in the case of anencephaly). Nevertheless, research shows that women in Latin America face barriers when seeking legal abortion services—in other words, real access to legal abortion may be more restricted than what is currently provided for by law.[5]

Actors engaged in efforts to expand or limit abortion rights in the region have used a variety of strategies, legal mobilization being one of the most prominent. By "legal mobilization," I mean strategies that use rights and the law as central tools for advancing a contested political goal.[6] Legal mobilization can be used by the state, by political actors outside the government, and by non-partisan organizations and individuals. These actors may use legal mobilization in different spheres: the legislature, the courts, and even outside the state apparatus. In most cases, they use two or more of these spheres at once.

Using Peru as a case study, this article explores "societal legal mobilization," which refers to legal mobilization outside the legislative and judicial branches.[7] Like other Latin American countries, Peru has recently experienced an increased use of such legal mobilization in efforts to expand or restrict abortion rights.

To conduct this analysis, and operating under the notion that print media is one of the sites of societal legal mobilization, I reviewed op-eds published in two national newspapers between 1990 and 2015. As some scholars highlight, for social movements, the process of producing and mobilizing meaning on a massive level is crucial because it allows them to get their messages into the mainstream, expand the debate around an issue, and increase their legitimacy.[8] Social movements involved in the type of societal legal mobilization analyzed here are not merely carriers of ideas and meanings; rather, they are active participants in the production and maintenance of meaning.[9] This process is what social movement scholars call framing, and it has several core features: (1) it is an active process in the sense that it is dynamic and responds to a certain situation; (2) it is produced by social movements; and (3) it is contentious to the extent that it generates new interpretative frames or challenges existing ones.[10]

The media is not a neutral or passive actor easily influenced by social movements. While the media can be a part of social movements, it also has its own agenda that can shape the space and coverage it provides to the different positions presented in sociopolitical struggles.[11] For example, with regard to the type of material analyzed here—op-eds written by actors with a stated position on abortion rights—the space and coverage provided by the two newspapers in question reflect these newspapers' desire to communicate certain positions on abortion rights.

Societal legal mobilization is not isolated from other types of legal mobilization. Scholars have described how legal mobilization in the courts influences public opinion by, for example, increasing the amount of news coverage devoted to a particular issue or affecting the way the issue is framed.[12] Other authors have described how the media is a site of legal mobilization in its own right—not just a space influenced by legal mobilization—noting, for example, how the number of op-eds and editorials regarding a judicial case may be higher before and after the trial, as well as how social movements may make instrumental use of print media by creating narratives around an issue of interest.[13] This article is aligned with the second approach, analyzing the media as a site of legal mobilization in its own right, and not just as a space affected by legal mobilization. I argue that the media can determine whether a topic such as abortion receives coverage, independently of the legal mobilization taking place in congress or the courts. Unsafe abortions are a daily occurrence in Peru and do not always receive media coverage. However, when legal mobilization is being waged before congress or the courts, the media is also an arena where these disputes are reflected. I argue that the media not only covers the news but also frames the disputes taking place before the legislative and judicial branches.

The article begins by surveying key events regarding abortion rights legal mobilization in Peru between 1990 and 2015. I chose 1990 as the first year for this timeline in light of two key events that took place around that time: debates regarding the Peruvian Criminal Code in 1990, and the International Conference on Population and Development in Cairo in 1994. I chose 2015 as the ending year due to the availability of data and debates on bills to expand or restrict abortion rights in Peru.

I then explore two particular elements of media coverage around the times of these key events: (1) the number of articles published on abortion in two national newspapers, *El Comercio* and *La República*, and (2) the number of op-eds devoted to abortion in each of these newspapers.

Next, to assess changes in the framing of abortion by the actors involved in societal legal mobilization, I analyze the op-eds published by *El Comercio* and *La República*. My analysis follows an inductive approach and adopts a critical discourse analysis—in other words, it goes beyond a tracing of the sequence of texts and considers the context in which these texts were created.[14]

Abortion rights legal mobilization in Peru

Therapeutic abortion to save the lives and protect the health of pregnant women has been legal in Peru since 1924. However, for many years, Peruvian authorities neglected to develop and implement regulations and national-level guidelines for the application of therapeutic abortion, and also failed to train health workers on the procedure. This negligence in relation to abortion's practical accessibility has been challenged before national courts and international bodies (for example, two landmark cases, *KL v. Peru* and *LC v. Peru*, were brought to the United Nations Human Rights Committee and Committee on the Elimination of All Forms of Discrimination against Women, respectively).[15] As a result of such litigation, and following recommendations issued by the Human Rights Committee, Peruvian authorities committed in 2013 to issuing national guidelines on therapeutic abortion. These guidelines were approved in June 2014.

In addition, Peru has seen legislative attempts to both expand and restrict the legal grounds for abortion; some of the most outstanding among these include the debates that took place within the framework of criminal code reforms in 1990–1991 and 2014–2015, and the constitutional debates that took place in 1993 and 2002. Moreover, in 1997, Peru enacted a new health code requiring physicians to report abortion cases, including those of women seeking post-abortion care. During the 2001–2006 legislative term, two bills to expand abortion rights were debated: one in 2001 to expand the grounds of legal abortion to include serious fetal malformations, and one in 2004 to expand the grounds to include sexual violence and eugenics. Meanwhile, in 2001, congress passed Law 27716 incorporating offenses against the unborn into the criminal code. Finally, in 2004, Congress passed Law 27654 establishing a national "Day of the Unborn."

During the 2006–2011 legislative period, some members of congress presented a bill seeking to regulate therapeutic abortion, abortion in cases of sexual abuse, and eugenic abortion (*aborto eugenésico*). The bill, which was debated in 2008 and 2009, included a list of conditions and a fixed period of 90 days during which an abortion could be carried out legally.

During the following legislative period (2011–2016), several legislators presented a bill to decriminalize abortion in cases of sexual abuse (2014 and 2015), while others presented a bill to increase the criminalization of abortion (2015).

Moreover, Peru has seen the presentation of bills regarding issues indirectly related to the provision of abortion. In 2003, a bill was presented to grant humanitarian treatment to women who are detained after having an illegal abortion, and during the 2006–2011 and 2011–2016 legislative periods, three bills to criminalize the advertisement of abortion services were presented.

Debates on abortion rights have also touched on the distribution of modern contraceptive methods, as well as emergency oral contraception (EOC) for victims of sexual violence. Key moments in this regard include 1995, when the Ministry of Health issued Resolution 572-95-SA/DM establishing free family planning services (including surgical contraceptives) in public health facilities; 2001, when the Ministry of Health issued Resolution 399-2001-SA/DM including EOC among the contraceptive methods to be distributed free of charge at public health facilities; 2002, when the Ministry of Health announced that it would not distribute EOC due to doubts regarding whether it is an abortifacient; 2003, when High-Level Commission to Evaluate Emergency Contraception created by the Ministry of Health issued a final decision stating that EOC is not abortive and that its distribution does not violate Peruvian law; 2006, when the Constitutional Court issued Decision 7435-2006-PC/TC ordering the Ministry of Health to distribute EOC, stating that it is not an abortifacient; and 2009, when the Constitutional Court issued Decision 02005-2009-PA/TC banning the distribution of EOC.

Trends in print media coverage: *El Comercio* and *La República*

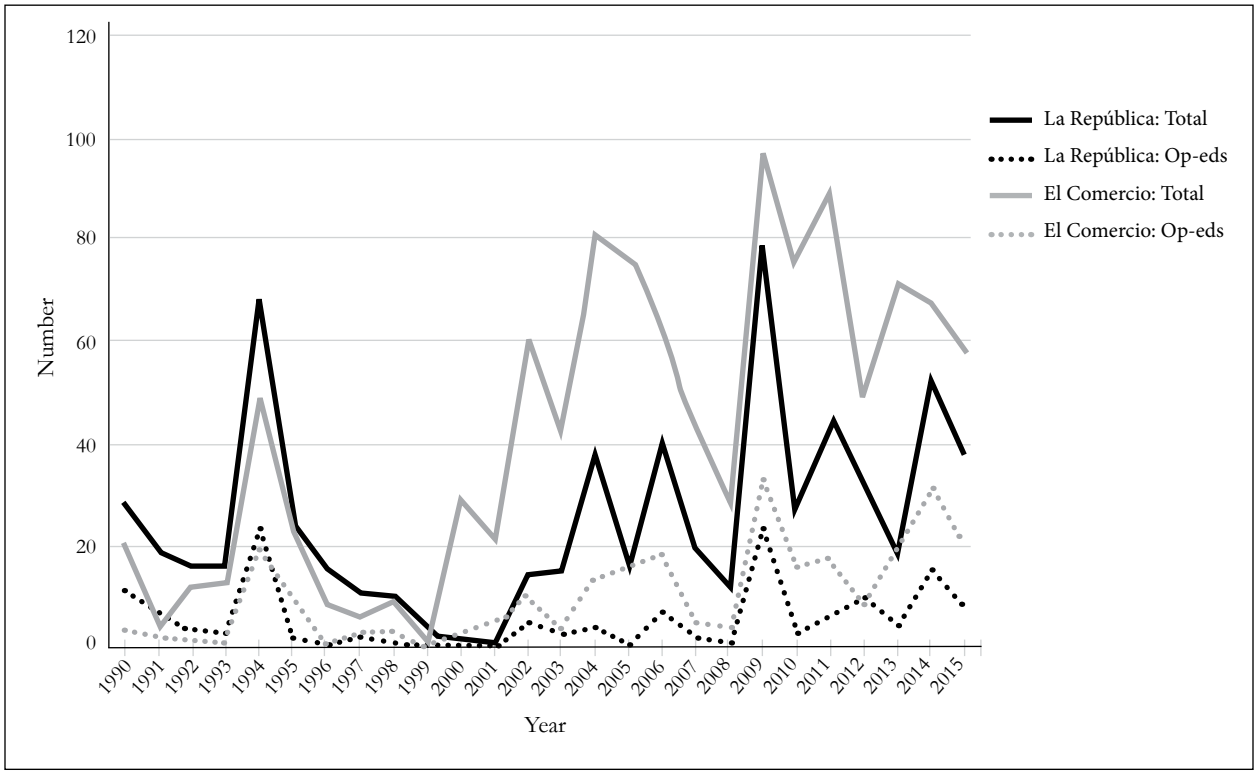
As mentioned above, I selected two national newspapers for this study: *El Comercio* and *La República*

(hereinafter *EC* and *LR*, respectively). My selection of these two newspapers was based on the following criteria: (1) the papers' stability, for both were printed and distributed on a daily basis during the period in question; (2) the papers' reputations as serious, informative newspapers; (3) the fact that neither of these newspapers was controlled by former president Fujimori's regime (such newspapers are referred to as the *chicha* press); (4) the papers' identification with different ideological positions (*EC* is the country's oldest newspaper, with a center-right tradition, and *LR* has been traditionally closer to the left); and (5) until recently (2013), the fact that the two newspapers represented two different conglomerates (*EC* belonged to Grupo El Comercio and *LR* to EPENSA; however, in 2013, Grupo El Comercio acquired 54% of EPENSA).[16]

I obtained the articles from two sources: printed newspapers (*LR* 1990–2015 and *EC* 1990–1999) and digital archives (*EC* 2000–2015). I searched for and recorded all articles mentioning abortion. In total, I collected 1,755 articles: 665 from *LR* and 1,090 from *EC*. It is important to note that *EC* is a longer newspaper in terms of content, which could explain the difference. Of this total, 407 are op-eds (143 from *LR* and 264 from *EC*).

When analyzing the trends in coverage—specifically, determining whether coverage was simply reactive to other types of legal mobilization or, as this article argues, whether coverage also responded to the media's own agenda—I observed that coverage peaks corresponded to some of the key years identified, such as 1994 (Cairo conference), 2003, 2004, 2006 (debates around the distribution of EOC), 2009 (bill seeking to allow abortion in cases of sexual abuse and eugenics), 2011 (*LC v. Peru*), and 2014 (approval of therapeutic abortion guidelines). Interestingly, despite being a smaller newspaper, *LR* provided more coverage to the debates around criminal code reform in 1990–1991, as well as to the Cairo conference, showing the paper's interest in these issues. However, in general terms and with the exception of 1999, *EC* maintained a minimum level of coverage of abortion, showing fewer severe peaks than *LR*, which seems to be more reactive to the legal mobilization taking place

FIGURE 1. Number of articles and op-eds per year and newspaper



in the legislature and judiciary. These differences in trends are even more marked in the op-eds. This could be explained by the fact that *EC* has a section devoted to religion, which regularly dedicates op-eds to the issue of abortion.

Regarding the op-ed positions on abortion rights, I went beyond a mere classification of the positions as either pro-choice or anti-abortion. To classify the op-eds, I adopted an inductive approach, meaning that I read each op-ed and recorded the main topics discussed. This initial analysis allowed me to create six categories and classify each article according to one of these categories (see Table 1). When the op-ed defended a total abortion ban, including the use of EOC or the use of family planning methods on the grounds that they were abortifacients, I classified it as "against all types of abortion and EOC." Some op-eds addressed the debate on abortion rights but focused on certain aspects, such as family planning methods; when an op-ed was in favor of family planning and did not state a position on abortion, I classified it as "in favor of family planning." This type of op-ed was more common around the Cairo conference. Similarly, within the debate around EOC, some op-eds defended EOC, highlighting that it was not an abortifacient. When an op-ed defended EOC and did not state a position on abortion, I classified it as "in favor of EOC." When an op-ed stated that it was in favor of therapeutic abortion but not any other type of abortion, I classified it as "in favor of therapeutic abortion." Finally, I classified as "neither/informative" any op-ed that did not state a position on abortion, instead addressing the issue from an informative angle, such as by describing debates in congress.

My analysis shows that, overall, *EC* published more op-eds rejecting abortion rights (51.1% of its op-eds were against abortion rights), however, beginning in 2009, it increased its op-eds in support of abortion rights and EOC, and in 2015 it published more op-eds in favor of abortion rights than against. This trend is clearer when analyzing peak moments, such as 1994 (Cairo), 2004 (EOC), and 2014 (therapeutic abortion guidelines). As Table 1 shows, in 1994, of the 19 op-eds published by *EC*, 15 were against abortion rights and four in favor of family planning without citing a particular position on abortion rights. In 2004, five out of 15 were against abortion rights, and two indicated a clear position for abortion rights. Finally, in 2014, 12 out of 31 op-eds were in favor of abortion rights, five in favor of therapeutic abortion only, and 13 against abortion rights. These numbers show a dramatic change over 20 years toward a greater balance between the different opinions. This evolution could be related to changes in the newspaper's management, including the removal of Sodalitium Christianae Vitae members (such as Marta Meier and Hugo Guerra, two columnists who wrote against abortion rights) from the editorial board. In the case of *LR*, this newspaper was by and large a platform for those in favor of abortion rights (58.4% of its op-eds were in favor of abortion rights), the distribution of EOC, and family planning policies and modern contraceptive methods in general. In particular, 2009 stands out as a key year, when *LR* published 17 op-eds in favor of abortion rights, out of a total of 23 op-eds.

It is also interesting to note who the expert voices were. During the 1990s, technically skilled elites and members of the feminist movement wrote the majority of the op-eds published by both newspapers. No editorial columns were published in defense of abortion rights, and few regular columnists (such as Rodrigo Montoya from *LR*) wrote in support of abortion rights. During those same years, we can find columns from regular contributors, editorials, and op-eds from politicians written in opposition to abortion rights. This changed dramatically in the mid-2000s, when regular columnists began to write in favor of abortion rights (for example, Mirko Lauer from *LR* and, more prominently, Fernando Vivas from *EC*). A new generation of regular contributors also appeared (such as Gabriela Wiener and Raúl Tola from *LR* and Jenny Llanos and Patricia del Río from *EC*), who began to write in favor of abortion rights.

Particularly notable in the case of *EC* are op-eds written by high-ranking members of the Peruvian Catholic Church (such as Monsignor Luis Bambaren and Monsignor Alberto Brassini), as well as high-ranking members of the Peruvian

Table 1: Number of op-eds by newspaper

	Op-ed tendency																			
	Against all types of abortion and EOC		In favor of EOC		Only in favor of therapeutic abortion		In favor of abortion		Neither/ informative		In favor of family planning		Total	
	LR	EC	LR	EC	LR	EC	LR	EC	LR	EC	LR	EC	LR	EC
1990	6	3	0	0	0	0	5	0	0	0	0	0	11	3
1991	2	2	0	0	0	0	4	0	0	0	0	0	6	2
1992	1	2	0	0	0	0	2	0	0	0	0	0	3	2
1993	1	1	0	0	0	0	2	0	0	0	0	0	3	1
1994	9	15	0	0	0	0	11	0	1	0	2	4	23	19
1995	1	8	0	0	0	0	0	0	0	0	1	0	2	8
1996	0	1	0	0	0	0	1	0	0	0	0	0	1	1
1997	1	3	0	0	0	0	1	0	0	0	0	0	2	3
1998	0	3	0	0	0	0	0	0	0	0	0	0	0	3
1999	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2000	0	1	0	0	0	0	0	0	0	2	0	0	0	3
2001	0	5	0	0	0	0	0	0	0	0	0	0	0	5
2002	1	6	0	0	0	0	4	3	0	1	0	0	5	10
2003	1	2	0	0	0	1	1	1	1	0	0	0	3	4
2004	0	4	3	4	0	0	1	1	0	5	0	0	4	14
2005	0	5	0	1	0	0	0	2	0	7	0	0	0	15
2006	1	2	5	2	0	0	1	5	0	9	0	0	7	18
2007	0	1	0	0	0	0	1	0	1	4	0	0	2	5
2008	0	3	1	0	0	0	0	0	0	1	0	0	1	4
2009	3	18	1	4	1	1	17	9	1	1	0	0	23	33
2010	0	9	0	1	0	0	0	4	3	2	0	0	3	16
2011	0	7	0	0	1	0	4	7	1	3	0	0	6	17
2012	2	6	0	1	0	0	7	2	1	0	0	0	10	9
2013	0	10	0	0	0	0	4	6	1	2	0	0	5	18
2014	2	13	0	0	2	5	11	12	0	1	0	0	15	31
2015	0	5	0	0	0	0	6	12	2	3	0	0	8	20
Total	31	135	10	13	4	7	83	64	12	41	3	4	143	264

LR= La República
EC= El Comercio

Catholic Church who were linked with Opus Dei or Sodalitium Christianae Vitae (such as Archbishop Juan Luis Cipriani and Archbishop José Antonio Eguren). Lay members of Opus Dei and Sodalitium Christianae Vitae were also frequent contributors. For example, in 1999, *EC* published five anti-abortion op-eds by Luis Solari.

Framing the topics in dispute

As mentioned earlier, the op-ed writers' positions go beyond a pro-choice/anti-abortion dichotomy. For example, not all of the pieces written in opposition to abortion rights call for harsher penalties; for some authors, women who obtain abortions are victims. For others, however, abortion is an offense that requires punishment:

> *Instead of promoting abortion, human rights committees should look after the more innocent ones and also women who, many times, opt for abortion while in a state of anguish, without really knowing what it is about.*
>
> *—Rossana Echeandía, EC, April 2, 2013*[17]

> *I believe in the need to modify article 120 of the Criminal Code, but not to decriminalize a practice that, I repeat, has been exempt from punishment for many years. Rather, [the practice] should be effectively penalized, which means raising the penalties in accordance with the gravity of the transgression.*
>
> *—Efraín Vasallo, EC, October 17, 2009*[18]

It would also be a mistake to lump all of those writing in support of access to abortion into the same group. Some writers argue that abortion should be allowed under specific circumstances, while others support more liberal access to abortion:

> *Furthermore, liberals are being stigmatized as abortion promoters, which is a huge distortion, because nobody promotes abortion but rather its partial decriminalization, allowing women to abort only up to a certain stage of pregnancy and under certain circumstances.*
>
> *—Fernando Vivas, EC, March 11, 2014*[19]

> *We cannot talk about safeguarding women's rights unless we also mention their rights to freely exercise their romantic and sexual life; to access the most effective contraceptive methods; and to decide freely for or against motherhood, including the right to freely abort and in healthy conditions.*
>
> *—Joseph B. Adolph, LR, March 31, 1992*[20]

Framing the right to life

One of the main issues in the abortion dispute centers on the right to life, which is framed within broader societal aims by the different actors involved in abortion legal mobilization. In this way, the disputes on abortion rights also reflect disputes on the understanding of society and societal values. For those against abortion rights, the unborn have absolute rights from the moment of conception. Their position against abortion is framed as a defense of the life of the unborn, which is defined as an independent and vulnerable being:

> *Fundamentally, we cannot forget that the unborn is another human being, distinct from the mother and not part of the woman's body ... The victim of abortion is not the woman who aborts—because she is the one who decides it—but an innocent human being whose life is eliminated and who in this case is also completely helpless.*
>
> *—Rafael Rey, EC, August 2, 1994*[21]

> *I am an unborn child, the smallest and most fragile member of the Peruvian family. Though I cannot vote, from the moment I was conceived in my mother's womb, I am as Peruvian as that compatriot who is able to do so.*
>
> *—Archbishop José Antonio Eguren, EC, July 2, 2011*[22]

Positions against abortion rights are framed as protecting basic societal ideals—such as protecting life and the weak—and are embedded in an inaccurate interpretation of constitutional rights, presenting constitutional rights as absolute rights. By presenting constitutional rights as absolute, and the right to life as a superior right, authors denied any venue for weighing up rights, as if constitutional analysis of rights does not allow weighing analysis between competing rights.

> *The plight of a raped woman is enormous. The question is whether that woman's suffering is above the right of the unborn. I believe that it is not. More-*

> *over, I believe that the Constitution places the right to life above any other. It recognizes the right to life not through a creature's parents but directly for that person, individually, from the moment they were conceived.*
>
> *—Federico Salazar, LR, October 18, 2009*[23]

> *We must say the same about the defense of life and threats to life, such as the crimes of abortion, euthanasia, and experimentation on embryos. Modern science is emphatic and unanimous in stating that human life begins with conception. Therefore, human beings must be respected and treated as persons from the moment of their conception and thereafter must enjoy all their rights as people, mainly the inviolable right to life. This not is a confessional matter, as some say in order to silence the Church, but one of humanity.*
>
> *—Archbishop José Antonio Eguren, EC, May 25, 2011*[24]

These legal arguments are rooted in what Lemaitre (2012) called Catholic constitutionalism, which lies in the reasoning that there is a universal moral truth, and a universal moral order, which is superior, and accessible to the non-believers "by reason alone." This universal moral order must guide and be reflected on the interpretation of constitutional rights, and because of its moral superiority cannot be challenged by interpretations (such as weighing) which is against the development of "mainstream constitutionalism.[25] Catholic constitutionalism arguments used by anti-abortion authors like Federico Salazar are rooted in a religious doctrine; for these authors, religious doctrines reflect a universal truth, and therefore are neither dogmatic nor religious.

Catholic constitutionalism arguments do not allow space for other views, such as those of indigenous people, in a multicultural country such as Peru.

But beyond the legal framework, the banning of abortion rights is portrayed as a societal responsibility: society must show its capacity to protect the most vulnerable from murder. "Eugenic abortion" (a term used in the 2009 bill) is regarded as a Nazi-like crime, based on a desire to cleanse society and discharge those considered useless:

> *International eugenics has come to Peru. Its baggage: to consider that there are "useless" people who should be killed ... It seems that Herod has arrived, for asking us to become a country in which persons with disabilities are killed before birth is not only Spartan- or Nazi-like eugenics but also an attempt to implement a Herodian policy in our country: to kill innocent people.*
>
> *—Luis Solari, EC, October 12, 2009*[26]

Abortion is also described as a perversion that goes against family values and therefore society as a whole:

> *We believe it is urgent to save both the lives of the innocent and the structure of the family, which would be severely battered by a mechanism so destructive of life.*
>
> *—Manuel Fabrega, EC, July 13, 1990*[27]

While arguments in defense of the right to life from the moment of conception are used constantly in op-eds against abortion and EOC, there is no corresponding core argument similarly used to defend abortion rights. Op-eds defending abortion rights and EOC include arguments that are not necessarily representative of a shared, central idea, sometimes drawing on notions that are still in dispute. One such notion is the definition of "conception," which is defined by those against abortion and EOC as occurring at the time of fertilization. Advocates of emergency contraception, on the other hand, define conception—and hence the beginning of pregnancy—as the moment when the fertilized egg implants in the uterus. Under this approach, support for contraceptives (which prevent ovulation or prevent the fertilized egg from implanting in the uterus) does not violate the rights of the unborn because there is no unborn to speak of:

> *At the international level, the World Health Organization and the Ethics Committee of the International Federation of Gynecology and Obstetrics, and in the national context, the Peruvian Society of Obstetrics and Gynecology agree that pregnancy or conception starts with a fertilized egg's implantation in the uterus. Therefore, pregnancy and fertilization are not synonymous. Fertilization occurs before pregnancy, and it is not possible to establish its precise moment of occurrence (up to seven days can pass between coitus and fertilization. Fertilization leaves no medical trace). The legal field does*

not discuss when life begins. This debate is perhaps a task for philosophers. The law establishes that life begins with conception—in other words, with pregnancy. —Juan Antonio Ugarte, EC, April 14, 2004[28]

At the same time, this dispute has been framed as independent from discussions on abortion rights, with one of the main arguments being that EOC is not an abortifacient:

By conviction, I must say that I am against abortion. I hope I never have to deal with a case of this kind in my personal environment, as I believe it is essential to defend human life. However, as a liberal citizen, I also believe in the importance of building an open society on the basis of tolerance, respect, and non-discrimination. Because of this, and because it has been shown from a scientific and legal perspective that the morning-after pill is not abortive, I agree with its mass distribution.

—Hugo Guerra, EC, June 19, 2004[29]

However, the right to life has also been at the core of abortion rights arguments and has been linked to societal values. In these cases, the focus is on the woman, for embryos are seen as dependent on women's lives. This dependent relationship places women in a special vulnerable situation:

I refuse to think of women as mere beings with uteruses and eggs who may become pregnant by any method, to give birth nine months later. I refuse to accept that there is some type of miracle in submitting a human being to such damage. Seriously, I refuse to believe that there is a right to snatch away our lives like this, using life as an argument.

—Patricia del Río, EC, May 30, 2013[30]

There is a predominant narrative of abortion as something difficult and dramatic—a last resort where women have few options. It is within this setting that society must be sensitive and respectful of women's autonomy to decide:

I ask you, medical doctor, to put yourself—with a bit of sensitivity, of course—in the place of a woman who aborts, who I'm sure never wanted to go through the experience of removing a piece of possible life from her uterus—a frustrating, painful, and risky situation for life in this country.

—Patricia Córdova, LR, August 8, 1994[31]

It must be stated clearly that abortion is an extremely traumatic and painful solution that in no way can be thought of as a regular method of contraception. It is a very difficult decision that no one wishes to face but which corresponds to the most intimate sphere of each individual.

—Raúl Tola, LR, March 12, 2011[32]

For many of those in favor of expanding the grounds for legal abortion, the criminalization of abortion disproportionately affects the most vulnerable women—those who are unable to pay for safe abortion—and this group includes women and girls who are victims of sexual abuse. Unsafe abortions and unwanted pregnancies are portrayed as urgent public health problems. Expanding the grounds for abortion is therefore a social justice measure because it allows those in need to have access to safe abortion. This line of argument is closely related to legal mobilization in the legislative and judicial branches that seeks to guarantee access to EOC.

The saddest thing is that many unwanted pregnancies lead many women to such desperation that they will abort anyway, regardless of the legal status of abortion (let's not forget that 360,000 Peruvian women choose this option each year). The only difference will be that if abortion continues to be criminalized, the quality of an unsupervised procedure will depend on the price paid and one's social position. Poor and isolated women will face a real risk of dying. So, as a matter of public health, decriminalization (nobody proposes "legalizing" it and much less promoting it, because nobody celebrates abortion) is a humanitarian measure to prevent some women from dying unnecessarily, but it will not increase abortions (there is no precedent for such an increase). For this reason, advanced democracies have adopted it as a basic service in a civilized society.

—Carlos Cáceres, EC, October 21, 2009[33]

With this, the state and its citizens have the opportunity to address a serious problem in our society, a difficult and harmful reality before which we cannot simply cover our eyes or entrench ourselves in moral prejudices or religious beliefs in order to ignore it. Our country is home to South America's highest rate of reported rapes. According to the Ministry of Women and Vulnerable Populations, in 2010, 34%

of girls and adolescent women between 10 and 19 years of age who were treated in emergency centers for sexual assault were pregnant as a result. For the Ministry of Health's General Directorate of Epidemiology (Minsa), unsafe abortion is one of the main direct causes (29%) of maternal deaths among adolescents. Opponents to the proposal have tried to distort the debate by claiming that these statistics are inaccurate.

—Veronika Mendoza, EC, April 23, 2015[34]

(Un)dogmatization of abortion legal mobilization

Interestingly, actors against and in favor of abortion rights regularly present their positions as neither dogmatic nor ideologically oriented. Rather, they describe them as "objective." This perception can be seen in the references to scientific evidence and the law:

[D]octor Guzmán says that pregnancy begins with implantation; this statement is inaccurate. From a scientific point of view, human life begins with fertilization or conception (the union of the egg and the sperm), and from that moment all the genetic information of the new being (DNA with 46 chromosomes) is present; this is recognized in all modern medical embryology books (Moore 2008, Sadler 2006, O'Rahilly 2001, Larsen 1998). Furthermore, it is now known that the embryo, in its early hours (and prior to implantation), produces different hormones (HcG, IL-1a, IL-1ß), which help it implant into the maternal endometrium (Lindhard 2002, Licht 2001, Wolf 2001). Therefore, it can be said that pregnancy (as a state of the gestational mother) also begins with fertilization.

—Germán Alvarado, EC, March 26, 2010[35]

[Life is] neither a religious dogma nor a metaphysical moral. Life is a human right. What do I mean? It is the most important right. Transgressing this right leaves all others very fragile, and it damages both those who violate it and the society that promotes it.

—Rossana Echeandía, EC, April 16, 2013[36]

Another absence was the regulation of therapeutic abortion, legally established in the Criminal Code since 1924. It refers to an abortion, consented by the pregnant woman, in order to save the woman's life or avoid serious and permanent damage to her health. After 88 years, we are still waiting for this norm's regulation so that it can be applied in very specific cases and in defense of the mother's life or to prevent a serious and permanent disability.

—Javier Diez Canseco, LR, March 26, 2012[37]

The use of scientific evidence relies on the idea of scientific neutrality. Besides the questionability of this assumption, the acceptance of scientific evidence is not linked to the use of a scientific method. There is not a systematic approach to the evidence. Authors choose the facts that support their positions, ignoring those facts that could question or that are opposed to their statements. For example, the quote from Rossanna Echeandia published in *EC* on April 16, 2013 refers to human rights but explicitly ignores relevant evidence such as jurisprudence from the Inter American Court of Human Rights. This includes the 2012 decision on *Artavia Murillo et al* ("In vitro fertilization"*) v. Costa Rica*, where the court recognized the adequate balance between competing rights and interests and said "the absolute protection of the embryo cannot be alleged, annulling other rights."[38]

These efforts to influence the public opinion show how active the op-ed authors are on the legal mobilization and the central role played by the media on the disputes on abortion rights in Peru. The dispute is also clear when authors discredit their opponents, portraying the opposing arguments as dogmatic, biased, or uninformed:

Then I asked for the figures on infected abortions, since those of us who have worked in health services know the main cause of why a criminal abortion would end up in a hospital. The figure was 2,114. Have you read this clearly? If we applied the same one-out-of-every-five criterion used by the aforementioned "study," the number of criminal abortions would be 10,570, vastly less than the 271,150 cited by the "study."

Why lie to inflate the figures of criminal abortion? Obviously, this is in order to later say that we should decriminalize abortion and offer it under "safe conditions." That's a message quite removed from and opposed to our legal system, which inherently rejects the death of the defenseless, an essential characteristic for a culture based on the protection, promotion, and defense of human rights. —Luis Solari, EC, March 26, 2009[39]

The debate on the decriminalization of certain types of abortion suffers from acute distortion due to ideological-religious fundamentalism that obstructs rational argument. But the truth is that beyond our narrow limits, at the level of the international community, abortion in cases of rape, danger to the pregnant woman's life, or congenital defects and serious neuropathies that make life unfeasible for the conceived one is absolutely not a matter of religious confession but of public health and the fundamental rights of women.

—Ronald Gamarra, LR, October 16, 2009[40]

Relationship between judicial, legislative, and societal legal mobilization

This analysis of the content in the op-eds concurs with my earlier quantitative analysis: there is a relation between, on the one hand, legal mobilization in the courts and legislature and, on the other, legal mobilization in the print media. However, the relationship is not a linear causal one where legal mobilization in the judiciary and legislature is the independent variable, while the legal mobilization in the op-eds is the dependent one. A closer analysis reveals two main ways in which this relation is expressed.

The first one is a reactive relation: op-eds refer directly to the legal mobilization taking place in the courts and congress, but not merely to describe what is happening. Rather, this reactive stance presents and defends a position:

The proposed reform to the Criminal Code, drafted by a review committee and sent to the executive, includes the crime of abortion, which cannot be criticized because it is the conscious and voluntary action of depriving life from the product of pregnancy.

—César Fernández, LR, December 11, 1990[41]

For the last few weeks, there have been clamors against abortion as part of a hard and ongoing campaign, but what is strange is that there is not a single abortionist project in Peru; the defenders of the decriminalization of abortion do not have sufficient force to impose their reasoning ... They respond that the threat exists and is called THE CAIRO CONFERENCE. It is said that the conference's preliminary document seeks to impose the legalization of abortion around the world. Those who have read the preparatory document know that this is false.

—Ignacio Sánchez, LR, September 7, 1994[42]

One of the main issues at congressional discussions on constitutional reform is the article on the right to life. The proposal to create a possible exception to this fundamental right has caused some anxiety, because abortion—or the termination of pregnancy, which is the same thing—transgresses this primordial right.

—Jaime Millas, EC, December 31, 2002[43]

The second relation is an interpretative one: op-eds use international and national legal mobilization as part of their argumentation, and they seek to achieve the (un)dogmatization of the legal mobilization described above.

This time, the Constitutional Court has acted accordingly, with a democratic and technical debate. This ruling is historical and has, in my opinion, direct consequences for the next congressional debate on abortion. If the distribution of the morning after pill is forbidden because of its abortive potential, isn't this all the more reason to make unconstitutional the failure to criminally punish the practice of abortion, as is unfairly sought by proposed legislation?

—José Chávez, EC, October 29, 2009[44]

K.L. and L.C., two Peruvian citizens who litigated and won against the Peruvian state in international human rights courts, survived the state's refusal of a therapeutic abortion, but with serious damage to their health. K.L. and L.C. are still waiting for justice, and we hope for them and for women today who are going through similar circumstances that times will change and that their lives will really matter to our country's authorities.

—Rossina Guerrero, EC, March 11, 2014[45]

Cases in the courts, as well as debates in the executive and legislative branches, are also contested by the op-eds. In this way, the op-eds are a space for contestation, revealing the linkages between the different types of legal mobilization:

> *It's clear that those judges who are forcing women to risk their lives by having an [illegal] abortion or to have children they don't want would buy Levonorgestrel for their daughters or lovers in less time than it takes the sperm to reach the egg, ensuring that the cervical mucus thickens and inhibits ovulation. But when they refer to poverty-stricken women, may they get pregnant!*
>
> *—Jorge Bruce, LR, October 24, 2009*[46]

> *What Minister Midori de Habich calls "uterine contents" in her protocol for "therapeutic" abortion has another name, one that does not lie about what it really is: a human being with rights expressly stated in the Peruvian Political Constitution that she and all Humala government members are obligated to respect and enforce.*
>
> *—Rossana Echeandía, EC, July 8, 2014*[47]

Conclusion

This article aimed to assess the extent to which print media is a site of societal legal mobilization. My analysis shows, in line with previous studies, that the media has an agenda and that in the case of abortion legal mobilization, this agenda influences the coverage allocated to the topic, as well as the space given to different positions. However, this agenda is not immune to change. In Peru, both *El Comercio* and *La República* have gradually given more space to positions supporting abortion rights.

Based on this analysis, it is possible to conclude that these two newspapers have served as sites of societal legal mobilization. Op-eds have been written not only to describe legal mobilization in congress and the courts; sometimes, they are used to frame abortion legal mobilization in general, without the need for debates in the legislature or judiciary. This is especially clear in the case of *EC*. However, even when the op-eds refer to legal mobilization in the legislature or judiciary, they are used to frame debates, to contest or support positions, to influence public opinion, and to influence legal mobilization taking place in the legislature or judiciary. Former ministries of health, Catholic Church authorities, and congressional representatives have written op-eds supporting or challenging decisions made by the executive, congress, and the courts regarding abortion rights in Peru.

Framing is a central element of the strategy deployed by different actors. Societal values and aims are repeatedly brought to the debate. Interestingly, this analysis shows that actors with opposing views quote some of the same phrases, but with different angles. This reveals a type of legal mobilization around the framing of key concepts, such as the definition of conception (fertilization versus implantation), autonomy (embryo autonomy versus women's autonomy to decide), vulnerability (vulnerability of the fertilized egg/embryo versus that of women), and the social responsibility to protect (protection of the fertilized egg/embryo versus that of women, especially poor women and victims of sexual violence).

An especially noteworthy feature of the analyzed material is authors' continuous attempts to present their positions as neutral and objective, when in fact abortion legal mobilization addresses broader debates around societal aims and values, including understandings of equity, social justice, women's role in society, and women's rights. Abortion rights legal mobilization involves far more complex positions and debates than those simply for and against abortion rights, or those around when life starts. The law and scientific evidence are frequently used to avoid more philosophical and moral questions. This finding is in line with previous studies showing a strategic use of facts to present one's position as a representation of reality or the truth.[14] In the case of the topic analyzed here, which entails a debate on women's autonomy, the analysis shows a preference for facts and an almost nonexistent debate over issues related to women's autonomy. This is a worrying finding because it demonstrates an extremely positivist approach, in which law and science are seen as the only valid sources of information. In a country such as Peru, with a significant indigenous population, indigenous knowledge and understandings of abortion are not present in the debates, as if they were not valid sources of information.

One of the main limitations of this study is

that it does not provide an analysis of regional-level trends and debates. Because of the methodology selected and the availability of sources, it was not possible to perform such an analysis. However, my methodology, which involved the review of printed newspapers, allowed for an analysis of trends in Peru over a 25-year period, which would not be possible using online archives alone. A web-based search method would not cover this period of time. Covering a 25-year period is not an arbitrary decision: legal mobilization is a dynamic process in which actors deploy different strategies. Therefore, examining a 25-year period allows for a comprehensive analysis and description of dynamics, which in turn provides a better understanding of legal mobilization's effects.

Using a qualitative approach also provides the opportunity to analyze and describe how arguments change over time, and consequently gives a better understanding of how litigation could shape the framing of the topic. This would not be possible with a quantitative analysis of trends.

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The Moderating Influence of International Courts on Social Movements: Evidence from the IVF Case Against Costa Rica

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Abstract

Feminists and religious conservatives across the globe have increasingly turned to courts in their battles over abortion. Yet while a significant literature analyzes legal mobilization on abortion issues, it tends to focus predominantly on domestic scenarios. In this article, we consider the effects of this contentious engagement of pro-choice and anti-abortion movements in international human rights fora, asking what happens to social movement claims when they reach international human rights courts. We answer the question through a detailed description of a single case, *Gretel Artavia Murillo et al. v. Costa Rica*, decided by the Inter-American Court of Human Rights in 2012 but with ongoing repercussions for abortion rights, given its authoritative interpretation of embryonic right to life. Through our analysis of *Artavia Murillo*, we show how legal mobilization before international human rights courts moderates social movement claims within the legal arena, as rivals respond to one another and argue within the frame of courts' norms and language.

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Introduction

Feminists and religious conservatives across the globe have increasingly turned to courts in their battles over abortion. Yet while a significant literature describes legal mobilization on abortion issues, it tends to focus on domestic scenarios, and even then often fails to consider the effects of movement-countermovement confrontation in the courts on social movements' framings of key issues.[1] More generally, socio-legal literature on legal mobilization focuses on movements' use of legal claims (whether limited to litigation or espousing wider cultural approaches to rights language), with little attention to the specific nature of movement-countermovement engagement in court.[2] Social movement moderation has been linked to the effect of organization rather than to the effect of recourse to law or to engagement with opponents in court.[3] In this article, we consider the effects of this contentious engagement of pro-choice (feminist) and anti-abortion (conservative) movements in international human rights fora. We ask what happens to social movement claims when they reach international human rights courts and how these courts react to the presence of movement and countermovement claims. These are the key questions addressed, rather than the much broader issue of effects of contentious engagement on social movements themselves.

In order to answer these questions, and given the dearth of literature on contentious engagement in international courts, we adopt a case-study methodology, relying on detailed description to help us navigate the impact of contentious engagement in the international arena on social movement claims as they go transnational. The selected case study is *Gretel Artavia Murillo et al. v. Costa Rica*, decided by the Inter-American Court of Human Rights (IACtHR) in 2012, but with ongoing repercussions both in Costa Rica and throughout Latin America. We base our analysis of the case, and of movement and countermovement claims, mainly on documentary sources, offering a close reading of the 39 amicus briefs submitted by individuals and organizations, as well as press and other secondary documentation on the case and the organizations and individuals involved. This documentary review is complemented with a snowball sample of interviews of eight lawyers who had participated in the case at different stages, either writing amicus briefs for feminist organizations or serving as clerks in the inter-American human rights system.

Artavia Murillo is a case of singular importance in the inter-American human rights system. In *Artavia Murillo*, the IACtHR ordered Costa Rica to lift its unique ban against in vitro fertilization (IVF), rejecting Costa Rica's argument that embryos had personhood and full human rights following article 4(1) of the American Convention on Human Rights Convention (henceforth the American Convention). Together with *Karen Attala Ruffo v. Chile* (on parental rights for gay people), it is one of only two sexual and reproductive rights cases that have completed the process from domestic tribunals all the way to the IACtHR, and it clearly shows the trajectory from domestic jurisdiction to the regional human rights system, and back.

The reference to the right to life in *Artavia Murillo*, ostensibly about IVF, quickly transformed it into a landmark abortion case. The American Convention, as had been abundantly argued, is unclear on the point of the beginning of life. Article 4(1) reads, "Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life." Religious conservatives have long used the phrase "in general, from the moment of conception" to reject abortion rights and support the criminalization of abortion. Feminists, on the other hand, have insisted, first, that the actual meaning of the phrase is ambiguous because the process of life that begins at conception does not necessarily entail personhood and, second, that the words "in general" mean that states are free to protect the right to abortion.

Interpretation of the protection of the right to life afforded by the American Convention is of extreme importance for legal activism, both for religious conservatives and for feminists. It not only affects international law but also directly affects

domestic law, since regional constitutional law in Latin America tends to integrate the provisions of the convention. Thus, the unprecedented opportunity to elicit an authoritative interpretation of article 4 from the IACtHR had immediate legal relevance for domestic battles over abortion rights in a region characterized by contradictory impulses toward both liberalization and increased criminalization.[4]

Hence, from its inception as a seemingly obscure dispute over access to IVF in Costa Rica, the case grew into a major abortion rights case in the Americas, given the potential impact of an authoritative interpretation of the right to life. Over the years, the list of amici in the case grew to read like a "who's who" of transnational conservative and feminist activism for and against abortion rights: all the major regional activists are present, including nongovernmental organizations (NGOs), human rights clinics, and law professors. The large number of amicus briefs (for the inter-American human rights system) represented a wide range of positions on both sides of the international conservative Catholic and feminist divide, presented by an impressive range of influential regional and international actors, in turn indicating emerging alliances and strategies. The case became a landmark in the legal battle over sexual and reproductive rights between feminist and religious conservative (mostly Catholic) lawyers in the Americas. For feminists, *Artavia Murillo* was a triumph: the IACtHR adopted their interpretation of a progressive protection of human life *in utero*, linked to the protection of the pregnant woman's health and well-being, and excluded rights for embryos outside a female uterus. For religious conservatives, it was a serious setback to a concerted effort to convince the inter-American human rights system that the American Convention is in fact "a pro-life treaty," a position that has influenced Costa Rica's reluctance to date to implement the IACtHR's ruling. In the following sections, we describe the unfolding of the case, the social movement actors that mobilized for and against the ban, and the final decision and its implications. We focus in particular on the moderating effect of legal mobilization.

Costa Rica bans IVF as a violation of the right to life

In January 1995, news broke that the first "test tube baby" had been successfully conceived in Costa Rica, the result of the work of a single private clinic that first brought IVF to Costa Rica. The news was met with condemnation, particularly from the country's Catholic Church hierarchy and congregations, an important factor given that Costa Rica's 1949 Constitution establishes the Catholic Church as the official state church. That same year, Pope John Paul II published a major encyclical, *Evangelium Vitae*, which insisted that human life was a sacred gift from God from its beginning, that embryos had the same dignity and right to respect as a child born, and that discarding embryos killed innocent human creatures and was morally unacceptable.

In March 1995, the Costa Rican Ministry of Health adopted a decree that regulated IVF for the first time. This decree stipulated that up to six embryos could be transferred into the woman's uterus at a given time and specifically limited the intervention to heterosexual couples who were married or living in civil unions. Conservatives challenged the decree before the Constitutional Chamber (Sala IV) of the Costa Rican Supreme Court of Justice.

The conservative challenge wielded traditional Catholic arguments aligned with *Evangelium Vitae*, but precluding religious references. The claimant was Hermes Navarro del Valle, legal counsel for the Costa Rica Catholic Bishop's Conference.[5] In his brief, Navarro asked the Constitutional Chamber to declare unconstitutional the Ministry of Health's decree and the procedure of IVF, as they violated the right to life of the embryos discarded during the IVF procedure. The argument built on the view, widely and transnationally disseminated by Catholic scientists and lawyers, that human personhood begins at the moment a distinct chromosome emerges from the encounter of a human egg and sperm. The biological product of conception thus defined deserves the respect and consideration due to a human being.

In 2000, after five years of deliberation, the Constitutional Chamber banned IVF in Costa

Rica, agreeing with the plaintiff that life begins at conception, that this life has personhood as well as human rights within Costa Rica's legal system, and that the surplus embryos produced by IVF procedures had dignity and human rights that were violated by IVF. The conservative ruling precluded any reference to religious authority but reflected the Catholic Church's position as described above. Additionally, the court extensively cited the American Convention and other documents produced within the inter-American system, interpreting them to insist on the existence of personhood and full human rights from the moment of conception.

Plaintiffs take their case before the Inter-American Commission on Human Rights

In 2001, 12 Costa Rican couples brought a case before the Inter-American Commission on Human Rights (IACmHR), claiming that the ban violated their rights to family, equality, and non-discrimination. The case was not brought as part of a focused litigation campaign but rather filed by former patients of the Instituto Costarricense de Fertilidad—married, heterosexual couples denied access to IVF following the 2000 ruling. In 2004, the IACmHR admitted the case.

Over the next six years, transnational activists—conservatives as well as feminists—and the IACmHR itself would slowly come to understand the relevance of *Artavia Murillo* for the wider struggle around abortion rights. The IACmHR received a handful of amicus briefs during this period: three for the claimants (presented by the Center for Reproductive Rights in 2004, the Allard K. Lowenstein International Human Rights Clinic at Yale Law School in 2005, and the University of Toronto in 2009) and two for the defendants (submitted by Human Life International in 2005 and the University of St. Thomas School of Law in 2008). Amici mobilization around the case was still weak.

The IACmHR declined to address the Costa Rican (and Catholic) argument that life—and thus full human personhood and rights—begins at conception. In its final report on the merits of the case in 2010, the IACmHR attempted to find a middle ground and skirt the issue of abortion rights by avoiding an interpretation of article 4, focusing instead on IVF.[6] It decided unanimously that the Costa Rican ban violated the rights to private life (article 11) and to family life (article 17), arguing that there were less restrictive alternatives to protect the right to life. It also linked the case to regional practice, pointing out that Costa Rica was the only country in the Western Hemisphere to enforce a total ban on IVF, thus opening a door to delinking the case from abortion and abortion rights, since there is no similar consensus on the criminalization of abortion. The case could then remain as decided by the IACmHR or, following the system's procedure, be referred to the IACtHR for a binding judicial decision.

Neither feminists nor religious conservatives were pleased with the IACmHR's report. Feminists were concerned that it opened the door for an authoritative IACtHR interpretation of article 4 as recognizing embryonic personhood, precisely because the IACmHR avoided the issue and linked the case to regional practice, which criminalizes abortion. Conservatives were concerned that interpretation could go the other way, and two leading legal figures in the regional anti-abortion movement, Ligia de Jesus and Álvaro Paúl, published separate law review articles in 2011 examining article 4 and arguing that it included a clear right to life for the unborn and recognition of legal personhood for embryos.[7] Both camps braced for an IACtHR decision, which was inevitable given Costa Rica's defiance of the orders contained in the report.

Transnational activist networks mobilize before the Inter-American Court of Human Rights

Costa Rica accepted the decision but never implemented the recommendations. This spurred the IACmHR to take the case to the IACtHR. In submitting *Artavia Murillo* to the IACtHR, the IACmHR argued that the case raised issues of inter-American public order, meaning it had important implications for a wider understanding of the rights protected by the inter-American human

rights system. Specifically, the IACmHR argued, the case referred to the scope and content of the rights recognized in articles 11 and 17 (privacy and family life), but the question in everyone's mind was abortion.

It was before the IACtHR that *Artavia Murillo* became a major case for both feminist and conservative transnational social movements, based for the most part out of the United States. Both were concerned with the IACtHR's possible interpretation of article 4. Of the 39 amicus briefs presented in this case, 16 were clearly conservative and 13 clearly feminist. The conservative briefs defended the IVF ban, arguing generally that life begins at conception and that embryos have a right to life; feminist briefs argued that the ban represented a disproportionate violation of a number of women's and couples' rights, especially the rights to health, to privacy, and to have a family. The remaining 10 amici took issue with conservative claims about scientific evidence, especially claims that the embryo was a person and that IVF was harmful to the health of both fetuses and women.

Many of the feminist briefs came from the United States and Canada, signaling these countries' centrality to feminist legal mobilization. The Center for Reproductive Rights presented two: one put forward by its Latin American office and the other by its New York headquarters, written together with Rebecca Cook and Bernard Dickens of the University of Toronto. The Center for Reproductive Rights is the leading advocate for sexual and reproductive rights in the international arena, as well as a well-known domestic organization. Cook and Dickens both teach at the University of Toronto, and for many years Cook has co-directed the International Reproductive and Sexual Health Law Program. Two US universities with a history of feminist advocacy in the international arena also submitted amicus briefs: the American University and Yale Law School, both from their human rights clinics. The additional US-based amicus came from Catholics for Choice, originally a US-based NGO with a long history of confrontation with the Catholic Church's positions on abortion and contraception.[8]

The case also activated feminist networks working on sexual and reproductive rights in Latin America. One amicus was submitted by an alliance of reproductive rights NGOs from Colombia, Mexico, and Argentina and from the Latin America branch of Ipas, based in the US. An alliance of sexual rights advocates in Brazil submitted another brief, as did a human rights clinic at the Universidad de los Andes in Bogotá and the Colombian human rights NGO Dejusticia. Two professors at the Universidad Torcuato di Tella in Argentina, one of whom had studied at the University of Toronto, also submitted a feminist amicus. Only two feminist amici came from Costa Rica, and both seem to have links with the same small NGO the Colectiva por el Derecho a Decidir.

A number of briefs were presented by liberals who were not directly affiliated with the feminist movement but who were supportive of IVF as a safe and ethical medical procedure. Perhaps the most impressive of these amici was submitted by the Latin American Federation of Obstetric and Gynecological Societies, an umbrella organization based in Panama that includes several national chapters and thousands of members. According to our interviews, further liberal briefs were submitted by human rights organizations in response to requests from feminist activists who employed a deliberate strategy to diversify the profile of the briefs supporting the plaintiffs.

On the conservative side, the transnational amici also outnumbered the Costa Rican briefs, revealing the importance of the case for the regional and global anti-abortion movement. Again, US-based organizations were quite present, but so were organizations with links to the Vatican. These briefs for the most part trace networks that adopt Catholic definitions, framing them not as religious arguments but as bioethics. The first transnational amicus emphasizing Catholic bioethics was signed by a group of Italian politicians and bioethics professors who teach at the Catholic University of the Sacred Heart in Rome, as well as representatives from the US-based organizations Human Life International and the Fund for the Defense of Bioethics, in addition to a little-known Mexican association Crece Familia. The presence of Human

Life International and the Fund for the Defense of Bioethics is particularly significant: the former, like the Population Research Institute, which participated in various amici, was founded by US Catholic priest Paul Marx to promote anti-abortion views around the world.

The remaining briefs further illustrate the strong presence of Catholic bioethics as the main conservative legal mobilization frame against IVF. This is a recurrent reference in the amicus brief signed by a group of Peruvian bioethics specialists from a Catholic University and the brief signed by a group of Peruvian NGOs linked to the Population Research Institute. Two additional amici were submitted by conservative legal scholars—the first by Álvaro Paúl and by the directors of a number of Catholic US-based NGOs (the Alliance Defense Fund, now Alliance Defending Freedom; C-Fam, the leading Catholic NGO at the United Nations; and Americans United for Life). Paul is a professor at a Catholic university in Chile and a respected expert in the inter-American legal system. The second was submitted by Ligia de Jesús, professor at the Ave Maria Law School and author of several academic articles defending conservative Catholic interpretations of the American Convention, together with Rafael Nieto Navia, professor at the Pontificia Universidad Javeriana in Bogotá (a Jesuit university) and a former judge of the IACtHR. Their transnational links with Catholic bioethics networks might explain some of the other amici, such as those from the president of the Spanish Association of Bioethics and Medical Ethics, from bioethics activists in Mexico, and from a pro-life doctors' association in Guatemala.

Catholic views on the beginning of human life are the common denominator of many of the conservative amicus briefs in the *Artavia Murillo* case, as evidenced by their affiliations and arguments. However, many of the claims made in other fora are not present in the amici: for example, none expressed the conservative hostility toward feminism so often framed in the critiques that feminist ideas promote both "gender ideology" and a "culture of death."[9] Similarly, feminist organizations eschewed the more polemic historical arguments about achieving women's liberation through reproductive freedom. The next section analyzes this moderating trend affecting both movements.

The moderating effect of legal mobilization

The majority of the arguments presented in the briefs were moderate in comparison with each movement's framing of the issues for its supporters: a deep religious faith for conservatives, and a strong commitment to women's liberation for feminists. Our conclusion is that all actors moderated their claims before the IACtHR.

Feminist lawyers, usually adamant in their rejection of female stereotypes and their central defense of female autonomy, strategically appealed instead to women's rights to health, to privacy, and to a family, as well as the right to equality of couples and infertile women. The arguments defending abortion rights appear in the feminist amici in a more moderate form than they do in general feminist theory and social movement claims. For example, the briefs never mention the right to choose pregnancy as a human right derived from the rights to autonomy and privacy, and they generally avoid making the link between the IVF case and abortion rights. The Center for Reproductive Rights, for example, describes reproductive choice as the core of its organizational vision: "We envision a world where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive healthcare available; where every woman can exercise her choices without coercion or discrimination."[10] In this vision, abortion is a constitutional right as well as an international human right.

Besides avoiding hardline positions defending abortion as a human right, the feminist briefs also generally avoided the movement's usual emphasis on women's points of view and experience. The only references in this regard were quotations from the plaintiffs themselves, some of whom appealed to stereotypical notions of women in order to characterize the harms caused by the IVF ban—for example, that women's natural urge to motherhood was harmed by the ban. These arguments remained unchallenged in the feminist briefs.

In addition to the exclusion of autonomy arguments, and the appeal to motherhood, legal language and techniques of interpretation—especially appeals to proportionality and balancing—act as a moderating force in framing the feminist amici. There is an inherent moderation in saying that one's claims must be balanced against those of the other side, or that all laws, adverse or favorable, must be applied by taking into account a proportionate relation between the rights protected and the harms caused by this protection. Hence, the value of human life since conception must be protected, but only in a fashion consistent with the rights of pregnant women carrying this life in their uterus. The Center for Reproductive Rights argues in its amicus:

> *While States may take certain measures in order to advance an incrementally-growing interest in developing human life, this is different than granting legal rights prior to birth because the granting of legal rights creates an inherent conflict between the rights of women and the embryo. The latter characterizes the Costa Rican Supreme Court's decision, which states that even before gestation begins, the embryo is already entitled to all human rights to such an extent that these rights trump and nullify women's fundamental human rights. This characterization is impermissible under international human rights norms, as it inevitably infringes upon women's human rights as well as the principle of proportionality.*

Proportionality and balancing are similar in that both call for interpretation that recognizes the importance of the different rights in question and demand that the protection of one right (in this case, the right to life) be respected in such a way that the harm to other rights (in this case, family life, autonomy, and privacy) is *proportionate* to the benefits of protecting the first right. These techniques of legal argumentation entail recognition of at least some of the claims of the counterpart and address them directly without completely denying their validity. This is probably the strongest feature of the feminist briefs in terms of adapting to the culture of the inter-American human rights system, which has frequently emphasized proportionality as an important form of interpretation of the rights protected in its treaties.

The strength of feminist appeals to proportionality can be directly traced to the feminist movement's high level of comfort with the culture of international human rights, signaling another distinct feature of the international women's movement: its legalism. The claim that women's rights are human rights has been a decades-long staple of the transnational feminist movement, which has argued that the defense of sexual and reproductive rights derives from international human rights treaties. The orientation toward rights claims includes feminist appropriation of Catholic appeals to human dignity, the right to life, and the right to a family. This appropriation is especially striking in the case of the right to a family—a conservative aspiration that in these briefs becomes closely linked to the right to opt for IVF.

Conservative activists also moderated their claims, eschewing an important portion of their mobilizing frames in order to litigate before the inter-American human rights system. Perhaps most importantly, they excluded all mention of faith, God, and church. The importance of faith, however, is clear in the websites of the conservative NGOs that submitted briefs. Human Life International, for example, describes itself as "pro-life missionaries." This is its description of its mission:

> *[Human Life International] defends both the God-given life and dignity of all human persons from conception until natural death, and the natural family based on marriage—the fundamental human institution defined by a lifetime union between one man and one woman that is open to life. As followers of Jesus Christ and members of the Catholic Church, our goal is to build a Culture of Life and of Love around the world through education, outreach, and advocacy.*[11]

These types of religious claims do not appear in the conservative amici, in line with trends among conservative Catholic lawyers who have eschewed from their arguments the religious basis of their conviction of the full humanity and personhood rights of human life in utero.[12] In addition, other frames closely linked to the Catholic Church—such as the references to "gender ideology" and the

"culture of death," as well as general references to good and evil, to love and prayer, and to God and his will—also disappeared from the framing of the IVF issue. References to nature were decoupled from the Catholic link between nature and God as creator, and to a natural law that would predate state law and be outside state purview.

Instead, the conservative amici focused on developing two lines of argument. First, they defended the embryo's right to life from conception, arguing that conception occurs at the moment of fertilization, when distinct DNA emerges. Second, they used arguments referring to appropriate techniques for legal interpretation of article 4. The references to the right to life are repeated across the different briefs, while the arguments on legal interpretation (the recourse to the original intent of the framers, and respect for states' margin of appreciation of human rights treaties) are found in the amici submitted by conservative legal scholars. Originalist arguments are central to the conservative turn in US constitutional law, and margin-of-appreciation doctrine has a similar function in the European Court of Human Rights. However, these associations are contextual, as there is nothing inherently conservative in appealing to them; they are not, however, the dominant form of interpretation in the inter-American human rights system, which has overtly rejected both originalism and margin of appreciation. In this context, they served conservative claims by showing that the intent of the framers had been to allow the prohibition of abortion through article 4 and by giving Costa Rica the margin of appreciation needed to pass the IVF ban. In conclusion, conservatives, like feminists, used more moderate arguments than those in seen on their websites and in street protests against abortion.

Outcomes: Feminist triumph but careful response to conservative arguments

In 2012, the IACtHR ruled against Costa Rica, ordering specific remedies for the victims and, more generally, as a measure of non-repetition, the repeal of the ban on IVF. The court concluded that the prohibition of IVF violated the rights mentioned by the IACmHR in its report: the rights to personal integrity, to personal liberty, to privacy, and of the family. It also went further, arguing that the right to privacy includes reproductive autonomy and linking sexual and reproductive health to the right to the benefits of scientific progress, to conclude that these rights were nullified by the IVF ban.

The court's judgment clearly inclined toward the interpretations put forward in the feminist briefs. While it does not mention or cite the amici in its ruling, it does accept the argument of incremental protection of embryonic life, ruling that the embryo is not a rights-holding person but that the state does have an interest in protecting embryos, an interest that accrues gradually during the course of pregnancy. It also concurred with the liberal medical amici that conception takes place not at fertilization but rather at the implantation of an embryo into a woman's body. It rejected the argument that personhood is present in a fertilized ovum, linking it to the attribution of "metaphysical attributes" to embryos and explaining that the adoption of such religious conceptions would imply imposing a certain type of belief on people who do not necessarily share in these beliefs. It specifically said that the phrase "in general"—referring to article 4's protection of the right to life "in general, from the moment of conception"—could not be interpreted in defiance of the need to protect the rights of pregnant women, precluding balancing and proportionality.

In terms of forms of interpretation, the decision specifically rejected the margin-of-appreciation doctrine, arguing that "this Court is the ultimate interpreter of the Convention" and also adopting feminist arguments that rejected this possibility. Likewise, the decision did not openly reject a historic interpretation of the treaty but rather echoed the Center for Reproductive Rights' interpretation of the *travaux preparatoires* as excluding the possibility of fetal personhood. It also rejected originalism by saying that historic interpretation coexisted with the recognition that treaties are living instruments that evolve.

After more than two decades of failure, the transnational feminist movement finally succeeded

in securing a ruling from the IACtHR that could potentially be used to support national and regional struggles to decriminalize abortion. Similar positions had previously been taken by constitutional courts in Mexico, Argentina, and Colombia, but the fact that the movement's and countermovement's legal activism eventually prompted the IACtHR to define article 4(1) of the American Convention signaled the fundamental importance of the regional human rights system for national battles over abortion, contraception, and assisted reproduction. Because IACtHR decisions are binding on the 22 countries that have ratified the American Convention, *Artavia Murillo* has effects for legislation and policies regulating access to emergency contraceptives, therapeutic abortion, embryonic stem cell research, and reproductive health care more generally.

Domestically, the IACtHR did not completely settle the matter, although it tilted the scale in favor of feminist and liberals who opposed the ban. In September 2015, Costa Rican President Luis Guillermo Solís, following a public follow-up hearing on the case in the IACtHR, issued a presidential decree finally regulating IVF. However, on February 3, 2016, the Constitutional Chamber of the Costa Rican Supreme Court declared the decree unconstitutional because it violated the legal reserve that meant that only the legislature could regulate in human rights matters, including IVF. While apparently deciding only on matters of competency, the Constitutional Chamber insisted that this was a human rights issue concerning the rights of both the mother and the embryo.[13] A few weeks later, on February 26, the IACtHR responded by issuing additional orders demanding compliance; the issue remains open to contestation.[14]

Conclusions

Despite its slow pace in the inter-American human rights system, litigation has increasingly become a focus for social movement activists who attempt to secure favorable interpretations or framings of human rights instruments. In contrast to other judicialized rights disputes in the inter-American human rights system—for example, on indigenous rights, where movement activists confront the state—in sexual and reproductive rights, transnational movements and countermovements directly engage each other.

Our conclusion shows that the moderating effect of movement-countermovement engagement in court extends to the international arena. Similar to patterns within the United States described by Reva Siegel, in the context analyzed here, actors discipline and shape their claims into reasoned legal arguments that are intelligible to officials in the inter-American human rights system and its own forms of legal arguments.[15] Part of this intelligibility has to do with the formality and rules of appellate argumentation in courts generally, which emphasize legal analysis. This article contributes to the literature on legal mobilization on abortion issues, which tends to focus on domestic scenarios and fails to consider the dynamics of movement-countermovement confrontation in courts.

Artavia Murillo is significant in that it forced the movement and countermovement to engage with each other's claims to a far greater extent than had previously occurred. It also signaled the growing conservative legal mobilization and the secularization of previously faith-based invocations by, for example, deploying arguments from the field of bioethics to bolster claims that life begins at conception. The feminist movement, in turn, was obliged to engage with the arguments of countermovement conservative lawyers, even incorporating aspects of their arguments into their own briefs in order to refute the countermovement's broader claims about the American Convention and its interpretation. In general and at least in the short term, this contentious engagement served to legitimate the inter-American system, even though the outcome of *Artavia Murillo* clearly favored one side—a side that already had significant, albeit contested, influence in the system.[16]

However, there is an open possibility of backlash, and also of delegitimation of the IACtHR. It must be noted that while the IACmHR's 2010 report recognizes the importance of the right to life argument in Costa Rica's case (making an explicit

reference to the Constitutional Chamber's decision, which says that the embryo has the same right to life as a human person), the IACtHR—while careful to acknowledge opposing arguments—rejected the Constitutional Chamber's interpretation of article 4. In doing so, it rejected the possibility that national courts could be authoritative interpreters of the American Convention, an issue that could lead to backlash from national judiciaries. Paúl and de Jesus have published law review articles lamenting *Artavia Murillo* and signaling a possible loss of legitimacy of the IACtHR stemming from the decision, while at the same time attempting to steer the system back to more conservative interpretations and to limit the impact of the court's ruling as precedent for abortion rights in the region.[17] This could signal further backlash in domestic courts if they adopt Paúl and de Jesus's arguments and if the case for a national margin of appreciation of the American Convention gains clout within the states party to the convention.

Nonetheless, in the broader context of the inter-American human rights system, adopting the affirmation that article 4 gave the embryo a prenatal right to life and upholding Costa Rica's ban would have been a significant challenge to the status quo, not only in terms of the regional system but also in terms of the other international systems with which the IACtHR finds itself in dialogue, particularly the European human rights system.

In this article, we have identified a moderating effect of contentious engagement within the inter-American human rights system, an effect that may possibly extend to both feminist strategizing after the decision and to conservative reactions to it. As we have shown in our analysis of this case, in which we focus particularly on the amicus briefs presented by different organizations and individuals, the conservative side limited its references to faith and its close relation to the Catholic Church hierarchy and dogma, insisting instead on originalist and textual interpretations of the American Convention, as well as on scientific evidence of the beginning of life and of harms allegedly derived from IVF. On the feminist side, activists limited their emphasis on women's autonomy and reproductive choice, instead insisting on balancing rights and proportionality and recruiting liberal scientists to disprove the scientific evidence brought forth by conservatives. At the end of the day, feminist arguments won the case, but it was the more moderate frame, not the original claims for autonomy and abortion rights, that prevailed within the inter-American human rights system. Further research is needed in order to explore the relationship between feminist strategies in court (which in this case clearly involved moderation in order to maximize the possibilities of a favorable judgment) and broader social movement repertoires and actions on sexual and reproductive rights beyond the courts, which may entail moderation or radicalization, depending on other factors, such as internal movement dynamics and opportunity structures. Certainly, feminist activists in countries throughout Latin America are reflecting on how to use the *Artavia Murillo* judgment in future domestic litigation. At the same time, issues of backlash and domestic compliance by Costa Rica are still unfolding.

In conclusion, we argue that evidence from *Artavia Murillo* shows that legal mobilization before international human rights courts moderates social movement claims, as rivals respond to one another and as they argue within the frame of courts' norms and language. It is clearly difficult to generalize from a single case and a limited set of materials; further research should explore this effect in other cases and courts, including the particularities of the international system, where, unlike with national courts, there is no clear engagement with national publics and disputes but rather with a more diffuse transnational arena.

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Why is a "Good Abortion Law" Not Enough? The Case of Estonia

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Abstract

There are various ways to critically discuss abortion. Constructing or finding the most suitable analytical framework—whether rooted in legal formalism, socio-legal considerations, or comparativism—always depends on the country of subject and whether the analysis is for litigation, advocacy, or more theoretical purposes. This paper offers a model for analyzing abortion in Estonia in order to connect it as a thought-provoking case study to the ongoing transnational abortion discussions. I set out by describing the Estonian Abortion Act as a "good abortion law": a regulation that guarantees in practice women's legal access to safe abortion. Despite this functioning law, I carve a space for criticism by expanding the conversation to the broader power relations and gender dynamics present in Estonian society. Accordingly, I explain the state of the Estonian feminist movement and gender research, the local legal community's minimal engagement with the reproductive rights discourse, and the lingering Soviet-era narratives of reproduction and health, which were not fully extinguished by the combination of human rights commitments and neoliberalism upon restoration of independence in the early 1990s. I consequently show that Estonia's liberal abortion regulation is not grounded in a sufficiently deep understanding of human rights-based approaches to reproductive health, therefore leaving the door open for micro-aggressions toward women and for conservative political winds to gain ground.

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Introducing the case study: Estonia and its "good abortion law"

Estonia is a parliamentary democracy in the Baltic region of Northern Europe, with a population of 1.3 million. There is no state church, only 30% of the population describes itself as religious (Lutheran, Catholic, Orthodox, Muslim, Buddhist, Pagan, or other), and religion does not play an essential role in Estonian society. Having restored independence in 1991 after the nearly 50-year-long Soviet Union occupation, Estonia became a member of the European Union and the North Atlantic Treaty Organization in 2004. Estonia has signed every important regional and international human rights treaty, and its Constitution, adopted in 1992 through a referendum, upholds the rule of law, democracy, and equality.[1]

Abortion in Estonia is regulated by the Termination of Pregnancy and Sterilization Act (hereafter the Abortion Act), which came into force in 1998 in the context of the country's transition to parliamentary democracy.[2] The Abortion Act has been amended a few times over the years, and the regulation currently in force combines the two most common approaches to abortion regulation: the indications model and the term model. Namely, it stipulates that abortion is available on request before 12 weeks of pregnancy. If the pregnancy has lasted for more than 12 but fewer than 22 weeks, it can be terminated if there is a danger to the woman's health, if the child may suffer a severe health damage, if there is a danger of an illness or health problem which would hinder the woman from raising the child, or if the woman is younger than 15 or older than 45 years. Abortion is subsidized by the state, and women do not need a referral from a general practitioner.

The preparatory works of the Abortion Act's draft bill from 1998 cited the Patient's Rights Declaration of the World Health Organization (1994), the European Convention on Human Rights and Biomedicine (1997), and practice and laws in Sweden and Finland.[3] These references speak of an ideological choice—Estonia considered the standards of the United Nations, the European Union, and Scandinavian countries as models. This was not surprising since after the restoration of independence, the new democratically elected parliament and the government were fully committed to reconnecting Estonia with the West.

Furthermore, when the then minister of social affairs presented the draft bill, she emphasized that the Abortion Act was meant not to influence the declining birth rate but to respect "free choices of the woman" and aim for "safety and protection."[4] The transcripts of the parliamentary hearings from 1998 do, however, reveal some hesitation about the law. For example, one member of parliament (MP) referred to "other countries" and asked the minister whether abortion is "a violent act of taking a life" and whether the term-based model is somewhat arbitrary. Another MP raised the issue of requiring a husband's (or partner's) consent. Nevertheless, both of these questions were phrased as inquiries of general interest rather than expressions of strong opposition to abortion. One MP also noted supportively how "Estonia is not a Catholic country, so women have the right to give birth, or have an abortion if necessary."

Overall, it can be said that opposition to a liberal abortion law was not strong. The conservative voice against abortion emerged more vigorously and strategically only in the 2000s, as I show later below. When I asked the then minister of social affairs Tiiu Aro about this phenomenon, she explained that in the mid-1990s medical expertise regarding abortion was well respected by politicians. Thus, the health and safety argument supported by the medical community kept potential moral and political opposition at bay.

In addition, as noted above, Estonia was not—and continues to not be—a religious society with a strong church presence; thus, in the mid-1990s, typical religious arguments were not raised. Furthermore, Tiiu Aro noted that she and some colleagues had just attended the International Conference on Population and Development in Cairo in September 1994 and were aware of the reproductive rights language, which also inspired the founding of the Estonian Family Planning Society (now the Estonian Sexual Health Society) in November 1994.[5] The high-quality work of the Estonian Sexual

Health Society—which brings together not only gynecologists, obstetricians, and midwives but also people from other disciplines—has proved an essential force in supporting reproductive rights in Estonia in the 2000s.

In short, timely and legal access to abortion is guaranteed to women in Estonia in both law and practice. Such a conclusion, backed with supporting empirical data, would not necessarily spark further examination. However, with this paper I carve a space for a more insightful discussion in which I argue that it is possible to find subtle but persistent harmful narratives about women's bodies and sexuality, even in a country with a perfectly commendable human rights track record and liberal access to reproductive health services.

The "white-cube syndrome" of abortion analysis

In 1976, Irish art critic Brian O'Doherty published an essay collection in which he deconstructed the impact of a white-walled gallery space. O'Doherty explained how although the white-cube space serves as a seemingly neutral context in which art is presented, it actually creates an illusionary world where some of the everyday context is left out, thus constructing a reality for us in one specific way.[6] O'Doherty's essays commented on the crisis of post-war art and had no link to the second-wave feminist agenda concerning women's sexuality and reproductive rights. Still, I borrow from O'Doherty and explain briefly how the contemporary legal analysis of abortion and women's reproductive rights in general in Europe suffer from what I term "white-cube syndrome."

White-cube syndrome may reveal itself on two levels. First, it can create a general research bias, which means that the majority of human rights scholarship on reproduction is often tilted toward studying the extremes: countries that criminalize or prohibit abortion entirely, that have high maternal mortality rates, or that show a continuing unwillingness to fight against systematic forced sterilizations and female genital mutilation. I believe that this considerable blindness to the much more nuanced spectrum of reproductive rights issues is also tied to the harmful dichotomies of developed/developing and Western/other. Such depictions may result in a misleading image of a homogenic, progressive, and emancipatory Europe that hinders discussion about abortion beyond the "usual suspects" of Poland and Ireland. This is especially problematic for Estonia, which is left out from critical conversations since women in Estonia can access abortion legally and effectively.

Second, in addition to the "suspect bias," white-cube syndrome means that the contemporary legal analysis of abortion is often funneled into specific inquiries (for example, the design of abortion laws, women's access to abortion in practice, or how different landmark abortion decisions have traveled between jurisdictions) and does not look at the much larger discussions on reproduction and power.[7] This second layer of white-cube syndrome is troublesome for Estonia as a country with a "good abortion law" that is well implemented in practice and to which many of the existing conversations from the Global North are not relevant or helpful due to its different history.

Thus, with this paper I draw attention to the need to find a cure for white-cube syndrome and, in the case of Estonia, to use a nuanced analytical frame that explicitly deconstructs abortion into broader questions about power, control, and gender narratives. With this approach, a regulation usually accepted as a "good abortion law" might actually be insufficient for meaningful and steadfast reproductive rights protection.

The following sections explain this alternative analytical frame and show the concerns that emerge when the frame is applied to Estonia.

Alternative space for analysis: A reproductive rights-based approach

What is the alternative analytical frame that can push the Estonian abortion discussion out of its safe, white-walled gallery? When making general observations about the evolution of abortion laws, Rebecca J. Cook and Bernard M. Dickens propose distinguishing three phases: first, when abortion

is regulated within criminal law; second, when it passes through decriminalization and becomes a public health issue; and lastly, in the phase that is most desirable for human rights scholars and abortion rights advocates, when abortion is framed within constitutional law or as a human rights matter.[8] Indeed, there are many examples of domestic constitutional bodies or transnational human rights forums tackling abortion.[9] The specific legal framings and analyses suggested in these cases are somewhat different from one another, and there exists a considerable amount of varied legal scholarship on them.[10] I, together with Alicia Ely Yamin, have been focusing on the lack of a reproductive rights-based analysis.[11]

A reproductive rights-based approach is inspired by Yamin's work on understanding health within the human rights framework—an approach proposing that health concerns can, and indeed should, be explained by looking at broader societal power relations and (gender) stereotypes.[12] Thus, one cure for white-cube syndrome is the reproductive rights-based approach, which deconstructs abortion into broader questions about gender and power. Accordingly, I argue that in the case of Estonia, a critical legal analysis of abortion ought to be interested in the narratives in which the current abortion regulation is rooted and should thus ask whether there is a meaningful commitment to women's reproductive rights and gender equality that protects women from shaming, micro-aggressions, and harmful stereotypes.

Applying a reproductive rights-based approach: Tracing the power and gender narratives

The Estonian feminist movement

As argued above, a reproductive rights-based approach to abortion requires an understanding of underlying gender and power narratives. This means that Estonia's abortion conversation needs to reflect on the general state of the feminist movement and on public and private engagement with gender research.

Helen Biin and Anneli Albi argue that "the history of women's suffrage in Estonia is inseparable from the history of the Estonian national movement and the fight for the country's independence in general" and therefore that "the story of the women's suffrage movement began, and can only be told together with the story of the nationalist movement."[13] Accordingly, the beginning of the women's movement in Estonia dates back to the last two decades of the nineteenth century, when the first voluntary women's groups were founded.[14] Initially, these groups were concerned primarily with issues of nationality, but deeper discussion of women's rights and suffrage also soon surfaced as the nationalist movement peaked during the Russian Revolutions of 1905 and 1917.[15] For example, in 1917, these women organized the First Women's Congress, where, for the first time, Estonian women's social status and civil rights were openly discussed in front of a large audience.[16] Delegates of the congress established the Union of Estonian Women's Organizations, which set the aim of "improving women's legal, economic, educational, and health status."[17]

However, due to a rapidly changing political situation, this newly established union could not properly pursue its goals: after the collapse of the Russian Empire in 1917, Estonia proclaimed its independence in February 1918, only to succumb to German occupation a day later. When the German occupation ended in November 1918, the Soviet Russian army invaded and the two-year Estonian War of Independence broke out. In the context of the history of the women's movement, women were granted political rights on equal terms with men through the Declaration of Independence that established the Republic of Estonia in 1918; these rights were further consolidated through the first Estonian Constitution, which came into force in 1920, after Estonia won the War of Independence.[18] However, women's actual participation in politics remained low during the short period of independence and peace between 1920 and 1939. Once World War II began, Estonia was occupied by Nazi Germany and then by the Soviet Union until 1991.

During the nearly 50-year-long Soviet occupation, there was neither rule of law nor a meaningful

feminist movement. Indeed, though the state organized a number of women's congresses and the laws stipulated a *de iure* equality of women and men, all initiatives or policies were controlled by the communist regime. Namely, as Biin and Albi explain, the socialist discourse tried to "create gender-neutral citizenship and to homogenize the male and female workforce, putting in place legislation on equal rights and a quota system to ensure a certain percentage of women in all positions."[19] This endeavor had nothing to do with women's human rights or treating people as equal. It was just a façade that subsequently managed to make people resentful of top-down gender policies during the post-communist years—a phenomenon that has been termed an "allergy to feminism."[20]

This allergy and distrust for feminism is strong in contemporary Estonia, where despite the formal commitment to equality and human rights, there is not enough state-level engagement with the country's huge gender-based pay gap, struggles with domestic violence, and gender imbalances in the legislative and executive branches.[21] Evelin Tamm has criticized how "local history recording is male dominated," which has forced research on and acknowledgment of the local feminist and women's movements to the periphery. Tamm has noted that such constant dismissal and disregard of women's achievements and contributions has "undermined and deleted most of local feminist history which could help to empower the current generation to claim their space."[22] In practice, this means that the contemporary Estonian feminist movement is fairly fragmented and often ridiculed by politicians, the mainstream media, and the public, and there are no strong nongovernmental organizations specifically focused on women's rights.

Reproduction and abortion in the Soviet Union

I demonstrated above that the Estonian Abortion Act of 1998 was introduced and adopted as a law to protect women's reproductive autonomy. However, applying a reproductive rights-based approach forces us to open up a space for a conversation about the power dynamics between individuals and the state in the context of health and reproduction. In the case of Estonia, this means going beyond the *travaux préparatoires* of 1998 and investigating how health and reproduction were framed during the very long Soviet occupation. In other words, in which narratives is Estonia's "good abortion law" rooted?

The Abortion Act of 1998 did not create an entirely new situation for women seeking abortion services but rather confirmed democratically the reality of what had been happening during Estonia's occupation, as abortion had been legal during the Soviet occupation. In November 1920, the Soviet Union became the first country in the world to legalize abortion "upon the woman's request" during the first trimester of pregnancy.[23] Abortion was prohibited in 1936 (except in cases of danger to the woman's life, a serious threat to her health, or the existence of a genetic disease), but the Soviet Union's legislative body repealed this prohibition in 1955, establishing that abortions could be performed freely during the first 12 weeks of pregnancy and, after that point, in situations when pregnancy or birth would harm the woman.[24]

It is important to note, however, that the Soviet Union's permissive abortion regulation was not rooted in respect for women's individual life plans and commitment to their reproductive rights. Instead, it was motivated by the state's wish to exercise control over women's health in order to guarantee the quality of the workforce. Barbara Havelkova has explained this situation, arguing that the state's incentive to legalize abortion was not respect for women's reproductive autonomy but rather public health in the social planning context. Thus, abortion was allowed "in order to further care for healthy development of the family, endangered by damage caused to health and life of women by interruptions done by unconscientious persons outside of health establishments."[25]

The general approach to health and medicine in the Soviet Union has been described as "social medicine" which "emphasizes public health and hygiene, prevention and control of communicable diseases, and universal health services."[26] Such an understanding was neither a communist invention nor unique to the Soviet Union—the idea that "the

health or sickness of individuals can represent a threat to the whole country" can be traced back to the writings of ancient Greek philosophers and gained momentum throughout Europe in the late nineteenth and early twentieth centuries.[27]

Viewing all individuals in society as a single body is problematic, however, because such an approach reduces people to "a passive aggregate" and consequently justifies "normative assessments of people's work habits, sexual behavior, and personal hygiene."[28] This normative assessment and control of all aspects of people's lives was also fundamental in the Soviet Union. Particularly, Libor Stloukal has described how in socialist regimes, "social policy was always seen as an important instrument for social planning and control."[29] Stloukal explains that while everyone was indeed entitled to certain rights (for example, to work and to health care), these "rights" were not rooted in the notions of individual autonomy or human dignity, as the task of social policy was to "regulate the ways in which these rights were implemented while retaining a productive and loyal workforce."[30] For example, in order to ensure an expanding labor reserve, some governments were convinced that "family planning was not a human or legal right, but rather a part of socioeconomic planning for which all individuals shared responsibility."[31]

Framing health through the lens of socioeconomic planning therefore naturally affected women's reproductive rights in the Soviet Union and thus also in occupied Estonia. Susan Gal and Gail Kligman have explained how women's reproductive bodies were seen by the totalitarian state regime as tools for population growth:

> *Thus, women are blamed for demographic decline, and for being too "selfish" to have children … The control of women thus becomes a logical project of nationalism. A classic means of such control is the regulation of women's reproductive capacity, whether by forcing unwanted births or restricting wanted ones.*[32]

This state control was expressed by allowing abortion but prohibiting contraception. Estonian gynecologist and scholar Kai Haldre has explained how since there was no universal sex education in schools, and since contraception was not available behind the Iron Curtain, abortion was the *one available legal method* for family planning.[33] This phenomenon has been termed the "abortion culture."[34] Additionally, women's reproductive abilities were monitored via employment guidelines (which kept women away from jobs requiring heavy lifting) and by regular medical consultations at schools and mandatory gynecological examinations for adult women.[35]

All in all, this shows that a permissive abortion regulation does not equal a reproductive rights-based approach to reproductive health. For Estonia, this meant that after the restoration of independence in 1991, the number of abortions remained high and both the reproductive health care system and the state's fundamental understanding of health were in need of transformation.

Reproductive health in Estonia after the end of the Soviet occupation

The Abortion Act in 1998 was just one part of the desired transformation. Additionally, with the lobbying and advocacy efforts of Estonian gynecologists and other relevant legislation, the changes were much broader, as explained by Made Laanpere et al.:

> *During the last 20 years Estonia has embarked on a radical transformation of its social and health care system, including education and sexual health services. Sexuality education has been a mandatory part of the Estonian school curriculum since 1996 … More than 90% of citizens are covered by social health insurance. Affordable contraceptive methods are available: hormonal contraceptive methods are subsidized by Estonian Health Insurance Fund, which covers 50%; copper IUDs have reimbursement of 100% during one year after delivery. Emergency contraception has been available over-the-counter since 2000.*[36]

These developments are also in sync with the steadily declining abortion rates during 1992–2015: while in 1992 the number of induced abortions per 1,000 women of childbearing age was 69.9, it dropped to 16.9 in 2015.[37] Furthermore, a 2014 study on Esto-

nian women's health indicated that most women were satisfied with reproductive health services and that better health literacy and a higher quality of health care had made sexual behavior safer, increased the usage of effective contraception, and decreased the age difference between partners at first sexual intercourse.[38]

Making such progress within 25 years is impressive, but again I would argue that white-cube syndrome covers the remaining problems with deeper socio-legal narratives about reproductive health. Accordingly, applying a reproductive rights-based approach forces us to look beyond the described success and explore whether these indicators are supported by new narratives about women's bodies, reproduction, and health that reject the Soviet Union's population control and instrumentalist approaches to women. Is the mandatory sex education at schools, increased access to effective contraception, and guaranteed access to abortion reflecting a firm societal and political understanding of women's power over their bodies?

Unfortunately, the answer is no. Although a 2014 research article on abortion trends in Estonia claims that "[t]he issue of abortion is perceived, in Estonian society, as a sexual and reproductive right of women," I would have to disagree with such a statement.[39] As emphasized in this paper, women can indeed effectively access abortion and contraception, but this access has neither eliminated the frequent micro-aggressions toward women exercising their reproductive rights nor banished the stereotypical ideals about women's "societal reproductive duties." For example, in 2007, the then minister of population planned an awareness-raising campaign to reduce the number of abortions, which, according to her, would help reverse the country's declining birth rate. The minister explained, "I want the pregnant woman to be very seriously aware and consider that there is actually a human being inside of her belly."[40] And in 2014, there was a high-level conference entitled "Why Don't Estonian Women Give Birth?," organized by the publicly funded foundation Valuing Life. Furthermore, an MP from the Conservative People's Party expressed during an interview to a mainstream newspaper that a 27-year-old woman without children is "a harmful element for society and part of the birth rate problem."[41] Another MP argued during a parliamentary hearing how "irresponsible women who have children with men who then do not pay maintenance should be sterilized."[42]

These state-level micro-aggressions are just a few examples, but they demonstrate a persistent disconnect between available health care services and the deeper sociopolitical understandings around why reproductive health matters. While these examples pale in comparison to the communist state rhetoric, such naming and shaming of women, their sexuality, and their reproductive health needs is neither something that women should have to accept nor in line with the concept of reproductive rights. Therefore, despite the "radical transformation" in reproductive health services over the past 25 years, harmful narratives about the need to monitor women's reproducing bodies persist.

Estonian legal scholarship and human rights approaches to abortion

A reproductive rights-based approach also encourages a more traditional inquiry into abortion and legal culture. The creation of new, transformative reproductive health narratives and sociopolitical progress is hindered both by the general lack of state-level support for feminism and gender research and by the Estonian legal community's limited understanding of how gender and human rights intersect in reproductive health.

The Estonian chancellor of justice, who exercises constitutional review and ombudsperson functions, has analyzed the issue of abortion three times.

First, in 2002, the Estonian Council of Churches inquired whether the Abortion Act was constitutional.[43] The chancellor's opinion issued in response centered on the proportionality of the abortion regulation and placed a heavy emphasis on the counseling requirement, explaining that such a system was chosen over a punitive penal system in the hope of encouraging women to make the "right and responsible choice." The opinion referred to

women's right to life and bodily autonomy and to the harmful consequences of criminalizing abortion, and it concluded that a balance between different interests had been struck with the Abortion Act.

However, despite its generally commendable approach, the opinion was sprinkled with statements that revealed a limited understanding of reproductive rights. For example, it stated that "abortion is a risky and complicated operation which can have dangerous complications, and no reasonable person would choose the most dangerous choice out of all the choices"; that abortion is a question of "society's moral judgment"; and that "counseling should entail information about not only the medical but also the ethical meaning of abortion since termination of pregnancy also means destroying developing life and thus needs a high ethical awareness." Consequently, although the chancellor pushed back on the unconstitutionality concern, the overall analysis rang as somewhat apologetic and did not emphasize a human rights perspective, instead treating abortion as a social-moral issue.

Six years later, in 2008, the Young Conservatives, the Institute of Culture of Life (a conservative think-tank that runs an anti-abortion website), and the Society of Parents in Estonia asked the chancellor to review the constitutionality of funding abortion through universal health care and to determine whether this violated the right to life.[44] The chancellor concluded that such funding was not unconstitutional. This opinion was different from the 2002 opinion because it entailed more emphasis on women's right to self-realization as guaranteed by the Constitution; however, the lack of references to reproductive rights and gender-based power dynamics remained. The chancellor affirmed the idea that the right to life of the fetus was under the protection of the Constitution but noted that there was a "moral conflict" between that protection and a woman's right to self-realization—and in this situation, a woman must not be forced to give birth. The opinion noted that it was important to cover abortion with universal health care to avoid situations where access to abortion services becomes dependent on one's economic status.

Finally, in 2014, the chancellor recommended that Parliament amend the Abortion Act so that women under 18 years would not need parental consent for an abortion.[45] The need for this consent was added to the act in 2009 through malign legislative practices, without the involvement of important stakeholders.

The chancellor, referring to paragraphs 19 (right to free self-realization), 26 (right to private and family life), and 28 (right to health) of the Constitution, deemed the restriction unconstitutional. Additionally, since the provision specifically concerned minors, the chancellor explained how a minor was also a holder of fundamental (that is, constitutional) rights and that if she was receiving a health care service with her consent, patient-doctor confidentiality protected her privacy, including from her legal guardian. Thus, the chancellor concluded that a minor could not be "stripped from her right to decide over issues concerning health and bodily autonomy just because she is under 18 years old."

The transcripts of the parliamentary hearings covering the chancellor's proposal show a contrast with the ones from 1998 described above. For example, one MP commented, "We have prohibited a minor from buying a pack of cigars and a bottle of cider, how come we see an infringement of rights when she cannot make the abortion decision herself?"[46] He continued this line of argument during the following session over a month later:

> *You need to understand that not having an abortion is never a tragedy, because the outcome of that is the birth of a little child—the birth of a little tender child! … We were all once these tiny humans, whose right to life today's decision seriously impacts. Thank god we were allowed to be born!*[47]

Nevertheless, Parliament agreed with the proposal and changed the law in January 2015.

There are no landmark Supreme Court cases dealing with abortion, but the Civil Chamber of the Supreme Court handed down a decision in 2011 in which it reviewed a district court's resolution to not force a woman with restricted active legal capacity to terminate her pregnancy against her will, as requested by her legal guardian.[48] Because the case

dealt with a delicate personal matter, public access to the case's full factual circumstances is restricted and only extracts of the analysis and the resolution are available. Also, as explained above, the abortion regulation regarding minors and adults with restricted active legal capacity has changed since 2011. Nonetheless, the parts of the judgment that are publicly available serve as a snapshot of how the highest court in Estonia approached abortion just six years ago.

The Supreme Court's decision focused on understanding abortion and restricted active legal capacity within civil law and the law of obligations. The three judges behind the decision referred to termination of pregnancy as a "health care service" regulated by the Abortion Act and treated abortion conceptually as a legal transaction. Therefore, the court was concerned mainly with whether the district court had correctly evaluated the limits of the woman's active legal capacity. The Supreme Court argued that for this, the district court did not need the medical opinions of doctors but instead needed only to establish whether the woman understood the meaning of becoming a parent and forming a family. There are no explicit references to human rights in the decision (at least in the available excerpts), and although the judgment refers to the Constitution's paragraph 20 (right to liberty and security of person), it links the right to civil proceedings. The court argued that, hypothetically, it could allow an abortion against a person's will but that the law "does not provide how this health service could be applied mandatorily," and even if the Code of Enforcement Procedure (which provides for the rights and obligations of debtors, claimants, and bailiffs and the procedure for the execution of enforcement instruments) did apply, mandatory abortion could not be possible as part of "enforcement procedure."[49] The Supreme Court concluded that although the district court's analysis had shortcomings, the final resolution (that is, not forcing the woman to terminate the pregnancy) stood.

To conclude, the chancellor's three opinions from 2002–2014 and the Supreme Court's case show a persistently limited understanding of abortion as a human rights issue in Estonia. There are references neither to reproductive rights nor to the obvious gender dimensions of abortion. This gap is in line with Estonian legal education, which is defined by masculine norms; indeed, no law school offers a specialized course on gender and law or on women's rights. Raili Põldsaar Marling has analyzed feminism and gender studies in Estonia, concluding that "gender studies in Estonia are shaped by the unspoken presence of the forty-year Soviet annexation that removed Estonian society from the international exchange of ideas during the time when gender became, first, a political issue and, second, an object of academic study."[50] She continues, "According to Soviet ideology, gender was irrelevant in the Soviet Union as the equality of men and women had supposedly been achieved."[51]

As a result, Põldsaar Marling argues, "in the 1990s, Estonia sought to turn its back on all that was assumed to be Soviet, including the Soviet ideology of gender equality," which is why it became very difficult to establish a strong, institutionally supported community of scholars doing gender research.[52] She lists a number of scholars who, despite the backlash, have engaged with gender studies and provided excellent scholarship; but importantly, there are no legal scholars on this list.[53]

Human rights-based approaches and neoliberalism

Through different examples, I have demonstrated how focusing on power and gender narratives reveals a considerable lack of wider political and legal understandings in Estonia that acknowledge abortion services as an issue of human rights. In this last part, I draw attention to an additional dimension.

Although communist narratives on disciplining women's bodies continue to have a considerable impact in 2017, I would argue that the problem is not that too little time has passed since the restoration of independence. Rather, in addition to the "allergy of feminism" and the lack of understanding of women's rights within the legal community, in the 1990s the newly elected government substituted the Soviet Union's communism with neoliberalism that entailed commitments to human rights treaties but that also praised free markets and free

individuals operating in the marketplace. However, this substitution did not create new human rights-based health narratives that could have provided a solid foundation for broader reproductive rights protection beyond the progressive and informed medical community.

The new human rights agenda, coupled with neoliberalism, focused on a particular set of rights. As Audrey Chapman has explained, neoliberalism does not deny the existence of rights per se: neoliberal thinkers are, for example, particularly supportive of a set of political and civil rights—such as the right to property—that they perceive as "negative" rights which do not entail positive actions by the state.[54] Social and economic rights, on the other hand, are not perceived as legitimate human rights or genuine entitlements, since the market-based approach promoted by neoliberalism sees the state's role as minimal: "neoliberal policies also envision health to be an economic commodity rather than the social good conceptualized by human rights law."[55] The desire to minimize interference by the new democratic government was indeed a natural reaction to the communist regime that had regulated every aspect of a person's life. However, neglecting the human rights dimension of health also meant that the creation of new reproductive and health narratives remained the sole responsibility of the active and progressive community of Estonian gynecologists.

Conclusion

If there were a section called "World's Abortion Laws" in the same white-cube gallery that sparked O'Doherty's post-war critique in the 1970s, then the exhibit of Estonia would be comfortably labeled "Good Abortion Law," since it guarantees women timely and safe access to abortion. However, just as O'Doherty called out the white-walled galleries for constructing a distorted version of reality for the viewer, I have explained here that there is much more to the case of Estonia. Namely, I have adopted a reproductive rights-based approach, which explicitly moves beyond a single-issue approach, and have deconstructed abortion into broader reflections on power and gender dynamics in Estonia.

With the help of this more nuanced analytical model, I have traced gender and power narratives in Estonia, reconsidering the post-Soviet commitment to human rights, lingering post-communist attitudes, and the new conservative powers. I have demonstrated how despite the "good abortion law" adopted in 1998, as well as a progressive community of obstetrician-gynecologists spearheading many transformations, the other important pillars supporting a steadfast reproductive rights protection remain missing. In particular, the local feminist movement is fragmented and often publicly ridiculed, gender research is neither understood nor prioritized by the state, the reproductive rights discourse is completely overlooked by the legal community, and the Soviet-era narratives defining women through their reproductive bodies is still present, thus providing new material for contemporary micro-aggressions against women.

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Macro- and Micro-Political Vernaculizations of Rights: Human Rights and Abortion Discourses in Northern Ireland

CLAIRE PIERSON AND FIONA BLOOMER

Abstract

How abortion is dealt with in law and policy is shaped through the multiple political and societal discourses on the issue within a particular society. Debate on abortion is constantly in flux, with progressive and regressive movements witnessed globally. This paper examines the translation of human rights norms into discourses on abortion in Northern Ireland, a region where abortion is highly restricted, with extensive contemporary public debate into potential liberalization of abortion law. This paper emanates from research examining political debates on abortion in Northern Ireland and contrasts findings with recent civil society developments, identifying competing narratives of human rights with regard to abortion at the macro- and micro-political level. The paper identifies the complexities of using human rights as a lobbying tool, and questions the utility of rights-based arguments in furthering abortion law reform. The paper concludes that a legalistic rights-based approach may have limited efficacy in creating a more nuanced debate and perspective on abortion in Northern Ireland but that it has particular resonance in arguing for limited reform in extreme cases.

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Introduction

"Culture wars" on abortion refer to the battle over the meaning of abortion and abortion legislation.[1] We argue (in conjunction with authors such as Ferree and Feltham-King and MacLeod) that who says what about abortion contributes to the outcomes that we will see in law and policy.[2] In particular, we are concerned with *how* women's needs and interests with regard to abortion are represented in political and public civic discourse. Literature on abortion in Ireland has illustrated the largely anti-abortion rhetoric perpetuated by political elites and the conservative Christian churches.[3] However, there is a gap in our understanding of the evolving plurality of abortion speak. In Ireland, north and south, the culture war over abortion is reaching a critical juncture with an almost constant media focus and public discussion on legislative restrictions and reforms. Accordingly, with legal reform on the political agenda, this is a timely period to address the framing of abortion rights in one of the legislative jurisdictions of Ireland, Northern Ireland, and the potential limitations and opportunities going forward. In addition, with abortion rights being continually challenged internationally, it is imperative to consider contextually how rights-based arguments can further or limit legislative change on abortion law.

Human rights offer a contested yet universal and global set of rights and freedoms, providing a framework to argue for justice and legislative reform when breached. Human rights as a legal tool are based on the premise that states intervention in their citizens' lives must be regulated and contained through universal, global human rights principles and respect for individuals' rights.[4] Human rights can be contended to be an emancipatory tool for vulnerable people; for women, it can help to contextualize and provide legal recognition of the various injustices resulting from gender inequality. However, core global norms must be contextualized to local settings in order for them to be viewed as both relevant and legitimate, and subsequently, to become a driver of social and legal change. Processes of vernaculization and indigenization take place, firstly, to package the language of human rights in a relevant contextual language, and secondly, to define strategies of action and make ideas and arguments persuasive.[5] International human rights norms have been successfully mobilized in the Northern Ireland context primarily for conflict-related abuses, and accordingly, the architecture of human rights was mainstreamed into the peace agreement. Consequently, the language and potential of rights-based arguments as a mechanism for social change or justice has a high level of resonance in this context. Understanding the historical and social understandings of rights in specific contexts is key to comprehending the "frames" that rights-based discourses take. Analyses of human rights-based abortion discourses have largely taken place in regions where abortion law is more liberal; such discourses have had less analysis in regions hostile to abortion law reform.[6] A notable exception to this is analysis of religion and human rights discourse in Latin America.[7]

This paper is based on research conducted on political discourse on abortion in Northern Ireland. Thematic content analysis of political debate on abortion in Northern Ireland identified a growing use of human rights-based language when discussing both liberalizing and restricting abortion rights. We contrast the presentation and vernaculization of international human rights norms at the macro-political level (defined by the authors as elected political representatives and parties) with that of civil society actors (referred to here as micro-political actors). We illustrate that despite the centrality and long history of human rights-based arguments surrounding inequality and conflict in Northern Ireland, a rights-based framework to understanding and lobbying against abortion restrictions is a process which has only recently started and which is currently ongoing. The paper therefore contributes to understanding how human rights are translated at a local level (both at a macro- and micro-political level) and to appreciating the complexity of articulating human rights-based discourses around abortion. The paper concludes that there are dualistic understandings and framings of rights at the macro- and micro-political

level that conflate with global discourses on abortion rights, and questions the potential of human rights to drive substantial legal change and provide a more nuanced context within which to discuss abortion. We will show that rights have high resonance in extreme cases, such as fatal fetal anomaly (FFA) and sexual crime, in the Northern Ireland case study, but are less effective in arguing for liberal abortion laws.

Translating the global to the local

There is extensive and ongoing debate as to whether human rights are a universal concept or a product of Western conceptions of rights and freedoms and consequently not directly translatable within all cultures and societies.[8] While we do not present a critique or defense of universalism within this article, we do recognize that human rights norms are viewed to be most effective when reframed or vernaculized to local conceptions of justice.[9] Through these processes of vernaculization and indigenization, ideas can be reframed dramatically and may move away from the international language of human rights to suit local conceptions.[10] However, this is not to say that rights are fixed within particular locales but that local rights consciousness shifts with emerging concerns and awareness, and as such, notions of what are key rights issues may shift accordingly. Understanding processes of vernaculization and indigenization must include an understanding of both historical and contemporary culture and social structure in particular locations.

Vernaculization refers to processes in the 19th century whereby national languages in Europe separated, moving away from transnational use of Latin towards a more differentiated sense of nationhood based on national language.[11] In a similar way, human rights language moves from global, universal norms and is vernaculized to local, specific contexts. Indigenization relates to shifts in meaning, how ideas are framed within particular social and cultural contexts.[12] One of the key approaches to translating and adopting rights norms is "framing," which is the interpretive package surrounding an idea. A theory of social movements, it analyzes ways of packaging and presenting of ideas which creates shared beliefs and motivates collective action.[13] Butler's exploration of framing presents it as a means of controlling or defining the surrounding discourse, and consequently establishing the constraints of reality.[14] The greater the resonance framing has with cultural traditions and narratives, the more appealing it is said to be. However, Ferree reasons that often for activist groups, non-resonant discourses can be more politically radical, and accordingly have more potential for long-term social change, whereas resonant frames, although more successful in the short-term, may be required to sacrifice ideals and exclude particular groups and demands.[15] In our example, a non-resonant discourse would be the complete decriminalization of abortion, whereas a resonant discourse would include abortion in cases of FFA and sexual crime.

Rights are translated through "intermediaries" such as national human rights commissions or community leaders. Those who translate norms are seen to be conversant in both global norms and local contexts and able to move between the two, translating up and down.[16] Such institutions and people are places where global norms merge with local ideologies, and as such are where local definitions and priorities are conceptualized. There are power relations imbued into such relationships; who is seen as able or legitimate to translate global norms to local contexts is an important consideration.[17] Processes of translation are not always successful; there can be active resistance to human rights claims based on a perceived loss of power or conflict with local conceptions of rights or justice. Resistance has been much more heavily documented with regard to the Global South and in particular to conflicts with Islam.[18] In addition, although human rights may be successfully translated to local contexts, articulation and implementation by the state is necessary for the legal and justiciable realization of rights. The perception and articulation of rights at the macro-political level is particularly important in our example, as abortion rights are restricted and resisted through legislation. Western democracies are perceived to naturally adopt human rights norms as they largely conflate with Western justice systems, but the site of abortion law and access is

one where global and local Western norms can in some cases clearly diverge.[19]

Global norms on women's human rights constitute particular ideas about gender equity and selfhood. Notions of gender equality often focus on liberal notions of formal rather than substantive equality, that is, making women the same as men through equal political and workforce participation, property and family rights, and equal citizenship. These rights are expressed internationally through the Convention on the Elimination of Discrimination Against Women (CEDAW).[20] Although CEDAW has been ratified by 187 of 194 UN member states, it remains the international human rights treaty with the most state reservations, meaning that although states may sign up to the general idea of gender equality, in practice they are not willing to adopt all global norms. Coomaraswamy argues that this is because women's rights have the least resonance globally and that this lack of resonance prevents the effective implementation of women's rights.[21] Consequently, women's rights are particularly susceptible to arguments of cultural relativism. Such arguments are framed around religion, culture, tradition, and women's "natural" place in society, and are often presented in a bipolar vision of the world, with the Global North being presented as progressive on women's rights and the Global South as backward. Our case study, located in Western Europe, begins to break down binary notions of women's rights in the Global North and South and provides a more complex reading and understanding of women's rights.

Abortion is a complex issue to frame in human rights terminology. There is no particular right to abortion in international law; for example, while the European Court of Human Rights (ECHR) has articulated that abortion must be provided within the limits of the law in several cases (concerning Poland and the Republic of Ireland); it has not conceded to abortion as a right per se.[22] However, there has been an expansion of international and regional human rights standards and jurisprudence that support women's human right to abortion.[23] More severe cases, usually regarding fetal anomaly and sexual crime, are framed around the right to be free from inhumane and degrading treatment, with wider access to abortion framed around the right to private life or social and economic rights, such as the right to health or equality in health care treatment. There is also increasing recognition that the criminalization of abortion is a human rights issue. Alongside this are the competing rights claims that those who are opposed to liberal legislation on abortion make—for example, that the fetus has an equal right to life as a woman and that by restricting abortion, the rights of the vulnerable are being protected. Such arguments often take on a dualistic, binary nature positioning a woman against a fetus, and result in what has been described as a zero-sum game attitude to recognition in abortion rights debates.[24] We illustrate the complexity of framing abortion rights in our case study example showing how, despite current and ongoing vernaculizing of abortion rights in Northern Ireland, the macro-political level continues in the main to perpetuate an anti-abortion discourse based on the manipulation of human rights discourse, in contrast to a more complex discussion within wider society on abortion rights.

The case study: Northern Ireland, abortion, and human rights

Northern Ireland is commonly referred to as a divided society. It remained a region of the United Kingdom after the Republic of Ireland gained independence in 1921. Antagonism and inequality between the Catholic and Protestant populations of Northern Ireland resulted in a conflict commonly referred to as the Troubles, which lasted from the late 1960s to the paramilitary ceasefires of 1994 and the Good Friday/Belfast Peace Agreement of 1998.[25] Northern Ireland governance operates on consociational (power-sharing) principles including a cross-community, power-sharing executive with minority veto rights and cultural respect for both Protestant and Catholic communities.[26] In Northern Ireland, ethno-national identity is specifically linked to religious affiliation. In effect, party political structures have developed on ethno-religious grounds and voters are positioned as solely focused on protecting

ethnic interests.[27] The right to veto legislation based on the parity of community consent model positions all issues along the ethno-national divide and makes passing legislation more difficult.

Northern Ireland has woven human rights into its vocabulary of conflict and post-conflict peace-building. It is a core yet contested feature of the cultural landscape of discussions about peace and conflict. Before the outbreak of conflict, the creation of the Northern Ireland Civil Rights Association in the 1960s prompted mass civil rights marches calling for reforms from three predominant sources of inequality: the gerrymandering of local council constituency borders to facilitate a Unionist majority vote, the allocation of public housing, and the high level of unemployment. With the outbreak of violence in the late 1960s, it is argued that human rights had little role in the understanding or management of conflict. Dickson reasons that by 1981 (a high point of the Northern Ireland conflict) human rights had become a propaganda tool for all sides to the conflict.[28]

International and regional bodies did, however, highlight human rights abuses related to the "management" of conflict. The policing method in Northern Ireland of counterinsurgency tactics and a process of criminalizing political violence has been formally judged on several occasions to be outside the limits of the law and in contravention of human rights standards. For example, in 1978, the European Court of Human Rights found the British government guilty of using inhumane and degrading treatment through police use of hooding and food and sleep deprivation during interrogation of suspects.[29] International organizations such as Amnesty International and Human Rights Watch have also criticized actions such as the 1971 introduction of internment without trial.[30]

Peace negotiations in the mid 1990s culminated in the Good Friday/Belfast Agreement of 1998. Strand 3 of the agreement (British–Irish intergovernmental relations) relates to rights, safeguards, and equality of opportunity, and the ways in which both the UK and Irish governments will ensure they are protected.[31] The agreement cemented human rights into the institutions and structures of governance of Northern Ireland through the incorporation of the European Convention on Human Rights into Northern Irish law, and the creation of the Northern Ireland Human Rights Commission (NIHRC) as a non-departmental public body and the national human rights institution for Northern Ireland. The commission's role is to promote awareness of the importance of human rights in Northern Ireland and specifically to advise on the scope for a bill of rights to supplement the European Convention on Human Rights. However, despite a lengthy consultation process, reaching agreement between stakeholder groups proved divisive and ultimately impossible. As a result, the bill of rights remains unimplemented some 16 years after it was announced. Abortion has not been recognized as a right in any draft of a bill of rights for Northern Ireland.[32]

Despite the mainstreaming of human rights in Northern Ireland, it continues to have a conflicted status within the region. The weight that is afforded to human rights within Irish nationalist political agendas furthers a zero-sum game approach to politics wherein the extensive protections afforded to rights in the agreement were viewed by many British unionists to primarily reassure Irish nationalists (Irish nationalists support the reunification of the island of Ireland and are commonly Catholic, British unionists support remaining as part of the UK and are commonly Protestant).[33] Rights-based arguments are also viewed apathetically within many British unionist communities because of their failure to solve contested issues. Women's human rights tend to be marginalized in an understanding of equality to mean equality between Protestant and Catholic communities.[34] Within the Good Friday Agreement, women's rights are only mentioned once, and only because of lobbying from the Northern Ireland Women's Coalition. The "right of women to full and equal political participation" comes last on the list of rights, and to date, has had no specific implementation mechanisms attached.[35] The structures of governance, based on an ethno-national power-sharing arrangement, also work to marginalize concerns that are not ethno-national in focus. [36]

It has been argued that women's rights, and in particular, international norms, have little traction

at the macro-political level.[37] Politicians demonstrate a lack of understanding of the applicability of international norms; an example of this occurred during a justice committee meeting on abortion law, when politician Alban Magennis (who is also a qualified barrister) stated without opposition from other committee members that "CEDAW is not justiciable in this jurisdiction."[38] The Northern Ireland Executive has also displayed outward antipathy toward UN human rights bodies. For instance, it failed to send a representative to the review of the Committee on Economic, Social and Cultural Rights of the UK in June 2016. Other devolved administrations were present, as well as the UK government and civil society organizations from Northern Ireland. No reason was offered as to the lack of representation from the Northern Ireland Executive.[39]

Legal abortion is highly restricted in the Northern Ireland context. The British 1967 Abortion Act, which provided greater access to abortion for women in England, Scotland, and Wales, has not been extended to Northern Ireland. The region remains under the 1861 Offences Against the Person Act and subsequent case law, which renders abortion a criminal act unless to save the life or long-term health of the mother. Official guidelines for health care practitioners on interpreting the law have gone through a series of legal challenges, which has had a "chilling effect" on many health care providers' willingness to consent to provide abortion services.[40] As a result, an average of 39 abortions are performed in Northern Ireland per year on the National Health Service, with approximately 1,000 women per year traveling to England to have the procedure performed privately (at their own expense). Other unknown numbers of women travel elsewhere, obtain the abortion pill from an online provider, or access abortions from Marie Stopes International Clinic in Belfast.[41]

Repeated public opinion polls indicate that there is appetite for at least limited reform of abortion laws in the region, yet politicians continue to block legislative change.[42] For example, in March 2016, when two amendments to the criminal justice bill were put forward to allow for abortions in the most limited circumstances (FFA and sexual crime), they were voted down. Although there are very few openly pro-choice politicians in the Northern Ireland Assembly, more have been vocal about extending the law in this area, particularly drawing on personal experience.[43] Outside of devolved assembly, politicians in Westminster (who have legislative power over human rights issues) have taken few steps to attempt to liberalize abortion law in the region and have backed away from the issue when Northern Ireland politicians declare that any change to abortion law would be "a threat to the peace process."[44]

International bodies, in particular the CEDAW committee, have noted the UK's non-compliance with international standards with regard to abortion. Since 1999, CEDAW has made repeated statements on Northern Irish abortion law in their recommendations to the UK, and has become more forceful in its approach. In 1999, they noted "with concern that the Abortion Act 1967 does not extend to Northern Ireland where, with limited exceptions, abortion continues to be illegal." They recommended that "the Government initiate a process of public consultation in Northern Ireland on reform of the abortion law," while in 2013, they recommended that "the State party should expedite the amendment of the anti-abortion law in Northern Ireland with a view to decriminalise abortion."[45] The United Nations Committee on the Rights of the Child replicated this recommendation in its concluding observations to the United Kingdom of Great Britain and Northern Ireland in 2016.[46] Other international bodies that have highlighted the inadequacies of abortion law in Northern Ireland include the Committee on Economic, Social and Cultural Rights (ICESCR), the Committee on Civil and Political Rights (ICCPR), and the ECHR.

The international community is becoming more aware of restrictions on abortion in Ireland, north and south, and of politicians' reticence to remove these restrictions. The Republic of Ireland underwent its Universal Periodic Review (UPR) on human rights obligations in 2016. Fifteen of the participating countries made specific recommendations on its abortion laws.[47] The UK undergoes its UPR in 2017, and based on Ireland's recommenda-

tions, Northern Ireland's abortion laws will likely be noted by the Human Rights Committee.

The research approach

This paper considers a human rights framework and its impact on political discourse within a devolved region of the UK through detailed examination of policies and political debate between 1998 and 2016. The paper emanates from ongoing research, funded by the British Academy, that offers for the first time critical analysis of policy and political discourse on abortion in Northern Ireland. The methodology comprised analysis of a longitudinal policy and political discourse data set. All major debates, five in total, and policy documents, five in total, produced since the Northern Ireland Assembly was formed in 1998 through to 2016 were included in the study. The five debates included in the study were as follows:

- June 2000: A motion "That this Assembly is opposed to the extension of the Abortion Act 1967 to Northern Ireland."
- October 2007: A motion to oppose the introduction of proposed guidelines on the termination of pregnancy in Northern Ireland
- March 2013: An amendment to the criminal justice bill that would restrict provision of abortion services to NHS premises
- June 2015: An amendment to the criminal justice bill that would restrict provision of abortion services to NHS premises
- February 2016: An amendment to the criminal justice bill that would allow for abortion on the grounds of FFA.

Content analysis was conducted to identify terminology used to refer to the act of abortion and women seeking abortion. Content analysis allows for quantification of phrasing in documents alongside qualitative analysis of meanings of text.[48] Each data set was read thoroughly by the two members of the research team, first independently and then again jointly upon identification of thematic areas. This process allowed for discussion of thematic areas and consensus on the categorization of themes.

In this paper, we focus on one of the themes "interpretations of human rights" in political debate. In considering this, we draw on the material identified in the critical analysis of policy and political discourse and add a further layer to the analysis by considering how civil society has responded to the human rights framework. Here we draw on our observations of civil society documents and public meetings on abortion and human rights and provide an analysis of human rights vernaculizing in Northern Ireland.

Willful misinterpretation? Abortion and political debate

The five debates on abortion that Northern Ireland has held since 1998 have been permeated with an anti-abortion rhetoric occasionally punctuated by lone voices who are supportive of abortion law reform. More recent debates, with the focus shifting to abortion in the case of FFA, have seen those voices growing in number. Thematic analysis of the five debates has illustrated an understanding of rights that is solely concerned with the "right to life" of the fetus, a non-resonance with international norms and the framing of local ideologies as against global norms, and more recently, a protectionary discourse toward women and the fetus through the restriction of abortion rights.

In order for vernaculization of rights to be successful in realizing rights, those at the state level must also take ownership of this translation. However, from analysis of political debate it is clear that the majority of politicians do not find resonance with rights-based claims towards abortion. Politicians, instead, repeatedly refer to the specific culture of Northern Ireland (or that of the island of Ireland) as being opposed to abortion, in effect arguing that international norms and standards cannot be translated into the Northern Irish context:

> *The outworkings of that in Great Britain have been that almost 7 million abortions have been carried out since 1967 ... In China, 400 million abortions have been carried out under its one-child policy ...*

> *People say that, if we do not go down this route, we are the backwoods people … Are you telling me that that is advancement and that we in Northern Ireland are in the backwoods? If this is the backwoods, I am glad that we are in it, because I do not want to go down a route that the places that I have just mentioned have gone already. It is clearly a wrong and a dangerous place to be.*
>
> *—Edwin Poots, Democratic Unionist Party, 2013*[49]

A consistent argument throughout political debate is one that attempts to argue that there is a balancing of rights in abortion. This argument positions the rights of women against the rights of fetuses, with the phrase "unborn child" being used much more frequently than "fetus" within debate. This trend mirrors international trends towards defining and expanding the rights of fetuses.[50] In the example provided directly below, it is noteworthy that lives lost in the conflict of Northern Ireland or as a result of sectarianism are conflated with lives lost through abortion, and that the SDLP (an Irish Nationalist party that opposed violence related to the conflict) continues to reiterate its civil rights credentials:

> *As a party that was born out of the civil rights movement, the SDLP believes that the right to life is the most basic right of all. That includes the right to life of the unborn. My party has been consistently opposed to the taking of life, whether it be the life of Paul Quinn, who was so brutally murdered in Monaghan at the weekend; life that was lost during the civil conflict that society has endured for the past four decades; or life that is taken by the state through capital punishment. It is for that reason that the SDLP opposes abortion, upholds the right to life of the foetus and opposes the extension of the Abortion Act 1967 to Northern Ireland.*
>
> *—Carmel Hanna, Social Democratic and Labour Party, 2007*[51]

Alongside the right to life of the fetus, more recently the limiting of abortion rights in the region has been positioned as a means of protecting women, mimicking the discourse of anti-choice groups in the region that use the slogan "Love them both."[52] Such discourse positions rights as a paternalistic protectionary measure, as opposed to an emancipatory framework, and politicians as protectors of the vulnerable. The following statement was made in relation to proposals seeking the closure of the Marie Stopes International Clinic, which opened in Belfast in 2012:

> *The protection of vulnerable women and unborn children is an issue that transcends normal politics and religious boundaries.*
>
> *—Paul Givan, Democratic Unionist Party, 2012*[53]

This shift to positioning women seeking abortion as vulnerable reflects global trends.[54] The frame has shifted from selfish women, too busy with careers or social lives, to one of women who are in need of guidance or incapable of making a rational decision. Within the 2013 debate on abortion provision in Northern Ireland, the word "vulnerable" was uttered 31 times and the word "protect" was used 75 times, compared to 11 times in the 2007 debate.

One of the debates that has facilitated misinterpretation of human rights norms is that which focused largely on FFA (in 2016). Such debate has particularly misused disability rights, indicating that abortion in cases of fetal anomaly (despite the fact that any consultation on legislative amendments has contained the word "fatal") would inevitably discriminate against those with disabilities. This argument has been put forward by politicians and the Attorney General for Northern Ireland. For example:

> *Yes, we are subject to the United Nations Convention on the Rights of Persons with Disabilities; yes, that convention sets out principles of which the focus is on the equal protection of the right to life for those with disabilities and those without.*
>
> *—Jim Allister, Traditional Unionist Voice, 2016.*[55]

Within the earliest debate on abortion in Northern Ireland (in 2000), rights are only referenced on one occasion, negatively, to state that liberal abortion laws create a right to kill. The evolution of abortion debate to include frequent references to human rights norms indicates that politicians in Northern Ireland are aware of the legitimacy that a human rights-based argument brings to debate. However,

with regard to abortion, international norms have been in some cases dismissed and in others misinterpreted at the local political level. Politicians argue that Northern Ireland (and often the island of Ireland) does not want liberal abortion laws, and that therefore, rights claims can be rejected. The use of rights-based arguments to restrict abortion have moved towards a protectionary framework since 2013, arguing that restriction is necessary to protect women and the "unborn." Such confusion over rights on abortion filters down to the societal level and muddies the waters for civil society attempting to articulate a pro-choice rights-based framework for abortion.

Late to the game? Civil society and framing abortion rights in Northern Ireland

Civil society in Northern Ireland has not been vocal in its support for the removal of legal restrictions on abortion and has only recently become involved in the vernaculization of human rights norms with regard to abortion. Larger-scale human rights organizations have generally avoided the topic of abortion, arguably for the pragmatic reason of ensuring wider support and promotion for human rights in general (for example, Amnesty International lost its support in certain schools after launching the My Body My Rights campaign). Some have also avoided a focus on abortion due to personal moral stances on the topic by senior figures within organizations. Women's rights organizations, too, have generally had an ambivalent stance towards abortion; many have opted to remain neutral on the issue, with some larger organizations only recently adopting an overtly pro-choice position.[56]

Since 2014, a number of civil society and activist movements have articulated a variety of rights-based arguments with regard to abortion. These movements have begun the process of vernaculizing human rights-based discourses on abortion in Northern Ireland, and as such, highlighting Ireland's position as out of step with global norms. Activist campaigns and actions taken in court, however, present a number of framings of abortion rights which taken together can be read as a confusing discourse of rights for those unfamiliar with human rights vernacular.

As noted above, the Northern Ireland Human Rights Commission, Northern Ireland's national human rights body, did not include abortion in its draft bill of rights. In 2015, the commission took a judicial review to the Northern Ireland High Court on the basis that Northern Ireland's prohibition of abortion in cases of FFA and in cases of sexual crime, up to the date when the fetus can exist independently, are incompatible with UK human rights legislation. The High Court ruled in the commission's favor, stating that current prohibition of access to abortion in cases of FFA was incompatible with the Article 8 right to private and family life under the European Convention on Human Rights.[57]

Cases based on extreme circumstances such as FFA are largely supported by the public, as documented by repeated public opinion polls. Public opinion has also been affected by women who have chosen to speak out on their experience of traveling to England to access abortion. One woman, Sarah Ewart, has been particularly prominent in this debate. This discourse has been highly resonant with the public, who can empathize with a wanted pregnancy and the subsequent inhumane treatment. A difficulty, however, with a focus on extreme cases is that they affect a minority of women and although drawing huge sympathy, may work to reinforce the boundaries of "good" vs. "bad" abortions and "deserving" and "undeserving" women. This means that although limited legislative reform may take place, wider reform may be stifled by the long-term effects of this highly resonant frame.

Amnesty International launched its international My Body My Rights campaign in 2014 in Ireland (north and south) as part of its ongoing global focus on bodily autonomy and the theme of making decisions about one's body as a human right.[58] The campaign is primarily concerned with the decriminalization of abortion, as a result removing abortion from the criminal law. As a global campaign, its message is broad in scope, and although this opens space for global cooperation, it also becomes more difficult to vernaculize and

indigenize a campaign in local terms and increase local ownership and resonance. In Northern Ireland, Amnesty decided to align the first stages of the campaign with the limited legal reforms proposed by the minister of justice on grounds of FFA and sexual crime, and commissioned public opinion polls that sought views on abortion provided on these grounds. It did not seek views on abortion more generally. It later joined the judicial review action against the department of justice on legal reforms for FFA and sexual crime. However, this focus meant that the decriminalization focus became lost within the first stages of the campaign.

Smaller women's groups and family planning organizations have taken part in a number of human right-based actions. In 2001, the Northern Ireland Family Planning Association instigated judicial review proceedings to challenge the absence of guidelines from the Northern Ireland Department of Health, Social Services and Public Safety on the circumstances in which termination of pregnancy falls within the law. This review, most recently in the High Court again in 2013, did not seek to challenge the substantive law on abortion but to force the department to publish policy guidelines to improve clarity on the law. In December 2010, the Family Planning Association Northern Ireland, Northern Ireland Women's European Platform, and grassroots organization Alliance for Choice submitted evidence to the CEDAW Optional Protocol inquiry procedure. This procedure grants the committee power to initiate inquiries into "grave or systematic" violations of rights under the 1979 Convention. It provides an international platform for the scrutiny of domestic human rights violations and the making of recommendations by the committee, which are politically significant, although not legally binding.[59]

Activist groups such as Alliance for Choice, the main Northern Irish activist group, has supported the Amnesty campaigns but developed a more radical political approach of "trust women." The extent to which this has had wide resonance on public opinion is unclear; however, its campaign has engaged with all nine major trade union bodies, and other civil society organizations, and activists have made regular appearances in local, national, and international media outlets. In its campaign #trustwomen and its education program, it has adopted the approach of a lived-experience discourse, using case studies from real women who have been denied access to abortion in Northern Ireland to highlight multiple challenges and discrimination that women seeking abortion encounter. This approach draws on women's situated locatedness, allowing for shifts in understanding of abortion and recognition of the importance of the context in which they are living. It avoids a rights-based discourse due to the problematization of human rights discourse in Northern Ireland, but does refer to abortion as an equality of health issue.[60] A discourse based on choice for abortion under any circumstances has less resonance than the highly emotive framing of abortion for FFA or sexual crime, but as Ferree argues, non-resonant discourses may have more potential in terms of long-term societal change on how abortion is conceptualized.[61]

Discussion and conclusion

This article has sought to consider contrasting articulations of rights-based arguments for abortion in the context of Northern Ireland; the macro- and micro-political level. Adopting a human rights-based approach to abortion framing lends legitimacy to arguments, as they are conceptualized through global, normative standards. In addition, they provide a wider and less radical basis for mobilization and education on abortion than a feminist framework. However, engagement with processes of vernaculization and indigenization of rights in the Northern Irish context has illustrated the complexity of framing abortion rights and the ease with which rights can be co-opted to argue against liberal access to abortion. While human rights literature often emphasizes the positive outcomes of local interactions with international human rights norms, the Northern Ireland abortion case study is problematic, highlighting how the promotion of a rights-based framework to abortion has not translated up to the macro-political level where decision making takes place.

The evolution of abortion discourse in Northern Ireland has resonance with international developments. The growing lobby for the rights of the "unborn" and the framing of restrictive laws as protecting women is a clear reaction to the success of positioning abortion as a women's rights issue. That these discourses are evolving internationally also points to the resources and political influence of anti-choice groups. In order for human rights arguments to translate into legislative change, they must be accepted and indigenized by those making law. Unfortunately, with an overarching anti-abortion discourse facilitated by a misinterpretation of human rights norms prevalent at the Northern Irish Assembly, change on abortion access has been prevented, even in extreme circumstances. Although there are an increasing number of politicians in the current assembly who support either limited or full legislative change on abortion, there are still many who are opposed to any change in the law and who publicly support anti-choice campaigning groups. In this context, rights become another method of framing abortion as a moral issue, rather than a health care one, with the rights of the fetus pitted against the rights of women.

While internationally there is a growing trend towards liberal abortion laws, at the same time there are regressive movements seeking to restrict abortion access. Within this are countries such as Northern Ireland, where access has always been and remains highly restricted. Movements for change have been ongoing since the 1967 Abortion Act was introduced in Britain, yet the law remains unchanged. Framing abortion within human rights discourse is the latest method that civil society has embraced to argue for abortion rights. While this framework may provide resonance and potential future movement in the case of extreme examples (such as FFA), it has less long-term resonance for promoting wider abortion access and continues to discuss abortion in moral terms. Consequently, while translating human rights norms into local contexts may be important in understanding and articulating abortion rights, without ownership by political elites, it is unlikely to result in tangible legislative change.

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Exploring Legal Restrictions, Regulatory Reform, and Geographic Disparities in Abortion Access in Thailand

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Abstract

Despite decades of advocacy among Thai governmental and nongovernmental actors to remove abortion from the country's 1957 Criminal Code, this medically necessary service remains significantly legally restricted. In 2005, in the most recent regulatory reform to date, the Thai Medical Council established regulatory measures to allow a degree of physician interpretation within the confines of the existing law. Drawing on findings from a review of institutional policies and legislative materials, key informant interviews, and informal discussions with health service providers, government representatives, and nonprofit stakeholders, this article explores how legal reforms and health policies have shaped the abortion landscape in Thailand and influenced geographic disparities in availability and accessibility. Notwithstanding a strong medical community and the recent introduction of mifepristone for medication abortion (also known as medical abortion), the narrow interpretation of the regulatory criteria by physicians further entrenches these disparities. This article examines the causes of subnational disparities, focusing on the northern provinces and the western periphery of Thailand, and explores strategies to improve access to abortion in this legally restricted setting.

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Introduction

For decades, legal and regulatory strategies to expand the availability and accessibility of abortion services in Thailand have run parallel to public debate and political mobilization. Although abortion is legally restricted in the Southeast Asian country, both safe and unsafe abortion are widespread and common among all socioeconomic groups. Public hospital data reveal that each year approximately 30,000 abortions take place in Thailand, yet most abortions are carried out in private sector facilities, in unmarked abortion clinics, or by self-induction; consequently, 300,000 to 400,000 abortions likely occur each year.[1] Through the Centre of Excellent Health Care of Asia Initiative, the Thai government has worked to position the country as a global hub for medical tourism and advanced medical practice.[2] Therefore, that the national abortion case-fatality rate is still as high as 300 deaths per 100,000 abortions is of great public health concern.[3] However, this rate differs throughout the country, as legal, policy, and social factors have converged to shape the national and subnational abortion context.

Using content and thematic analyses, this paper draws on findings from a review of institutional policies and legislative materials, key informant interviews, and informal and formal discussions with stakeholders to explore dynamics shaping subnational differences in abortion availability and access. Between July and October 2016, we conducted six in-depth interviews with key informants who are working to expand safe abortion efforts in Thailand; these included health care providers, government workers, and advocates from the nonprofit sector. We conducted our interviews in Thai and subsequently summarized and translated them into English. In addition, we collected responses to a short questionnaire from 32 members of a safe abortion referral program. Questions focused on their experiences providing abortion care in Thailand and the integration of medication abortion into their hospital or clinic. We also draw from our informal discussions with stakeholders—including health service providers, government representatives, and nonprofit actors—that took place from 2014 to 2016 in several regions of Thailand.

We begin this paper by critically examining attempts at abortion law reform that have occurred over the last 40 years in Thailand, as well as recent efforts to address abortion restrictions through regulation. We then explore the compounding sociopolitical and cultural factors that influence the interpretation and implementation of abortion law in various regions of the country. These complex dynamics have resulted in persistent urban-rural disparities in the availability of abortion care, regional and subnational inequalities in the distribution of providers, and inequities in access to safe and legal services among different populations residing in the Thailand-Burma border region. Finally, we discuss advocacy measures and new initiatives in clinical practice at the national and local levels and argue that given the limited political appetite for federal legal reform, these alternative strategies to support women's reproductive rights may be more successful.

Origins of abortion law in Thailand and legal status today

Thailand's abortion law

Following a decade of widespread legislative reforms and revisions to Thailand's Criminal Code, the absolute prohibition of abortion ended in 1957. Sections 301–303 of the 1957 Criminal Code state the circumstances under which a woman, procurer, or provider can be penalized. If the abortion is obtained with the woman's consent and results in her death, the provider may be fined up to THB20,000 (approximately US$600) or imprisoned for up to 10 years.[4] Moreover, according to Section 304, if the abortion is unsuccessful in ending the pregnancy, neither the woman nor the provider is subject to criminal penalties.[5] Yet, in *Attorney General's Office v. Comemoon* (2014), the Supreme Court of Thailand upheld the convictions of two defendants for intent to distribute nonregistered anti-progestogens to a woman seeking an abortion and to organize a place for the medication to be consumed.[6] This decision is consistent with an overarching trend: legal action is more likely to be taken against non-qualified individuals who provide abortion without a

medical license or participate in the distribution of black-market medications than against qualified physicians. Non-qualified individuals providing abortions without a license can be convicted under the Hospitals Act 2541.[7]

Under Section 305 of the Criminal Code, abortion is permitted only under certain circumstances, including when the pregnancy threatens the woman's life or health, resulted from rape or incest, or occurred when the girl was under the age of 15 and therefore unable to consent to sex.[8] Throughout the 1970s, political activists lobbied to expand the grounds for legal abortion and joined with the medical community, lawyers, and academics to advocate for abortion law reform.[9] In 1981, these groups successfully lobbied the House of Representatives to pass the Abortion Bill, legislation that permitted abortion in cases of physical and mental health risks to the woman, fetal deformation, contraceptive failure in cases where counseling and contraceptive provision was conducted by a qualified medical provider, rape, and incest.[10] Per the legislative process in Thailand, after a bill passes in the House of Representatives, the Senate and the King must approve it in order for it to become law. The Abortion Bill was met with exceptional opposition mobilized by a coalition of religious organizations throughout Thailand and by Major General Chamlong Srimuang, a senator and the secretary-general of Phalang Tham, a Buddhist political party.[11] Chamlong successfully led the public campaign to block the Abortion Bill from passing in the Senate and set the tone for how future legal reform efforts throughout the 1980s would be opposed.[12]

Attempts to reopen abortion law reform

In the late 1980s, the HIV epidemic in Thailand reached its peak and began to affect the general population, including "housewives" and children; this garnered public support for Parliament to revisit abortion legislation for people living with HIV.[13] However, Chamlong and his supporters framed these efforts as seeking to provide "free abortion" and encouraging sexual deviance and promiscuity, and they were thus able to successfully diminish public support for abortion reform.[14] These anti-choice efforts also effectively framed abortion as an immoral act known as *bap*, which is consistent with a strict Buddhist interpretation of abortion. Given that 98% of Thais identify as practicing Buddhists, much of the discourse surrounding abortion reform is influenced by Buddhist religious traditions and social thought.[15] However, most moderate Thai Buddhists agree with a "middle path" interpretation that allows abortion in some circumstances not currently permitted by law, including when the woman has mental health problems or is carrying a fetus at risk of severe hereditary disease.[16]

Introduction of regulatory reforms

In 1999, Thailand's Ministry of Public Health conducted a study, supported by the World Health Organization, on unsafe abortion in Thailand. The findings suggested that unqualified providers performed nearly 30% of all abortions in Thailand, leading to considerable morbidity and mortality.[17] A strong desire for policy advocacy and reform to improve sexual and reproductive health, and the safety of abortion in particular, resulted from this high-impact study. Participants in consultative workshops and seminars determined that the non-government-affiliated Thai Medical Council would be the most effective independent body to lead policy recommendations for population health reforms. This consensus stemmed from recognition that past reform attempts at the national legislative level had failed and the capacity within ministerial departments was limited. The resultant task force of the Thai Medical Council researched and launched a series of supplemental regulations over a five-year period.[18] According to its "Regulation on Criteria for Performing Therapeutic Termination of Pregnancy in accordance with Section 305 of the Criminal Code," legally permissible circumstances for abortion include the following:

1. *Necessity due to the physical health of the pregnant woman;*
2. *Necessity due to mental health problems that are certified or approved by at least two medical practitioners, including the one who will perform the abortion; and*

3. *Severe stress due to the finding of fetal disability or high risk of severe genetic disease. The pregnant woman should be clinically documented as having a mental health problem and this should be acknowledged in writing by at least one medical practitioner other than the one performing the abortion.*[19]

Further, between January and October 2016, Thai authorities confirmed 392 cases of Zika, including 39 cases involving pregnant women.[20] In October 2016, Thailand was the first country in Asia to issue guidance related to Zika surveillance and treatment, which included making abortion permissible through 24 weeks on a case-by-case basis. Although the application of these new guidelines has yet to be fully documented, the legal permissibility for abortion on these grounds appears to fall within the Thai Medical Council regulations related to mental health and severe stress.

Accessibility of abortion in Thailand

Subnational regional disparities

An alliance of stakeholders throughout Thailand, including medical societies and Thai and international nongovernmental organizations (NGOs)—such as PATH, Tamtang, Women Help Women, the Women's Health and Reproductive Rights Foundation of Thailand, and the Population and Community Development Association—has long advocated for policy reform and continues to address gaps in abortion services. Comprehensive sexual and reproductive health care is supplemented by the Planned Parenthood Association of Thailand and the Population and Community Development Association, which provide contraceptive counseling, contraceptive supplies, and, in some contexts, safe abortion care. However, these organizations are limited by capacity, funding, and geographic reach, leading many low-income women to seek clandestine abortion care or to use district hospital facilities as a primary point of contact.[21] Women with economic means often go to private clinics for abortion care, which are generally located in urban centers. At these clinics, a manual vacuum aspiration procedure can cost up to THB5,000 (approximately US$150), while a medication abortion using mifepristone and misoprostol costs approximately THB500 (US$15), an amount that is still roughly 1.5 times the daily minimum wage.

National efforts to reduce regional disparities and increase access to abortion services are also spearheaded by the Referral System for Safe Abortion (RSA). The RSA is a multidisciplinary group of pro-choice physicians, counselors, advocates, and nurses that addresses gaps in abortion provision, unites advocates for reproductive choice, and coordinates the activities of medical professionals. Its main goal is to refer women with unwanted pregnancies to qualified legal providers near their place of residence. The RSA also accepts referrals from and supports a government-sponsored telephone hotline that provides non-judgmental, non-directive counseling and medically accurate information about pregnancy options, including abortion. RSA has members in all areas of Thailand, yet not all members are clinicians capable of performing abortions; in addition, some are physicians trained in abortion provision but who work at a facility where abortion care is limited. During our informal stakeholder discussions, RSA members indicated that the single most important factor for whether abortion was provided at their place of work was whether members of the upper-level administration were fellow participants in the RSA. RSA members claim that their participation in the network is driven by their commitment to improving public health in Thailand, their desire to mitigate social consequences resulting from unwanted pregnancies, and the reciprocal support they receive from other practitioners in the system who support reproductive freedom.

In the questionnaire we distributed to RSA members, most respondents reported that health care providers' attitudes significantly shape whether abortion is available at a clinic or hospital. This is especially salient for senior medical administrators, such as hospital directors, who may control institutional hospital policies and the purchasing of equipment and commodities. If hospital leadership does not support abortion provision, physicians—

particularly junior medical staff—are limited in their ability to provide legal abortion care.

In medical facilities located in both northern and southern Thailand, providers reported that the Thai Medical Council regulations are narrowly interpreted and that use of the mental health exception is limited. The strong institutional culture against abortion is often rooted in religious grounds and conscientious objection stemming from the Buddhist faith or, in the case of the southern provinces, the Muslim faith. However, conscientious objection appears to be clustered in centralized hubs and medical facilities in specific regions. The negative response from regional medical communities to the registration of Medabon, a combination package of mifepristone and misoprostol, demonstrates how subnational disparities in abortion provision can be influenced by geographically concentrated conscientious objectors.[22]

Medabon was registered in Thailand in late 2014. The registration specified that the medication abortion combination package can be provided only in government hospital facilities and only to women with a pregnancy of up to 9 weeks' gestation and, in some cases, up to 15 weeks' gestation. In addition, nine facilities have permission to participate in a multicenter trial to monitor Medabon's integration into the health care system and to assess acceptability among patients and providers. However, no hospitals in the urban center of Chiang Mai have applied to the Ministry of Public Health to integrate Medabon into their services or have joined the multicenter trial. That the second-largest metropolitan area in Thailand lacks the gold standard for medication abortion care suggests that the country's abortion divide is not merely urban-rural.

Although medical providers who conscientiously object to providing abortion are expected to refer eligible patients to another provider or facility, they do not always do so. Instead, women seeking abortion care, even in cases that clearly fall within the legal exceptions, may be reprimanded for committing *bap* and breaching Buddhist moral principles. Such dynamics within hospital and clinic environments, especially among leadership personnel, pose significant barriers to women's ability to access safe and legal abortion care, forcing them to seek care in the private sector or from a non-qualified provider.

Peripheral disparities: The Thailand-Burma border

The border that Thailand shares with Burma is a regionally unique peripheral space that also reflects subnational disparities in abortion access. Burma's long history of military rule and civil conflict, combined with poor economic opportunities, has led to significant in-country and international population displacement. Burma's 2011 elections represented a watershed moment in which a nominally civilian government came to power and subsequently enacted a series of political and legal reforms that have contributed to rapid change and growth in the country. The 2015 elections installed a democratically elected government and renewed optimism for peace and prosperity. However, many migrants and refugees have now lived in Thailand for decades, and economic opportunities in Thailand continue to draw large numbers of people from Burma. Displaced populations from Burma reside in Thailand as documented and undocumented migrants and as refugees in the nine unofficial camps located along the border. Thailand has not ratified the 1951 Refugee Convention and thus does not recognize the status of these refugees or the authority of the non-government-authorized camps.[23] Another subset of the Burmese population is often referred to as "cross-border," or people who occasionally cross into Thailand to seek temporary economic opportunities or medical care. Women from Burma who seek sexual and reproductive health care in Thailand face several unique and compounding challenges, including their migratory status, language barriers, and an increased risk of being subjected to sexual violence or exploitation.[24] Their access to safe abortion care, even in circumstances where the procedure is legally permissible, is significantly restricted.[25]

Abortion laws in Burma, which persist from the 1860 Burma Penal Code, are some of the most restrictive in the world. Abortion is prohibited in all cases, except when necessary to save the pregnant woman's life.[26] Furthermore, anyone who provides

an unauthorized abortion is subject to significant fines and to imprisonment; both criminal and civil penalties increase if the abortion takes place after "quickening."[27] Anecdotal evidence suggests that stakeholders in Burma, including clinicians and policy makers, recognize the consequences of unsafe abortion on women's health and lives and are open to discussing models of legal reform, but acknowledge the minimal likelihood that the law in Burma will change anytime soon.[28] Research shows that women in Burma use unsafe methods to end their pregnancies.[29] In eastern Burma near the Thai border, the lack of health services, limited capacity of health service professionals, and marginalization of ethnic minority populations further compound the consequences of unsafe abortion.[30]

Several initiatives have been established to reduce harm from unsafe abortion and help women from Burma obtain safe and legal abortion care in Thailand. For example, a referral system between Burmese community-based organizations and the district Thai government hospital in Mae Sot was established to refer eligible women to a qualified provider for safe and legal abortion care and is now being expanded.[31] In addition, the RSA and the government-sponsored hotline have a small number of members in the western provinces. Although women seeking advice regarding unintended and unwanted pregnancies would need to be sufficiently fluent in Thai to communicate with the Thai hotline staff, it is an additional resource that has the potential to disseminate information about safe and legal abortion care.

Efforts in Mae Sot, Thailand, are challenged by limited opportunities for abortion provision at the local hospital. Indeed, there is only one medical provider at the district hospital who is willing to perform abortions up to 12 weeks' gestation; further, the service is available only one day a week.[32] This poses a number of difficulties. First, for displaced women, many of whom are domestic or factory workers, travelling into the Mae Sot center on one specific day may be difficult and costly. Second, the eligibility criteria are interpreted narrowly at this district hospital, and abortion care on mental health grounds is rarely provided. Finally, given the reliance on one provider, patients who have been approved for a legal abortion must wait until the doctor is available. Our informal discussions with the community-based organization referral team suggested that if a woman's pregnancy surpasses 12 weeks' gestation while waiting for an appointment, she will be denied services.

Reducing subnational disparities in abortion provision

The disparities in abortion service availability in Thailand are influenced by socio-cultural taboos, the religious beliefs and moral positions of providers and politicians, and the resource capacities of facilities and health service professionals. Importantly, of all the obstetricians and gynecologists trained and practicing in Thailand, 65% work in the metropolitan areas around Bangkok, which has a population of 10 million. The rest of the obstetrician-gynecology workforce is distributed throughout the country and serves 55 million people.[33] Bangkok has become the primary site for abortion provision in Thailand and is widely known to be home to a number of providers who interpret the Thai Medical Council regulations, particularly the mental health exception, broadly. However, for women in border or rural regions for whom travel to the capital is legally restricted or cost prohibitive, it may be nearly impossible to access a safe abortion in Thailand.[34] Women's access to services is additionally shaped by whether they are knowledgeable of available public and private sector services in their area. Again, outcomes are highly dependent on the geographic and economic status of the woman.[35] In order to lessen these disparities in Thailand, provider distribution must be addressed—specifically the distribution of qualified Thai providers who offer abortion care to the fullest extent possible under law.

Government policies concerning the funding and availability of commodities for medication abortion must also be addressed to reduce subnational differences. The National Health Security Office (NHSO) established the first universal health coverage scheme in Thailand in 2001; this scheme

provides free public health care at the point of service.[36] Since the launch of the universal scheme, the decentralization of family planning program management to district-level health networks has resulted in an increased patient preference for oral contraceptives and a decreased uptake of long-acting reversible contraceptive methods, especially among young, unmarried women.[37] However, the fact that contraception is no longer fully subsidized through the program poses significant barriers for women who seek high-quality methods to prevent unintended pregnancy. Post-abortion care is widely available in Thai government hospitals and is fully covered under the national health insurance program.[38] However, abortion has never been insured through the NHSO, with the narrow exception of specific fetal anomaly cases. To address these limitations, future advocacy efforts should call for coverage of the full range of contraceptive methods and abortion services under the universal scheme.

Government recognition of abortion as a medically necessary procedure that is eligible for coverage under the NHSO is needed to address economic barriers. Furthermore, the key informants we spoke with reported that establishing more effective referral networks from small clinics to hospitals that offer induced abortion services may prove an important strategy for expanding access. In addition, more small clinics should be encouraged to apply to the Ministry of Public Health for access to Medabon for medication abortion. Research and training conducted by the Women's Health and Reproductive Rights Foundation may be influential in persuading such smaller clinics to incorporate early-induced abortion using misoprostol alone, Medabon, or manual vacuum aspiration. Long-term capacity building in public district hospitals and clinics should be prioritized in order to reduce subnational disparities.[39] This may be particularly relevant for marginalized and vulnerable groups, including young women, rural and ethnic minorities, and Burmese populations residing in or seeking medical care in Thailand.

Finally, despite legal restrictions, access to abortion services in rural or low-capacity centers remains a challenge for achieving parity in abortion care across Thailand. The 2014 registration of Medabon presents a window of opportunity to improve access throughout the country. However, according to well-positioned key informants, there appears to be a general lack of interest in applying for Medabon through institutional hospital procurement processes. If this gold standard for medication abortion care is available only on the basis of the religious or political motivations of hospital management, then it is unlikely that Medabon can achieve the uptake necessary to reduce disparities throughout the country. Sustained partnerships between civil society groups and the medical community are key for addressing these gaps. The active role of these actors in building a case for Medabon registration and the ongoing success of the RSA program and the government-sponsored hotline demonstrate that there may be opportunities for scaling up medication abortion provision throughout Thailand. Further, district hospitals, in particular, should be encouraged to apply for access to Medabon and to train providers in its use. RSA membership should also be encouraged for clinicians working at small clinics in areas where abortion is underprovided.

Conclusion

The country's move toward regulatory reform through the medical profession, which now permits abortion if a woman's physical or mental health is at risk, suggests that in the absence of a political appetite for legal reform, stakeholder advocacy can succeed through other channels. However, considerable barriers continue to impede women across the country from obtaining safe and legal abortion care. In particular, women living outside of Bangkok, where the majority of providers are located and where the law is most generously interpreted, may lack access to safe abortion care when the pregnancy threatens their physical or mental health. The case of Thailand also makes evident that legal reforms alone are insufficient to ensure access to safe abortion care and must be accompanied by efforts to increase the availability of and access to the procedure.

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Decriminalization and Women's Access to Abortion in Australia

BARBARA BAIRD

Abstract

This article considers the relationship between the decriminalization of abortion and women's access to abortion services. It focuses on the four Australian jurisdictions which are, with Canada, the only jurisdictions in the world where abortion has been removed from the criminal law. This paper draws on documentary evidence and an oral history project to give a "before and after" account of each jurisdiction. The paper assumes that the meaning and impact of decriminalization must be assessed in each local context. Understanding the conditions that shape access must incorporate analysis of the broader social, political and economic environment as well as the law. The article finds that decriminalization does not necessarily deliver any improvement in women's access to abortion, at least in the short term. Further, it is not inconsistent with the neoliberal policy environment that characterizes the provision of abortion care in Australia, where most abortions are provided through the private sector at financial cost to women. If all women are to enjoy their human rights to full reproductive health care, the public health system must take responsibility for the adequate provision of abortion services; ongoing and vigilant activism is central if this is to be achieved.

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Introduction

Four states/territories of Australia—the Australian Capital Territory, Victoria, Tasmania, and most recently the Northern Territory—stand with Canada as the only jurisdictions in the world where abortion is no longer regulated by criminal law. The Canadian Supreme Court decriminalized abortion in 1988; decriminalization in the Australian jurisdictions has happened in the 21st century. Legal scholar Kerry Petersen notes of Australia that this is "a trend to classify abortion mainly as a health matter." These reforms "represent a significant socio-legal shift."[1] This reclassification of abortion from crime to health care is a longstanding goal of feminist and pro-choice activists and is consistent with human rights principles.[2] This shift away from the criminalization of abortion is surely a valuable achievement, but identifying its effects to date in Australia is not so straightforward.

This article is a historical examination of the effects of three instances of decriminalization in Australian jurisdictions. It is too soon to assess decriminalization in the Northern Territory, which just occurred in 2017. That is, it concerns the law, politics, and provision of abortion in an affluent Western "liberal democracy." The great majority of Australians are "pro-choice."[3] The nation has a comprehensive public health system, albeit one that struggles under the trends and pressures characteristic of neoliberal policy approaches. Australia has a strong tradition of social democracy but at the level of everyday cultural practice and of government social and economic policy, individualism, choice, and market-based solutions in all areas of life have become common sense. The role of the state is to facilitate markets.[4] Health is understood largely as an individual responsibility, and the public health system (including public hospitals) negotiates competing principles in the context of ongoing pressure to privatize, limited resources, and constant restructuring. [5] Abortion is provided liberally in Australia, but mostly by private providers. Well-informed women in metropolitan centers with reasonable economic means seeking first trimester abortions are adequately served.

Discussion of decriminalization in Australian political, scholarly, and media contexts often proceeds with little if any attention to the relationship between the change in law and change in the adequacy of access for women to abortion services. Regarding discussion of abortion worldwide, legal scholar Rachel Rebouché notes: "There appears to be faith in liberal laws promising liberal access, and in restrictive laws restricting access." Yet "empirical studies, often in the field of public health, show this faith to be unfounded." This article is driven by a feminist commitment to understanding and promoting the advancement of access to safe, legal, and affordable abortion services for all who need them. It follows Rebouché's call for "an assessment of abortion laws in their functional capacity." She concludes that this "approach suspends the assumption that law has a direct or immediate or even a necessarily casual [sic] relationship with health outcomes."[6]

In this article, I argue that while decriminalization is consistent with feminist goals and human rights principles, unless there have been specific legal restrictions on abortion provision beyond defining the legality of doctors' authority to decide, it will make little or no challenge to the sources of inadequate access to abortion in Australia. I conclude that while decriminalization may be a precondition for the improvement of access to abortion services, it is only when public health departments take responsibility that equitable access will be delivered. In the current neoliberal policy environment and in the context of continuing moral conservatism in Australia, this will only happen under pressure of ongoing activism—and even then there are no guarantees.

The article begins with a brief historical background to the law, politics, and provision of abortion in Australia. It then tells a before-and-after story of decriminalization in each jurisdiction, although for the Northern Territory the discussion is brief. Finally, the article offers a critical feminist analysis of these stories to identify the forces that shape women's access to abortion in Australia. The article refers to women having abortions but, following the IPPF, acknowledges that "other people who do not identify as 'women' (such as trans men/

trans masculine people and non-binary people) can also experience pregnancy and abortion."[7] It draws from a range of published sources, including government and NGO reports and mainstream and alternative media. It also draws from oral history interviews that I conducted with "key insiders" between 2013 and 2017 as part of a project that is investigating the provision of abortion services in Australia since 1990. The Flinders University Social and Behavioural Research Ethics Committee approved the oral history project (no 5958) which produced these interviews. Thirty-five interviews were conducted with people who were then or had been significantly involved for a sizeable period of time in public and private abortion provision, advocacy, or activism, or related women's health work, in every jurisdiction. Some were approached through my own networks or because of their public profile, and others were recruited via a snowball method where interviewees recommended or referred others to me. Each interview was conducted in a semi-structured way to elicit a history of the provision of abortion in the jurisdiction(s) with which each person was familiar. All interviewees are identified by pseudonyms and are referred to in the narrative by their role in relation to abortion. The interview material adds subjective depth to what can be learned from documentary sources.

Abortion in Australia

Law concerning abortion in each state and territory in Australia followed the British 1861 Offences Against the Person Act. Legal liberalization began in 1969 and proceeded one jurisdiction at a time via legislative reform of the criminal law or court ruling in cases where doctors were facing abortion related charges.[8] Rebecca Albury points out that it was the broader context of social change in the 1960s and 1970s, as well as the activism of Abortion Law Reform Associations and feminists and the liberalization of the law, that transformed Australian attitudes to fertility control and delivered liberal access to abortion by the end of the 1970s.[9] The pattern of predominantly private provision that had been established by this time prevails at the time of writing, albeit with significant variation across the eight jurisdictions and an aging cohort of medical providers that points to workforce sustainability problems.[10] The listing of surgical abortion as a rebatable item on Medicare, the national universal health insurance scheme that was introduced in 1975, has been crucial in enabling access for women who attend private clinics. In the 2010s, though, the rebate covers only about half the cost of a first-trimester procedure and progressively less for procedures after 12 weeks.[11] Early medical abortion for women less than 9 weeks pregnant has slowly become available since 2006.[12] The medications are now imported commercially by a subsidiary of Marie Stopes International (MSI), a UK-based sexual and reproductive health care charity that operates internationally. MSI entered the Australian market as a private abortion provider in 2000 and now provides about one-third of all abortions in the country.[13] Medical abortion is available mainly as an alternative in existing clinics where it is no cheaper than surgical abortion.[14]

Pro-choice activism from the 1970s has been state-based. The anti-abortion movement is an irritant but generally not a dominant political force in Australia per se. The overwhelmingly pro-choice opinions of Australians and the 21st century trend to decriminalize abortion in Australia nonetheless coincide with public discourse that stigmatizes women and abortion-providing doctors.[15] More specifically, the period since 1996 has seen a re-energized Christian moral conservatism, most politically notable in the federal sphere, where Liberal governments were in place from 1996–2007 and since 2013.[16] Federal and state governments in Australia in the post-war period have been held by either the more socially and economically conservative Liberal Party or the more socially progressive Australian Labor Party (ALP). Decriminalization in each case has been achieved under state/territory governments led by the ALP. The status of popular feminism has waxed and waned, but a neoliberal retreat from social policy that aims to promote gender equality has been a feature of both Liberal and ALP governments since the 1990s, if in different degrees.[17] Notwithstanding this policy position, the

growing presence of women in all parliaments has made a significant difference in abortion votes.[18]

The Australian Capital Territory

The Australian Capital Territory is a small area enclaved within the state of New South Wales. The national capital Canberra, a city of about 380,000 people, is located here.[19] Abortion was decriminalized in 2002 following the success of a private members' bill.

From 1994, women in the Australian Capital Territory had enjoyed access to an abortion clinic in Canberra owned and operated by the not-for-profit ACT Family Planning Association (ACT FPA). But in 1998, Paul Osborne, a Catholic independent member of the Legislative Assembly, in a deal with the then-Liberal government, was successful in passing legislation that significantly restricted abortion provision. Women had to be given prescribed information, including pictures of fetuses, and a 72-hour waiting period between a woman's first visit to the clinic and the procedure was mandated.[20]

The FPA clinic did its best to resist and minimize the impact of the 1998 act on women.[21] Nonetheless, one woman who at the time worked in the organization in a management role told me in 2015 that "it was actually not so much about delivering the service but making sure that we met our obligations in case they were ever scrutinized in court, because we were scrutinized a lot."[22] Compliance with the 72-hour waiting period meant that women visited the clinic three times over a 10-day period. Following this decrease in the service's amenability, especially to rural women, some chose to go to a private clinic in nearby Queanbeyan (in New South Wales just outside the Australian Capital Territory), which had been established in the wake of the 1998 reform and was free of the legislative restrictions. As a consequence, the FPA clinic suffered a financially significant "decline in client numbers."[23]

After the 2001 election, which returned an ALP government and an increased number of women to the Legislative Assembly, ALP backbencher Wayne Berry, with colleague Katy Gallagher, had the opportunity to legislate. A new pro-choice community group was formed and campaigned intensively to counter the Right to Life organization, which was a significant force in opposition. Decriminalization legislation in 2002 delivered "the most minimal legal model regulating abortion in Australia."[24] Abortion no longer appears in the Crimes Act at all. New regulations concerning abortion were, however, put into the Health Act. There are no restrictions on women, but abortions must be performed by medical practitioners and only in approved premises. No person is required to perform or assist in an abortion.[25]

The FPA manager who spoke to me described decriminalization as a "brand new day."[26] But it was not only the legislation that had been working against the clinic. In the early 2000s, the clinic had about 10 lawsuits going against it.[27] The plaintiffs were alleging various forms of poor practice on the part of the clinic, most in relation to abortion. Most women were supported by Catholic anti-choice agencies. Then the HIH Insurance company went into provisional liquidation, "Australia's biggest corporate collapse."[28] The FPA abortion clinic was one of a number which were forced, overnight, into much more expensive insurance arrangements, as were its doctors.[29] In this context, the clinic's commitment to means-tested fees and "payment plans," the opportunity for women to pay for their abortion over time, became "financially unviable."[30] The regular protestors outside the clinic were a minor irritant, but the 2001 murder of security guard Steve Rogers by an anti-abortion gunman at the Fertility Control Clinic in Melbourne led to added security measures.[31] Hence, in the early 2000s, ACT FPA operated with a financial deficit. The financial, legal, and emotional pressure on the organization saw constant turnover in the membership of ACT FPA's governing council after 1998.[32]

Marie Stopes International Australia (MSIA) saved the day. FPA ACT sold the abortion providing part of the organization to MSIA in early 2004. It was one of their early acquisitions. Access to insurance through their global operations, and a different business model—they did not offer pay-

ment plans—meant that they were able to, as the FPA manager put it, "save the space where women could access services in the ACT."[33]

In 2017, MSIA still operates in the Australian Capital Territory, providing abortions for women up to 16 weeks, as does Gynaecology Centres Australia in Queanbeyan, which provides abortions up to 14 weeks. Both offer medical and surgical abortions. The availability of early medical abortion from the Tabbott Foundation, a service established in 2015 offering medical abortion via telemedicine to Australian women at a relatively cheap price, is compromised for Australian Capital Territory women by the legal requirement that abortions must be carried out in approved premises.[34] Public provision in the Australian Capital Territory is minimal. (One of the two public hospitals in the Australian Capital Territory is run by the Catholic Calvary Group, which does not provide abortions).[35] In sum, decriminalization was part of the facilitation in the Australian Capital Territory of the restoration of services to a situation similar to that which had been operating prior to the 1998 anti-abortion reforms. MSIA have made abortions available at later gestations than had previously been accessible, but they discontinued the payment flexibility that the FPA clinic had offered.

Victoria

Victoria is the second-smallest Australian state (a bit larger than Great Britain). About 4.5 million of the 6 million total population live in greater Melbourne, the capital city. Abortion was decriminalized by a government-sponsored bill in 2008.

Prior to this time, abortion was a matter of criminal law and its provision clarified in the 1969 Menhennit ruling. Abortion was legal if "necessary to preserve the woman from a serious danger to her life or her physical or mental health" and "economic and social grounds" could be considered.[36] Abortion was liberally provided. The Royal Women's Hospital (RWH) and some other metropolitan and regional public hospitals provided abortions at no cost, mainly to the poorest women, although they never met demand for this service. Public hospital provision comprised about 20% of all abortions.[37] Private clinics in Melbourne provided the rest. One account of the campaign for decriminalization describes it as a response to the increasingly anti-abortion climate generated in federal politics after the 2004 federal election.[38] It took place over four years and was driven by a coalition of organizations and individuals with interests in women's sexual and reproductive health and women's rights. After a report from the Victorian Law Reform Commission (VLRC), a bill was sponsored by Women's Affairs Minister Maxine Morand. The government eschewed complete repeal, the most radical of the VLRC's proposed models. Its stated intention was to "modernise and clarify" the law, removing abortion from the criminal law "without altering current clinic practice."[39] The bill passed without amendment.

The government's 2008 bill removed abortion from the Crimes Act, although it created a new criminal offense to make it unlawful for "an unqualified person to perform an abortion."[40] The Abortion Law Reform Act gives abortions up to 24 weeks the same status as any other matter of health care. It adds regulations, however, requiring that in cases where women are more than 24 weeks pregnant, two doctors must "reasonably believe that the abortion is appropriate in all the circumstances." Any breach of this requirement is dealt with by professional disciplinary means.[41] It also requires that doctors who have a conscientious objection to abortion must refer the woman to a practitioner who does not.[42]

Decriminalization in Victoria has had clear "intended and achieved" positive effects.[43] One women's health worker who I interviewed in 2013 said that "symbolically I think it's extraordinarily significant in that it says women are adults who are capable of making decisions about their own lives and their own bodies."[44] Another, who works with young people, stated that "from an education perspective it has been quite an improvement in relation to being able to clearly state what their rights to abortion access are."[45] Decriminalization has also increased clarity and comfort for abortion-pro-

viding doctors.[46] In 2015, I interviewed a medical provider who has worked in the public hospital sector; she felt that decriminalization had changed the nature of her interactions with patients:

> *Before decriminalization, you had to prove to me that I should grant you an abortion … and so women would sit there waiting to be granted an abortion, and I could see the moment where they thought "All right, I've got one," yeah. And so I feel a lot better about that interaction.*[47]

Those who expected more have been disappointed. The "experts in abortion" interviewed by Victorian public health academic Keogh and her colleagues did not think that there had been any decrease in the stigma attached to abortion, either for women or for providers.[48] The public sector medical provider quoted above reflected:

> *I probably thought that a little bit … after abortion law reform, there'll be more providers willing to do this job … But it hasn't panned out that way … I thought that there might be more services opening at public hospitals … That hasn't been the case.*[49]

Workforce sustainability is not the only unresolved problem. The "experts in abortion" thought that, coincidentally, "access to public services [had] shrunk." They were particularly concerned about the inadequacy and decline in services for women more than 20 weeks pregnant.[50] The only private clinic in Australia that offers abortions over 20 weeks for "social reasons" is operated by MSIA in Melbourne. ("Social reasons" for abortion are those that are principally the domain of the pregnant woman to identify. This term is used widely in Australia in comparison with "medical reasons" which are those that are diagnosed by doctors and/or medical science, typically maternal ill health and fetal anomaly.) Resources for the more complex procedure after 20 weeks are concentrated here and women travel from around the country to access the service. The clinic ceased offering services for women more than 24 weeks pregnant in 2012.[51] The public hospital provider to whom I spoke reported that surgical abortions for "social reasons" are available at the RWH only for women up to 18 weeks. [52] In both cases, these limits are imposed for reasons other than the law (although the limit at the MSIA clinic matches the post 2008 line after which legislated regulation applies). The other major disappointment concerned the lack of state government policy, described by the experts as "unfinished business."[53] In 2011, the Women's Health Association of Victoria produced a proposal for a sexual and reproductive health strategy as a means of pressuring the then-Liberal state government.[54] A public sector health care professional I interviewed in 2013 stated that while strategic planning was needed and "theoretically" decriminalization should make things possible, "law reform's happened and pretty much the bureaucrats and the politicians have said: 'Well we've done our bit, go away now, don't expect anything else.'" [55]

Keogh et al also comment on an unintended effect of decriminalization. Some of the "abortion experts" thought that the codification of conscientious objection had led to "whole institutions [being able to] justify not providing abortion services."[56] Overt resistance to decriminalization from an anti-abortion doctor and an independent member of parliament gained significant publicity in 2013–2014.[57] On the other hand, the coalitions forged in the decriminalization campaign have an ongoing legacy. This is evident in cooperation between public, private, and community agencies in the promotion of early medical abortion to rural doctors, notably without direct state government funding or coordination.[58] Keogh et al's experts note that the availability of early medical abortion since decriminalization has made abortion "a little bit more accessible."[59]

Up until 2017, the direct effects of decriminalization on access in Victoria seemed to be limited to the hope that legal clarity and comfort for doctors might, at some point in the future, lead to a greater supply of abortion providers and less stigma for women. Many experts and insiders expressed frustration. Then, in March 2017, the socially progressive ALP state government released its first-ever women's sexual and reproductive health strategy.[60] Three of 14 key priorities for 2017–2020 address abortion, with a focus on improving awareness of

and access to medical abortion. The impact of this policy, for which many have lobbied, remains to be seen at the time of writing.

Tasmania

Tasmania is a small island state, located to the south of Victoria and about one-third its size. It has a population of about half a million. On most indicators, Tasmania is the poorest state in the nation. Abortion was decriminalized in Tasmania in 2013.

Prior to this time, the conditions under which it was lawful for doctors to provide an abortion were defined in a 2001 amendment to the criminal law. The woman was required to give informed consent, which meant being counseled about medical risks and being referred for further counseling. Two doctors had to certify that she could be given an abortion. There was no upper time limit. [61] Through the 2000s, Tasmanian women were served by two private clinics in the capital city Hobart in the south and one in the city of Launceston in the north, all operating one day every two weeks with "fly-in-fly-out" doctors. The North West Coast was served intermittently until 2016 by a doctor who operated at a public hospital. One long-standing activist assumed that the two major public hospitals provided abortions for "medical reasons" only.[62] Another interviewee, a public sector policy worker, thought it likely that some Tasmanian women were traveling to Melbourne to access a private clinic during the 2000s, for reasons of confidentiality or to avoid waiting.[63] By the end of the 2000s, community-based health agencies were regularly reporting to the health minister that access to abortion services was inadequate, particularly for young and poor women.[64] Some doctors were claiming that, despite the 2001 reform, the law was ambiguous. Not until 2008 had the health department produced a booklet to inform doctors about the law.[65] One doctor who I interviewed in 2013 who had been performing abortions in Tasmania during the previous two decades disputed the claim that the law was unclear. "I don't think they're [doctors] confused at all. You know, I think they just don't want to—they just use that as an excuse not to refer women on." Abortion providers "just go ahead and do our own thing."[66] The two-doctor rule was, however, a nuisance.

In 2010, Michelle O'Byrne, then health minister in the ALP government, indicated interest in the abortion issue. ProChoice Tas formed and community women's and sexual and reproductive health organizations moved into action in 2011 and 2012.[67] O'Byrne's bill passed, after amendments, in November 2013.[68] It removed abortion from the criminal law, except that it is a criminal offense for a person who is not a doctor to perform an abortion. It added conditions to the Health Act. An upper time limit of 16 weeks applies, beyond which two medical practitioners, one of whom must be an ob/gyn, must support the woman's request. Similar to the Victorian law, doctors and counselors who hold conscientious objections must provide the woman with a list of services that provide all options.

Shortly after decriminalization came into effect, the Tasmanian government made efforts to educate the health community about the new law. According to the women's health worker with whom I spoke in 2017, publicity material led to improved knowledge about the law among Tasmanian women. But the year after decriminalization, a Liberal government was elected and these efforts ceased. The women's health worker stated that the new anti-abortion minister for health makes any ongoing activist efforts "like banging your head against a brick wall." Even advocacy with the public hospitals on behalf of individual patients is fraught with caution for workers at women's and sexual and reproductive health agencies that rely on funding from government.[69]

In the wake of decriminalization in 2013, Tasmanian women's access to abortion has significantly reduced, but not because of the law. In 2014, one of the two Hobart clinics closed. Then in 2016, the Launceston clinic closed. Both clinic owners cited the impending implementation of new regulations pertaining to day procedure centers (not specifically related to abortion provision), which would require upgraded premises. The Launceston clinic owner added that "additional costs of insurance, accreditation and compliance" made the business unviable. Further, this doctor report-

ed that the popularity of the Tabbott Foundation, which he had established in 2015, had produced a decline in demand for the Launceston clinic.[70] The clinic closure means, however, that women in northern Tasmania no longer have access to a local surgical abortion service.

Public hospitals remain unwilling to provide abortion in the wake of decriminalization, and knowledge of their approach to service provision is not freely available. According to one journalist, only about 6% of all abortions were provided by public hospitals in the early 2010s, mostly for "medical" reasons.[71] If any GPs offer medical abortions, this is not widely known. Some private ob/gyns do so, but they require a referral: "the law doesn't require it, but the hierarchy of the medical services does."[72] The women's health worker quoted above added ongoing ignorance and uncertainty, despite decriminalization, to the account above of Tasmanian doctors' conservatism and hypocrisy.[73] Rural women continue to be disadvantaged; even accessing medical abortion via the Tabbott Foundation may involve a trip to a city for the required ultrasound.

The Tasmanian Act established safe access zones around clinic premises to protect patients and staff from protesters. In the wake of this Tasmanian initiative, both the ACT Assembly and the Victorian parliament passed similar safe access zone legislation.[74]

Northern Territory

The Northern Territory is the fourth Australian jurisdiction to decriminalize abortion. The Northern Territory covers a large area, more than six times the size of Britain, but has a population of just 245,000 people, 30% of whom are Indigenous. ALP government Health Minister Natasha Fyles' reform bill passed through the Northern Territory Legislative Assembly in March 2017, and as of June 2017 is not yet enacted. Decriminalization comes after more than four years of campaigning and was achieved with the help of strong community support and the equal presence of women and men in the assembly.[75] Until the new law is enacted, the 1973 law reform applies. Provision since 1973 has been mainly in the two large public hospitals, in Darwin and Alice Springs, and so the Northern Territory is an exception to the national rule of predominantly private provision. It is, however, vulnerable to dependence on small numbers of willing medical personnel. There is currently no access to medical abortion.[76] While abortions performed at the public hospitals incur little or no cost, access is particularly compromised for Indigenous women in remote communities and others who must travel significant distances to a hospital.

The new act will remove abortion from the criminal law, except a new section is added that makes the provision or procurement of an abortion by a non-medical person an offense. It imports some of the restrictive provisions of the 1973 law, although only one doctor, not two, is now required to decide on an abortion up to 14 weeks.[77] Arguably the most significant change will follow from the combination of the removal of the two-doctor rule and the removal of the requirement that abortion be performed in a hospital. Commentators are stressing the increased access women will have to early medical abortion "in general medical practices, health clinics and home settings."[78]

Discussion

Decriminalization in four jurisdictions in Australia puts in place principles that should, in theory, enable movement towards the improvement of all women's access to abortion. It is important to acknowledge, however, that only one of these jurisdictions (the Australian Capital Territory) has achieved full decriminalization. In the other decriminalized jurisdictions, a new criminal offense applies to a person (not the woman) who is not a medical practitioner who performs an abortion. (This includes administering a drug). Further, requirements that were in the previous criminal law in the Australian Capital Territory and Northern Territory and entirely new ones regarding upper time limits in Victoria and Tasmania have been put into new law specifically about abortion. The continued requirement in all decriminalized jurisdictions that only doctors can perform abor-

tions, and in the Australian Capital Territory that abortions must be performed in approved premises, impedes the development of innovative ways in which early medical abortion, and other new technologies, might address the needs of women in regional and remote areas or in any primary health care setting. This continued exceptional status of abortion, not for clinical reasons, is evidence of the stickiness of moral discourse in relation to abortion and of the grip that medical authority has on this aspect of women's reproductive lives.

On the other hand, in legislating for safe access zones and, except in the Australian Capital Territory, requiring that doctors who have conscientious objections must provide women with information about doctors who do not, decriminalization contributes directly to the facilitation of timely and easeful access to abortion services. These measures will be most significant for clinics which have been the target of protesters and in rural areas, for example, where conservative doctors may hold sway. The comments from Victorian abortion experts about institutional use of the conscientious objection clause to avoid providing abortions is concerning and demonstrates the malleability of law as a cultural norm.

Fifteen years have passed since the Australian Capital Territory decriminalized abortion, and the provision of abortion has been stable there since 2004. The benefits delivered by decriminalization have been realized. They do not include a public hospital service, so all women have to pay. Perhaps it is too soon to assess the effects of decriminalization in Tasmania, another small, and conservative, place, or even Victoria. The decline in public hospital services in Victoria, presumably for systemic reasons internal to individual hospitals, has been coincidental with decriminalization but cannot be attributed to it. The decline in private clinics in Tasmania is also coincidental with, not caused by, decriminalization. It is, however, arguable that if there is no immediate positive change after decriminalization then the impetus of activist organization, government responsiveness (if it was present), and community awareness could be wasted. Certainly, the political climate in Tasmania since 2014 has halted any further progressive change. Whether future ALP governments will intervene to improve women's access to abortion in that state will be a matter of community pressure, and any such future mobilization will start from scratch. The rewards of ongoing activism and advocacy in Victoria are clear in the increase in the availability of early medical abortion, including in some rural areas, and the government's first women's sexual and reproductive health strategy. Decriminalization may have smoothed the way for these developments but they are not its direct effects.

The new Victorian women's health strategy rightly focuses on the rollout of medical abortion as the best method to address poor access to abortion services, especially in rural areas (although this should not be to the detriment of access to surgical abortion).[79] Indeed, the slow but perceptible growth particularly since 2013 in the provision of medical abortion by GPs is the most promising factor in addressing the problem of the inadequacy of women's access to abortion in Australia.[80] The availability of medical abortion nationwide was due to MSIA's initiative and investment. The development of telehealth as a mode of delivery for medical abortion is also an initiative of a private sector health provider. Notably, the Tabbott Foundation delivers medical abortion to New South Wales, Queensland, and Western Australia, jurisdictions where abortion is still defined in the criminal law. That is, in jurisdictions where there is no hospital requirement, this innovation has not depended on decriminalization. There are limits, though, to what the private sector can deliver. As Baum and Dwyer state, "health is essentially a public good, where market principles do not work."[81] Oversight and coordination, better public hospital provision, awareness raising among doctors and the general community and training of possible providers are all the domain of state governments.

Conclusion

Only in cases where the law was a specific impediment to the provision of abortion services, rather than a potentially threatening general atmosphere, can it be stated without qualification that decrim-

inalization has improved access. This was clearly the case in the Australian Capital Territory in the removal of the 72-hour waiting period, and will be so in the Northern Territory when abortions are no longer required to be performed in a hospital and only one doctor is required. On the other side of the coin, there is a risk when decriminalization creates change in a jurisdiction where abortion is provided predominantly by the public hospitals. If GPs, community-based health agencies, and the Tabbott Foundation begin to offer medical abortion in the Northern Territory, the hospitals might decide to pull back their surgical services, leaving women with less choice of procedure and having to pay. The removal of the two-doctor rule up to 16 weeks in Tasmania solves the second signature problem, but it will contribute to improved access only if GPs start to offer medical abortions.

The effect of the symbolism of decriminalization and the legal clarity it brings to abortion providers is harder to measure. While it makes current providers more comfortable, it has not yet motivated a significant number of doctors in Victoria or Tasmania who are not already committed. The idea that decriminalization will engender a slow process of attitude change that will eventually create greater willingness among doctors to become abortion providers assumes a liberal model of change that does not account for the multiple factors that shape doctors' motivations and their institutional and professional environments. Further, it begs the question of how to establish a period of time over which any attribution of change to decriminalization could be measured. It has not occurred significantly in Victoria after seven years. In any case, government policy and program initiatives are needed to capitalize on the safety delivered by decriminalization. The broader political climate, which Rebecca Albury claims was as much responsible for liberalization in the 1970s as was legal change, is relevant here.[82] The neoliberal political mood and approach to policy that prevails in 21st century Australia is not fertile ground for the action required to improve access to abortion services. On the other hand, decriminalization makes no demands on the predominantly privatized model of service provision that prevails in the Australian Capital Territory, Victoria, and Tasmania.

The value in adopting Rachel Rebouché's suspension of the assumption that law has any particular relationship with health outcomes is that it demands a fine-grained account of the specificity of whether and how state or territory law has obstructed access to abortion and what has worked, or might work in the future, to deliver better access.[83] This recalibrates the horizons of change beyond any simple faith in decriminalization. It brings into view a variety of mutually shaping forces which can rebalance in relation to each other when change is initiated in any one sphere. In the Australian case, this includes the law along with private-sector clinics, GPs, and specialists in private practice (all vulnerable to market logics), public hospitals, government health departments, health ministers, not-for-profit sector agencies, and community activists and advocates. This article shows that while solutions to problems can come from all quarters, it is the last group to whom the responsibility for keeping improved access to abortion at the forefront of the public agenda will inevitably fall.

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Australia: Abortion and Human Rights

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Abstract

This article adopts a human rights lens to consider Australian law and practice regarding elective abortion. As such, it considers Australian laws within the context of the right to equality, right to privacy, right to health, and right to life. After setting out the human rights framework and noting the connected nature of many of the rights (and their corresponding violations), the article shifts its focus to analyzing Australian law and practice within the framework of these rights. It considers the importance of decriminalizing abortion and regulating it as a standard medical procedure. It discusses the need to remove legal and practical restrictions on access to abortion, including financial obstacles and anti-abortion protestors. Further, it comments on the importance of facilitating access; for example, by keeping accurate health data, securing continuity of health care, increasing the availability of medical abortion, and ensuring appropriate care is provided to the most marginalized and vulnerable women.

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Introduction: Human rights and a "fair go"

In Australian vernacular, a "fair go" is about equality and non-discrimination, and is part of the Australian ethos. Australia is signatory to many international conventions that embody the concept of giving everyone a "fair go." We argue that Australian women do not receive a "fair go" regarding elective abortion.

International human rights law does not recognize a stand-alone right to abortion. However, the right to terminate a pregnancy falls within many recognized human rights; for example, depending on the circumstances, restrictions on abortion may be viewed as violating the: right to life; right to health; right to privacy/autonomy; right to equality/freedom from discrimination; and right to be free from torture or cruel, inhuman, or degrading treatment or punishment.[1] The relationship between unsafe abortion and maternal mortality underpins the argument that restrictions on abortion violate the right to life.[2] We argue that a woman's right to decide matters relating to her own body (such as the right to elective abortion) form an integral part of the right to: privacy, autonomy, liberty, and physical integrity, as well as the right to decide the number and spacing of one's children.[3] The view that laws restricting abortion services violate a woman's right to be free from gender-based discrimination is often based on the assessment that laws restricting access to abortion are informed by discriminatory assumptions about women and that the effect of such laws is to further entrench women's unequal status in society.[4] In addition, the argument that restrictions on abortion constitute torture or cruel, inhuman, or degrading treatment is based on the suffering that some women may experience if they are denied access to abortion services or access unsafe abortion services.[5] Many of these arguments are interrelated. Accordingly, while the international human rights law relating to abortion is not clear-cut, it recognizes, at least in certain circumstances, the importance of decriminalizing abortion as well as the need to both remove barriers to the accessibility of abortion and to ensure that access is provided.[6] Further, it should be noted that Australia has ratified the majority of international human rights treaties, thereby binding itself to their terms under international law (though not necessarily incorporating them into domestic law).

In Australia, elective abortion is regulated at the state and territory levels, though it should be noted that certain issues, such as Medicare funding for abortion and the inclusion of mifepristone and misoprostol on the Pharmaceutical Benefits Scheme, are regulated at the federal level.[7] The Australian government subsidizes many medicines to make them affordable to citizens through the Pharmaceutical Benefits Scheme (PBS) and this scheme is used by both private and public patients. One of the consequences of abortion being regulated predominantly at the local state level is that the following issues, which are engaged by the human rights norms discussed above, are addressed differently between the jurisdictions:

- decriminalization of abortion;
- removal of barriers to the accessibility of abortion, including "safe access zones" around clinics and the obligation on doctors to refer; and
- impediments to access, such as access for marginalized women, availability of medical (as opposed to surgical) abortion, prescribed settings where abortions may occur, and consent requirements.

These issues are discussed and related to the following four rights which they engage most relevantly within the Australian landscape: right to equality, right to privacy, right to health, and right to life. It should be noted that many issues may fall within several categories. For example, safe access zones protect women's right to health, right to privacy, and possibly their right to equality. Therefore, while this article discusses the different issues in the context of (what the authors view as) the most "relevant" right, other human rights may also be applicable.

Right to equality and to be free from discrimination

Regulating abortion as a standard medical procedure

In Australia, a number of jurisdictions have decriminalized abortion. The most recent reform occurred on March 21, 2017, when the Northern Territory Parliament voted to repeal Section 11 of the Medical Services Act 1982 and replace it with the Termination of Pregnancy Law Reform Bill 2017, a more progressive piece of legislation.[8] When this law comes into force, abortion will be decriminalized up to 23 weeks' gestation. Abortion was decriminalized in the Australian Capital Territory in 2002, Victoria in 2008, and Tasmania in 2013.[9] Abortion remains a crime in South Australia, New South Wales, and Queensland.[10] Where abortion has been decriminalized, it may nevertheless be subject to certain requirements, such as temporal requirements, but breaches of such temporal requirements do not carry the risk of criminal sanction. Western Australia is an anomaly in that elective abortion remains a crime technically but is available legally on request up to 20 weeks' gestation.[11] Thus in Northern Territory, Victoria, Tasmania, and Western Australia, abortion is legally available up to a certain stage of gestation without the need for a specific justification. Only the Australian Capital Territory does not prescribe such a temporal limitation on the legal availability of abortion services. This is significant for a number of reasons.

First, it means that only the Australian Capital Territory regulates abortion in the same way as any other medical procedure. All other jurisdictions, even those that have decriminalized abortion, nevertheless treat it differently to other medical procedures, where the requirements are a patient's informed consent and the clinicians' professional willingness. Accordingly, aside from the Australian Capital Territory, even in those jurisdictions where abortion has been decriminalized there remains a discriminatory component to the regulation which is inherent in the reality that elective abortion is deemed to be different from other medical procedures. This also reinforces the stigma attached to abortion (and the negative health sequelae that may flow from such stigmatization).[12] Differential regulation between an aspect of health care needed only by women and all other forms of health care, and its related stigmatization, is itself a form of discrimination against women.

Secondly, the fact that only the Australian Capital Territory does not prescribe a temporal limitation on the legal availability of abortion services without the need for a specific justification is also significant because such regulation means that there is no need for a "health exception." In all Australian jurisdictions, elective abortion is available where the pregnancy poses a risk to the physical or mental health of the woman, though the permissibility of abortion in broader circumstances varies between jurisdictions. From one perspective, the availability of elective abortion where continuation of the pregnancy is deemed harmful to the woman's health is positive for women, as it provides an avenue for access to legal abortion where it may otherwise be a crime. Such a position is, however, problematic in that it empowers doctors to determine whether a woman should be permitted to terminate her pregnancy thereby, enabling doctors to become the gatekeepers to legal abortion and concomitantly rendering women vulnerable to doctors who hold beliefs that demonize abortion. This conflicts with general medical practice where the ultimate decision maker is the patient, not the doctor. Such a discriminatory approach deprives women of their agency and autonomy and constructs them as incapable of making important and rational decisions.[13] This is particularly the case given that in most circumstances doctors rely on the *mental* health exception to enable their patients to access abortion services, which may lead to women being required to engage in unnecessary counselling from psychologists or referrals to psychiatrists.[14] Australian doctors are aware of this antiquated and non-evidence-based practice and note the complex decision-making processes that

doctors go through when deciding whether women are eligible for a lawful termination.[15] The manufacturing of existing or potential mental distress in order to stay within the limits of the law is commonplace for doctors in Queensland and New South Wales and means that they practice defensively in order to avoid prosecution from vague laws.[16]

Furthermore, there are very few instances where *two* doctors are required by law to make medical decisions; the only other area of health with this requirement is when the patient is mentally incompetent. Two doctors are required by law to certify mentally ill or mentally impaired patients and detain, restrain, or administer treatments. In the same vein, in the context of abortion the authorization of two medical practitioners is required in certain circumstances in Victoria, South Australia, West Australia, the Northern Territory and Tasmania.[17] These laws are inconsistent throughout the country and out of step with contemporary health care, and the established laws and procedures of consent that exist in Australia in relation to other aspects of health care. Once again, this phenomena of treating abortion differently to other forms of health care is inherently discriminatory.

Another area where elective abortion is treated differentially from other types of medical procedures is the need for hyper-observation. By this we mean that the patient is regarded as unreliable or incompetent in some respect. Generally, patients are prescribed medications and given the autonomy to take them at will; the health practitioner rarely stands over to observe. In early medical abortion up to nine weeks, the initial Royal Australian and New Zealand College of Obstetricians and Gynaecologist (RANZCO&G) guidelines for 2012 to 2015 included the recommendation to directly observe the patient take mifepristone and misoprostol.[18] This required the woman to make several visits to the doctor's practice with the associated inconvenience, increased cost, and risk of miscarriage during travel. The current RANZCO&G guidelines have removed the requirement that misoprostol be administered in the presence of the doctor as it had no evidence base but remain silent on whether mifepristone should be administered with a doctor watching.[19] With the requirements in some jurisdictions that abortion procedures occur only in a special facility hospital setting, this has led to confusion about the timing and location of treatments. For example, women have been required to travel to specific locations at specific times to be observed swallowing the medication(s). Misoprostol and mifepristone are not toxic substances to adults and are not dangerous or addictive medications that require a doctor to observe ingestion.[20] There are very few occasions where Australian patients are not entrusted to manage their own medications responsibly; these include pediatric patients, and patients who are mentally unwell, intellectually impaired, or addicted to drugs. There is no recorded case in Australia of a woman misusing her abortion medications that would suggest a need for hyper-observation. The requirement that abortions be carried out in an approved medical facility is one which was presumably intended to protect women undergoing surgical abortions, but is outdated and potentially harmful in the context of the availability of medical abortion.

The above discussion provides numerous examples of the differential treatment that the law accords to abortion as against other forms of medical treatment. Given that abortion is an aspect of health care required only by women, such differential treatment constitutes a form of discrimination against women. Only when abortion is regulated as a standard medical procedure will women achieve true equality in the context of access to health care.

Financial obstacles to health care

Each year in Australia, there are an estimated 85,000 abortions for a population of 23 million people or, put another way, an abortion rate of 19 per 1000 women; these numbers are declining slowly.[21] The 1970s saw significant social change and the implementation of safe, hygienic abortion procedures through the provision of universal health insurance (formerly Medibank and now Medicare) for the clinical cost of abortion services. However, the supply of public health clinics does not meet demand for elective abortions, which is met by private clinics charging fees well above that of the univer-

sal insurance rebate. Therefore, abortion services in Australia are provided by both the public and private health systems. In South Australia and the Northern Territory, the public health system provides the majority of elective abortions but these jurisdictions account for only a small percentage of the Australian population. Most abortions in Australia are performed in the private sector for profit with patients still paying above private insurance fees; with prices ranging from A$4400 to A$800 for a first-trimester termination and significantly more with later gestation.[22] This means that despite Medicare rebates and private insurance rebates women are left to cover the gap in health fees which may be hundreds of dollars. Consequently, there is a gradient of socio-economic access to reproductive health services that is inequitable and thus breaches the right to equality (as well as the right to health).[23] The price of a combined packet of mifepristone and misoprostol obtained through the Pharmaceutical Benefits Scheme is currently A$38, but the fees charged by health providers often range from A$250 to A$580.[24] These fees may be for screening tests, analgesics, anti-emetics, and information and counselling, which are time consuming. Thus, cost may pose a barrier to access, particularly for the most vulnerable women, thereby calling into question the extent to which abortion services are equally available to all Australian women.

Right to privacy

In Australia, jurisdictions have begun to recognize the importance of protecting the privacy of women seeking to enter clinics and of safeguarding them from harassment and intimidation. Accordingly, since 2013, Tasmania, the Australian Capital Territory and Victoria have introduced legislation providing for safe access zones around clinics providing reproductive health services.[25] The newest Northern Territory Termination of Pregnancy Bill (2017) includes similar provisions.[26]

Drawing on Victoria's 2008 abortion law reform efforts, Tasmania in 2013 also decriminalized abortion and became the first Australian jurisdiction to introduce safe access zones. The Tasmanian legislation prohibits protesters from harassing patients within 150 meters of a clinic providing abortion services. The Australian Capital Territory, as the next Australian jurisdiction to take up this mantle, passed legislation in 2015 which, according to the explanatory statement, aims to ensure that "women can access the health facilities in privacy, and free from intimidating conduct."[27] Thus the desirability of protecting the privacy of patients entering and leaving these clinics was at the forefront of Parliament's intent in passing this legislation. Shortly thereafter, in November 2015, Victoria also passed legislation establishing "safe access zones" of 150 meters around a clinic at which abortion services are provided, in order to "protect the safety and wellbeing and respect the privacy and dignity of" people accessing those services as well as employees and others who enter the premises.[28] Once again, the need to safeguard women's privacy was an explicit motivation for the passage of this type of legislation. Most recently, in March 2017, the Northern Territory Parliament also established safe access zones of 150 meters.

The Fertility Control Clinic in East Melbourne, Victoria, provides a useful example of why the introduction of safe access zones in some jurisdictions constitutes an important step in protecting the privacy of women seeking to terminate a pregnancy. The Fertility Control Clinic was established in 1973 by Dr. Bertram Wainer, a doctor and advocate of the decriminalization of abortion. It provides a range of reproductive health services, including contraception, pap smears, sexually transmitted infection testing, treatment of miscarriages and abortion (medical and surgical). Once it became apparent that women could have an abortion without further harm, anti-abortion protesting in front of the clinic became commonplace. It has taken the form of verbal insults, offensive posters, dispensing of anti-abortion pamphlets, attempts to close clinics by surrounding premises and supergluing locks, as well as physical obstacles preventing women from entering the clinic. Further, the impediments to accessing legal remedies have meant that anti-abortion protesting has caused harm with impunity.[29] In 2015, the Fertility Control Clinic, frustrated by

Melbourne City Council's failure to act to prevent this harassment, initiated legal action against the council on the basis that the activities of the protestors constituted a nuisance and that the council is obligated to remedy such a nuisance. The action was unsuccessful as the court decided that the council had the power to decide not to act to bring an end to the protesting.[30] It is against this backdrop that the Victorian State Parliament passed legislation preventing anti-abortion protesting from taking place within 150 meters of a clinic providing abortion services. Thus, when introducing the bill into Parliament, the Minister for Health noted that "This bill acknowledges that Victorian women have a right to access legal reproductive services without fear, intimidation or harassment. Women also have a right to access these services without having their privacy compromised."[31]

There are those who argue that the access zone laws should be struck down because they infringe the protestors' right to free speech.[32] It should be noted that in Australia there is no constitutionally entrenched right to free speech. However, the possibility of a High Court challenge has been raised on the basis that the access zones infringe the freedom of political communication that the High Court has held to be an implied right in the Australian Constitution.[33] This is highly debatable; in order to make a case for constitutional invalidity it would need to be established that the laws both impose a burden on political communication and fail the "compatibility testing" and "proportionality testing" requirements.[34] Unless such a challenge is mounted, it is not possible to predict precisely what approach the High Court would take, particularly given the subjectivity inherent in the test for constitutional validity. At the international level, the International Covenant on Civil and Political Rights (ICCPR) enshrines the right to free speech but provides that this right may be limited to respect the rights of others or to protect public health.[35] Similar provisions exist in Victoria, where the Charter of Rights provides for freedom of expression but allows it to be limited for the "protection of public health," and in the Australian Capital Territory, where the Human Rights Act stipulates that rights may be subject to reasonable limits.[36]

We believe that safe access zones play an important role in securing women's right to health/right to access appropriate health care. When discussing the effects of anti-abortion protests, Dean and Allanson, for example, observe that "such intimidation, harassment and intrusion of privacy can cause psychological or physical harm, especially when those targeted may already be under stress or anxious about an impending operation, an unplanned pregnancy, or a health-related medical or counselling appointment."[37] Safe access zones therefore play a significant role in protecting women's right to privacy and right to health.

Right to health

On March 4, 2016, the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR) released General Comment 22, focusing on the right to sexual and reproductive health.[38] In this comment, the committee recognized that the "right to sexual and reproductive health is an integral part of the right to health enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights" (as well as other international human rights instruments).[39] The inclusion of the right to reproductive health as part of the general right to health is not particularly ground-breaking. However, UNCESCR's explicit inclusion of the right to elective abortion as forming a part of the right to reproductive health and consequently the broader right to health, is representative of a gradual willingness to acknowledge the importance of securing a woman's access to safe and legal abortion services as a core component of her right to attain the highest attainable standard of health. The tenor of General Comment 22 makes it clear that the decriminalization of abortion is not on its own enough to ensure that women's right to health is adequately safeguarded; the provision of access to services and the removal of impediments to access are also essential to securing the protection of women's right to reproductive health.

In Australia, 30% of Australians live in rural or remote locations with limited access to, and op-

tions for, health services. Some additional barriers to reproductive autonomy are: moral opposition and harassment; lack of special medical training; insufficient staff and hospital workforce; geographical distance to services; stigma and financial costs.[40] While legislation cannot ameliorate many of these barriers, it should not enable the infringement of human rights. Novel approaches such as telehealth overcome the barriers of distance, costs associated with traveling to services, finding a specialized abortion provider, avoiding conscientious objectors, and curbside harassment.[41] Telehealth is the provision of health services when the doctor and patient are not in the same room, often by way of telephone or videolink. Yet some Australian legislation (such as the laws in South Australia) is interpreted to bar the provision of abortion services via telehealth. The below discussion considers some of the difficulties as well as positive aspects of Australia's approach to facilitating women's access to abortion services.

Access to accurate health data

In Australia, a lack of health data stymies the making of evidence-based clinical guidelines or health policies regarding elective abortion.[42] There is no systematic collection of health data at a federal level or policy directive regarding abortion, as there is for blood borne diseases or cervical pap screening for example, where national level health directives are implemented at the state level using state level data analyzed with a nationwide focus.[43] Only two jurisdictions, South Australia and Western Australia, collect data on elective abortion systematically, through acts of parliament reporting for about 18% of the population.[44] Abortion data can be useful as it is an indicator of women's health at a population level. It informs public health planners about the effectiveness of sexuality education and the accessibility and acceptability of contraception coverage and potentially the fertility outcomes of a population.[45] This theme recurred during the Northern Territory abortion law reform process, where various stakeholders called for public health data in order to understand the magnitude of need, or indeed denounce that there was a need, for better access to health services.[46] The Northern Territory data was outdated and lacked the nuances sought by stakeholders for decision-making during the legislative reform process.[47] The reformed law now has a provision which requires that abortions be reported to the chief health officer; this may go some way to the collection of relevant health data and the achievement of the right to the highest standard of health care.

The data and policy vacuum means that conservative forces can incite moral indignation with impunity. Australian experience with neo-conservatives during the 2000s exemplified this; certain politicians publicly suggested that there were too many abortions of convenience with the inevitable tropes against irresponsible and selfish women.[48] It is difficult to mount a rebuttal when the exact numbers are simply unknown and inferred through complex guessing. The *Sydney Morning Herald* reported, for example:

> *Deputy Prime Minister John Anderson says he agrees that too many abortions are carried out each year. "Many of us think that they (fetuses) are potential fellow Australians and that some people don't think through carefully enough their responsibilities before they fall pregnant, frankly."*[49]

As data is not collected systematically or analyzed, a parliamentary research brief in 2005 was unable to enumerate an accurate incidence of elective abortion; it found an imperfect system of information collection and pointed to better ways to obtain information—none of which have been implemented.[50]

Health providers as barriers to appropriate health care: conscientious objection

The emphasis on securing access to safe and legal abortion services is reflected in Australian laws requiring doctors with a conscientious objection to abortion to refer the patient to another practitioner who does not hold a conscientious objection. In Tasmania, Victoria, and now the Northern Territory, the legislation includes a provision for doctors to conscientiously object to participating in an elective abortion, outside of an emergency.[51] However, the law in these jurisdictions stipulates

that a doctor must provide a woman who might be considering a termination with information about where she can go to receive unbiased information about her options.[52] These provisions have been controversial, particularly because of outsourcing of health services and medical training to religious organizations, especially Roman Catholicism. Medical and nursing students trained in Catholic universities and hospitals, both private and public, require their staff to turn away women seeking abortion; this is both discriminatory and a violation of the right to health.

Further, at the time of the Victorian law reform, the archbishop of Melbourne threatened to close the maternity departments in Catholic hospitals should these provisions remain in the legislation; this threat was not carried out.[53] Others have argued that doctors should be compelled to provide abortion services as part of their professional obligations. For example, Fiala and Arthur argue that refusal to provide a key medical service should be characterized as "dishonourable disobedience" rather than "conscientious objection."[54] Further, the obligation to refer does not in practice necessarily translate into an obligation to refer without delay, a key consideration in circumstances like abortion where time is imperative. The importance of ensuring continuity of health care is demonstrated by the position adopted in a number of the medical profession's ethical codes and guidelines, such as the International Federation of Gynecology and Obstetrics, the World Medical Association, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Australian Medical Association, though interestingly, similar provisions are not found in Australian nursing or midwifery position statements.[55] Finally, it is notable that while the legislative requirement on doctors is an important step, it is unclear whether (and if so to what extent) it operates on the ground.

Availability of medical abortion

Medical abortion with mifepristone and misoprostol has had a convoluted, politicized, and overly bureaucratic entry into Australia.[56] These cheaper, effective, safe medications should theoretically be available to women at a primary health care level from doctors in general practice, but PBS data reveal very few prescriptions for mifepristone/misoprostol for terminations. For example, in 2015, there were 11,332 recorded prescriptions for medical abortion; given that there are approximately 85,000 terminations annually, this means that only an estimated 13% of all terminations were performed primarily using medications and not surgical methods.

Despite elective abortion being lawfully available for decades, the failure of laws to keep pace with medical and scientific developments inhibits women's equitable access to the highest possible standard of health care. Of particular concern is South Australian law, which restricts the prescription of medical abortion.[57] The Northern Territory, which voted to reform its law in March 2017, had previously criminalized and restricted access to medical abortion.[58] That said, section 11 of the Medical Services Act (MSA) provided that it was lawful for a medical practitioner "to give medical treatment with the intention of terminating a woman's pregnancy" in certain circumstances.[59] The problem, however, was that in the 1974 bill, "medical treatment" was defined to include all forms of surgery, but not medications. The MSA also specifically provided that the treatment was given in a hospital and included other restrictive provisions relating to consent and that opinions for treatment be formed by a gynecologist/obstetrician, thus limiting clinical treatment and type of provider and location. Similarly, South Australian law restricts abortion 'treatment' to prescribed hospitals, only five of which have established medical abortion services.[60] These differences in clinical practice do not directly relate to the vintage of the legislation in each jurisdiction, rather the overly prescriptive definitions and interpretation of law that is out of step with clinical practice. For example, Queensland has the oldest unreformed law, yet medical abortion is prescribed in this jurisdiction (though it should be noted that the 2010 case of *R v Brennan and Leach* involved a prosecution for medical abortion).[61]

These health care services are funded by federal health insurance and medications are subsidized as previously explained. Nevertheless, an increasing

number of women fall outside the safety net of the public health system due to limited space, and pay high prices for either medical or surgical abortions, which breaches the right to equality and freedom from discrimination as well as the right to health.[62]

Right to life

The right to life in this context refers to women's rights to survive pregnancy, childbirth, and motherhood. It is beyond the scope of this article to consider arguments related to the right to life of the fetus. Australia has very low rates of maternal mortality and morbidity due to a generally wealthy and healthy population, access to comprehensive skilled maternity care, and small-sized families stemming from high acceptance of contraception. The ability to not be pregnant and or have an abortion prevents maternal mortality by the fact that vulnerable women do not get pregnant or give birth in the first instance. Fertility management in the form of modern contraception, backed up by elective abortion, is a key way to reduce maternal mortality by preventing pregnancy and birth and hence deaths related to reproduction. Pregnancy and birth are a greater risk to women's lives than elective abortion.

Maternal deaths are recorded well in Australia and the following information is drawn from a national report over five years.[63] On average, 21 women die each year due to pregnancy and childbirth in Australia. From 2008 to 2012, there were 105 deaths resulting from complications from pregnancy and childbirth; 16 indirect maternal deaths were due to psychosocial reasons, including suicide.[64] That mental health and social problems have led to the deaths of Australian women means that some women are particularly vulnerable during pregnancy. One example is the link between domestic violence and poor reproductive health outcomes.[65] The lack of reproductive autonomy experienced by Australian women is unknown, but one study found that intimate partner violence is a strong predictor of termination of pregnancy among young Australian women and proposed that prevention and reduction of partner violence may reduce the rate of unwanted pregnancy.[66] The authors of the maternal deaths report note that psychological screening is equally important in antenatal and postnatal care.[67] Deaths during the first 14 weeks of pregnancy are not well recorded in Australia; however, the national report records 15 maternal deaths in the first trimester and found these were largely due to ectopic pregnancies, thromboembolisms, and cardiac and psychosocial events. No woman died as a direct result of an elective abortion.[68]

Indigenous women have higher rates of maternal morbidity and mortality than non-indigenous women, reflecting the gradient of inequity in health care and the burden of background illness. The indigenous maternal mortality ratio was 14/100,000 women who gave birth, as compared with 2/100,000 for non-indigenous women. During the same period 2008 to 2012, 12 indigenous women died due to direct or indirect causes related to pregnancy and childbirth and none directly due to an elective abortion.[69] Indigenous women often do not have the same access to reproductive health services as other Australian women, and they suffer from relative social disadvantage and poverty that impacts on their health outcomes. Access to fertility management and abortion services are therefore important to women's health.[70] For some Australian women, access to termination of pregnancy will save their lives.

Conclusion

This article considers Australian abortion laws in the context of human rights law and uses examples from clinical practice. Specifically, it considers the extent to which Australian laws may violate or protect the right to equality, right to privacy, right to health, and right to life of a woman faced with a problematic pregnancy. The first step towards protecting the rights of such women is the decriminalization of abortion, which has occurred in a number of Australian jurisdictions. As illustrated by the situation in New South Wales, South Australia, and Queensland, while abortion remains a crime, other protective measures remain out of reach. Accordingly, measures such as safe access

zones or provisions requiring doctors with a conscientious objection to ensure continuity of care have only been enacted in jurisdictions which have decriminalized abortion (at least to some extent). Therefore, the authors submit that as a first step to safeguarding the human rights of Australian women, all Australian jurisdictions must decriminalize abortion. Other significant steps (which have already been initiated in some jurisdictions) include: regulating abortion as a standard medical procedure and removing restrictions on access to abortion; removing financial obstacles to access; establishing safe access zones; ensuring the collection and analysis of accurate health data; securing continuity of health care; increasing the availability and affordability of medical abortion; and ensuring that appropriate care is provided to the most marginalized and vulnerable women.

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Abortion Care in Nepal, 15 Years after Legalization: Gaps in Access, Equity, and Quality

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Historical context

Reproductive rights are considered to be an inseparable part of women's human rights and within that the right to abortion is seen to hold an important place.

—Lakshmi Dhikta v. Nepal, Supreme Court of Nepal, 2009[1]

Nepal is often heralded as a model of the successful implementation and rapid scale-up of safe abortion services. Prior to 2002, Nepal had very restrictive abortion laws that prosecuted and imprisoned women and their family members for undergoing pregnancy terminations. Up to one-fifth of incarcerated women were convicted for abortion-related crimes.[2] Despite the restrictive laws and legal implications, many unsafe abortions were still performed by untrained providers throughout the country.[3] Government data from 1998 indicated that 54% of gynecologic and obstetric hospital admissions were due to unsafe abortions.[4] Data from one hospital-based study attributed more than half of maternal deaths during the one-year study period to abortion-related complications.[5]

Nepal legalized abortion in 2002 in response to advocacy efforts that emphasized the high rates of maternal morbidity and mortality attributed to unsafe abortions. First-trimester surgical abortions were made available throughout the country in 2004. Second-trimester abortion training began in 2007, and medical abortions were introduced in 2009. The law permits abortion with the consent of the pregnant woman for any indication up to 12 weeks' gestation and up to 18 weeks' gestation in cases of rape and incest. Abortion is legal at any gestational age if a medical practitioner declares that the women's mental or physical health is at risk or that the fetus is deformed. In cases of women who are younger than 16 or are not mentally competent, consent of the woman's nearest relative or immediate guardian is required.[6]

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The landmark 2009 Supreme Court decision in *Lakshmi Dhikta v. Nepal* not only reinforced the right to abortion but also emphasized that access to abortion is a human right. The case centered on a poor, rural woman who was forced to give birth to her sixth child due to her inability to afford the required fees for an abortion (approximately US$20). The decision outlined that abortion should no longer be a criminal matter regulated under criminal law but rather an issue of women's human rights that warrants protection under a comprehensive, special piece of legislation.[7] The court stated that abortion rights are a part of reproductive rights and essential to realizing the right to self-determination. Forced pregnancy constitutes violence against women and may become a cause of inequality between men and women. The court held the government accountable for building the necessary institutions and implementing policies to make abortion services affordable and accessible.[8]

Implementation of safe abortion services

Strong government leadership established the foundation for safe abortion service implementation in Nepal. This leadership engaged the Abortion Task Force, a multisectoral task force of public and private stakeholders, including national and international nongovernmental organizations, to develop policy and key strategies for training and implementation. The Nepal Society of Obstetricians and Gynaecologists provided important technical support in the development of standardized protocols and training guidelines. The Abortion Task Force was dissolved in 2004 and replaced by the Technical Committee for Implementation of Comprehensive Abortion Care. This committee worked to ensure that abortion policy was grounded in public health and scientific evidence, and adapted accordingly as new data emerged.[9]

Nepal's Safe Motherhood Initiative, launched in 1997, was well established by the time abortion was legalized, and it put in place systems for post-abortion care. There was a cadre of providers already familiar with manual vacuum aspiration, the main technique used for both post-abortion care and surgical abortions.[10] During the initial implementation of safe abortion services in 2004, however, only physicians were trained in safe abortion practices. Family planning literature from several other countries provided data on the safety and efficacy of shifting abortion care to mid-level providers.[11] In response, Nepal decentralized services by training nurses and auxiliary nurse midwives as providers. Since 2008, mid-level providers have been authorized to provide manual vacuum aspiration up to eight weeks' gestation. Auxiliary nurse midwives have been providing medical abortions since 2009.[12]

Fifteen years after legalization, safe abortion services are present in all 75 districts. Currently, there are over 2,000 trained providers, and between 2011 and 2016, over 2,000 trained providers, and government data between 2011 and 2016 reported over 400,000 abortions were performed at legal, safe abortion sites.[13] Maternal mortality in Nepal decreased from 548 deaths per 100,000 live births in 2000 to 258 deaths per 100,000 live births in 2015.[14] It is unclear exactly how much of this decline can be attributed to abortion legalization, as data show a decline in maternal mortality beginning in 1995, even prior to legal abortion.[15] The data, however, do support the conclusion that since legalization there has been a downtrend in the proportion of serious complications, including septic abortions, relative to all abortion-related complications. This decline was most markedly seen during 2007–2010.[16]

Abortion legalization in many ways posits a paradigm shift in Nepal: women's reproductive rights are now recognized as fundamental human rights, and abortion is constitutionally protected.[17] Despite the legal reforms, however, further improvement in protocols and infrastructure is necessary to ensure that all women truly have equal access to affordable services. Second-trimester services, for example, remain extremely limited, with many women still lacking access. Moreover, abortions by illegal or uncertified providers remain prevalent.[18] This paper discusses such challenges to safe abortion implementation in Nepal, 15 years after legalization, where gaps in access, equity, and quality threaten the realization of reproductive rights.

Gaps in access

Second-trimester services

Globally, only about 10% of abortions take place at or after 13 weeks' gestation. Risk factors for second-trimester abortions include lack of access to early care, late recognition of symptoms of pregnancy, adolescence, poverty, lack of awareness of abortion laws, substance use, fear of stigma, fetal anomalies, and maternal medical conditions.[19] Data indicate that even in settings with high access to first-trimester services, the rate of second-trimester procedures remains relatively stable over time, indicating an ongoing need.[20] While great strides have been made to improve access to first-trimester services in Nepal, access to second-trimester services remains more restricted. Given that women who seek second-trimester abortions are often the most vulnerable and socially disadvantaged, it is imperative that policies focus on expanding equal access to second-trimester services.

The Government of Nepal initiated second-trimester abortion training in 2007, and services grew eightfold from 2007 to 2012.[21] As of 2014, there were 22 hospitals providing second-trimester abortions.[22] Forty-six providers had been trained and over 1,800 women had been served.[23] While the initial rollout appeared promising, there have been delays in training additional providers and expanding services. Provider training for second-trimester abortions were temporarily discontinued in 2015, in part due to controversial sex-selective abortion cases, and resumed only in January 2017.

Government-imposed requirements for facilities providing second-trimester abortions (both medical and surgical) have contributed to the slow scale-up. These regulations mandate that certain resources be made available, including 24/7 comprehensive emergency obstetric and neonatal care, a functional operating room, blood transfusion services, and obstetric providers capable of providing caesarean sections.[24] In contrast, international safe abortion guidelines state that second-trimester abortions can be safely provided in both hospital and outpatient clinic settings, as long as these facilities are properly equipped and have clear referral mechanisms in place for emergencies. These international guidelines recommend that second-trimester sites have at least the same basic facilities as those required for first-trimester procedures, and there are no stipulations for transfusion services or comprehensive emergency obstetric and neonatal care.[25] The Government of Nepal's regulations impose standards for second-trimester abortion services that are not required of other medical procedures of similar acuity and risk imposing burdens that many facilities, including some government district hospitals, cannot bear. Accordingly, these regulations likely do not provide safer services for women but instead may hinder the decentralization of services and further limit access.

Sex-selective abortion

The introduction of second-trimester abortions has heightened concerns around sex-selective abortion. The drivers of sex-selective abortion are complex. Deeply entrenched societal gender discrimination manifests in religious beliefs that value men more highly than women and in inheritance and land rights laws that favor men. Additionally, the dowry system in Nepal forces economic hardships on parents with daughters.[26]

In Nepal, the law explicitly prohibits abortion for sex selection and restricts the use of antenatal technology to determine fetal sex.[27] However, with increased access to ultrasound services and a higher prevalence of routine ultrasonography during antenatal care, this law is rarely enforced effectively. Women may obtain an illegal sex-determination ultrasound at one clinic and then go to a different facility for their abortion. It is difficult to determine the true number of women who present for sex-selective abortions, as women's decision making and indications for pregnancy termination are complex and multifaceted. In one qualitative study, providers expressed concerns that women were being denied abortion services. The providers acknowledged social pressures on women to bear sons and feared that women who are denied sex-selective abortion may turn to unsafe termination alternatives.[28]

There is inherent tension between support for unrestricted abortion access and opposition to sex-selective abortion. Efforts to reduce sex-selective abortion may affect efforts to improve access to abortion services. It is critical, however, to recognize that while abortion access and sex selection are two separate and independent issues, they are both manifestations of systems that perpetuate gender inequality. Broader anti-discrimination initiatives and comprehensive efforts to address women's rights and gender-based violence are needed to address both issues simultaneously. Regulations that target one issue and not the other should be implemented with caution, as they risk disproportionately inflicting harm on the most socially disadvantaged women. These women face the greatest societal pressures to have male infants yet have the least access to abortion services and the most compromised right to self-determination.

Medical abortion services

Implementing first-trimester medical abortion services has been an important strategy to further expand abortion access, since medical abortion can be more easily provided in rural areas. Medical abortions now constitute over 50% of all abortions in Nepal.[29] Facilities providing first-trimester medical abortions do not need to have surgical abortion capacity.[30]

Studies have demonstrated that first-trimester medical abortions can be safely provided by mid-level providers, such as auxiliary nurse midwives, even in remote health care clinics.[31] Auxiliary nurse midwives working in the public sector who are trained as skilled birth attendants are authorized to provide medical abortions. Many private sector auxiliary nurse midwives, however, are not trained as skilled birth attendants and are therefore not authorized to provide medical abortions.[32] A commitment to scaling up the role of both public and private auxiliary nurse midwives in abortion care can further decentralize abortion services and improve access in remote areas.[33] Similarly, the expansion of medical abortion for second-trimester abortions may also improve access in remote rural areas where there are no trained surgical providers available. Based on the 2016 Safe Abortion Service Guidelines, however, second-trimester medical abortions can be performed only in facilities with comprehensive emergency obstetric and neonatal care, which includes surgical staff.[34]

Preventing medication stock-outs at remote health care facilities is critical. In some areas, the supply chain for medical abortions has been poorly managed and there are reports of women being denied legal abortions due to a lack of abortion medications.[35] This has been further complicated by the black market for medical abortion medications, especially along the Indian border.[36] These medications are often of unclear quality, dosage, and efficacy, and, as a result, may lead to abortion complications.[37]

Private pharmacies have emerged as a prevalent dispenser of medical abortion medications, although most pharmacists are not approved by the government to do so and have not had adequate training on medical abortion counseling.[38] Increased efforts to regulate, train, and support pharmacists to provide medical abortions may help reduce illegal abortions, further decentralize services, and improve access to appropriate medications. Pharmacies in most rural communities have successfully delivered other reproductive medications, including oral contraceptive pills, condoms, treatment for sexually transmitted infections, and emergency contraception.[39] Strengthening partnerships and referral systems between community pharmacists and clinic providers may be an important opportunity to improve access. As the demand for medical abortion continues to increase, it will be imperative to invest in parallel efforts, such as task shifting, supply-chain management, and collaboration with community pharmacies, to ensure that these services are widely available, well regulated, and of high quality.

Post-abortion contraceptive services

Despite being included as a priority area in the National Safe Abortion Policy of 2003, post-abortion contraceptive update in Nepal remains low.

Population-based data from 2011 indicated only 56% of women who had an abortion within the previous five years used any contraceptive method during the first year post-abortion, and almost half discontinued their method within the first year.[40] A prospective study of four facilities providing legal abortions showed that one-third of women received no counseling on effective methods of contraception. Nulliparous women and women who were not currently living with their husbands were less likely to receive contraceptive counseling. Many women who desired a long-acting reversible contraceptive or permanent sterilization at a later time did not leave the facility with an effective short-term method to use in the interim. Only 44% of women who desired a long-acting reversible contraceptive at the time of abortion actually had the contraceptive placed within six months after the abortion. This study highlighted several gaps in post-abortion contraceptive counseling, follow-up, and access.[41]

The substantial increase in first-trimester medical abortions also presents new challenges for post-abortion contraceptive use. Some effective contraceptive methods, such as the intrauterine device, cannot be placed until the abortion has been confirmed complete; therefore, a follow-up appointment is necessary.[42] Follow-up, however, may be difficult for some women, especially those living in rural, mountainous areas. Medical abortions are also increasingly being provided at lower-level facilities, which typically offer only short-term contraceptive methods. Because discontinuation rates for short-acting methods in Nepal are high, improved access to long-acting reversible contraceptive methods is critical.[43] There is a need to increase the number of lower-level health care facilities equipped with long-acting contraceptive methods and trained providers who can place them. Better data on follow-up rates, women's preferences for contraceptive methods, and barriers to access can help guide improvements in service delivery. Access to the range of effective post-abortion contraceptive methods will contribute to lower rates of repeat abortions and the prevention of unintended pregnancies.

Gaps in equity

Geography

Nepal's diverse terrain creates geographic barriers that make the equitable distribution of services difficult. While first-trimester medical and surgical abortion services are available at the hospital level in all 75 districts, women in rural and mountainous areas still face barriers to access. In mountainous areas, women may be required to walk several days to access safe abortion services, which are available only at the district hospital.[44] First-trimester medical abortions are available at the health-post level (the second-lowest tier of Nepal's public health care system) in only 39 of the 75 districts.[45] These physical obstacles to access may cause women in remote areas to delay seeking services and present at later gestational ages. Second-trimester services, already limited nationwide, are even less accessible in rural, mountainous regions.

Cost, awareness, and stigma

In the past, government policies mandated a small fee—ranging from 800 to 1200 Nepali rupees (US$8 to 12)—for abortion. This cost did not include pain medications, antibiotics, gloves, or syringes.[46] Abortion was purposely separated from the package of free maternal care services, which includes ante- and post-natal care, contraception, and post-abortion care, out of concern that inclusion may promote abortion as a method of contraception.[47] While the landmark 2009 Supreme Court decision established the legal framework for the government to mandate free and accessible abortion services in the public sector, there was no policy to implement safe abortion services until the passage of the Safe Abortion Service Guidelines of 2016. Under these guidelines, all government facilities should provide free abortion services. However, the provider reimbursement scheme outlined in the guidelines is less profitable for providers than it was when women paid out of pocket.[48] It remains to be seen whether these new guidelines thus create monetary incentives that encourage providers to shift abortion provision from the public to the

private sector, thereby adversely affecting access at public facilities.

Additional barriers to equitable access include women's limited awareness of the availability and location of safe abortion services.[49] According to Nepal's 2011 Demographic and Health Survey, only 38% of women of reproductive age were aware of the legal status of abortion. Awareness of legal abortion was inversely related to wealth, with only 22% of women in the lowest wealth quintile recognizing the legal status of abortion.[50] This lack of awareness may lead women to pursue black-market sources for medications that are unnamed and whose dosages are unknown.[51] Indeed, despite the legalization of abortion and improvements in access to safe services, one study using indirect estimation methods calculated that of the 300,000 abortions performed in Nepal in 2014, nearly 60% were illegal procedures performed by unregistered providers.[52] Fear of stigma also prevents some women from seeking abortion services.[53] According to one study focused on young women, many such women do not seek abortion for an unintended pregnancy due to several factors, including partner and family influences as well as limited socioeconomic resources.[54]

Nepal has an established system of female community health workers who, if trained and engaged effectively, have the potential to improve early detection of pregnancy, awareness of legal abortion, and referrals to services. While this has been partially implemented in some districts with positive results, it has not yet been widely implemented.[55] Programs employing community health workers have successfully demonstrated that these workers can be trained to perform pregnancy tests and counsel on the prevention of unintended pregnancy, abortion law and rights, and how to access safe medical and surgical abortions.[56] By normalizing conversations around abortion laws and access, community health workers may be important change agents in improving awareness and decreasing stigma around abortion.[57]

Gaps in quality

Integration of abortion services into the health care system

The successful implementation and rapid scale-up of first-trimester abortion services can be partly attributed to deliberate efforts to integrate services into the existing health care system. Staff nurses and auxiliary nurse midwives were trained to provide services, while in some districts female community health workers were employed to disseminate information and provide referrals. The existing Health Management Information System was used for monitoring and evaluation. This monitoring system provided frequent updates on the state of services in the country (including service uptake) and complication rates. Policymakers and health officials were able to respond directly to data, perform frequent audits, and devise solutions to address ongoing challenges.[58] The centralized monitoring system greatly enhanced the government's ability to regulate service quality.

Second-trimester services, however, have not been as well integrated into the existing health care system. Currently, these services are not explicitly tracked in the government's Health Management Information System; therefore, there is limited up-to-date information on the state of service provision. Private facilities are not bound by the same requirements to monitor their service provision, nor are they required to provide routine data to the government.[59] Without real-time and transparent data, government officials are limited in their ability to effectively regulate and ensure service quality.

Recent policies passed by the Ministry of Health have also called into question the government's current and future commitment to integrate abortion services into mainstream health care provision. The ministry's Nepal Health Sector Strategy 2015–2020 is a comprehensive plan aimed at achieving universal coverage of essential health care services. It is a five-year plan that takes a multisectoral approach to reform the health care system, provide quality services, and improve equity. It lists

33 basic health care services that will be provided for free, as they are considered a "fundamental right guaranteed by the Constitution." The expansive list includes a range of services, from preventative care to mental health care. While maternal health care services, family planning services, and post-abortion care are listed, safe abortion services are notably absent from the list.[60] Free abortion services were later addressed through the separate Safe Abortion Service Guidelines of 2016.

It is difficult to predict the implications of this separation of abortion services from the remainder of basic health care services. It could lead to a lack of integration of abortion services with other reproductive health care services and to the development of separate, vertical programs. This silo effect could affect access and quality. Furthermore, it indirectly implies that safe abortion services are not included in the package of constitutionally protected health rights.

Impact of foreign aid

US foreign policy continues to influence the implementation of safe abortion services in Nepal. The Helms Amendment, passed in 1973, is a US law that limits the use of foreign aid for abortion "as a method of family planning."[61] As a consequence of this law, United States Agency for International Development (USAID) funding streams prevent the integration of abortion services into reproductive health care services. Many government and nonprofit clinics receiving USAID funding cannot provide abortions, and women seeking services at these clinics have to be referred to higher-level centers. The distance and cost of transportation to these higher-level centers often prevent women from accessing abortion services.[62]

USAID selectively supports post-abortion care and artificially separates it from comprehensive abortion care. While the same manual vacuum aspirator can be used to perform both abortions and post-abortion care, many USAID-supported clinics will perform only the latter while turning away women seeking services for the former.[63] These funding restrictions marginalize abortion services from the existing health care system and create clinics that provide less efficient care.[64]

Abortion services in Nepal will likely also be significantly affected by the recent reinstatement of the Mexico Policy, also known as the Global Gag Rule. While the Helms Act restricts the use of US funding directly for abortion services, the Global Gag Rule denies US funding to nongovernmental organizations that advocate, counsel on, or provide referrals for abortions, even if these activities are funded by other non-US donors and are performed in countries where abortion is legal. In the early 2000s, when the Global Gag Rule was active, several Nepali organizations rejected the terms of the rule and, in turn, suffered significant funding losses that resulted in program cutbacks and layoffs. The Global Gag Rule was rescinded by President Obama in 2009 and revived by the Trump administration in 2017.[65] While the full impact remains to be seen, the Global Gag Rule will likely create unnecessary barriers for women in Nepal who seek access to abortion services—services deemed by the Nepali government and courts to be legal and fundamental to the realization of a woman's reproductive rights.

Conclusion: Closing the gaps

Nepal has achieved considerable successes in the 15 years after the legalization of abortion, but many challenges remain. Women in many parts of the country continue to lack access to safe abortion services, especially second-trimester services. Given the important geographic barriers within the country, it will be critical to continue to prioritize the decentralization of services and increase the number of health-posts and sub-health posts with the capacity to provide first-trimester medical abortions. Additional efforts are needed to safely expand the provision of second-trimester abortions. Decentralization will need to be accompanied by an investment in technical support for providers in rural areas and referral networks to tertiary centers as needed. Early implementation successes offer valuable lessons on the importance

of data-driven, evidence-based policies and the integration of abortion services into existing health care provision in order to provide high-quality and responsive care. It will be important for policymakers and health officials to build on these previous successes in order to strengthen monitoring systems, react to data, and continue to innovate.

There are substantial data suggesting that the inclusion of additional health care personnel in abortion provision may help enhance abortion service delivery. Medical abortion access may increase with the inclusion of pharmacists as legal providers of the medications. Authorization of the role of pharmacists will also facilitate the government's ability to regulate, train, and ensure quality. Moreover, since many women prefer to seek care at private clinics, the inclusion of private sector auxiliary nurse midwives as medical abortion providers will be critical. Community health workers could also play important roles in improving awareness of legal abortion and the locations of safe services, as well as in beginning to address stigma around this issue.

To promote equitable access as ordered by the Supreme Court decision, safe abortion services should be safeguarded as a fundamental right. To do so, policymakers must begin by including abortion as a part of the package of basic health care services and integrating safe abortion services into the continuum of reproductive health care. The unmet need for post-abortion contraception continues to be an important missed opportunity, and improved access will be important for decreasing the number of unintended pregnancies. Furthermore, policies restricting sex-selective abortion need to be accompanied by broader initiatives to address structural forces that perpetuate gender inequality. Understanding the context in which policies are being implemented is paramount, and government policies need to protect the most marginalized and vulnerable women in society. By failing to understand the lived realities of women who are affected by restrictive abortion laws, we risk once again placing an undue burden on women and limiting their reproductive self-determination.

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EDITORIAL

The Case for International Guidelines on Human Rights and Drug Control

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This special section of *Health and Human Rights Journal* examines some of the many ways in which international and domestic drug control laws engage human rights and create an environment of enhanced human rights risk. In this edition, the authors address specific human rights issues such as the right to the highest attainable standard of health (including health protection and promotion measures, as well as access to controlled substances as medicines) and indigenous rights, and how drug control laws affect the protection and fulfillment of these rights. Other authors explore drug control through the lens of cross-cutting human rights themes such as gender and the rights of the child. Together, the contributions illustrate how international guidelines on human rights and drug control could help close the human rights gap—and point the way to drug laws and policies that would respect, protect, and fulfill human rights rather than breach them or impede their full realization.

Next year marks the 70th anniversary of the adoption of the Universal Declaration of Human Rights, the foundational instrument of the modern system of international human rights law, a system now underpinned by nine core UN treaties and multiple regional conventions. The growth of the international human rights regime has provided a critical tool to address the abusive and unaccountable exercise of state power. Multilateral treaties on drug control predate the foundation of international human rights law by several decades. Beginning with the 1912 International Opium Convention and evolving through a series of conventions adopted under the auspices of the League of Nations, drug control was already a well-established subject of international law by the time the UN General Assembly adopted the Universal Declaration in 1948, and the first UN drug convention in 1961.[1] The preamble of that treaty, the *Single Convention on*

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Narcotic Drugs, states that it is "concerned with the health and welfare of mankind," suggesting a public health-based context in which treaty provisions should be understood.[2] Over the last half-century, these two legal systems have exerted significant influence on state practice. Today, the impact of human rights norms can be seen in policy areas as disparate as warfare, terrorism, trade, intellectual property, the environment, and global health, while the three UN drug conventions influence—if not define—domestic drug control policy and law in almost every country of the world.

Both regimes have evolved and expanded over the course of the UN era. In the case of human rights, we have seen an increasing number of states ratify core instruments; an increasing diversity of the instruments themselves (both in terms of subject matter and regional specificity); and growth in the number and influence of UN and regional human rights courts and bodies. International law on drugs has also expanded. A second major treaty, the *Convention on Psychotropic Substances*, was adopted in 1971, bringing more substances under international control, and the *Single Convention* was amended by Protocol in 1972.[3] Over time, the punitive nature of the international drug control system also expanded and intensified, with criminal law being used to suppress drug use and drug markets. The third UN drug treaty, the 1988 *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, criminalized the entire drug market chain, from cultivation/production to shipment, sale, and possession (although this last obligation is subject to significant caveats, giving states leeway to refrain from criminalizing possession of scheduled substances for personal use).[4] The 1988 Convention includes not only offenses related to controlled substances, but also to precursors and money laundering.[5] The centrality of public health and welfare in the preambles of the 1961 and 1971 drug treaties is absent in the 1988 Convention, which is particularly significant given the ever-expanding evidence base on drugs, drug use, health, and development—evidence which should inform new approaches to drug laws and policies.

Drug control and enforcement activities are prime areas for human rights abuses, not least because, as Barrett and Nowak note, the very indicators of success for drug control efforts are also indicators of human rights risk, and in many cases are actual evidence of human rights violations committed in the course of enforcing various drug-related laws.[6] These indicators include the numbers of criminal offenses proscribed; people arrested and successfully prosecuted; people in detention; traffickers punished (including by execution in some states); people in drug treatment (both voluntarily and involuntarily); hectares of crops destroyed; and successful military operations against insurgents or criminal gangs.

The international drug control treaties contribute directly to this environment of human rights risk and violations.[7] The drug treaties are what are known within international law as "suppression conventions." Suppression regimes obligate states to use their domestic laws, including criminal laws, to deter or punish the activities identified within the treaty, and are therefore "important legal mechanisms for the globalization of penal norms."[8] However, while suppression treaties mandate all states to act domestically and collectively to combat crimes defined as being of international concern, they offer no obligations and little guidance on what is and is not an appropriate penal response. As a consequence, as Neil Boister notes, "the drug conventions...provide a broad framework and introduce a no-holds-barred ethos into domestic drug control."[9] Floors have been established with no ceilings. In many cases, this is an invitation to governments to enact abusive laws and policies, especially in a global context where drugs and drug trafficking are defined as an existential threat to society and the stability of nations, and people who use drugs and those involved in the drug trade are stigmatized and vilified.[10]

At an operational level, the UN exerts little energy toward ensuring that the domestic drug laws mandated by the treaties are drafted and implemented in a manner that safeguards human rights. The UN Office on Drugs and Crime (UNODC)

offers legal assistance to states to ensure their domestic drug laws comply with the terms of the UN drug control treaties. However, much less attention is paid to ensuring that such legislation is compliant with international human rights treaties and norms. The International Narcotics Control Board (INCB), the treaty body established under the drug conventions to monitor their implementation at the national level, routinely criticizes governments for what it considers weak enforcement of drug prohibition. This includes occasionally condemning the adoption of evidence-based measures to protect and promote health, despite this being a fundamental human rights obligation recognized in law by a large majority of the world's states. As recently as 2012, the INCB president publicly rejected the suggestion that the Board had any mandate or responsibility to comment on human rights violations resulting from the domestic drug enforcement measures the INCB itself encourages.[11] At the same time, the INCB has often dedicated little attention to encouraging states to fulfill the other major stated objective of the drug control treaties: ensuring access to controlled substances for medical uses, which is itself a matter of human rights.[12] This said, it should also be acknowledged that after years of campaigning by civil society, the INCB has recently become more willing to incorporate human rights commentary and advocacy for access to medicines into its work.[13]

The cumulative effect of these factors and others means that the human rights impacts of drug control are vast, spanning all regions of the world, engaging the full spectrum of civil, political, economic, social, and cultural rights, and affecting the health and welfare of people and communities, whether they have any involvement in drug use or the drug trade or not. As described by Boister,

> *Cultivators of land may find their right to property threatened by eradication operations involving the use of herbicides. Innocent holders of property may find their property subject to forfeiture as the proceeds or instrumentalities of crime. The privacy rights of [drug] users may be threatened by the criminalisation of private behaviour. The rights of residents of urban areas may be threatened through police raids, curfews and warrant-less searches. Suspected suppliers may be subject to detention without trial or the confiscation of property not proved to be linked to trafficking. Once arrested, alleged offenders may be denied fair pre-trial proceedings and a fair trial…Fugitive alleged offenders may be denied the right to be informed of an extradition request, the right to be heard, and the right to legal representation...Once in custody, alleged offenders may be subject to ex-post facto laws. Once convicted, offenders may not receive fair conditions of punishment and protection against cruel and unusual punishment. In particular, states that apply the death penalty for trafficking may threaten the right to life.*[14]

Despite these direct human rights impacts, and despite the influence of human rights on the development of other areas of international law and policy, international drug control law has evolved until quite recently largely absent this normative guidance. In 1996, Norbert Gilmore observed that "little has been written about drug use and human rights. Human rights are rarely mentioned expressly in drug literature and drug use is rarely mentioned in human rights literature."[15] More than 10 years later, the continuing lack of progress in this area led then-UN Special Rapporteur on the right to health, Paul Hunt, to conclude: "It is imperative that the international drug control system…and the complex international human rights system that has evolved since 1948, cease to behave as though they exist in parallel universes."[16] At the time of Hunt's comment in 2008, there was little serious discourse on the human rights impacts of drug control, either in the academic literature or the work of UN bodies. Even a cursory mention of human rights in the context of drug control in the statements of the UN Commission on Narcotic Drugs, UNODC, the Office of the High Commissioner for Human Rights, or the many UN human rights treaty bodies or special procedures was an oddity.

Today, human rights advocates and some human rights bodies certainly pay more attention to drug control issues, and drug control agencies pay more attention to human rights issues. In 2015, the Office of the High Commissioner for Human

Rights, at the request of the Human Rights Council, released a study on the human rights impact of the world drug problem. That same year, the UN Human Rights Council staged a thematic session specifically on the topic, drawing formal submissions from the High Commissioner for Human Rights, more than 20 member states, and more than 40 NGOs. Human rights was chosen as one of a small handful of themes formally examined during the UN General Assembly Special Session (UNGASS) on the World Drug Problem in April 2016, at which UN human rights treaty bodies and special procedures again forcefully called for rights-based reform of international drug policy.

The increasing (if often uncomfortable) inclusion of discussions of the human rights impacts of drug control within major United Nations human rights, drug control, and political bodies suggests these concerns are real and growing. Yet while attention to the human rights impacts of drug control has never been more visible, the gap between discourse and practice remains vast. Despite progress, the UN drug control and human rights systems still operate largely in isolation from one another. At the state level, the obligations contained in the three UN drug conventions are often interpreted and implemented in a manner inconsistent with human rights law. The UN drug control bodies still pay insufficient attention to the negative human rights consequences of drug enforcement in their work and their guidance to states. At the same time, the human rights implications of drug control are still not addressed in any systematic or ongoing manner within UN human rights mechanisms and bodies—although in recent years, several human rights treaty bodies have, in response to civil society submissions, begun to adopt conclusions and recommendations in this area on a more regular basis. Importantly, state champions for rights-based and evidence-informed change to international drug policy lack a shared set of standards clarifying human rights obligations in the context of drugs, making it difficult to progress political negotiations in either Geneva or Vienna. We should also not presume that references to "human rights" in UN consensus documents on drug control, while more common today, reflect a common understanding of that term among member states, or a shared commitment to make drug control efforts compliant with international human rights law. (The same can be said of the now-common reference by states to a "public health approach" to drugs.) As a result, human rights violations linked to drug control are unlikely to be addressed in any meaningful way, beyond simple assertions that drug control efforts must be consistent with human rights obligations, and drug control policies and their implementation are unlikely to be informed by human rights principles and considerations.

Closing this gap between discourse and practice is critical if progress on human rights and drug control is to move from debate or scholarly inquiry to an effective plan of action. A key tool in this effort will be the development and implementation of International Guidelines on Human Rights and Drug Control. Such a document would offer critical guidance to advocates, governments, intergovernmental organizations, and development partners on preventing human rights violations linked to drug control and enforcement, and would create a powerful human rights-based counterbalance to the "no-holds-barred ethos" of drug control described above. There are many precedents for such an endeavor. Over the past two decades, we have seen international human rights guidelines developed in the context of a wide range of global issues, including business, terrorism, HIV, natural disaster response, and protection against abuses based on sexual orientation and gender identity.[17] In numerous instances, such guidelines have been used to inform both legislative and judicial decisions and the conduct of various state (and non-state) actors, thereby advancing law, policy, and practice in ways consistent with states' human rights obligations—something member states have repeatedly declared is required. This existing body of work illustrates the value of taking a human rights-based approach to complex situations or stigmatized issues/populations, and also provides an important foundation of knowledge and experience from which we can learn in developing guidelines on human rights and drug control.

Article 28 of the Universal Declaration of Human Rights states: "Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized." However, the rights enshrined within the Declaration will never be realized in the context of drug control when the international legal order that defines the regime continues to perpetuate an environment of human rights risk, and when that regime is subject to little or no human rights scrutiny. International Guidelines on Human Rights and Drug Control would be a critical tool for closing this gap, and would help operationalize a human rights-based approach to drug control. Such guidelines are necessary and long overdue, and their advent would be a fitting way to celebrate the 70th anniversary of the Universal Declaration in 2018.

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4. UN Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (December 20, 1988) 1582 UNTS 95.; It is important to note that Article 3(2) of the 1988 drug convention allows some flexibility for States to not enforce criminal penalties for possession for personal use within domestic legislation should they so choose, while still maintaining treaty compliance. See Canadian HIV/AIDS Legal Network, Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS – Module 1: Criminal law issues (Toronto: Canadian HIV/AIDS Legal Network, 2006) pp 11-12. This flexibility has been adopted by a growing number of countries who have decriminalized or depenalized possession for personal use within their national laws. See N. Eastwood, E. Fox and A. Rosmarin. 'A Quiet Revolution: Drug Decriminalisation Across the Globe', (London: Release, 2016).

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How Drug Control Policy and Practice Undermine Access to Controlled Medicines

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Abstract

Drug conventions serve as the cornerstone for domestic drug laws and impose a dual obligation upon states to prevent the misuse of controlled substances while ensuring their adequate availability for medical and scientific purposes. Despite the mandate that these obligations be enforced equally, the dominant paradigm enshrined in the drug conventions is an enforcement-heavy criminal justice response to controlled substances that prohibits and penalizes their misuse. Prioritizing restrictive control is to the detriment of ensuring adequate availability of and access to controlled medicines, thereby violating the rights of people who need them. This paper argues that the drug conventions' prioritization of criminal justice measures—including efforts to prevent non-medical use of controlled substances—undermines access to medicines and infringes upon the right to health and the right to enjoy the benefits of scientific progress. While the effects of criminalization under drug policy limit the right to health in multiple ways, we draw on research and documented examples to highlight the impact of drug control and criminalization on access to medicines. The prioritization and protection of human rights—specifically the right to health and the right to enjoy the benefits of scientific progress—are critical to rebalancing drug policy.

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Background

The international drug control conventions and controlled substances

The international drug control conventions (hereinafter "the drug conventions") impose varying levels of control on a range of substances based, in theory, on their perceived risk of misuse and medicinal value. Substances are listed in four separate "schedules," with each schedule determining the requisite level of control for the substance listed within it. The drug conventions serve as the cornerstone for domestic drug laws and impose a dual obligation upon states: to prevent the misuse of controlled substances while ensuring their adequate availability for medical and scientific purposes.[1] The drug conventions further explicitly provide that controlled substances are indispensable for medical and scientific purposes. Indeed, the World Health Organization's (WHO) Model List of Essential Medicines includes 12 medicines that contain internationally controlled substances, such as morphine, methadone, buprenorphine, diazepam, and phenobarbital.[2] Essential controlled medicines are used across the spectrum of health care, from childbirth, surgical anesthesia, and pain relief in palliative care (such as for people with end-stage AIDS or terminal cancer), to mental health treatment, drug dependence treatment, and neurological care.

Many controlled substances embody the duality in the drug conventions—that is, they have both licit (medical) uses and uses defined as illegal in some jurisdictions. For example, benzodiazepines, when prescribed by a licensed professional, are used to treat a range of ailments such as insomnia, obsessive-compulsive disorder, and seizures. Outside of this medical context, however, their use is illicit due to the perceived risk of misuse that they carry, and they are included in the drug conventions' schedules. Despite the mandate that these two obligations be enforced equally, the dominant paradigm—in both the text of the drug conventions and their implementation—is an enforcement-heavy criminal justice response to controlled substances that centers on preventing what is deemed in law to be their misuse. This prioritization of restrictive control is to the detriment of ensuring adequate availability of and access to controlled medicines and infringes upon the rights of people who need them.

Balancing the medical merits of substances with their likelihood for non-medical use is, in theory, a matter of scientific judgment, and the drug conventions provide that the scheduling of controlled medicines should be based on WHO recommendations.[3] To this end, WHO convenes an Expert Committee on Drug Dependence (WHO Expert Committee) to study controlled substances and make recommendations on the level of risk of harm and the therapeutic utility of a substance, which should subsequently be reflected in the substances' scheduling under the drug conventions.[4] On several occasions, however, the UN Commission on Narcotic Drugs (CND) rejected the recommendation of the WHO Expert Committee, particularly when it comes to recognizing the potential therapeutic benefits of certain cannabinoids that are controlled (as is discussed below). Independent addiction experts and clinicians repeatedly assert that some controlled substances, including cannabis and 3,4-Methylenedioxymethamphetamine (MDMA), are wrongly placed in the drug conventions' most restrictive schedules.[5] Others have concluded that the WHO Expert Committee does not evaluate some substances frequently enough and would benefit from emulating the best practices of some national-level evaluators.[6]

Indeed, not all international scheduling determinations are replicated nationally. For instance, heroin is classified in the Single Convention on Narcotic Drugs, 1961 (the Single Convention) as a Schedule 1 and Schedule 4 substance, the most restrictive classifications, or "particularly liable to abuse and to produce ill effects…not offset by substantial therapeutic benefits." This judgment is embodied in most national drug laws.[7] However, a number of countries—including Switzerland, the Netherlands, the UK, and Germany—have, through law or public health regulations, established a licit use for heroin in treating well-defined cases of opiate dependence.[8] Of note, cannabis and cannabis resin are similarly classified in Schedules I and IV of the Single Convention—that is, they

are seen to be liable to abuse and without redeeming medical benefit. As with heroin, a number of countries have set policies legalizing and enabling access to cannabis for medical purposes, including for pain relief.

The Single Convention codifies the obligation on States parties to make adequate provision to ensure the availability of controlled substances for medical and scientific purposes, and stipulates three minimum criteria to which countries must adhere in national regulations: (a) individuals must be authorized to dispense substances controlled under the Single Convention by license (license to practice medicine or special license); (b) controlled substances may be transported only between institutions or individuals authorized under national law; and, (c) a medical prescription is required for the dispensation of controlled substances. However, the Single Convention also provides that states may impose stricter rules or controls if deemed necessary, and many countries opt to implement additional requirements. The Convention on Psychotropic Substances, 1971, sets out a more limited obligation, requiring that access to psychotropic substances for medical purposes not be unduly restricted.[9]

Surprisingly, there is no provision in the drug conventions to manage the interaction between states' drug control obligations and their responsibility to ensure access to controlled medicines. The focus on drug control and punitive sanctions creates a frame that is heavily oriented toward criminal justice and policing, which can have profound effects even for medicines not currently controlled under the drug conventions. For example, against the advice of WHO, China attempted in 2015 to bring ketamine under international control, which would have severely limited access to a vital anesthetic in developing countries.[10]

WHO recognizes the bias of drug policy implementation in preference of control, as does the International Narcotics Control Board (INCB), which first highlighted the challenge as far back as 1989:

> *legislators sometimes enact laws which not only deal with the illicit traffic itself, but also impinge on some aspects of licit trade and use, without first having adequately assessed the impact of the new laws on such licit activity. Heightened concern with the possibility of abuse may also lead to the adoption of overly restrictive regulations which have the practical effect of reducing availability for licit purposes.*[11]

That said, the INCB itself has been as much a part of the problem as its solution, often saluting restrictive drug control regimes imposed by governments without paying sufficient attention to the consequences of those regimes on access to medicines.[12]

This paper aims to demonstrate that the prioritization of criminal justice and the desire to prevent non-medical use of controlled substances under the drug conventions undermine access to controlled medicines, and in doing so, infringes upon the right to health and the right to enjoy the benefits of scientific progress (right to science). The impact of drug control will be examined, from the text of the law to the de facto extension of criminalization beyond the scheduling of substances to the health sector, where patients and individuals seeking treatment, health service providers, and researchers are adversely affected. We draw on documented examples to show the interaction between drug control, criminalization, and these rights. The paper concludes that the prioritization and protection of human rights—specifically the rights to health and to science —are critical to rebalancing drug policy.

Access to controlled medicines and the international human rights framework

The right to the highest attainable standard of physical and mental health (hereinafter "the right to health") has been guaranteed in international law since the Universal Declaration of Human Rights in 1948 (UDHR).[13] It is now protected in a range of conventions, notably in Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966 (ICESCR), and Article 24 of the Convention on the Rights of the Child (ratified by every country in the world except the United States of America).[14] Under this right, access to essential medicines, as defined by WHO, is accorded

the highest priority.[15] The ICESCR construction of the right to health expands on the narrower mention in the UDHR of the right to medical services and "security" for people who are ill.[16] Access to essential controlled medicines encompasses not only their availability, accessibility, acceptability, and receipt via high quality health services, but also includes access to information about the function and use of those medicines. Hence, realization of a core component of the right to health is, in practice, impeded by legal, regulatory, and attitudinal barriers (among others) which result from the restrictive manner in which the drug conventions have been interpreted. In reviewing states' compliance with the right to health, UN treaty bodies have, for example, recommended steps to address barriers and increase access to medication-assisted treatment in Belarus, Georgia, Indonesia, Lithuania, Russia, Ukraine, and Uzbekistan.[17] In a case currently pending before the European Court of Human Rights, applicants have challenged the Russian ban on opiate substitution therapy (also known as medication-assisted treatment) on the grounds of freedom from cruel, inhumane, and degrading treatment, the right to family life and privacy, and the prohibition of discrimination under the European Convention on Human Rights (ECHR).[18]

The right to science has similarly been guaranteed since the adoption of the UDHR (Article 27). It is further elaborated in Article 15(1)(b) of the ICESCR, which guarantees the right to enjoy the benefits of scientific progress and its applications.[19] This right includes not only the right to knowledge and information generated from investigation, but also freedom of inquiry, the latter indispensable to scientific research. Despite these provisions—and the fact that independent scientific research is critical to an understanding of a substance, its properties, potential for harm and potential medical use—research into controlled substances is significantly hampered by onerous bureaucratic requirements and undue criminalization.[20]

Paul Hunt, the former UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (hereinafter "the Special Rapporteur on the right to health"), has commented on the "scant regard" of drug control for international human rights law and the generally disjointed interaction of the two legal frameworks.[21] This disregard for human rights persists despite their place in the UN Charter, and supremacy of the obligations of UN member states under the charter over any other international agreement.[22]

The importance of respecting, protecting, and fulfilling human rights in the context of drug control has been affirmed in a plethora of international commitments and resolutions. As the UN General Assembly agreed in a 2007 resolution and reiterated in the outcome document of the UN General Assembly Special Session (UNGASS) on drugs in 2016, states have a legal obligation to carry out drug control "in full conformity with the purposes and principles of the Charter of the United Nations, international law and the Universal Declaration of Human Rights, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States, all human rights, fundamental freedoms, [and] the inherent dignity of all individuals ."[23] Similarly, Barrett observes:

> *Human rights in international drug control have ... traditionally been absent, and are viewed as a nuisance by many governments and UN agencies … [T]he system consciously avoids addressing important but controversial issues in order to preserve the appearance of international consensus.*"[24]

In the context of access to controlled medicines for pain relief, Lohman et al. argue that excessive over-regulation by governments and ignorance of health care providers conspire to create a vicious cycle of under-treatment, and conclude that poor prioritization of controlled medicines for pain relief is not a result of the low prevalence of pain but of the invisibility of its sufferers.[25]

The observations of Hunt, Barrett, and Lohman et al point to the normative gap between the human rights and drug policy frameworks, and the relative power imbalance between those

promoting health and rights, and those with a criminal justice agenda.

Drug policy undermines access to controlled medicines and infringes upon the right to health

Where drug policy disproportionately emphasizes preventing diversion and non-medical use of controlled substances over ensuring their availability and access for medical and research purposes, it risks violating the right to health.[26] Independent bodies charged with overseeing the aforementioned treaties have authoritatively interpreted the normative content of the right to health and related obligations. The Committee on Economic, Social and Cultural Rights (CESCR), for example, considers access to essential medicines, as defined by WHO, to be a core obligation within the right to health, meaning that access should be immediately prioritized by all state parties and not just added along the way toward progressive realization.[27]

Further, CESCR has clarified that the right includes both freedoms and entitlements, as well as immediate and progressive obligations to ensure healthcare facilities, goods and services are available, accessible, acceptable and of sufficient quality.[28] Accessibility includes affordability as well as non-discrimination, such that "health facilities, goods and services must be accessible to all, including the most vulnerable or marginalized sections of the population, in law and in fact."[29] The right to health additionally includes obligations to take steps to prevent, treat, and control diseases, and to avoid policies that are likely to result in unnecessary morbidity.[30] Consequently, UN treaty bodies have expressed concern at the Russian ban on opiate substitution therapy, and have called on a range of other countries to take steps to ensure access to such therapy.[31]

The global state of access to controlled medicines for pain relief illustrates the detrimental impact restrictive drug controls have on realizing the right to health. The INCB estimates that 5.5 billion people have limited or no access to these medicines, with 92% of the world's morphine consumed in countries that constitute just 17% of the global population.[32] While there are myriad reasons for this, including economic barriers, prescriber regulations, and marketing practices, it is difficult to overlook the role of overly burdensome regulatory frameworks, which have their roots in emphasis on restrictive control in the regulation of controlled medicines. Indeed, when we consider the effects of the drug conventions on the right to health, we see an incursion of the restrictive control and criminal justice mindset into the medical realm.

De facto criminalization

Punitive sanctions arising from the drug conventions (related to production, supply, and/or possession), efforts to prevent the diversion and misuse of controlled substances, and heavily politicized drug policy have collectively given rise to criminalization over and above the letter of the law. The result is the de facto criminalization not only of controlled substances and those who use them, regardless of their licit use or status, but also of those who prescribe them.

De jure and de facto criminalization weigh heavily upon the work of health professionals. In many jurisdictions, health professionals face disproportionate penalties for errors in the handling or prescribing of controlled medicines; are burdened by onerous security-related storage requirements; and are often subject to law enforcement oversight beyond what is prescribed in law or regulation.[33] Twenty-one countries participating in a 2014 INCB survey indicated that the fear of sanctions or prosecution represented a barrier to the availability of controlled medicines in their country, while a total of 81 countries reported implementing penalties for the inadequate recordkeeping of controlled medicines, varying from fines and license revocation to prison sentences.[34] This incursion of criminalization into the sphere of health undermines professionals in the delivery of ethical health care, poses a considerable disincentive to the therapeutic use of controlled substances, and creates an environment

of constant, implicit accusation that health professionals are on the verge of misconduct.[35]

The negative impact of de facto criminalization reaches beyond health professionals: it is evident in the mistreatment of people who use drugs and people in medical need of controlled substances in non-judicial settings that nonetheless bear the imprint of the law. In the case of people who seek treatment for opioid dependence, the deforming influence of criminalization means that patients in need—like the controlled substance itself—become something to be contained and controlled.[36] For example, people may be subjected to humiliating requirements such as having to collect their medicines at a police station, undergoing mandatory urine testing to assess non-medical substance use, being shifted from weekly methadone collection to daily supervision, and not being permitted to touch their medicine (which can only be administered by a physician or nurse).[37]

Where opioids are used in drug dependence treatment, doctors are required to maintain a degree of control over not only the controlled substances, but the patient's behavior, suggesting a policy that not only pre-empts diversion, but hints that patients and even doctors are not to be trusted. Many countries require patients to attend a clinic on a daily basis for their dose of methadone, rather than making take-home doses available as is the case for most medicines. And, while a number of treatment options for opiate overdose or dependency exist (such as medicines that block intoxication like buprenorphine and medium-term control options such as injectable extended-release naltrexone), treatment choices are often guided by overly punitive and restrictive policies and provider prejudice rather than medical need.[38] In the United States, for example, drug courts—meant to offer treatment as an alternative to imprisonment—frequently require that patients pursue treatment with opioid blockers, naltrexone, or enter drug-free treatment rather than using methadone or buprenorphine, two medicines with demonstrated beneficial effect (and psychoactive properties).[39] In the UK, Release, the UK center of expertise on drugs and drug law, reports similarly restrictive or punitive measures including withdrawal of a methadone prescription where a client is deemed to have exhibited behavioral issues (a measure in breach of national guidelines); coerced reduction of methadone or buprenorphine dosage; and conditional methadone prescription, such as requiring patient engagement with other interventions. Release argues that these measures fall short of the UK's commitments under ICESCR and points out, "In no other area of treatment would we see the choice of the individual to be able to access a widely available and evidenced treatment at the expense of political ideology."[40]

The overemphasis on regulating controlled medicines and patients who need them extends beyond those seeking drug dependence treatment. Use of morphine and other opioids for pain relief, for example, is heavily stigmatized in Armenia, Kenya, and many other low- and middle-income countries.[41] Patients may be denied the appropriate medicine, prescribed an inadequate amount to control their pain, or permitted to take home only a small supply of medicine.[42]

These medicines are mythologized for their capacity to cause dependence. The implication is that a patient becomes criminal should dependence occur, though technically, a patient only becomes a criminal when denied a legal source of controlled substances. Rigid laws also mean that overbearing efforts are made to prevent the diversion of controlled medicines to illicit markets, even when there is a lack of evidence about diversion or the development of dependence in those to whom these medicines are prescribed. A systematic review demonstrates that, among patients with no history of substance misuse who were treated with opioid analgesics, only 0.43% misused their medication, while just 0.05% developed dependence.[43] There is little justification, therefore, for restricting prescriptions for controlled medicines or denying their availability. Indeed, such measures undermine the right to health, not only by impeding access to essential controlled medicines, but because they fly in the face of the notion of health as a fundamental constituent of human dignity.[44]

The following case studies further highlight the de facto criminalization of patients and health-

care professionals, in violation of the right to health.

Case study 1

A 2015 Human Rights Watch report on palliative care and access to pain relief in Armenia found that fewer than 3% of those in need of morphine had access to it. Oral morphine is not available, and outpatient (out of hospital) access to injectable opioids is available in limited doses to cancer patients only (as prescribed by an oncologist). In flagrant violation of patient confidentiality, oncologists reported being required to provide written monthly reports to the police disclosing details of patients who receive opioid pain relief, including their names, addresses, and ID numbers.[45] Human Rights Watch observed that police oversight and control, along with participation in the regular destruction of morphine ampules at health facilities generate "a sense of trepidation among oncologists and pharmacists."

While steps to reform oncologist reporting practices were initiated in 2016, the de facto criminalization of patients, caregivers, and health professionals continues via excessive regulatory requirements. For example, oncologist prescriptions must be approved by a standing commission of multiple doctors and bear four different stamps of authorization. Patients or their caregivers are also required to return the empty ampules before a new prescription is issued.[46] These requirements, among others, inculcate a significant degree of stigma around opioid analgesic use and require thousands of people in severe pain to wait for effective pain medication or simply go without it. These barriers unnecessarily limit access to medicines for pain relief, in violation of both the right to health and the prohibition of cruel, inhuman, or degrading treatment.[47] They additionally indicate disproportionate interference with the right to respect for private and family life.[48]

Case study 2

The overreach of restrictive control into the realm of health also plays out at the international level. While WHO's health expertise is enshrined in the drug control treaties, it has often been resisted in the CND and opposed by the INCB. Cannabis and cannabinoids are examples. Delta-9-tetrahydrocannabinol (Δ^9-THC), a formulation of the main psychoactive ingredient in cannabis, has been reviewed several times by the WHO Expert Committee.[49] One of the chemical variants of Δ^9-THC, dronabinol, has been available by prescription in many countries for some years.[50] In 1989, the WHO Expert Committee recommended that dronabinol be reclassified under the 1971 Convention to a schedule that recognized both its potential for abuse and therapeutic value due to its effectiveness in reducing nausea secondary to chemotherapy.[51] This recommendation was rejected by the CND the first time it was considered, though was eventually approved by the CND in 1991.[52]

In a later report, the WHO Expert Committee concluded that dronabinol was useful for the treatment of chronic pain, multiple sclerosis, neuropathic disorders, arthritis, and AIDS-associated anorexia, and that other medical uses were likely to be found.[53] It therefore recommended that dronabinol be reclassified to a schedule that reflected a greater balance in favor of therapeutic importance relative to potential for harm. The CND declined to vote on the recommendation, deciding instead to request a further review by the WHO Expert Committee.[54] When it comes to the medical value of cannabinoids as judged in UN mechanisms, it has been difficult for health experts to overcome the politicization of drug control, and the consequent undue restrictions put on access to controlled substances with potentially great medicinal value. Hence, overly restrictive drug control can impede research into the medical benefits of controlled substances, thus infringing also on the right to science, as discussed below. Fortunately, in 2016 the WHO Expert Committee outlined its intention to conduct a pre-review within the following 18 months on whether or not to consider re-scheduling cannabis under the conventions, a move which could influence domestic legal regimes.[55]

Case study 3

Since 2000, the United States has seen a nearly fourfold increase in opioid overdose deaths, in which both drug control policy and a confluence of

other factors have played a part.[56] There is no single agreed explanation for this phenomenon. In at least some parts of the country, it seems that periods of increased legitimate prescription of opioids for pain relief, perhaps with inadequate monitoring of these prescriptions, led to crackdowns on prescription opioids, which in turn led to the wider use of heroin and other street opioids, of which the purity and toxicity are unknown.[57] Overly restrictive controls on opioid prescribing, however, are rarely sufficient to tackle misuse, and indeed can unduly limit access to pain relief medications.

Overly restrictive drug control policy may promote overdose deaths in several ways.[58] First, methadone and buprenorphine maintenance treatment, which reduces additional narcotic usage, remain heavily restricted, not integrated into primary health care, and not sufficiently available in many parts of the country.[59] Second, most jurisdictions still do not have policies that encourage the ready availability of naloxone for overdose reversal to people who use drugs, their families and friends, as well as first responders.[60] Third, in spite of its excellent results elsewhere, the US has not adopted heroin-assisted treatment, which could be useful in cases where other treatment has not succeeded, which are, by definition, cases at high risk of overdose. Various human rights bodies have interpreted a requirement to ensure access to medication-assisted treatment under the right to health.[61]

Case study 4

In Russia, as mentioned above, methadone and buprenorphine for treatment of addiction are illegal: police can arrest those in possession of the medicines, and prosecutors threaten those who distribute information about these medications with violation of laws prohibiting propaganda about illegal drugs—criminalization which impedes deeply into the sphere of health.[62] This is despite the fact that WHO categorizes both methadone and buprenorphine as essential medicines. They are among the best-studied and most effective treatments for opioid dependence and have demonstrable benefit in reducing HIV risk via injecting, which accounts for the largest share of Russia's HIV epidemic. The ban on these medicines is a clear violation of the right to health, and equating education about the medicines with propaganda further violates the right to information. Despite the stance of their government, Russian representatives have served for years on the INCB, sponsor UNODC's informal working group on science, and participate actively in debates on drug dependence treatment and other measures at the CND.

Drug policy undermines access to controlled medicines and impedes the right to enjoy the benefits of scientific progress

The right to health and the right to enjoy the benefits of scientific progress are interrelated and interdependent. The right to science is "sometimes considered a prerequisite for the realization of a number of other human rights" and is explicitly linked to rights to health, the rights of older persons, and development.[63] As yet, CESCR has not made a detailed interpretation of the right to science as it has the right to health. The right to enjoy the benefits of scientific progress is enshrined under Article 27 of the UDHR ("Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits") and Article 15(1)(b) of ICESCR, as well as regional standards in Africa, the Americas, and Europe. Under ICESCR, the right is supplemented by a negative obligation under Article 15(3), which provides that states must respect the freedom indispensable for scientific research. This has been interpreted to mean the state is obliged not to interfere with choices and priorities decided by scientists and not to impose a certain topic or method of research on the academic community.[64]

The right to science is broadly acknowledged to be of great significance in the context of globalization, the communication revolution, and the accelerated pace of scientific and technological development; and yet, it is poorly implemented to the extent it was referred to as a right at "vanishing point" by Schabas in 2007.[65] In 2009, recognizing the increasing relevance and continued neglect of

the right to science and its applications, UNESCO convened a series of discussions designed to clarify the normative content of the right and enhance its implementation. The conclusions and proposals for the normative framing of the right, captured in the Venice Statement, emphasized freedom of inquiry as a vital element in the development of science, access to the benefits of scientific progress, and the "creation of an enabling and participatory environment for the conservation, development and diffusion of science and technology" as core components of the right to science.[66] The right to science has since been the subject of increased attention.[67]

The Special Rapporteur in the field of cultural rights stipulated that a prerequisite for implementing the right to science is "ensuring the necessary conditions for everyone to continuously engage in critical thinking about themselves and the world they inhabit, and to have the opportunity and wherewithal to interrogate, investigate and contribute new knowledge."[68] The Special Rapporteur also sets out the normative content of the right to science—to paraphrase: access to knowledge and to the benefits of science without discrimination; opportunities to contribute to the scientific enterprise and freedom indispensable for scientific research; information to enable informed decision-making "after considering both the possible improvements offered by scientific advances and their potential side effects or dangerous usages" as well as participatory decision-making in determining what constitutes "benefits" of scientific progress; and an enabling environment.[69] The two normative conditions most pertinent in the context of drug policy are access and freedom of inquiry, specifically:

In terms of access: the innovations "essential for a life with dignity should be accessible to everyone, in particular marginalized populations."[70] This non-discrimination obligation demands eliminating both de jure and de facto barriers.[71]

In terms of freedom of inquiry: freedom of scientific research has been interpreted as "the right or freedom to assess and choose the preferred path of scientific and technological development."[72] The Special Rapporteur on cultural rights clarifies that freedom "means ensuring that the scientific enterprise remains free of political and other interference, while guaranteeing the highest standards of ethical safeguards" and explicitly notes that barriers to scientific research must be overcome.[73]

In the context of drug policy, the incursion of criminalization and overly restrictive control into research restricts the scope and implementation of scientific inquiry. This frequently occurs via heavy administrative and bureaucratic regulation of controlled substances under the auspices of anti-diversion measures, which effectively impede freedom of inquiry. Below, we argue that disproportionate bureaucratic, legal, or other restrictions may violate states' obligations under Article 15(3) of ICESCR.

In a similar vein, the American Association for the Advancement of Science reported that scientists participating in its 2013 focus groups remarked that "over-regulation can have the cumulative effect of stifling the freedom indispensable for scientific research and creative activity" and that "[w]hile regulations individually may or may not be reasonable responses to concerns about national security [and] trade … an accretion of overlapping, vague and contradictory regulations can smother the scientific enterprise."[74] When researchers are able to initiate and demonstrate the medical value of a controlled substances—for example, prescription heroin in Canada—the de jure criminalization of controlled substances means access to medical treatment and related information may still be impeded.[75] Even where law reform reflects scientific findings, de facto criminalization lends stigma and additional impediments to accessing the substance.

Furthermore, de facto criminalization engenders bias and tends to politicize issues related to controlled substances. This impacts judgment and decision-making from scientific review to funding. The Special Rapporteur on cultural rights commented on "the diminishing role played by the State in research and development and the concomitant extensive increase in the involvement of the private sector," adding that the state should not rely entirely on the private sector and should make all efforts possible to ensure publicly funded research.[76] We argue that de facto

criminalization weakens access to science and its applications, and amounts to a violation of (often vulnerable or marginalized) individuals' rights. Finally, we recognize that scientific freedom is not absolute, "but centers on the nexus of freedom and responsibility."[77] Any restriction to the right to science must comply with the relevant legal standard. For example, Article 4 of ICESCR provides that rights in that covenant can only be restricted in a manner that is according to law, consistent with the nature of the right, pursuant to a legitimate aim (such as the protection of public health), and strictly necessary for the promotion of general welfare in a democratic society. CESCR has stated that "such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available."[78]

The following case studies highlight the de facto criminalization of patients and researchers, in violation of the right to enjoy the benefits of scientific progress.

Case study 1

In the UK, researchers require a special license in order to hold Schedule 1 controlled substances (those subject to the most stringent level of control). Obtaining such a license may take up to one year, cost GBP3000 (plus an additional GBP2000 for security equipment and police checks), and furthermore may require additional import licenses, since most suppliers of controlled substances are located outside the UK. David Nutt, psychiatrist and neuropsychopharmacologist, estimates that overcoming these hurdles increases the cost of the research into controlled substances "by about 10-fold."[79] Consequently, just four hospitals in the UK hold a Schedule 1 dispensing license. As such, research into the medical value of Schedule 1 substances is effectively smothered, closing opportunities for discovery of therapeutic benefit (or harm).[80] Despite initial case reports suggesting a medical value for MDMA analogues (similar in structure to MDMA) in alleviating dyskinesia (involuntary movements) associated with Parkinson's disease, media hype around potential misuse of MDMA analogues resulted in their blanket classification as Schedule 1 substances.[81] This effectively criminalized both the analogues and the research, as the sites conducting the research could not afford Schedule 1 licenses.[82]

Similarly, in Canada, it took a research group sponsored by the Multidisciplinary Association for Psychedelic Studies more than four years to be permitted to import MDMA from Switzerland under a special license, even though the group had already obtained approval from the federal department of health and a Canadian institutional review board to conduct research into the therapeutic use of MDMA in post-traumatic stress disorder.[83] Nutt notes there are no known instances of diversion of Schedule 1 or Schedule 2 drugs from research labs, "So the law simply censors research rather than protects the public; indeed the limitation to clinical research produced by the regulations almost certainly has done much more harm than good to society by impeding medical progress."[84]

Case study 2

The issue of access to cannabis for medical treatment received a high degree of attention in the US after a series of television documentaries on the beneficial effects of a cannabis derivative for children with Dravet syndrome, or treatment-resistant epilepsies, among other conditions.[85] Dr. Sanjay Gupta, CNN's chief medical correspondent, documented the story of more than 100 American families who moved to Colorado (which authorized patients and their caregivers to possess, cultivate, and use cannabis for medical purposes in 2000), in order to secure regular access to the substance for medical use for their children. As the law currently stands, these patients and families must stay in Colorado, because transporting their medicine (a non-psychoactive cannabis oil) puts them at risk of criminal prosecution.[86] Previously, therapeutic benefits of the cannabis extract had not been scientifically evaluated. Critics of overregulation note that this was the result of restrictions on research with cannabis and its derivatives in the US, including licensing restrictions and refusal to reschedule cannabis by the Drug Enforcement Agency, which

retained authority of the decision despite lack of health expertise. These restrictions violate both freedom of inquiry and the requirement for non-discriminatory access to the benefits of scientific progress.

Case study 3

LSD is another case in point. Notwithstanding accounts suggesting that LSD may have considerable therapeutic value for treating alcoholism in some patients, researching the medical value of LSD in Europe is made impossible by the fact that there is no approved source of LSD formulation for human clinical trials.[87] In this case, marginalized members of European society—people in need of treatment for alcoholism—are denied access to the benefits of research.

Case study 4

In the US, researchers published multiple papers noting that MDMA caused dopaminergic brain damage. The finding was widely circulated, and retracted only after it was revealed that the researchers had mistakenly used methamphetamine—known to impair dopamine function—rather than MDMA, in the experiment. Widespread media coverage of the erroneous finding, along with a lack of appropriate scrutiny of results or interest in replicability, reflects the presumptive prejudice and bias toward detection of harm built into research on psychoactive substances.[88]

Restrictions on the exercise of the right to science such as these need to be carefully considered in light of the permissible limitations of rights outlined in Article 4 of ICESCR, outlined above. Specifically, they should be reviewed to consider whether they are the least restrictive measures in pursuit of a legitimate aim (protection of public health). Given, for example, that the risk of diversion from research laboratories is extremely low, the calculation of proportionality in assessing these restrictions on research should also consider the lost possibility for treatment and medical benefit resulting from drug restrictions. In these circumstances, we argue that draconian restrictions on the right to science, which have a potentially significant impact on the right to health and which seek to combat a small risk of diversion, are often disproportionate and therefore in violation of ICESCR.

Finally, the bias against psychoactive substances also requires attention to the questions not asked or comparisons not conducted in scientific research. For example, the trial used to approve long-acting naltrexone, an opioid blocker for addiction treatment, compared this medicine to placebo and counseling alone (shown to be inferior to existing treatments in multiple previous studies) rather than to opioids with known medical benefit (and psychoactive effect) used in addiction treatment.[89] Since approved, the opioid blocker has become the treatment preferred by multiple actors in the US criminal justice system, with respondents from that sector reporting that they prefer it to the psychoactive treatments because of the medical evidence indicating superiority.[90] This is striking, of course, because there has been no comparative study. Ethicists and researchers have flagged this lapse, and a genuine comparison is now underway between the opioid blocker and the medicines which comprise the gold standard of care.[91] Scientific gaps caused by bias threaten the right to science by undermining the balance of freedom and responsibility in research.

Conclusion

As noted by the Johns Hopkins–*Lancet* Commission on Public Health and International Drug Policy, impediments to access to controlled medicines go hand in hand with other elements of overzealous drug control, such as mass incarceration for minor offenses, even if cloaked in the guise of health concerns. Both are fueled by the demonization of people who use drugs, and by unscientific notions of addiction that dominate the public mind, with health clinics and other non-judicial spaces bearing the imprint of criminal law through what we have referred to as de facto criminalization.[92] The massive denial of opioids and other controlled medicines to people who desperately need them—which remains a quintessential example of global

health inequity—is furthered by the difficulty faced by researchers whose work could explore the therapeutic benefits of controlled medicines but who cannot obtain controlled substances or official approval for their research.

The Johns Hopkins–*Lancet* Commission report suggests ways to emerge from the unscientific demonization of drugs and the futile pursuit of drug prohibition in favor of an approach based on the idea that the harm of psychoactive drugs, like the harms of tobacco, for example, can be controlled by pragmatic public health measures. A truly health-oriented drug policy requires openness by policy-makers, institutional review boards, health professionals, and society to the idea that controlled substances have benefits for human health and human dignity, and that their study and use to promote public health is a worthy enterprise. Indeed, their contributions to health and well-being are as essential to compliance with international law as the regulation of substances that can cause harm. States' obligations related to the right to health extend to a duty to uphold that right through international cooperation and assistance. This means, for example, that they should respect, protect, and fulfill the right to health in their joint action in intergovernmental bodies such as the CND.

In regular sessions of the CND in recent years, as well as in the 2016 UNGASS on drugs, member states—including some with relatively repressive drug laws—pledged to adopt "public health approaches" to drug control policy that conform with human rights.[93] The INCB ended its 2017 session with a press release urging vigilance and cooperation in addressing the world's drug problems, but "in conformity with human rights."[94] In many cases, national level pledges took the form of commitments to treat people who use drugs as patients, not criminals.[95] It remains to be seen if these commitments have any meaning, or if they will distract attention from unchanged health- and human rights-unfriendly policies under a different banner. If countries or international mechanisms are truly interested in a health-based approach to addressing drug problems, they must prioritize improving access to controlled medicines, thereby also meeting their obligations to respect, protect, and fulfill the rights to health and the benefits of scientific progress.

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International Guidelines on Human Rights and Drug Control: A Tool for Securing Women's Rights in Drug Control Policy

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Abstract

Discrimination and inequality shape women's experiences of drug use and in the drug trade and the impact of drug control efforts on them, with disproportionate burdens faced by poor and otherwise marginalized women. In recent years, UN member states and UN drug control and human rights entities have recognized this issue and made commitments to integrate a 'gender perspective' into drug control policies, with 'gender' limited to those conventionally deemed women. But the concept of gender in international law is broader, rooted in socially constructed and culturally determined norms and expectations around gender roles, sex, and sexuality. Also, drug control policies often fail to meaningfully address the specific needs and circumstances of women (inclusively defined), leaving them at risk of recurrent violations of their rights in the context of drugs. This article explores what it means to 'mainstream' this narrower version of gender into drug control efforts, using as examples various women's experiences as people who use drugs, in the drug trade, and in the criminal justice system. It points to international guidelines on human rights and drug control as an important tool to ensure attention to women's rights in drug control policy design and implementation.

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Introduction

In recent years, United Nations (UN) human rights and drug control entities, UN member states, and civil society have begun to pay closer attention to women's drug use and participation in the drug trade and to the impact of international drug control efforts on women (here, conventionally defined).

At the international level, there is consensus among UN member states and UN drug control and human rights entities about the importance of integrating a 'gender perspective' into drug control efforts, with 'gender' limited to those conventionally deemed women. At the 2016 UN General Assembly on Drugs, UN member states committed to "mainstream a gender perspective into and ensure the involvement of women in all stages of the development, implementation, monitoring and evaluation of drug policies and programmes" and to develop "gender-sensitive" measures that "take into account the specific needs and circumstances faced by women and girls with regard to the world drug problem."[1] They also recommended that states address "the conditions that continue to make women and girls vulnerable to exploitation and participation" in the drug trade; take into account the specific needs and multiple vulnerabilities of "women drug offenders" in prison; and ensure non-discriminatory access to health care services, including in prison and for pregnancy.[2] In 2016, the Commission on Narcotic Drugs (CND) also called for states and the UN Office on Drugs and Crime (UNODC) to mainstream a gender perspective in drug-related policies and programs, enumerating steps to take to develop and implement drug policies and programs that take women's and girls' specific needs into account.[3]

These political commitments encompass some of the human rights obligations that most states have undertaken as parties to international human rights treaties, including the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of People with Disabilities.

While these commitments have begun to align with established human rights obligations, they remain rhetorical. Meanwhile, there exists no systematic assessment that brings these two areas of international law and policy together. More importantly, national policymaking on drugs fails to meaningfully incorporate even this conventional gender dimension on a systemic scale, and all kinds of women remain particularly at risk of recurrent violations of their rights in the context of drugs. The elaboration of international guidelines on human rights and drug control is an important tool to ensure that all women's rights are respected, protected, and fulfilled in drug control policy design and implementation.

Gender is a relational concept that captures the operation of socially constructed identities, attributes, and role expectations for persons deemed male or female (based on their presumed biological sex).[4] These roles affirm and reestablish privilege in all spheres of life, including with respect to resources, employment, and personal autonomy.[5] A gender perspective may target people based on their identity as women, girls, lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming persons, as well as men or boys. This article explores what it means to mainstream drug policy from the perspective of persons conventionally deemed female, using as examples these particular women's experiences as people who use drugs, in the drug trade, and with the criminal justice system. When we use the word 'women' here, we are primarily referencing those conventionally deemed women: this focus brings out important issues, while its limitation also suggests important areas for research and intervention on transwomen and other non-gender conforming persons to ensure their rights and health.

Gender and human rights

The right to non-discrimination and equality on the basis of sex was first enshrined in the UN Charter and later in all main human rights treaties.[6] Several UN treaty bodies have acknowledged the existence of intersecting discrimination, defined as distinct discrimination resulting from multiple,

intersecting factors of disadvantage.[7] Women may experience discrimination due to the intersection of sex with other factors, such as race, ethnicity, religion, health status, age, or class.[8] These factors combine to produce distinct forms of discrimination, such as the denial of reproductive health services to women based on race and economic status.[9] Intersecting discrimination may express itself as the stereotyping of subgroups of women, such as the stereotype of women who use drugs as immoral, sexually promiscuous, and unfit to be mothers, caregivers, or partners.

International human rights law establishes a state obligation to take all necessary steps to give effect to rights enshrined in treaties, including women's rights to non-discrimination and equality.[10] It also requires states to adopt and pursue policies to address intersecting forms of discrimination and their compounded negative impacts.[11] The obligation to ensure women's right to health, for example, requires removing legal and other obstacles that prevent women from accessing and benefiting from health care on a basis of equality, including by addressing traditional, historical, religious, and cultural attitudes that affect access to determinants of health and health goods and services.[12]

Gender mainstreaming

The Beijing Platform for Action of 1995 established gender mainstreaming in all policies and programs as a global strategy to promote gender equality.[13] In 1997, the UN Economic and Social Council approved guidelines requesting that UN functional commissions incorporate a gender perspective in their work.[14]

Historically, women's rights have not been considered by UN drug control entities tasked with the oversight of the three UN drug conventions. None of the drug conventions mention discrimination based on sex or other issues faced by women, despite the fact that CEDAW preceded the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances and notwithstanding the significant gender architecture in the UN system by the time the convention was being negotiated.[15]

In recent years, this has begun to change. In 1995, the CND adopted its first resolution directed at women, urging member states to "recognize, assess and take into account in their national policies and programmes the problems that drug abuse poses for women."[16] The Political Declaration adopted in 1998 by the UN General Assembly called on member states to "ensure that women and men benefit equally, and without any discrimination, from strategies directed against the world drug problem, through their involvement in all stages of programmes and policy making."[17] CND resolutions adopted in 2005, 2009, and 2012 elaborated on structural problems faced by women in relation to drugs and drug policies; urged states to take action to eliminate gender-specific barriers limiting women's access to drug treatment and to address social and economic factors driving women to work in drug cultivation and trafficking; and raised concerns about sexual violence and other trauma experienced by women who use drugs.[18] As noted above, a 2016 CND resolution called for mainstreaming a gender perspective in drug-related policies and programs, with particular attention to women in custody for drug-related offenses.[19]

UNODC has also worked with UN health and human rights bodies, as well as networks of people who use drugs, to develop technical guidance on gender-specific harm reduction interventions and health services, including for women in prison.[20] The International Narcotics Control Board's 2016 annual report opened with a chapter on women and drugs, focusing primarily on women who use drugs.[21]

Engagement by the CND, UNODC, and International Narcotics Control Board to address the gender dimensions of drugs issues is important, but these commitments are hortatory. International guidelines on human rights and drug control would help expose the distinct, often disproportionate impact of drug control efforts on certain populations of women and provide guidance on how to systematically integrate a gender perspective within a human rights framework for international drug control, as well as strengthen accountability and assist with implementation at the national level.

Drug control efforts from a gender perspective

This section applies a gender perspective to explore the experiences of women who use drugs, women who are incarcerated, and women who cultivate drugs or live in communities where drugs are cultivated or traded. It then points to state obligations to address the distinct experiences of women in order to meet their international legal obligations to ensure gender equality.

Women who use drugs

Gender stereotypes around women's domestic roles and their socially and morally prescribed responsibilities for reproduction and parenting contribute to high levels of stigma and discrimination against women who use drugs.[22] These factors, often compounded by poverty, race, and other categories of social inequality, impede access to health and social services for women who use drugs, threaten family ties, and put women at risk of incarceration and involuntary detention and treatment.[23]

While health care and social services are scarce for most people who use drugs, women's specific needs are particularly ignored. Harm reduction services, generally developed with male drug users in mind, rarely acknowledge or address women's unique needs, such as for sexual and reproductive health care, child care, and gender-specific health information.[24]

Women who use drugs more commonly experience physical and sexual intimate partner violence than non-drug-using women—three to five times higher, according to some studies.[25] In many countries, they also face high rates of sexual and physical violence from police and law enforcement agencies.[26]

Many women cite pregnancy as a reason to seek drug treatment, and some countries do give pregnant women (effectively, the fetus) priority in drug treatment services.[27] Yet punitive policies that separate women who use drugs from their children, together with shaming and hostility when accessing services, deter pregnant women and mothers from seeking drug treatment, prenatal care, and other health services.[28] In many countries, women with a history of drug use are considered unfit to parent, and pregnant women who use drugs may be pressured to have abortions or to give up their newborn infants.[29]

In some countries, pregnant women who use drugs (including legal drugs that have been prescribed) face civil or criminal detention for extended periods of time—sometimes for the length of the pregnancy.[30] In several US states, pregnant women suspected of drug or alcohol use can be involuntarily detained without due process and forced to undergo medical treatment, often without sound medical evidence that they have a drug dependency or that the health of the fetus was jeopardized.[31] These laws, as well as laws criminalizing drug use or requiring government officials and health care and social workers to report women who use drugs to child protective services, may deter women from seeking prenatal care or speaking openly with their doctors about their drug use and the best course of treatment for them.

In some countries in Eastern Europe and Central Asia, registration as a drug user—required by law for those seeking state-sponsored drug treatment—can trigger termination of parental rights, which strongly deters women from seeking treatment and other medical services, including prenatal care.[32]

States have positive obligations to ensure women's equal access to health care services and "appropriate services in connection with pregnancy."[33] Laws, policies, and practices that impede women's access to these services infringe women's fundamental right to health.[34] Detention and forced medical treatment on the grounds of pregnancy likewise constitute gender-based discrimination and also violate fundamental protections against arbitrary detention and ill treatment. The Working Group on Arbitrary Detention has raised concerns that deprivation of liberty because of drug use during pregnancy "is obviously gendered and discriminatory in its reach and application" and deters women from seeking needed health care.[35]

Women and the criminal justice system

Women comprise a small minority (6.8%) of the

global prison population, but their numbers are increasing, and at a rate faster than for men.[36] And while men are more likely than women to be involved in drug possession, sale, and use, in most countries where data are available, a significantly higher proportion of women than men are imprisoned for drug-related offenses.[37] This imbalance has caught the attention of UN human rights mechanisms. Rashida Manjoo, former UN Special Rapporteur on violence against women, noted in 2013 that "domestic and international anti-drug policies are a leading cause of rising rates of incarceration of women around the world."[38] The CEDAW Committee has also expressed concern about the significant increase in women imprisoned for drug-related offenses.[39]

Research from Latin America shows that women often become involved in the drug trade because poverty and discrimination limit their opportunities for education and employment. Many are single heads of households with multiple children and other dependents, pressured by family members or subject to violent coercion by recruiters linked with organized crime.[40]

Most women incarcerated for drug offenses are non-violent and first-time offenders.[41] Despite working at the lowest levels of the drug chain, they are subjected to the same or worse penalties as those with more substantial involvement in the trade, frequently lacking either information or representation to plea-bargain in exchange for reduced sentences or to avoid imprisonment altogether. In some countries, criminal laws and sentencing guidelines impose more severe penalties for drug-related offenses than for crimes such as rape and murder.[42]

The transnational nature of drug trafficking means that many women are detained or incarcerated in foreign countries, with devastating consequences for their lives and the lives of their children and dependents.[43] The UN Bangkok Rules encourage the use of gender-specific and non-custodial measures and sanctions that take into account the accused's history, the circumstances of the offense, and her care responsibilities and urge the use of alternatives to incarceration for non-violent offenses.[44] Yet awareness of the Bangkok Rules appears lacking.[45]

Racial disparities in drug law enforcement have been documented in many countries, with laws criminalizing the possession, sale, and use of drugs aggressively enforced in low income-neighborhoods and among racial minorities. The intersecting discrimination has not been properly addressed in drug control entities' resolutions and recommendations.

In the United States, for example, although black and white women sell and use drugs at comparable rates, black women are arrested and incarcerated on drug charges at rates that greatly exceed their proportion in the population and that are many times greater than for white women.[46] In many countries, women from racial minorities, including indigenous women, represent the fastest-growing segment of the prison population. A 2005 report noted that in the United States, for example, the imprisonment rate for black women for all offenses, a large proportion of which are drug-related, increased by 800%—twice the rate for all other groupings.[47] Latina and black women also receive harsher punishment—incarceration—than white offenders, who are more regularly offered community supervision.[48]

Several countries have enacted legislative or policy reforms to address the harmful consequences of drug control efforts on women, taking into account their age, economic status, caretaking responsibility, and pregnancy.[49] Guidelines on drug control and human rights could assist in evaluating such efforts to highlight the gender dimensions of law enforcement and guide the development of drug control policies that protect women's health and human rights.

Women and crop cultivation

Many small-scale farmers in drug-producing countries are pushed to cultivate drug crops due to poverty and a lack of viable legal alternatives. In these communities, women typically take care of activities such as planting, harvesting, and transporting small amount of plants and products, usually to attend to the family's basic needs.[50]

The 1961 Single Convention on Narcotic Drugs prohibits the production, manufacture, export, import, distribution, trade in, use, and possession of coca leaf, opium poppy, and cannabis outside of medical or scientific purposes and requires states to adopt measures to ensure that such actions be punishable offenses.[51] The 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances requires states to criminalize cultivation of these crops for illicit purposes (with leeway for states to opt out of criminalizing cultivation for personal consumption if this is unconstitutional or otherwise contrary to their legal systems).[52] It also requires states to prevent illicit cultivation and eradicate illicit crops, respecting traditions, human rights, and environmental standards.[53] This safeguard provision is limited, however, by the requirement that any measures must not be less stringent than those set out in the 1961 convention.[54]

These requirements conflict with state obligations to protect women's economic, social, and cultural rights and especially burden rural, indigenous, and Afro-descendant women. Development experts have raised concerns about alternative development programs' limited ability to reach those who rely exclusively on illicit crops for livelihoods, leaving the most vulnerable outside these programs' scope and reinforcing existing inequalities.[55]

Crop eradication efforts and the enforcement of opium, coca, and cannabis bans have eliminated the principal source of income for thousands of families. Eradication campaigns have also threatened food security, contaminated water supplies, and degraded land, displacing populations dependent on drug crops, as well as those who are not.[56] Displacement exacerbates the poverty and insecurity of poor farmers, with disproportionate impacts on rural, indigenous, and ethnic minority women. Eradication efforts also affect women in distinct ways. In Colombia, aerial spraying of coca crops with the herbicide glyphosate has been associated with dermatological and respiratory-related illnesses and miscarriage.[57] Exposure to glyphosate has also been associated with breast cancer.[58]

Women's health and economic circumstances are often ignored in efforts to provide alternative livelihoods in rural communities dependent on illicit crops. Alternative livelihoods programs that foster the cultivation of alternative crops usually target landowning farmers. UN Women has observed that "[i]n Colombia, women in rural areas are mainly responsible for the food safety of their families, but the fumigation of coca crops affects other crops and water sources, while crop substitution programmes mainly benefit men, who are traditional title holders and often the sole beneficiaries of agricultural extension services, training, credit, and tools."[59] These programs further inscribe gender inequality, as women are barred by law or practice from holding title to land in many crop-cultivating areas.[60]

States have positive obligations under CEDAW to take account of problems faced by rural women and the significant roles women play in their families' economic survival. They are also obligated to take action to ensure women's rights to access agricultural credit and loans, markets, marketing facilities, and their right to equal treatment in land and agrarian reforms and resettlement schemes and to enjoy adequate living conditions, particularly with regard to housing, sanitation, electricity, water supply, transport, and communications.[61] Yet as the CEDAW Committee has noted, rural women often have limited rights over land and natural resources and face discrimination in land rights.[62]

The CEDAW Committee has highlighted how gender stereotypes regarding women's and men's roles, such as laws giving preference to male heirs over female heirs and practices that authorize only heads of household to sign official documentation (such as land ownership certificates) and to receive parcels of land from the government, perpetuate discrimination against women and negatively affect their access to land. The committee has called for the abolition of these stereotypical concepts in administrative practice and law and for the legal recognition of women's rights to own and inherit land.[63]

UNODC technical guidance recognizes that addressing the gendered division of labor, access to and control over resources (such as land, labor, and technology) and benefits, participation in decision making, and gender norms and cultural

expectations that influence these factors is key to mainstreaming gender in alternative development programs.[64] In practice, however, their implementation has been inadequate, as UNODC has itself acknowledged.[65]

Conclusion

UN member states and UN drug control and human rights entities have recognized that gender inequality and gender power relations shape women's experience of drug use and in the drug trade and the impact of drug control policy on them in ways that are often distinct from their impact on men. They have called attention to the harsh impact of drug control efforts on poor and marginalized women and agreed on the importance of integrating a gender perspective in efforts to address discrimination and ensure women's equality. They have also recognized the Sustainable Development Goals as a framework for the implementation of drug control efforts. The development of new and better metrics to effectively describe, measure, and quantify the impacts of drug control on women are critical to designing new strategies for intervention. More broadly, the elaboration of international guidelines on human rights and drug control would be an important tool to assist states in meeting their international obligations to ensure women's rights in drug control policy design and implementation and in achieving Sustainable Development Goal 5 on gender equality.

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The Child's Right to Protection from Drugs: Understanding History to Move Forward

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Introduction

The UN Convention on the Rights of the Child (CRC) stands alone among the core UN human rights treaties in setting out a human right to protection from drugs. Article 33 provides that "States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances."[1] There are two points to note here; first, Article 33 contains two clauses: one relating to drug use and one to involvement in the drug trade. And second, the CRC is connected via Article 33 to the three UN drug control conventions: the Single Convention on Narcotic Drugs 1961 ("Single Convention"), the Convention on Psychotropic Substances 1971 ("1971 Convention"), and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 ("Vienna Convention").[2] These are the relevant international treaties to which the provision refers. In turn, the preamble of the Vienna Convention sets out, by way of justification for the provisions that follow, States parties' deep concern that "children are used in many parts of the world as an illicit drug consumers market and for purposes of illicit production, distribution and trade in narcotic drugs and psychotropic substances, which entails a danger of incalculable gravity."[3] This speaks to the issues of drug use and involvement in the drug trade addressed in Article 33. The CRC and the drug control system appear to hold consistent views: States have an obligation to protect children from drugs and concurrent obligations to control those drugs in certain ways. But are there deeper inconsistencies relating to theories and principles underpinning each regime?

The drug supply chain imperils children at each stage, from production to use. Children are harmed through drug use, parental drug dependence, drug-related violence, exploitation in trafficking, and a range of other ways.[4] But it is meaningless to simply say that children have the right to protection from drugs. What matters is what states do to implement that right, and unlike many other areas of child rights, implementing Article 33 requires action in a legal and policy area long characterized by considerable human rights risks.[5] It is plausible to ask whether the CRC serves to mitigate these risks or if it provides a child rights justification for the actions that generate them.

According to Anne Orford, law "is inherently genealogical…The past, far from being gone, is constantly being retrieved as a source or rationalisation of present obligation."[6] This is not in itself a bad thing, but it be-

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comes problematic when the original justifications for the creation of a regime have been forgotten, become irrelevant, or are now questioned, and where consequently the obligations in place are no longer suited to present conditions. This commentary looks to the development of the international drug control and child rights systems to ask questions about the origins of the child's right to protection from drugs and how that history may affect present understanding of norms. It is an invitation to think critically not only about the drug conventions, but also about the role of child rights in relation to drug policy. It asks, by way of conclusion, whether a teleological approach to Article 33 may expose tensions between apparently complementary regimes.

A brief history of parallel systems and their convergence

The history of the development of the international drug control regime has been investigated at various times and from differing academic disciplines.[7] None of these investigations have focused explicitly on children and young people; indeed, most do not focus on them at all, focusing instead on the primary drivers of the creation of the regime. On the other hand, while there have been numerous articulations of the development of child rights in the 20th century, the history of the recognition of the child's right to protection from drugs in international law has not received sufficient attention.[8] The convergence between the drug control and child rights systems is therefore an important gap in the existing literature. I do not propose to provide a comprehensive history in this short commentary, but instead to offer some observations that might be reflected upon when considering how to approach the child's right to protection from drugs today.

While there is a rich history leading to it, the Shanghai Opium Commission of 1909 is widely recognized as the genesis of the international control of drugs. During the proceedings, the Dutch delegation suggested that the prohibition of opium sales to children should be included in the final resolutions of the commission.[9] But the British delegate, Cecil Clementi Smith, provided an instructive response. This, he said, "has already been carried out…by every civilised country."[10] In other words, it was too obvious to warrant inclusion as a new international norm. In the end, the commission made no mention of minors in its influential resolutions, and the Opium Convention of 1912, which made some of the Commission's resolutions legally binding, also made no such mention, focused as it was on trade and supply.

An international obligation (outside of colonial possessions) to protect children from drugs was not agreed for another 80 years. This does not mean that concerns about drugs and children were absent in national debates. As Virginia Berridge records, as far back as the 1860s in the UK, "it was the dosing of children that first drew the attention of public health interests." The majority of opium poisoning deaths at the time were among young children, especially babies under a year old.[11] In Canada, the Opium and Narcotic Drug Act 1911 was a response both to the recommendations of the Shanghai Commission and to a "cocaine panic, initiated by the Montreal Children's Aid Society."[12] But this kind of concern was not yet sufficient for international attention.

In 1919, the League of Nations was entrusted with mandates relating to both opium (and other drugs) and child welfare under Article 23(c) of its covenant. Two major international conventions on drugs were adopted in 1925 and 1931.[13] Children, minors, and young people are not mentioned in these conventions; they appear only in treaties of lesser scope adopted in the same years, and which refer to prohibitions of opium sales and smoking in colonial territories.[14] In 1936, the League of Nations adopted a treaty against drug trafficking, but it was very unpopular, reaching as it did too far into national sovereignty.[15] It also omitted mention of children unlike its counterpart, the Vienna Convention, adopted 50 years later.

In 1924, the League adopted the Declaration on the Rights of the Child, often seen as the birth of child rights in international law. It was a short document containing five major points, so did not get into the detail of specific social issues.[16] Even so, longer, more detailed drafts of this declaration that did address various minutiae also did not include

drugs.[17] Indeed, throughout the League period, the work of the Committee on Child Welfare and the Opium Advisory Committee, though both in the same section, did not intersect.[18] Each had more pressing concerns.

Following World War II, the drugs and social mandates of the League were transferred to the United Nations through the Charter, along with a new human rights focus. The new General Assembly addressed drugs and children from its earliest sessions. In 1946, for example, UNICEF and the Commission on Narcotic Drugs were both established. But these issues remained separate. Three further protocols on drugs were adopted under the auspices of the UN in 1946, 1948, and 1953.[19] None referred to children or minors.

In 1959, the UN adopted the Declaration of the Rights of the Child. While expanded, and far more of a rights-based document than the welfarist 1924 version, it was also brief, and there is no reference to drugs.[20] There was, however, a major focus on drug control at the UN at the time: the patchwork of drugs treaties in place needed consolidation and the idea of a Single Convention on Narcotic Drugs was proposed in the late 1940s. After a decade of negotiation and three major drafts, the Single Convention was adopted in 1961. Children were not a focus in the drafting and do not appear in the final text. Indeed, issues relating to drug users of any age were rare in the negotiations.[21] The Single Convention remains the bedrock treaty of international drug control; subsequent treaties build upon it, and national drug laws are modelled upon it globally.

By the end of the 1960s, synthetic drugs were becoming a major concern at the UN and weaknesses in the Single Convention were identified. The Convention on Psychotropic Substances was adopted in 1971 to address the former concern, and the Protocol amending the Single Convention in 1972 to address the latter. Among other changes, the Protocol improved its provisions on drug treatment. Neither treaty focused on young people, however, outside of the inclusion of "education" among "measures against drug abuse" in article 38 of the amended Single Convention. By the early 1970s, then, and really by the early 1960s, the basic strategies and structures of international drug control were in place, and had been developed without reference to specific issues facing children or what this might mean for legal obligations and related responses on the ground.

Unlike the Single Convention, the negotiations of the 1971 and 1972 agreements did include discussion of the threat to young people, albeit in passing. Indeed, it is at this time that we see children entering into drug diplomacy for the first time. The first UN General Assembly resolution focusing on the threat drugs pose to children was adopted in 1971 at a time, when General Assembly resolutions on drugs in general changed in tone and content from being technical and administrative to being more threat-based.[22] The threat to mankind and "especially youth" starts to appear more often.[23]

During the 1980s, we see the parallel development of the CRC and the Vienna Convention. In 1979, to mark the 20th anniversary of the Declaration of the Rights of the Child, a working group of the Commission on Human Rights was established to begin drafting a new Convention on the Rights of the Child. China presented the first draft provision relating to drugs in 1982, but it was not discussed at the time.[24] The first draft of the Vienna Convention was submitted in 1984, and its preamble included the threat to youth as a component of the view that drug trafficking was a crime against humanity.[25] That year, a Declaration on the Control of Drug Trafficking and Drug Abuse had been adopted, again expressing the threat to youth.[26] In 1986, after two further suggested drafts, the working group on the CRC finally discussed the drugs provision, coming back to it again for technical review with the UN drug control program in 1988.[27] Article 33 was ultimately adopted with very little discussion or debate, compared with many other articles in the treaty.[28] The General Assembly adopted the CRC in 1989.

The General Assembly adopted the Vienna Convention in 1988, bringing into international law many aspects that were not possible in 1936. In its preamble, the Convention lays out the threat to children, and substantive provisions deal with aggravating circumstances for increased penalties

to meet that threat.[29] Both treaties entered quickly into force in 1990.

Critical reflections on the right to protection from drugs

The above is just a sketch, but from it we can make some observations to spur debate around Article 33 of the CRC and its relationship to drug law and policy.

First, the concurrent drafting of the CRC and the Vienna Convention illustrates the political environment from which the right to protection from drugs emerged. As we have seen, the concept of drugs as a threat to children first appears in international discourse in 1971. Most working in drug policy recognize the importance of that year: President Nixon declared drugs as public enemy number one, beginning the "war on drugs" as we now know it. In the years that followed, the narrative of threat became more prominent in drug diplomacy.[30] By the late 1980s, when the CRC and Vienna Convention were adopted, "crack baby" scares and the Just Say No campaign of the Reagan era were prominent. The war on drugs was at full steam. It is at this stage that drug control and child rights law converge on the international stage for the first time, in the form of new obligations in a drugs treaty, and a new human right.

Second, the protection of children was an ex-post facto justification for a system that was already long in place, and a reason to ramp up its severity if drug use among young people was worsening over time, this was despite the regime that had been put in place. This raises an important question: If the legal architecture for drug control had never been built in this form, but the child's right to protection from drugs had still been agreed, would we necessarily develop the same drug control system to realize that right? Some States parties to the CRC, after all, have not ratified the drugs conventions. Some may well denounce them in future. The CRC creates obligations independent of the drugs conventions. So what, in other words, does the child's right to protection from drugs add, independent of its apparent connection to the those treaties?[31]

This leads to a third observation. While drugs entered into international human rights law through what is rightly recognized as a milestone in the development of child rights, this seems to have been done with little discussion as to what it meant in practical terms for children to have a human right to protection from drugs. Meanwhile, children entered into international drug control law via the most punitive and repressive drugs treaty to date, a characterization justified by its own terms. Despite their apparent coherence, the CRC and the drugs conventions are different kinds of laws. The former is a rights document. The latter put in place a system of market control and transnational criminal law with very little regard for human rights. The case of incitement illustrates the importance of this basic difference. In the drafting of the CRC, incitement to become involved in the drug trade was rejected.[32] But it was included in the Vienna Convention at around the same time.[33] It was easier, in effect, to include a measure raising clear freedom of expression concerns and other legal problems in a treaty the drafters knew contained elements that could be unconstitutional for some states, than in one focused on protecting human rights.[34]

There could be two possible effects of this convergence of different kinds of laws: drug control could be pulled towards child rights and tempered by it, or child rights could be pulled more towards drug control and equated with it. This reflects an ongoing disagreement among NGOs and researchers about Article 33. Some see the CRC as an important check on state actions in drug control.[35] Others see it as a child rights confirmation of the existing drug control apparatus, with the concurrent development of the Vienna Convention and the CRC providing support for this view.[36] Given the human rights risks associated with drug control, this is a serious debate for child rights scholars and advocates. Protecting children from drugs will be carried out in the context of drug policies, not some abstract realm of child rights implementation. If the right to protection from drugs is merely a child rights stamp on existing drug policies, then Article 33 of the CRC is arguably part of the human rights risk presented by international drug control laws. As I have set out elsewhere, there is evidence that this is how states have seen this right, and that

there has been little resistance to it. For example, States parties have consistently included incitement laws in their periodic reports to the Committee on the Rights of the Child, and the Committee has welcomed and encouraged such laws. In this way, a measure that has been put in place pursuant to the Vienna Convention has translated into child rights compliance uncritically, and after the fact. Further evidence from the periodic reporting process under the CRC shows that more than half of states that retain the death penalty for drug offenses have reported such laws as part of their implementation of Article 33. The Committee has never challenged it.[37]

Conclusion

The UN drug control system is an example of the past being retrieved as rationalization for present obligations. We see it in celebrations of the centenaries of the Opium Commission and the Opium Convention.[38] That history, proudly remembered, reinforces commitment to *present norms*, through which, according to celebratory resolutions, "great progress" has been made.[39] But this system was developed without children in mind, whereas the CRC was developed precisely because of the differences in approaches needed for children's rights and the issues they face. So can that (legal) past be retrieved legitimately to underpin a child's right to protection from drugs, or do we require a new beginning that starts with child rights theories and approaches? This is important because if the child has a positive right to protection from drugs, agreed by 196 States parties, and if we take child rights seriously at all, then they have the right to drug control of some sort. The question is whether Article 33 provides the imprimatur of child rights to an existing system developed without attention to children's needs or rights, or whether it can be employed to ask searching questions of that system.

I conclude, therefore, with an empirical challenge rooted in an aim of Article 33. States parties must take appropriate measures to prevent the use of children in the illicit drug trade. So we may ask: Does the criminalization of the drugs market decrease or increase opportunities for the exploitation of children in the drugs trade? If the answer is that it increases such opportunities, Article 33 is being directly countered. By this teleological reasoning, Article 33 and the drugs conventions would be far from complementary, as their texts and the historical concurrence of the Vienna Convention and the CRC may suggest. They would instead be in conflict in a way that goes to the core strategy of the drug control system.

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Drug Policy and Indigenous Peoples

JULIAN BURGER AND MARY KAPRON

Abstract

This paper identifies the principal concerns of indigenous peoples with regard to current international treaties on certain psychoactive substances and policies to control and eradicate their production, trafficking, and sale. Indigenous peoples have a specific interest in the issue since their traditional lands have become integrated over time into the large-scale production of coca, opium poppy, and cannabis crops, in response to high demand from the American and European markets, among others. As a consequence, indigenous peoples are persecuted because of their traditional use of these and other plant-based narcotics and hallucinogens. They are also victims of the drug producers who remove them from their lands or forcibly recruit them into the production process. As indigenous peoples are caught in the violent world of illicit drug production, law enforcement often targets them first, resulting in disproportionate rates of criminalization and incarceration.

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Introduction

In light of ongoing international discussions on drug policy, the increasingly recognized failure of the "war on drugs," and the interests of the human rights community to ensure that drug control in its current or future forms fully respects human rights, the paper argues that indigenous communities must be involved in discussions on drug policy and human rights. It also recalls the United Nations Declaration on the Rights of Indigenous Peoples, adopted by the General Assembly in 2007, which constitutes the framework for the inclusion of indigenous peoples' rights and interests in reform efforts.

The purpose of the present paper is to flag some of the issues that require further elaboration and examination and to stimulate a debate on an appropriate new approach to illicit drugs and respect for the hard-fought and universally recognized rights of indigenous peoples to be fully taken into account in any eventual new drug regime. It recognizes that current efforts to develop international guidelines on drug policy and human rights are one means of complementing and working towards this objective. Further research is needed to assess the impact of current drug policy at the community level, as well as drug use within indigenous communities, especially among youth and children. It is also desirable to involve indigenous experts in the elaboration of human rights guidelines. The paper concludes with possible future areas of research and action. The present article does not cover the production of cannabis as there is no strong correlation between the areas of production of cannabis and indigenous peoples' lands.

The current international drug control regime

The international drug control system is based on three treaties: the 1961 Single Convention on Narcotic Drugs, as amended by the 1972 Protocol (Single Convention), the 1971 Convention on Psychotropic Substances (1971 Convention), and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988 Convention).[1] Together, these conventions define licit drug production, supply, and use, and create a system to suppress any illicit activities. Their primary goal, as set out in Article 4 of the Single Convention, is "to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs."[2]

Examining coca specifically, the Single Convention lists the coca leaf as a Schedule 1 substance alongside cocaine, making it subject to various control measures, including that coca bushes must be destroyed if cultivated illegally.[3] Article 49(2) created a temporary exception for the traditional use of coca leaf, but outlawed coca leaf chewing as of December 12, 1989.[4] The rationale behind prohibiting coca stemmed from the United Nations Economic and Social Council's Commission of Enquiry on the Coca Leaf and was done to eradicate consumption of the coca leaf itself and to prevent cocaine production.[5] The commission classified coca as "Indian," and although its sacred nature was documented, this was not recognized as a valuable cultural practice but considered a superstition. The report undermined traditional uses of coca chewing, concluding that coca leaf chewing should be eradicated.[6] The report also incorrectly determined that coca leaf caused malnutrition, adversely affected the user's personality, and limited their economic activity.[7] More recent research on coca chewing shows that many of the findings of the report were false.[8]

While the 1971 Convention reduced interference into indigenous uses of plant derivatives, the 1988 Convention took a hard-line approach in addressing the illicit traffic of narcotic drugs, obliging states to criminalize possession and purchase of controlled substances.[9] Article 14 of the 1988 Convention recognizes the traditional use of certain plants, including the coca bush, but also stipulates that measures shall not be less stringent than the obligations of the Single Convention.[10] Therefore, the Single Convention's requirement that traditional use of the coca leaf be eradicated remains unchanged. Further, Article 14 does not require consultation with and the eventual consent of indigenous communities before actions are taken to eradicate illicit crops on their lands.[11] The

International Narcotics Control Board's (INCB) continuous criticism of coca leaf chewing further legitimizes the deeply prejudicial views of coca that are now entrenched in international law. In 2007, the INCB called on states "to abolish or prohibit activities that are contrary to the 1961 Convention, such as coca leaf chewing and the manufacture of *mate de coca* (coca tea) and other products containing coca alkaloids for domestic use and export."[12] However, in its latest report, the INCB recognized that "under the reservation, and since February 2013, the chewing of coca leaf and the consumption and use of the coca leaf in its natural state for 'cultural and medicinal purposes' are permitted on the territory of the Plurinational State of Bolivia."[13]

The Single Convention also lists opium as a Schedule 1 substance.[14] However, the opium poppy and poppy straw are excluded from the Convention's schedules and restrictions on cultivation only apply to the "cultivation of the opium poppy for the production of opium."[15] As with the coca leaf, Article 49(2) creates a temporary exception for traditional uses of opium, but only permits such persons registered as of January 1, 1964 to smoke opium and states that quasi-medical uses of opium must be abolished by 1979.[16] Additionally, while Article 14 of the 1988 Convention also recognizes the traditional use of the opium poppy, it also stipulates that measures shall not be less stringent than the obligations of the Single Convention.[17] Therefore, the Single Convention's requirement that traditional uses of opium be eradicated remains unchanged.

With regards to psychoactive and hallucinogenic drugs, as stated, the 1971 Convention took a more lenient approach to drug control. This was because pharmaceutical companies pressured North American and European governments to lobby for weaker controls.[18] The Convention excluded from the schedules plants from which alkaloids could be extracted, while listing the alkaloids themselves.[19] This resulted in greater protection being given to indigenous use of plant derivatives. For example, ayahuasca and peyote were not placed under a schedule.[20] During debates surrounding the drafting of the 1971 Convention, the United States argued: "It was not worth attempting to impose controls…[t]he American Indians in the United States and Mexico used peyote in religious rites, and the abuse of the substance was regarded as a sacrilege."[21]

Human rights impacts of current drug policy on indigenous peoples

Correlation of drug production and indigenous peoples' lands: Indigenous peoples and ethnic minorities are disproportionately affected by the production of illicit drugs, trafficking, and the "war on drugs." The major production areas of the raw materials—coca and the opium poppy—for the most commodified drugs are often on the traditional lands of indigenous peoples and ethnic minorities. The traditional opium-producing areas are in the highlands of the "Golden Triangle" (Myanmar, Laos, and Thailand) and the "Golden Crescent" (principally Afghanistan), populated largely by hill tribes and ethnic groups. Poppy cultivation is also carried out in Mexico, Colombia, and Northeast India, often by indigenous peoples and ethnic groups.[23] Coca is grown in South America (Colombia, Peru, and Bolivia, and on a smaller scale in Brazil and Ecuador) on lands often considered ancestral indigenous territory.

Forced displacement: The mass production of illicit crops has resulted in the violent removal of indigenous peoples and other rural groups from their homes. In Colombia, where the civil war has displaced up to 6 million people, a significant cause of displacement has been the internal war to produce and control the lucrative production of cocaine by drug traffickers, the armed opposition movements such as FARC and the paramilitaries. The "war on drugs," which has been particularly virulent in Colombia, drove the producers onto indigenous peoples' lands. From 1990-2000, funds from drug trafficking were used to seize more than 5 million hectares of the country's agricultural land.[23] The "war on drugs" has also impacted poppy growers in Thailand and northern Myanmar, especially affecting the Wa people. In these countries, conflict involving governmental forces, irregular armed groups, and criminal drug traffickers has

led to the displacement of indigenous peoples. The production of coca and opium often involve violent and exploitative labor conditions and the criminalization of indigenous individuals who may unwillingly engage in the production, refinement, use, and transport of these raw and transformed materials, either through force or due to poverty and the absence of alternative means.

Militarization of indigenous peoples' lands: Outside the geographic areas of drug production, trafficking in countries such as El Salvador, Guatemala, Honduras, and Mexico has led to militarization, excessive use of force, and human rights violations, especially in rural areas, which in these countries are often predominantly indigenous. The breakdown in law and order, and impunity in cases of homicide, femicide, and enforced disappearances perpetrated by either the authorities or criminals involved in drug trafficking, has resulted in this region having the highest levels of homicide in the world and has caused the population, especially young people, to flee to neighboring states and the United States. Many of those fleeing the violence associated with drug trafficking are indigenous people.[24]

Criminalization and impacts on women and children: As noted, drug production and trafficking on indigenous peoples' lands has the effect of criminalizing entire communities that the authorities view as involved in these activities.[25] Women are particularly affected.[26] They are often pressured through poverty and a lack of alternatives into taking up low-ranking, low-paying, high-risk positions, and a disproportionate number of women, especially those from ethnic minorities, work as drug mules.[27]

Impact on subsistence activities: The large-scale introduction of illicit crops and the disruptions to communities as a consequence of official measures to eradicate these crops has reduced the capacity of indigenous peoples to maintain their subsistence activities. The aerial spraying of illegal crops during the Plan Colombia period from 2002 to 2015 damaged the environment and prevented planting and harvesting of food for local use. Drug control policies implemented by states as a result of drug conventions severely impacted indigenous peoples' rights to subsistence. Crop eradication methods, such as aerial spraying, affect indigenous peoples' health, right to a healthy environment, and livelihoods.[28] In cases where ethnic groups and indigenous peoples are no longer able to grow illicit crops due to repressive action by the state, they have been driven deeper into poverty.[29] International bodies focusing on law enforcement rarely see crop substitution and more integrated alternative development programs as an option. When such policies have been implemented, as in northern Thailand, although bringing some benefits, the rights of local indigenous producers to be consulted and to establish their own development priorities have not been respected.[30]

Violation of indigenous peoples' religious, cultural, and health rights: Among some of the indigenous peoples affected by drug policies, the opium poppy and coca, as well as certain other illicit drugs, have historic, cultural, health, or religious value and have been produced for local use over centuries prior to the introduction of international laws. Opium production in Afghanistan, Myanmar, and other neighboring countries making up the "Golden Crescent" and "Golden Triangle" are often valley and hill regions where indigenous peoples and other distinctive ethnic groups have traditional lands and subsistence activities. The use of opium for health, religious, and cultural reasons has a long history and remains of importance for some hill peoples in the regions, such as the Hmong of northern Thailand, Vietnam, and Laos. [31]

Intellectual property issues: Incidental to the impacts of current drug policy on indigenous peoples, plants and combinations of plants used by shamans, healers, and other traditional knowledge holders are often the subject of interest by outside commercial interests. In an ironic twist of the prevailing drug regime, indigenous peoples criminalized for the use of certain psychoactive drugs

for community use may lose intellectual property rights to their inventions. This occurred with ayahuasca, a psychoactive plant-based product used by Amazonian indigenous peoples for spiritual and healing for which a US patent was requested in 1986 and affirmed in 2001.[32]

Indigenous peoples and a human rights framework for drug policy: key questions

The decades-long "war on drugs" has not measurably reduced the production, trafficking, or consumption of illicit drugs and by most accounts has resulted unwittingly in the proliferation of production and the expansion of organized crime with its violent and corrupting impacts. Current drug policy has considerably worsened the human rights of those drawn into its orbit. In the case of indigenous peoples, the consequences have been disproportionately negative as a result of their proximity to areas where the drugs are produced and their relatively weak economic and political situation.

As we consider a new approach to international drug policy, we must ensure that all human rights are protected for all. Indigenous peoples, in light of their cultural specificity require particular attention in these efforts to ensure human rights protection. In 1961, when states negotiated the present drug regime, the predominant thinking was that indigenous peoples would eventually be assimilated into the wider society and that their practices, deemed backward, would also disappear. The emerging rights, elaborated during the 1980s and 1990s and resulting in the adoption of UN Declaration on the Rights of Indigenous Peoples (UNDRIP) in 2007, recognize the distinct cultural identity of indigenous peoples and their right to self-determination. Since the General Assembly adopted UNDRIP, the international community has universally accepted human rights standards that any new drug treaties and policies need to take into account. Not to reflect these rights would be to create unnecessary tensions or even contradictions within the corpus of international agreements and commitments.

Such a conflict exists under the current arrangement. At present, states committed internationally and under their constitutions and national laws to respect indigenous peoples' cultures, including their right to the traditional use of plants for religious, cultural, or health purposes, are also signatories to the international drug control treaties which require them to eliminate the production and use of these plants. For states with indigenous peoples traditionally using plants that are prohibited under these international agreements, a suitable accommodation needs to be found to enable the peoples concerned to enjoy their culture without hindrance.[33]

The right to self-determination: Article 3 of UNDRIP recognizes the right to self-determination of indigenous peoples. It acknowledges, inter alia, the right of indigenous peoples to freely pursue their own cultural development. Other rights in UNDRIP flow from this over-arching recognition and include the right of indigenous peoples to maintain their customs, use traditional medicines, determine the use of their lands, set their development priorities, and be consulted fully through their own decision-making bodies in matters that may affect their communities.

Rights to lands and resources: Article 26 of UNDRIP recognizes the rights of indigenous peoples to own, use, develop, and control the lands, territories, and resources that they possess by reason of traditional ownership or other traditional occupation. This right gives indigenous peoples the possibility of continuing to produce crops and plants that they have traditionally grown for their own religious, medicinal, or customary purposes, and which constitute a part of their cultural practice and identity. The question may arise about whether this also includes a right to produce plants or crops that may be transformed into illicit drugs that are prohibited nationally and internationally. In certain countries, in the absence of alternative means of survival, indigenous peoples have been drawn into using their lands for the production of illicit crops. In such cases, rather than prosecuting the producers, a human rights approach developed in cooperation with the

indigenous peoples would be appropriate in order to find marketable substitute crops.

Right not to be forcibly removed from their lands: Article 10 of UNDRIP addresses forced relocations or removals of indigenous peoples from their lands. It is unequivocal in prohibiting the forced removal of indigenous peoples from their lands and, in the event of undertaking such an operation, requires states to obtain the free, prior, and informed consent of the indigenous peoples concerned.

Right to enjoy their culture: Article 8 of UNDRIP states that indigenous peoples have a right not to be subjected to the destruction of their culture; this is described as any action that deprives them of their cultural values or ethnic identity. Article 11 recognizes the right of indigenous peoples to practice and revitalize their cultural traditions and customs. Article 12 recognizes the right of indigenous peoples to manifest, practice, develop, and teach their spiritual and religious traditions, customs, and ceremonies. Article 31 recognizes indigenous peoples' rights to maintain, control, protect, and develop their cultural heritage, traditional knowledge, and traditional cultural expressions, as well as the manifestations of their sciences, technologies, and cultures, including human and genetic resources, seeds, medicines, and knowledge of the properties of fauna and flora. The article also protects indigenous peoples' intellectual property rights over their cultural heritage, traditional knowledge, and traditional cultural expressions. The various rights set out in the Declaration require that any new drug policy, in order to accommodate the rights of indigenous peoples established by member states, needs to ensure that indigenous peoples have the right to grow and use all plants, including those that may have psychoactive effects. These plants and their use form a part of their cultural identity and constitute a recognized cultural practice. In 2009, the Permanent Forum on Indigenous Issues called for the amendment or repeal of those portions of the 1961 Convention regarding coca leaf chewing that are inconsistent with the rights of indigenous peoples to maintain their traditional health and cultural practices, as elaborated in UNDRIP.[35]

Right to the conservation of indigenous peoples' lands: The "war on drugs," particularly measures taken to eradicate the production of crops through aerial spraying, has had a negative impact on the environments on which indigenous peoples depend. Article 29 requires governments to ensure the protection of the productive capacity of indigenous peoples' lands and resources, a commitment that is not compatible with measures taken to poison large areas of crop production.

Right to health: Article 24 of UNDRIP recognizes the right of indigenous peoples to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants. Among many indigenous peoples, medicines are obtained from locally grown or harvested plants. In the absence of easily available Western medicines, or because of cost, or even because local medicines are considered more efficient than Western alternatives, indigenous communities are dependent on local plants and medicines for their health and well-being. If prohibitions continue to be applied internationally to the production of certain plants, indigenous peoples should not be deprived of the right to produce, harvest, and use them if they are essential elements that contribute to the health and well-being of their communities.

Right to peace and security: Indigenous peoples have been affected by heavy-handed policing and military operations on their lands in the "war on drugs." Article 30 of UNDRIP addresses this concern, calling on governments to desist from military operations in the lands or territories of indigenous peoples unless justified by a relevant public interest or otherwise freely agreed upon or requested by the indigenous peoples concerned. The article requires consultation and a good faith assessment of the threats to the public and indigenous community before considering military operations on indigenous peoples' lands.

Article XXX (5) of the American Declaration on the Rights of Indigenous Peoples, adopted in June 2016, limits military operations on indigenous peoples' lands except in the public interest or if requested by indigenous peoples. Although Colombia includes a reservation stating that "the provision would be in breach of the principle of need and effectiveness of the security forces, preventing them from fulfilling their institutional mission, which renders it unacceptable."

The right to be consulted: Flowing from the right to self-determination, a number of UNDRIP articles call upon states to consult with indigenous peoples. Article 19 calls on states to consult and cooperate in good faith with the indigenous peoples through their own representative institutions in order to obtain their free, prior, and informed consent before adopting and implementing legislative or administrative measures that may affect them. This principle extends to the international arena, where indigenous peoples argue—and states increasingly recognize—that indigenous peoples have a right to be consulted in international agreements that may impact their lands, resources, cultures, and identities.[36]

The requirement to respect human rights: UNDRIP requires indigenous peoples, in the practice of their cultures, customs, and legal systems, to respect established human rights. While the intention of this qualification is to ensure that the Declaration complies with internationally agreed human rights, and is usually referred to in matters relating to indigenous peoples' justice systems, it has application more generally to customs and cultural practices that may affect human rights.

Conclusion

The purpose of this article is to argue that any new international framework for drug policy or national drug control policies need to recognize the particular situation of indigenous peoples. Crops currently prohibited internationally may in some communities be part of their cultural heritage and play a fundamental role in religious, health, and customary practices. De facto, certain states accept these traditional uses of plants, as is the case with some Andean countries and coca leaf chewing.[37] In countries like Peru, Bolivia, and Colombia, it is impossible to reconcile respect for the cultural practices of indigenous peoples with a blanket eradication and criminalization of coca growing.[38]

In the discussions that will be carried forward to elaborate a new approach to drug policy, it is indispensable that indigenous peoples are consulted to ensure a full understanding of the traditional use of plants that are subject to prohibition. Consultation and consent are principles now accepted by states in relation to indigenous peoples. The right of consultation of indigenous peoples extends to the international level when reviewing and deciding upon policies that may affect them. Furthermore, there exist mechanisms for consultation with indigenous peoples. These include the special rapporteur on indigenous peoples, the Expert Mechanism on the Rights of Indigenous Peoples of the Human Rights Council, and the Permanent Forum on Indigenous Issues that advises the Economic and Social Council. It would seem indispensable that the General Assembly draw upon the expertise represented by these mechanisms as it reviews a new drug policy.

At the time of elaborating drug policy, the rights of indigenous peoples had not been acknowledged and given universal recognition. This is no longer the case. UNDRIP represents a framework of rights accepted by all member states, and future international law needs to operate in compliance with these newly established norms. Any new bans on plants used by indigenous peoples as part of their cultural heritage would violate their rights. Although the Declaration is non-binding, it represents a universal consensus and has binding force, particularly with regard to the right to culture, through its association with existing international human rights law. In any future agreement on drug policy, consideration needs to be given, inter alia, to the right of indigenous peoples to use plants they have used historically and that are part of their customs. It must address their right to be

free to grow these crops on their own lands for their own use without interference. Future drug reform efforts must ensure that the forced removals of indigenous peoples from their lands is prohibited and that there is no damage to the long-term viability of indigenous peoples' lands and environment through actions to eradicate illicit crops. Action taken to address the production of illicit drugs on indigenous peoples' territories should be undertaken only after consultation and the consent of the peoples concerned has been obtained. The right of indigenous peoples to be secure on their lands and to be consulted in matters affecting them are rights established by UNDRIP, incorporated into national law in many countries, and recognized as such by intergovernmental human rights bodies such as the Inter-American Court of Human Rights.[39]

Looking forward, there is a need for further research and action in relation to indigenous peoples and any future drug policy. Little has been said in this article about the right to health implications of drug use within indigenous communities, the devastating effects on youth and children, and on culturally appropriate action to address this challenge. As noted, in some countries indigenous peoples may be disproportionately incarcerated as drug producers, traffickers, and users, raising questions about the operation of the justice system and its impact on vulnerable groups. Are there alternative models, drawing on indigenous peoples' own legal traditions that could play a more active role? Further research is needed on the economic and environmental impacts of drug production and illicit crop eradication and on culturally appropriate and community-driven and controlled alternatives. Ultimately, fulfillment of UNDRIP's provisions, recognition of indigenous peoples' rights to their lands and resources, and recognition of their right to determine their own development offer the best basis for a relationship between states and indigenous peoples in their joint efforts to eliminate the violence and destructive impact of criminal drug trafficking organizations while protecting indigenous peoples' cultures.

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Mechanisms of Accountability for the Realization of the Right to Health in China

SHENGNAN QIU AND GILLIAN MACNAUGHTON

Abstract

China ratified the International Covenant on Economic, Social and Cultural Rights in 2001. It thus bears obligations under Article 12 of the covenant to take appropriate measures at the domestic level to realize the right to health in China. Accountability is an important component of the right to health. This article examines whether the Western concept of accountability, recently imported into China, has the potential to improve the protection of the right to health within China's existing political, legal, and cultural framework. In so doing, it reviews current Chinese institutional mechanisms and considers the use of less formal mechanisms by which duty-bearers might be held accountable in China. More specifically, this article provides an overview of a range of health-related accountability mechanisms, including judicial, political, administrative, professional, and social accountability arrangements. It concludes that although there is the basis of an accountability framework for the right to health in China, the effective operation of accountability mechanisms is hindered by longstanding cultural and political barriers.

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Introduction

On August 23, 2016, Philip Alston, the United Nations (UN) Special Rapporteur on extreme poverty and human rights, issued a statement at the end of his mission in China. Alston noted the extraordinary progress that China has made over the past three decades in bringing people out of poverty. In particular, he reported that "[i]n 2003, only 10% of the population had health insurance" whereas "[b]y 2013, some 95% were covered, including most of the rural poor and vulnerable urban groups."[1] Additionally, between 2000 and 2012, the infant mortality rate fell by 60% and the maternal mortality rate fell by 49%, and between 1990 and 2012, life expectancy increased from 69 to 75 years. Alston, accordingly, concluded that there were lessons for other countries to be drawn from China's achievements. Significantly, he declared that "genuine political will to alleviate poverty is arguably the most important ingredient of all."[2]

On the other hand, Alston reported a number of challenges for economic and social rights, in particular the lack of genuine accountability mechanisms to enable rights-holders to seek remedies for violations of their human rights. The absence of "effective options for seeking redress or letting steam off," he noted, often leads to violence both by and against petitioners and protesters.[3] Accordingly, the development of effective domestic mechanisms of accountability in China is a crucial issue. In this context, this article provides an overview of accountability mechanisms in China, focusing on the right to health specifically and revealing where such mechanisms are lacking and how they might be improved. Accountability may involve a broad range of mechanisms—such as litigation, elections, public hearings, town meetings, professional oversight, social actions, and media reports—and China is a large and complex country. The article, therefore, does not attempt to provide a comprehensive review and does not examine any particular mechanism in depth. Nonetheless, the overview and analysis have implications for accountability for the right to health and all economic and social rights in China.

China ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 2001 and "has consistently emphasized its commitment to guaranteeing these rights" in its National Human Rights Action Plans.[4] Article 12 of the ICESCR recognizes the right of everyone to the highest attainable standard of physical and mental health (often referred to simply as the right to health).[5] It also establishes the obligations of states parties to take steps to achieve the full realization of the right to health by, for example, providing for infant and child health, improving environmental conditions and workplace safety, preventing epidemics and occupational diseases, and ensuring health care for all. Under Article 12, states parties are required to respect, protect, and fulfill the right to health, including the right to health care and the underlying determinants of health—such as nutritious food, potable water, and safe housing—by taking concrete and targeted steps to progressively realize the right.[6]

Fulfilling these obligations involves complex processes and efforts on the part of the state. For example, it requires that the state implement a non-discriminatory and effective health system; that it guarantee the availability and accessibility of clean water and essential medicines; and much more.[7] Many state actors are involved in implementing these processes. In terms of the right to health, these actors constitute duty-bearers. Supervising and monitoring the actions of these actors in relation to their duties is essential. In this way, these duty-bearers can be held accountable if they fail to fulfill their respective obligations and responsibilities, or if they abuse their powers. Accountability is an important component in the realization of the right to health, and accountability mechanisms play crucial roles in the supervisory process required to enhance the realization of this right.[8]

As this Western idea of accountability is a newly imported concept in China, this article examines how far, if at all, institutional norms and structures of accountability have been absorbed into or transformed to fit the existing Chinese legal, political, and cultural frameworks. In so doing, it reviews current Chinese institutional mechanisms and considers the use of less formal mechanisms by which duty-bearers might be held accountable

for the right to health. More specifically, the article discusses judicial accountability, political accountability, administrative accountability, professional accountability, and social accountability. In short, it explores whether the Western concept of accountability has the potential to improve the protection of the right to health within China. The article concludes that there is a domestic accountability framework—although very different from that of Western democracies—operating at various levels in China with some capacity to protect the right to health. Nonetheless, this accountability framework involves largely top-down processes and fails to provide adequate avenues for rights-holders to complain and to seek remedies for violations of their rights.[9]

Accountability for the right to health

Accountability is a key component of human rights, including the right to health. In General Comment 9 on the domestic application of the covenant, the UN Committee on Economic, Social and Cultural Rights, the body responsible for monitoring implementation of the covenant, stressed that the central obligation of states parties in relation to the ICESCR is to ensure that the rights recognized by the covenant are fulfilled.[10] Although the ICESCR adopts a flexible approach that enables governments to take into account the particularities of their own legal and administrative systems, governments must nonetheless use all the means at their disposal to realize the rights recognized in the covenant.[11]

Accountability is crucial to ensuring that states parties meet their obligations under the covenant. Governments are required to provide appropriate means of redress to aggrieved rights-holders.[12] There are many types of accountability mechanisms, including judicial, quasi-judicial, administrative, political, and social mechanisms.[13] While the type may vary, the purpose of each mechanism is to ensure that governments are answerable for their actions or inactions regarding the right to health and that rights-holders have effective remedies when their rights have been violated.[14] There are a number of potential remedies for violations of the right to health. Restitution, compensation, and rehabilitation focus on addressing impacts of rights violations on individual right-holders or groups of rights-holders.[15] Satisfaction and guarantees of non-repetition are remedies aimed at addressing rights violations at the systemic level.[16]

Importantly, accountability is "sometimes narrowly understood to mean blame and punishment, whereas it is more accurately regarded as a process to determine what is working (so it can be repeated) and what is not (so it can be adjusted)."[17] In this sense, accountability for human rights also hinges on the notion of participation of people and groups in all health-related decision making. Governments ensure one kind of participation through the creation of accountability mechanisms and effective remedies.[18] In addition, individuals and groups are entitled to participate in meaningful ways in the development and design of health policies and in monitoring and evaluating the implementation of these policies.[19] In order to ensure avenues for meaningful participation, governments must create fair and transparent processes that are accessible to and inclusive of diverse groups.[20] Participation methods vary but could include regional or national conferences, local health committees, focus groups, budgetary oversight, and public meetings.[21]

Effective monitoring and evaluation by government, civil society, and rights-holders also requires transparency. Governments have an obligation to provide the public with information about their efforts to realize the right to health.[22] Continuous monitoring of efforts and outcomes serves a number of purposes. First, it provides governments with valuable information about the impact of their efforts.[23] Second, it provides rights-holders with information they need to participate meaningfully in health-related decision making and to hold their government accountable for realizing the right to health.[24]

Accountability mechanisms for the right to health in China

The exact term "accountability" (*wen ze*) was first introduced into the Chinese political system in 2003.[25] The outbreak of severe acute respiratory syndrome

(SARS) that occurred in China that year exposed the lack of accountability in the existing administrative system, so much so that the notion of accountability was dramatically brought into public focus.[26] Before long, the term "accountability" was encapsulated in the Chinese word *wen ze* (问责). Scholar Kit Poon explains, "Unlike the terms *ze ren* [责任] (responsibility) or *fu ze* [负责] (taking responsibility) that have previously been used in Chinese political discussion, *wen ze* carries with it the connotations of 'questioning' and 'blaming', closely reflecting the essence of the liberal notion of accountability."[27] In a dramatic move in 2006, the prime minister, during the fourth session of the 10th National People's Congress, delivered a report on governmental reform and development and stressed the need to strengthen administrative accountability. Later that the same year, he further emphasized the principle of transparency as an important component in the process of developing appropriate systems of accountability.[28]

Learning from the experiences of other societies, China has gradually started to build an accountability system tailored to its own political and cultural characteristics. The newly adopted Western concept of accountability has the potential to play an important role in structuring mechanisms and systems that can be applied to various aspects of the right to health, such as policymaking, professional administration, and health care delivery. Accordingly, the concept of accountability presents a primary tool for translating abstract principles into specific standards for measuring progress and for developing efficient laws, policies, institutions, procedures, and mechanisms that ensure the delivery of entitlements and redress for rights-holders.[29]

In this context, this article provides an overview of the evolving framework of accountability relevant to the right to health in China. It addresses five categories of accountability: (1) judicial accountability, the traditional human rights mechanism; (2) political accountability, including participation, as it plays a crucial role in justifying policy decisions; (3) administrative accountability, as health policies and strategies are carried out largely by administrative organs; (4) professional accountability, as quality health services must be delivered by qualified health professionals; and (5) social accountability due to the special value system in Chinese society.

Judicial accountability

China has ratified the ICESCR and other international treaties that guarantee protection of the right to health for specific populations.[30] However, international human rights laws cannot be invoked directly in Chinese courts; rather, they must be incorporated first into domestic law.[31] Thus, in practice, the international human right to health has never been invoked in a Chinese court. At the national level, the Constitution of the People's Republic of China obligates the government to provide a comprehensive health system that guarantees individuals' access to health care.[32] However, there is no constitutional court in China, and no rights-holder has claimed a constitutional right to health in any Chinese court.

Nevertheless, this does not mean the right to health is not justiciable in domestic courts in China. In practice, the right to health can be deconstructed into component rights, including the right to health care, the right to clean water, the right to safe food, the right to clean air, the right to a healthy environment, and so on. Thus, in many circumstances around the world, the realization of the right to health is achieved in practice through judicial successes with other legal rights. Therefore, the right to health might be justiciable in China by means of other health-related rights.

Within China's legal system, there are other statutes and regulations concerning the health protection of different groups. For example, Articles 53 and 54 of the Labour Law provide health protection standards for worksites[33] The Women's Rights Protection Law addresses many health-related rights for women, including health benefits related to childbearing, health and safety at work, and the prohibition against domestic violence.[34] The Environmental Protection Law gives attention to quality air and water, which are underlying determinants of health.[35] Meanwhile, at the provincial level, there are also regulations concerning health issues. Although the original purpose of these laws was not

to protect health as a human right, some aspects of the right to health have been indirectly protected in courts through litigation under these laws.

Such health-related judicial cases have increased in recent years. One example is China's first public interest litigation on air pollution, initiated by the All-China Environment Federation, which was adjudicated in July 2016. The Dezhou Intermediate Court found that the defendant's air emission from its factory did not meet national standards and ordered the defendant to pay 21 million RMB (about US$3 million) to the government for air reparation.[36] Additionally, individuals have been surprisingly successful in contract lawsuits against commercial insurers for the denial of benefits and in malpractice claims against hospitals for the poor quality of health care provided.[37] While courts may hold these market participants to market norms, they have been less effective in holding state actors to account.[38]

Moreover, as Christina Ho notes, "[l]itigation is a relatively weak tool in China."[39] Because courts are expensive and answerable to political bodies, among other reasons, people often prefer alternatives such as mediation and arbitration.[40] Further, in keeping with the desire to maintain a "harmonious society," the government has also preferred mediation over litigation and has encouraged courts "to meet quotas for successfully mediated cases."[41] As a result of this pressure to pursue mediation, people may also be steered away from litigating in the courts.[42]

Political accountability

Political accountability means that the government is required to ensure participatory processes for the adoption of health policies and strategies. The right to health requires the government to set up an appropriate health system and remedy market failures through both regulation and resource allocation. A central concern of the right to health is participation in the development of laws, policies, and practices to realize the right to health. This concept of political accountability has its roots in Western democratic political systems, where it is understood that political accountability requires mass participation by individuals.[43] Whether meaningful political accountability can be achieved with a single party government like that in China is, as Alston states, "[t]he most difficult and complex challenge."[44]

Generally speaking, political accountability demands a democratic political framework carried out through mechanisms such as free and fair elections and the workings of parliaments; thereby, the party in power may be removed if it fails to satisfy the public.[45] By contrast, however, in China there is only one party governing the country. Nevertheless, political accountability in the broader Western sense is not entirely absent. In theory, the National People's Congress provides a mechanism similar to a parliament by which political power is monitored. According to the Constitution, the National People's Congress plays the legislative role, and the State Council, which practices executive and administrative power, is authorized and supervised by the National People's Congress.[46] The State Council is directly accountable to the National People's Congress for all its decisions and actions. In relation to the right to health, three forms of political accountability are reflected in the Chinese political system. These include accountability of the National People's Congress, which concerns supervision of political power in the process of decision making; accountability of the State Council, which concerns the use of available resources and the equal allocation of resources for the right to health; and accountability within the Communist Party, which has a unique form with particular Chinese characteristics.

The National People's Congress

In China, political accountability is carried out mainly through the People's Congress System. Under this system, individuals participate in the health policymaking process through the People's Congress.[47] According to the Constitution, people elect representatives—directly at the primary level and indirectly at the provincial and national levels—who are accountable to their constituents.[48] The National People's Congress is composed of representatives at the national level, and these rep-

resentatives can hold the State Council accountable for its decisions and actions.[49] Since the Ministry of Health is an organ of the State Council, it is accountable to the National People's Congress. The head of the Ministry of Health is obliged to account for the ministry's performance if so requested by the National People's Congress.

The Ministry of Health is mainly an executive administrative organ within the State Council. It carries out national health strategies and, accordingly, makes executive policies. The national health strategies are enacted by the Development and Reform Committee, which is a specific organ under the State Council that makes all strategy decisions concerning development and reform, including economic strategies, health strategies, and others. The strategies are introduced as proposals, which must be approved by the National People's Congress before they are given effect. If the People's Congress has approved a national strategy but that strategy fails to achieve its goals, the National People's Congress is accountable.

At the provincial level, provincial governments are accountable to the Provincial People's Council.[50] There is a provincial health department, which is the delegate of the provincial government charged with carrying out its policies and making health-related decisions in the province. Thus, provincial health departments are administratively accountable to provincial governments. At the local level, the government operates similarly; local health organs make local health plans, carry out these plans, and are accountable for their decisions and actions.

In practice, being a people's representative in China is regarded as a symbol of honor rather than the exercise of a political function.[51] Candidatures at all levels of the people's representatives system are composed of elites from various professions. The people holding these positions also enjoy certain legal privileges. Although in theory every individual with Chinese citizenship is eligible to be elected, in practice most candidates are nominated by the Nomination Committee of the People's Congress at each level.[52] Thus, even if people have the right to nominate and vote for any person they wish, it has almost always been those whose names are on the nomination list who are elected. Additionally, at the national level, the percentage of people's representatives from urban areas is four times higher than that from rural areas, even though the rural population is about the same size as the urban population.[53] Therefore, the interests of residents living in rural areas are not well represented. As an accountability mechanism, elections in China are not adequately representative of the population.

In China, political accountability is sometimes achieved by the resignation of relevant officials. As an executive organ, the Ministry of Health is accountable for its actions and the implementation of adopted strategies. After the mass outbreak of SARS, Minister of Health Zhang Wenkang resigned for failing to control public health safety, a specifically enumerated obligation under Article 12 of the ICESCR.[54] *The Economist* reported, "It almost looks like the way that politics works in a democratic, accountable country."[55] However, the resignation of officials is more of a political gesture than an act of political accountability. Moreover, this form of political accountability is rendered less effective by the fact that it is activated by the government rather than rights-holders. There is no procedure for rights-holders to trigger a process of accountability other than indirectly—for example, by reporting transgressions to the media. Nevertheless, in light of the political importance of social cohesion and the moral pressure to maintain it, even in a one-party communist state such as China, the government is often pressured to act by voices of the public.

Reporting of the State Council

The right to health demands that health facilities, services, and medicines be available, accessible, acceptable, and of good quality.[56] This involves the allocation of resources, which is a two-stage process. At the first stage, resources from the whole state budget are allocated to health; at the second stage, these allocations are further distributed to satisfy different demands within the health system. In the context of health as a human right, the first stage requires the allocation of maximum available

resources. At the second stage, the distribution of resources must abide by the principle of non-discrimination; that is, resources must be distributed without discrimination when satisfying the needs of various groups, while paying special attention to vulnerable groups.[57]

The first stage—the process of allocating resources from the state budget to health—requires approval of the National People's Congress.[58] During the annual meeting of the National People's Congress, the prime minister, as the head of the State Council, reports on the spending details (including resources allocated to health) of state budgets over the prior year and outlines proposals on state budgets for the forthcoming year. Both the concluding reports and the spending proposals must be approved by the National People's Congress. National people's representatives give comments and demand revision until they are satisfied. The National People's Congress is also obliged to examine the financial report to see if expenditure was in compliance with the proposals adopted the previous year. However, if the national people's representatives are not satisfied with the report, or find that a distribution was not in compliance with the adopted policy, there are no concrete remedies available other than to criticize and request further review.[59] This creates a dilemma in that there is no effective mechanism to hold the State Council accountable for poor performance. The public is not able to obtain remedies for the council's failure to implement the approved governmental plan. Given that further revisions can be requested of the council, accountability functions well insofar as it relates to government planning, but it does not function for the review of performance, as no remedy or sanction is available if there is a failure.

The second stage, which involves distributing health resources within the health sector, is a complicated process. In China, both the central government and the provincial governments have the power to collect taxes, distribute resources, and make policies, provided policies made at the provincial level are not in conflict with those at the central level.[60] Thus, at the provincial level, resources for health are composed of two parts: allocations from the provincial budget and allocations from the central government.[61] Inequalities in health budgets among different provinces exist due to the unbalanced levels of economic development across provinces, which result from both provincial development strategies and uneven central policies designed by the State Council. Consequently, although the central level budget is equitable, the provincial portion of the health budget varies greatly across provinces, and there is no accountability mechanism to challenge the uneven economic development or the health budget differences among provinces.

Accountability within the Communist Party

In China, the vast majority of government officials, including health officials, are members of the Communist Party. As such, they are subject to an internal supervisory procedure that holds officials accountable in vertical administrative relationships. Additionally, the Central Commission for Discipline Inspection of the Chinese Communist Party is a quasi-governmental body whose main function is to root out corruption and malfeasance among members of the Communist Party.[62] Thus, to some degree, accountability functions within the party. Health officials are considered for promotion based on their political and administrative performance. If health officials are proven to have failed in implementing their duties, besides being moved away from administrative positions, they may face dismissal from the Communist Party.[63] This accountability mechanism functions downward only, however, and is not necessarily responsive to failures to realize right to health. Within the Communist Party, accountability essentially functions through a combination of both political and social accountability. Once social accountability is triggered by the public (see below), political accountability may follow and work effectively.

Administrative accountability

Administrative accountability includes monitoring and supervising health administrative management, as well as administrative procedures for people to bring complaints. Health officials are delegates of those government organs that carry out health strat-

egies and policies. In this respect, there are two types of accountability mechanisms: general administrative mechanisms, which cover both hierarchical and horizontal levels, and supervisory organs for specific issues, such as food and medicine.

General administrative mechanisms

Supervision: In China, each level of the government is apportioned power and authority over policymaking decisions within its area of dominion. Each health authority is accountable to its corresponding government at the same level; and hospitals are accountable to the corresponding health department at that level. In this way, the government control system aims to ensure that health policies and plans are effectively enforced, especially in times of public health emergencies. Yet, the complex multilevel system often results in several governmental entities with overlapping responsibilities and functions for the same health issues. Beyond the health care authorities, the Ministry of Health also plays a role in monitoring and supervising a number of other actors through regulatory monitoring and enforcement. These actors include public health care providers at the central, regional, and local levels, as well as private health care providers. As an executive body, the Ministry of Health is not simply called on in its own right to meet accountability requirements but also demands accountability from other organs.

Policy making and monitoring: For the purpose of policymaking and monitoring, transparency regarding information on budgets, regulations, quality of performance, achievement of targets, and so on is crucial. Paul Hunt, former UN Special Rapporteur on the right to health, recommended that states use a human rights-based approach to health indicators to assess the progressive realization of the right to health, the effectiveness of health policy, and the participation of individuals and groups in the development, implementation, and review of health policy.[64] This approach, however, has generally not been reflected in China's policymaking, implementation, and review process until recently. It is only in the past 10 years that the government has moved toward increasing transparency and public participation in health policymaking.[65] Government agencies at the national and local levels have published draft laws and regulations for public comment, and in some cases have considered the comments.[66]

Nonetheless, China's move toward transparency and participation is not yet reflected in its monitoring of implementation of health policy. Notably, in 2014, the UN Committee on Economic, Social and Cultural Rights recognized the absence of reliable statistics in China that would allow an accurate assessment of China's fulfillment of these rights.[67] In his 2016 report, Alston also expressed concern about the lack of transparency in the data collection process, allegations that unfavorable data were not published, and the lack of disaggregated statistics, which are necessary to determine who is being left behind.[68]

Complaints mechanisms: In clinical practice, when malpractice occurs, the patient has the choice of seeking a remedy from the administrative mechanism, relevant health authority, or the courts. Similarly, when a health authority fails to fulfill its duties, such as failing to grant quality health care to individuals, the individual may seek a remedy through administrative procedures, the government at the next higher level, or the courts.[69] In practice, seeking administrative accountability is relatively inexpensive compared to resorting to the courts, but it is generally not a fruitful option.[70] Indeed, many claimants are prevented by local authorities from complaining to higher levels of government about inaction or abuse at the local level.[71]

Supervisory organs

The right to health encompasses both the right to health care and the underlying determinants of health, such as safe food, healthy working and environmental conditions, and so on. Although these underlying determinants may not be directly protected and provided in the name of the right to health, states sometimes employ supervisory procedures addressing specific underlying determinants of health. Monitoring and supervision is operated mainly through administrative organs of the

government. These administrative organs thereby potentially provide accountability mechanisms for the right to health.

For example, in recent years, inadequate food safety has become a big threat to health in China.[72] The Sanlu milk powder scandal in 2008 drew considerable attention to this issue.[73] The scandal was reported first by the media, and then the government started an investigation. In 2016, a vaccine scandal was exposed, again first by the media, with the Ministry of Health following up with a special investigation.[74] One might ask whether this failure of the government to take the lead on such matters is due to the absence of supervisory mechanisms in this area. Surprisingly, the answer is no. There is an administrative organ, the State Food and Drugs Administration, which is directly authorized by the State Council to legislate, make policies and work plans, set market criteria, license, and supervise industry. However, in both these cases, it was the attention of the media, rather than the State Food and Drugs Administration, that resulted in the government taking action to hold the responsible parties accountable.

In practice, an official's failure to carry out the responsibility attached to his or her position will lead to forced resignation or dismissal from the position. In cases that lead to serious consequences, a criminal procedure will be triggered. There is, however, no procedure available for individual complaints against the government or the specific official in these organs. The administrative mechanism can be triggered directly by senior officials or organs at higher levels or, as with political accountability, indirectly by public pressure or the exposure of the case. Thus, the administrative mechanism is not accountable to the individual harmed, although it may be accountable to the public once supervisors at the higher level are determined to seek accountability. Similar to many other administrative organs in China, the State Food and Drugs Administration has supervisory duties but does not play a satisfactory role as an accountability mechanism in practice because it has no mechanism for individual complaints.

Professional accountability

The delivery of high-quality health services demands the professional performance of health practitioners. It is important, therefore, to have effective mechanisms to regulate and monitor health practitioners. Professional accountability requires, among other things, that health professionals answer to hierarchical superiors, participate in hearings to provide answers to the public, and provide explanations of treatments administered to patients.[75] Within any health system, health professionals are obliged to provide appropriate and efficient treatment. However, due to information asymmetries between health professionals and their patients, not every patient is able to judge whether services and treatment they receive meet professional standards and are the most suitable for their needs. Examination of the quality of health delivery requires professional knowledge. Therefore, professional accountability mechanisms must rely upon experts in health care or operate through associations with professional knowledge.[76]

In some countries, professional associations supervise and monitor health professionals through licensing requirements and codes of conduct. In China, there are medical professional associations, such as the Chinese Medical Doctors Association (CMDA), but these organizations are not in charge of training and regulating health professionals or establishing standards for practice. According to the Medical Practitioners Act of 1999, the qualification of health professionals is managed by health authorities at each level, but with the assistance of medical associations. Thus, health practitioners are actually monitored by health sectors at different levels of the government.

Nonetheless, professional health organizations may play important roles in realizing the right to health. For example, founded in 2002 in light of the 1999 Medical Practitioners Act, the CMDA is authorized by the Ministry of Health and registered with the Ministry of Civil Affairs. Registration for health practitioners is not compulsory. The CMDA's main functions are to collect data and investigate the extent of implementation of the act

in practice, and to propose amendments to the act to the Ministry of Health. It may also investigate medical disputes in hospitals through its regional sub-associations under the authority of the Medical Administration of the Ministry of Health.

The CMDA has no authority to issue licenses or put professional restraints on medical practitioners. However, it is obliged to provide professional opinions if requested by judicial or administrative organs. Suspension from medical practice must be made by an administrative decision or court ruling. Thus, patients cannot remove health professionals from their positions by means of professional accountability through the CMDA. The CMDA simply assists the courts by providing professional opinions.

Despite this interlocking system of accountability, there are important areas where professional accountability of health professionals is absent. Due to the economic reforms that started in 1978, hospitals are no longer funded solely by public revenue. Even public hospitals have been driven to chase revenue by charging fees.[77] In many hospitals, doctors' income is linked to the quantity of their work, which includes the quantity of operations they perform and the quantity of medicines they prescribe. It is also common for doctors to get rebates from pharmaceutical companies for prescribing their medicines to patients. Moreover, hospitals share rebates from pharmaceutical companies with doctors.[78] These incentives lead to the unnecessary overprescribing of medicines, which wastes medical resources and is harmful to the health of patients. Whether a prescription or treatment is suitable or necessary, however, is difficult for individual patients to assess. It is also difficult for individuals with no professional knowledge to provide sufficient evidence to hold health care providers accountable. In this light, professional accountability mechanisms in China are not effective due to immoral incentives, the knowledge and power imbalances between health professionals and patients, and the absence of effective complaint mechanisms.

Social accountability

Social accountability draws its authority from social moral values. In China, the main mechanism is public exposure through the media. Due to its lack of direct enforcement mechanisms, social accountability is seen internationally as relatively weak and as having less immediate effect. However, in Chinese political thought, society has a high moral expectation of the government and of other members of society. For example, to get promoted, one must have high moral standards.

Social accountability supplements formal accountability, especially in China, where the contemporary goal of the central government is to achieve a harmonious society. Under this goal, social accountability becomes more direct when other forms of accountability do not function well. For example, if individuals are not sure which mechanisms they should rely on or whom they should hold accountable, or if they are not satisfied with the remedies they receive through a formal process, they may turn to the media. In many cases, after the media exposes the facts behind such claims, relevant administrative organs launch formal investigations.

The following case study illustrates how social accountability works in combination with professional accountability and judicial accountability. On finding that her colleagues were providing light quantum therapy by using unlicensed equipment on patients, which was harmful to their health, Dr. Chen wrote to the hospital's professional supervisory board. However, she did not get a satisfactory answer from the board; instead, she was dismissed from her position. She then wrote to the local professional supervisory office, but here too failed to get a satisfactory response. Next, she decided to turn to the judiciary. However, relevant regulations allow only patients and their families to sue a hospital for malpractice.[79] It thus became difficult for Dr. Chen to hold relevant duty-bearers to account. As a last resort, she decided to pretend to be a patient in order to expose the truth. Although she was a healthy person, the hospital still accepted her as a patient, immediately providing her with illegal treatment.

Through her undercover action, Dr. Chen was finally able to collect evidence and file the case before a court.[80] Later, the media reported her story, which pressured the Shanghai Medicine Administration Office into initiating a special investigation on illegal treatments in all hospitals in Shanghai.

In this case, social accountability did not work independently but rather triggered professional accountability, administrative accountability, and judicial accountability. There are other judicial cases resulting from such an application of social accountability. For example, the Sanlu milk powder scandal was first reported by the newspapers. Social accountability is necessary when there is a failure of other formal accountability mechanisms. The presence of effective social accountability—acting through the media in China—is therefore an essential component to hold formal accountability mechanisms for the right to health to account.

Conclusion

Although very different from Western democracies, five types of accountability mechanisms in China are operating at various levels and have some ability to protect components of the right to health. Additionally, these mechanisms exhibit certain interdependencies with one another. Nonetheless, all five types of accountability mechanisms need improvement if China is to fully realize the right to health. The article points to some failures of the accountability mechanisms in order to highlight where they might be improved. It also sheds light on the need for further research, including the conditions under which each type of mechanism is most effective, the extent to which they interact effectively, and what their practical impacts are in promoting the right to health.

Despite China's ratification of the ICESCR, the right to health is not directly justiciable in Chinese courts. Nonetheless, it is partially justiciable through other health-related rights that are directly justiciable. Political accountability in China has traditionally been performed through the National People's Congress, through the reporting of the State Council, and through supervision mechanisms within the Communist Party. Although there is an identifiable framework of political accountability, lack of public participation has rendered it a very weak mechanism by which to hold the government to account. It has therefore recently come to be practiced in combination with a new process of public censure through the media. Additionally, in recent years, the government has started to explore other means of public participation, such as a 2008 pilot of an online feedback system that invited individuals to comment on ongoing health care reforms.[81]

By contrast, administrative accountability can be used to monitor and supervise officials who perform delegated duties. This process can be achieved by government action or through administration litigation. Nonetheless, administrative accountability has often resulted from the publicity of some scandal rather through a systematic procedure. In response to the failures of administrative supervision and litigation, in 2017 the Chinese government began piloting "powerful" supervisory commissions in Beijing, Shanxi, and Zhejiang.[82]

Further, although there are statutes and regulations on medical professional standards, there is no distinct professional accountability mechanism. People must rely on administrative or judicial mechanisms in cases of professional incompetency. Because of information asymmetry and the lack of oversight through professional medical associations, it is difficult, however, to hold health care providers accountable through these mechanisms. In short, professional accountability, like political accountability, does not function independently but works together with other forms of accountability.

Finally, a less tangible form of accountability—that of social accountability—may have some relevance for the contemporary protection of the right to health in China. As noted above, although it has no legal effect, social accountability—reinforced by general public expectations of standards of official conduct—has recently gained momen-

tum through media censure.[83] Indeed, the media has spurred the Communist Party of China to take action in a number of highly publicized cases, and the party is the mechanism that has the most power and ability to bring about the changes necessary to realize the right to health.

In conclusion, although the basis of an accountability framework in relation to the right to health is operating at various levels in China, the process of accountability has been hindered by longstanding cultural and political barriers. In particular, as Alston noted in his 2016 report, Chinese mechanisms of accountability "rely almost entirely on top-down processes."[84] This means that for individuals, there are few opportunities to hold duty-bearers directly to account or to seek remedies for violations of the right to health.

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Human Rights in the World Health Organization: Views of the Director-General Candidates

BENJAMIN MASON MEIER

Before the 2017 election of the Director-General of WHO, and given the importance of human rights to global health governance through WHO, Health and Human Rights *asked the three final candidates for their views on human rights, WHO's human rights mandate, and the role of human rights in WHO programming. These questions were developed by the author in collaboration with Audrey Chapman, Lisa Forman, Paul Hunt, Dainius Pūras, Javier Vasquez and Carmel Williams. Based on responses to these questions from each of the three candidates, this Perspective was originally published online on April 26, 2017. On May 23, 2017, Dr Tedros Adhanom Ghebreyesus was elected Director-General and will begin his five-year term on July 1, 2017.*

Background

WHO's 1948 Constitution declared that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being," and this mandate has framed the organization's work to advance human rights in global health over the past 70 years.

WHO has long worked to address human rights as part of its organizational efforts to direct and coordinate global health, developing health-related human rights through the United Nations (UN) and implementing human rights in its own institutional practices. Affirmed in Resolution 23.41, the World Health Assembly identified "the right to health as a fundamental human right," stating that "the health aspect of human rights … is within the competence of the [WHO]." States have repeatedly reaffirmed this commitment to health as a human right, with the World Health Assembly developing over 60 subsequent resolutions that address human rights on a variety of WHO programs, including health development, women's health, reproductive health, child and adolescent health, nutrition, HIV/AIDS, tobacco, violence, mental health, essential medicines, indigenous peoples' health, and emergencies.

With the UN seeking for the past 20 years to "mainstream" human rights across its programs, policies, and activities, the UN Secretary-General has confirmed that "human rights must be incorporated into decision-making and discussion throughout the work of the Organisation." WHO has sought to realize this system-wide commitment to human rights through a "rights-based approach to health," with the World Health Assembly and Executive Board both endorsing such an approach. Building from WHO's evolving

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work to advance a rights-based approach to health, the 2012 creation of WHO's gender, equity and rights team has helped the organization mainstream gender, equity, and human rights across all organizational activities.

Dr. Tedros Adhanom Ghebreyesus, WHO Director-General 2017- formerly Ethiopia's foreign minister and former health minister

HHRJ: *How should WHO's constitutional recognition of the right to health inform the organization's response to global health challenges?*

I have always been inspired by WHO's constitutional recognition of the right to health. It entails that every person, regardless of who they are or where they live, has access to quality health care that is timely, acceptable, and affordable. These principles and WHO's mandate are just as relevant today as they were at its founding. However, the challenges in global health and development today are drastically different from what they were seven decades ago. To address these, WHO must evolve and adapt, put the right to health at the core of its functions, and be the global vanguard to champion them.

I believe that focusing on, driving toward, and ultimately achieving universal health coverage is our best path to live up to WHO's constitutional commitment to the right to health. And if I am elected Director-General, my topmost priority will be universal health coverage. The growing momentum around universal health coverage—combined with the global commitment to sustainable development and its motto of "leaving no one behind"—offers unique opportunities to advance equity in health.

HHRJ: *How do you see the right to health and rights-based approaches guiding WHO's work with national governments and civil society?*

Every year, hundreds of millions of people go without essential health care or fall into poverty trying to pay for it. That is a violation of the human right to health that demands our full attention and urgent action. All of us—national government leaders, members of civil society, health workers, patients and families, and religious and community leaders—have critical roles to drive progress on universal health coverage. Developing technical policies to ensure universal health coverage is an important start, but policies alone will not be sufficient. Implementation of those policies is much more difficult and requires collaboration and partnership across stakeholders.

That approach guided Ethiopia's pursuit of equitable health access when I was minister of health. We maintained a firm commitment to the principle that health is a basic human right by dramatically expanding coverage of primary health care services. We achieved success by (1) directing new domestic investments in primary health care to people in areas where the need was greatest, including rural and pastoralist areas; (2) engaging communities as partners in local health governance; and (3) building political commitment and promoting accountability at all levels and across all stakeholder groups.

Reflecting these experiences, I believe WHO can and must play an enabling and catalytic role to help all governments achieve universal health coverage and, in turn, advance the human right to health, and I believe it must engage a diverse set of partners, including civil society, in these efforts to ensure success.

HHRJ: *How can WHO organizational reform (of staff, resources, and partnerships) strengthen UN system-wide efforts to "mainstream" human rights in public health programming? How can a WHO human rights unit support these organizational efforts?*

I am committed to transforming the way that WHO operates. A more effective and efficient WHO will strengthen the entire UN system. As we reform WHO's infrastructure and ways of operating, we will make sure that the core principles of health as a human right and universal health coverage for the most vulnerable are at the forefront of all our work. Too often, human rights and gender equity are secondary considerations when UN organizations develop programming. This is outdated and must change.

When it comes to rights issues in the reform, importantly, it's not so much the design of the processes or structures that will make a difference. Far more important is ensuring that health as a human right is engrained into the mindset and attitudes of staff. We need to make sure WHO staff take this core value of the organization to heart and truly believe in it. That is how I believe we will most effectively mainstream human rights in WHO's public health programming.

Given WHO's mandate, it will be important to strengthen the existing human rights unit to ensure there are dedicated resources and focus on this issue. That said, as the ultimate guarantor of the right to health, WHO requires more than a single unit in its organizational structure devoted to human rights.

Human rights should be the responsibility of each and every unit. In order to reach this point, we have to effectively mainstream human rights throughout the organization and regularly evaluate to see what impact the mainstreaming is having. That is what I will do if elected Director-General.

Dr. David Nabarro, from the UK, sustainable development adviser to United Nations Secretary-General Ban Ki-moon

HHRJ: *How should WHO's constitutional recognition of the right to health inform the organization's response to global health challenges?*

WHO has a constitutional mandate to advocate for all people's right to health. The right to health offers us a powerful lens through which to examine responses to global health challenges. When we use the right to health lens, we know that we will encounter difficult issues. Who is left behind? Who is unable to access good-quality care? Who is not included in actions for public health? The right to health lens can be applied globally, regionally, or in individual settings. It can be applied to the work of governments, civil society, and international organizations.

The 2030 Sustainable Development Agenda is often portrayed as a contract between people and their states—a social contract. It is based on human rights principles, something I have defended and upheld throughout my career. From a human rights perspective, people being put at risk of financial ruin as a result of illness or being excluded from health care services that they need are both unacceptable and in my view reflect violations of people's rights.

I am committed to leading a WHO whose work in health will make a major contribution to the realization of rights and, particularly, to universal health coverage. In this respect, universal health coverage seeks to achieve better health outcomes through access to all required services along with financial protection. In addition, it provides a universal standard for people's entitlements and explicitly sets out the choices nations need to make if they are progressively to realize that standard. Universal health coverage offers indicators for the measurement of progress toward that standard, which serve as metrics for accountability.

HHRJ: *How do you see the right to health and rights-based approaches guiding WHO's work with national governments and civil society?*

I anticipate that WHO will continue to reflect the directives of its governing bodies and support the use of human rights-based approaches in planning and programming across everything the organization seeks to achieve. Disaggregated data on health trends provide an important measure through which to identify persons and population groups who are at greatest risk (in terms of health outcomes) and tend to be excluded from responses. This group tends to include refugees, migrants, and around 10 million people (of whom 3 million are children) who are stateless in their own country or liable to be forcibly displaced. But more specific information is needed for effective tracking of who is being left behind and the measures being taken to address the situation.

Civil society organizations that can provide additional insights (for example, on inequities and discrimination) have important contributions to make. Under my leadership, WHO will encourage accurate and impartial reporting of all health data. The information will be made available to human

rights treaty bodies as they conduct individual country reviews.

HHRJ: *How can WHO organizational reform (of staff, resources, and partnerships) strengthen UN system-wide efforts to "mainstream" human rights in public health programming? How can a WHO human rights unit support these organizational efforts?*

A focus on the realization of the right to health is not an optional add-on to WHO's work; it is fundamental to it. We face a broad range of global health challenges—too many to cover comprehensively in a short response—which demonstrate that human rights work in WHO must be mainstreamed throughout the organization. There will be a need for the development and application of tools that enable right to health considerations to be incorporated in WHO's work and to be shared with the other bodies with whom WHO works to advance health for all. There will also be a need for all staff to have appropriate human rights capabilities—in country offices, regions, and headquarters. They will be expected to advocate for, articulate, and report on human rights aspects in their respective areas of expertise. To this end, I will seek to ensure that there is appropriate health and human rights advice available for all parts of the organization. This will include appropriate reporting arrangements that enable me to appreciate what is happening in this aspect of our work and to understand whether additional emphasis is needed as I take responsibility for driving policy across WHO.

Dr. Sania Nishtar, Pakistan's former health minister

HHRJ: *How should WHO's constitutional recognition of the right to health inform the organization's response to global health challenges?*

The WHO Constitution states that the enjoyment of the highest attainable level of health is a fundamental right of every human being; as a result, adopting a human-rights based approach to health is critical to achieving health for all.

While member states have the primary responsibility for protecting the human rights of their populations, and for ensuring that health rights are enshrined in domestic constitutional provisions and legislation, they have mandated the Secretary-General and the UN system to help them achieve the standards set out in the UN Charter and the Universal Declaration of Human Rights.

WHO is bound both by its mandate as a UN agency and by its own Constitution to be the champion and steward of the right to health for all. WHO must therefore integrate a human-rights based approach to health into its scope of work at all levels—human rights should be a lens through which the organization views its policies and programs.

As elaborated in my book *Choked Pipes*, it should also be noted that the Universal Declaration of Human Rights forms the basis of understanding for the concept of socioeconomic rights and the question of their enforcement. The declaration was initially intended as one instrument but was later bifurcated into two distinct and different covenants, namely the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Many states that supported the separation were of the opinion that the two sets of rights could not be equated and that social and economic prerogatives of citizens could not be the basis of binding obligations in the way that civil and political rights needed to be. This split allowed states to adopt some rights and not the others. Recently, however, there has been a burgeoning international trend toward a progressive interpretation of rights, including adoption of normative frameworks, such as the landmark resolution by the UN Human Rights Council acknowledging preventable maternal mortality as a human rights issue.

HHRJ: *How do you see the right to health and rights-based approaches guiding WHO's work with national governments and civil society?*

The 2030 Agenda and Sustainable Development Goals reaffirm the responsibility of member states to "respect, protect and promote human rights, without distinction of any kind as to race, colour,

sex, language, religion, political or other opinions, national and social origin, property, birth, disability or other status," signaling a renewed commitment to human rights. In line with this, WHO has developed a roadmap to integrate equity, gender, human rights, and social determinants into ongoing activities—a welcome step. I will build further on that.

In terms of engagement with national governments, it must be appreciated that WHO has a dual role. It is a member-state-governed organization and, as such, must execute policy set by member states. But on the other hand, it is also the global guardian of health, and therefore there are situations in which it must stand firm to promote a rights-based approach to health.

As for civil society, WHO has an explicit mandate to engage as agreed by member states through the Framework of Engagement with Non-State Actors. Civil society has a comparative advantage in relation to advocacy and accountability, which is where strategic engagement with civil society can help promote a rights-based approach to health.

I come from a civil society background and have been a longstanding and strong promoter of the rights-based approach to health. The dedication of my last book, *Choked Pipes*, epitomizes my commitment: "Dedicated to the silent and unjustified suffering of millions of individuals for whom the right to health remains unrealized—and whose lives I strive and aspire to touch." *Choked Pipes* provides a blueprint for how low- and middle-income countries can move toward universal health coverage from a mixed health system. In aspiring to lead WHO, I aspire to lead an organization that positions health as a wider reflection of a broad social policy vision and a universal right rather than a commodity.

Throughout my work as a doctor, in government, in civil society, in academia, and with international agencies, I have always based my work on the rights-based foundation. It was this strong grounding that led me to set up an innovative financing facility in Pakistan that helps the poorest and most marginalized communities avoid catastrophic expenses when accessing health. I will continue to walk the talk on the right to health as Director-General of WHO.

HHRJ: *How can WHO organizational reform (of staff, resources, and partnerships) strengthen UN system-wide efforts to "mainstream" human rights in public health programming? How can a WHO human rights unit support these organizational efforts?*

Too often, when health experts are asked about human rights or gender in their work, they pass off the questioner to a human rights or gender expert. From my perspective, this is simply unacceptable. A human rights approach, like the social determinants and life course approach, must be part of the organizational DNA and "everybody's business."

To deliver a rights-based approach in our work, we must exemplify the change we want to see in terms of transparency, accountability, and impartiality. My whole life's work has been based on these attributes. In terms of WHO reform, this also means adopting a transparency and accountability framework that is straightforward to enforce and is guided by independent voices. In my "10 Pledges for a New WHO," I have committed to delivering on this premise as a priority.

For this reason, in addition to supporting work to further national commitment to the covenants mentioned above (ICCPR and ICESCR), WHO must support countries in the implementation of all international commitments that outline actions and mechanisms for a rights-based approach to health, including the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, the Declaration of Alma Ata, the Programme of Action of the International Conference on Population and Development, and the Beijing Platform for Action.

Human rights, as well as gender and equity, should not be stand-alone programs; rather, they should be integrated into organizational ethos and everyday work and should cut across all programming. While we must have a unit of highly qualified technical experts, they cannot work in a silo and should not carry the burden of full accountability for this area of work.

As a critical part of my tenure, I will establish a delivery unit and priority metrics, which will regularly assess organizational and institutional performance. To this end, while the gender, eq-

uity, and human rights group will provide expert support, there would be accountability and responsibility of each and every staff member to make sure these perspectives are appropriately integrated into all areas—from strategy to daily work.

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UNstoppable: How Advocates Persevered in the Fight for Justice for Haitian Cholera Victims

Adam Houston

In 2016, December 1st—already an occasion to highlight the importance of health and human rights as World AIDS Day—took on new significance as a landmark in one of the highest-profile health and human rights cases of the twenty-first century. This was the day that United Nations (UN) Secretary-General Ban Ki-moon finally issued an apology on behalf of the organization for its role in causing the Haitian cholera epidemic that has claimed close to 10,000 lives and made another 800,000 fall ill.[1] This simple apology is something that victims of the epidemic have been waiting to hear for years, ever since cholera-infected feces from a United Nations Stabilization Mission in Haiti (MINUSTAH) peacekeeping base were allowed to enter the river system relied on by tens of thousands of Haitians back in October 2010. That the apology took this long to receive highlights the struggles that advocates continue to face in getting the UN to make things right for victims of the epidemic.

Haitians devastated by cholera—through their own illness or the deaths of breadwinners and loved ones—first petitioned the UN for remedies in November 2011, a year after the epidemic began. The obligation to provide remedies for "personal injury, illness or death arising from or directly attributed to MINUSTAH" is explicitly contemplated in the Status of Forces Agreement between the UN and the government of Haiti, itself rooted in the Convention on Privileges and Immunities of the United Nations (CPIUN), which makes the mandatory settlement of claims a reciprocal duty in exchange for broad immunity from suit in court.[2] Nonetheless, the UN did not dignify the request with a response until 15 months had gone by, at which point the request was tersely dismissed on the grounds that it was "not receivable" since "consideration of these claims would necessarily include a review of political and policy matters."[3] No explanation was given as to how negligent sanitation was a political or policy matter, or how the injuries suffered by Haitians differed from others the UN has compensated as a matter of course in the past.

The victims of the epidemic did not back down, however; instead, they took further steps to assert their fundamental rights, from the right to health to the right to due legal process. At the heart of the advocacy movement was a pair of organizations, the Haiti-based Bureau des Avocats Internationaux (BAI) and its American-based partner, the Institute for Justice and Democracy in Haiti (IJDH). Tiny organizations with limited resources, they faced Herculean odds taking on the world's largest intergovernmental organization. Nevertheless, seeking justice for their clients, BAI and IJDH launched a lawsuit against the UN in the fall

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Competing interests: Adam is a volunteer and former legal fellow with the Institute for Justice and Democracy in Haiti.

of 2013. The suit was filed in the Southern District of New York, home to UN headquarters. It was the last resort for the cholera victims.

It was novel, certainly. Nobody had ever successfully sued the UN in this way. Behind the boldness of the case, however, was sound legal reasoning: the suit argued that the UN was in breach of its legal obligations within the Status of Forces Agreement and the CPIUN, as a result of which immunity did not apply. At the core of the lawsuit was the idea that immunity was never intended as impunity. Such limits date back to the UN's Charter, which establishes that the organization has privileges and immunities "as are necessary for the fulfillment of its purposes," and to the drafting history of the CPIUN.[4] By the time of the lawsuit, there was already a body of legal scholarship establishing UN accountability for the epidemic.[5] Moreover, as the legal merits of the case became apparent, experts in international law from all over the world weighed in, many donating their time to further strengthen the solid legal grounding of a just cause.

It was not only legal experts who responded favorably to the message about the importance of the case. A crucial part of advocacy was getting the same message across to the world at large. To the casual observer, a cholera epidemic in the most impoverished nation in the Western hemisphere, occurring in the wake of a massively destructive earthquake, would hardly seem surprising. Therefore, it was vital to spread the knowledge that Haiti had never recorded a single case of cholera before October 2010 and that it was UN peacekeepers who had lit the spark igniting this raging inferno of disease. It was also crucial to highlight that the UN was continuing to fail the victims of the epidemic by not holding itself to the same standards of human rights and rule of law it was simultaneously proselytizing in their country.

The importance of this task was underscored by initial resistance in many quarters to the quest for justice, even from parties better placed to understand what had unfolded. An editorial in *The Lancet Infectious Diseases*, for instance, suggested that identifying the origins of the epidemic would be counterproductive or, at best, something that "may be a matter of scientific curiosity for the future."[6] Competing theories about the origins of the epidemic—absolving the UN—stuck around until long after the source had been proven. And the UN, holding onto the position that taking responsibility for the epidemic could potentially cripple its ability to intervene in future crises, failed to recognize that its refusal to accept responsibility was already harming its credibility as the foremost promoter of human rights and the rule of law. These attitudes seemed to stem from the identity of the perpetrator rather than the events that transpired; it is difficult to imagine similar views prevailing had Haiti's waterways been contaminated by a multinational corporation instead.

Under these circumstances, the dissemination of accurate information—whether through academic journals, the media, or meeting after meeting with stakeholders—was a crucial complement to the lawsuit itself. While the Associated Press and Al Jazeera had broken the story of the UN's involvement in causing the epidemic as it first unfolded, the lawsuit helped keep the story in the headlines. By 2016, other major outlets like *The Guardian*, *The New York Times*, and even Fox News were breaking new investigative reports, including scandalous revelations about the state of sanitation at UN facilities in Haiti both at the time the epidemic began and years afterward.[7]

Publication and dissemination of a conclusive, and growing, body of scientific evidence by advocates and through the media helped sway minds, as demonstrated by subsequent *Lancet* editorials supporting UN accountability.[8] Such evidence had begun with the epidemiological work of Renaud Piarroux and others in the earliest days of the epidemic, but gathered steam as genetic analyses of the responsible strain confirmed its origins. Together, this evidence showed that cholera had arrived in Haiti via a contingent of Nepalese peacekeepers. Although Nepal had been in the midst of its own cholera outbreak at the time, no steps had been taken to ensure that the troops being deployed did not import cholera into a country highly vulnerable to waterborne disease. As a result, contaminated feces entered Haiti's waterways from the MINUSTAH

base at Mirebalais shortly after the troops arrived. Indeed, an independent panel appointed by the UN itself had reached similar conclusions about the origins of the epidemic in May 2011, well before the initial claims by BAI and IJDH, only for the UN to seize on language in the report diluting responsibility; the authors of the report subsequently published a follow-up piece reaffirming their conclusions with additional evidence, underscoring UN recalcitrance.[9]

Political support followed a similar trickle-to-flood pattern, with Saint Vincent and the Grenadines the first to take a stand in favor of the victims.[10] Other states followed; in a rare bipartisan moment, so did politicians in the United States, who called for justice while questioning their government's role in obstructing access to remedies.[11] Within the UN system too, private criticisms became public and the chorus of voices expressing concern grew louder, particularly after High Commissioner for Human Rights Navi Pillay called for compensation.[12] High-profile calls for justice came via letters from serving UN Special Rapporteurs and human rights experts, as well as via the ongoing vocal support of former UN officials such as onetime Special Envoy for HIV/AIDS in Africa Stephen Lewis.[13] Most recently, Special Rapporteur on Extreme Poverty and Human Rights Philip Alston completed a thorough and scathing report on the UN's response to the epidemic, concluding that the organization's "existing approach is morally unconscionable, legally indefensible, and politically self-defeating"; a draft leaked in August 2016 finally helped tip the balance toward the UN's apology.[14] An issue the UN might once have hoped would fizzle out became a cornerstone of Ban's legacy as Secretary-General and a key topic in the race for his successor.

Despite its crucial role in asserting the rights of the victims, the lawsuit was rejected on jurisdictional grounds, in a decision released mere hours after the UN first reacted to Alston's report and at last acknowledged its role in the epidemic, prefacing Ban's subsequent apology.[15] Although the lawsuit was unsuccessful in a court of law, the final verdict in the court of public opinion—which is the only court where victims' human rights, not procedural matters, took center stage—was overwhelmingly in favor of the Haitian claimants. Looking back at the lawsuit, it is doubtful the UN would have taken effective action to provide redress without it. While the lawsuit was in its own right a credible legal case, it also ensured that the epidemic and the issue of accountability remained in the public eye long after they would otherwise have been forgotten by the international community.

The apology now marks a crucial moment in finding resolution for the victims of cholera. Accompanying the apology is a commitment of at least US$200 million for cholera control that could save hundreds, if not thousands, of lives, along with a similar amount as material support for victims that "represents a concrete and sincere expression of the Organization's regret."[16] There is still much work for advocates to do, however.

First, the UN's continued refusal to accept legal responsibility remains a concern, not merely in relation to what happened in Haiti but for the future. Most immediately, the absence of legal responsibility means the absence of a legal obligation to pay; thus, fulfilling this commitment remains dependent on voluntary contributions by member states. Only a small proportion has been raised to date.[17] More broadly, what is at stake is not simply the end result of a lack of accountability but the ongoing lack of transparency that underpins it. Few people within the UN apparatus, let alone outside it, have seen the legal opinion relied on so obstinately by the UN. This in and of itself is a serious failing of adherence to the rule of law on the part of the UN. The UN's legal position should be made publicly available for all member states and their citizens to see, and the boundary between necessary immunities and vulgar impunity should be made clear. Victims of future tragedies should not face a similar void of due process and coherent legal arguments when seeking to assert their rights.

Second, the UN must act to prevent similar tragedies in future. The UN has—quietly—modified its medical manual for field missions to acknowledge that peacekeepers may pose a risk of introducing public health concerns into vulnera-

ble populations they are meant to protect, and to incorporate some of the measures recommended by the independent panel in 2011.[18] Nonetheless, the ongoing sanitation saga underscores that having such measures on paper is insufficient, while decision making on what should be apolitical and purely scientific issues (such as cholera prophylaxis) has also suffered from a lack of transparency, particularly as new evidence emerges around effective interventions.[19] Furthermore, reforms have focused on cholera rather than broader changes in peacekeeping procedure, despite the fact that peacekeeping has come to light as presenting unique public health challenges.[20]

Finally, and most crucially, it is vital to ensure that the apology is only the first step, not the last, in responding to the victims. While invaluable, the apology does not undo the harms that have been done. Cholera, previously unknown in Haiti, is now an endemic threat there. Plans to address it have come and gone; a UN-endorsed US$2.2-billion plan to eradicate cholera failed to receive even a quarter of the funding required.[21] The money promised alongside the apology must be made available by the UN and its member states, and the victims must be at the center of the conversation on how best to use it. In turn, BAI, IJDH, and their allies in Haiti and internationally will stay the course to make sure the UN follows through on doing the right thing both morally and legally, something it has tragically shown it is incapable of doing on its own.

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LETTER TO THE EDITOR

Human Rights, TB, Legislation, and Jurisprudence

O. B. K. DINGAKE

People with tuberculosis (TB) experience infringements of their human rights on a daily basis. In far too many cases, they lack access to effective testing and treatment, face discrimination in employment and health care settings, and are unnecessarily detained and isolated against their will. Yet, even as TB has surpassed HIV as the top infectious disease killer in the world and the global threat from multidrug-resistant TB continues to grow, the ethical and legal issues around TB remain largely neglected in national TB programs and research agendas. New approaches are needed to address the social, economic, and structural factors driving the epidemic and drug resistance.

Commendably, this journal featured a special section on *TB and the right to health in June 2016*. As outlined in the editorial and a series of articles in the section, a human rights-based approach to TB establishes and protects the rights of people living with and vulnerable to TB, including the rights to life, health, non-discrimination, privacy, participation, information, liberty of movement, housing, food, water, and to enjoy the benefits of scientific progress. This includes access to the most recent treatments and diagnostic tools. In addition, human rights law at the international and regional levels and national constitutions create corresponding legal obligations for governments and responsibilities for private actors, promoting accountability and access to remedies for rights violations.

In line with this rights-based framework, the Stop TB Partnership's Global Plan to End TB 2016–2020 calls for a human rights- and gender-based approach to TB grounded in international, regional, and domestic law. The Global Plan acknowledges that TB programming will not be successful unless global and national programs ground their work in human rights and gender equity.

As part of the Global Plan's implementation, the TB and Human Rights Consortium—whose members include the Stop TB Partnership, University of Chicago Law School International Human Rights Clinic, and KELIN (Kenya)—has launched an inclusive, consultative process to promote adoption of the Nairobi Strategy on TB and Human Rights. Led by people with TB, TB survivors, and other allies, the strategy aims to implement several streams of work to foster diverse, focused, and sustained advocacy efforts. The objectives of the *Nairobi Strategy* are as follows:

- Support networks of affected communities of people with TB, TB survivors, and civil society at the global, regional, national, and local levels.

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- Enhance the judiciary's and legal communities' awareness of implementation of human rights-based approaches to TB.
- Expand legislators' and policy makers' capacity to incorporate human rights-based approaches into TB into laws and policies.
- Engage and advise international organizations and experts on the implementation of a human rights-based approach to TB in global policies and programs.
- Sensitize health care workers in the public and private sectors on the need to incorporate a human rights-based approach to TB in their work.
- Formulate and clarify the conceptual, legal, and normative content of a human rights-based approach to TB.
- Conduct qualitative and quantitative research to generate the evidence base for the effectiveness of a human rights-based approach to TB.

I was recently invited to give a keynote address at a consultation on the Nairobi Strategy organized by the TB and Human Rights Consortium with support from USAID on March 9–10, 2017, in Geneva, Switzerland. People affected by TB, communities, civil society, judges, lawyers, academics, clinicians, donors, and multilateral representatives engaged in a robust dialogue on the content and implementation of the strategy. The meeting was a follow-up to the TB, Human Rights and the Law Judicial Workshop held in Nairobi, Kenya, in June 2016, where the strategy was first developed. My address is presented here below. It is my hope that the Nairobi Strategy is adopted widely in order to recognize, protect, and fulfill the human rights of people with TB. Without this, current efforts to combat the disease will continue to fall short.

Tuberculosis and human rights: A judge's reflections on human rights-based legislation and jurisprudence

In a constitutional democracy, the primary lawgiver is Parliament—an assembly of elected representatives of the people. But Parliament is not the only lawmaker; judges too make laws, in the process of interpreting the law. It was once said that judges do not make laws; but that is a fairy tale. It is emphatically the province of the judiciary to interpret the law, and in countries where the constitution is the supreme law, the courts have the power to strike down legislation that is not in conformity with the constitution. This is one organ of the state which—because of its independence, knowledge, and integrity of the justices—can be the guardian of the constitution and ensure that the promise of the constitution is effected and that no one is excluded when it comes to the realization of human rights and freedoms.

In our last meeting in Nairobi, sometime last year, we heard heart-wrenching testimonies by many TB patients about widespread discrimination and stigma against TB patients and those affected by TB, as well as about other unacceptable violations of the right to liberty and freedom of movement that result in forced incarceration in circumstances where such incarceration is not strictly necessary to protect public health.

It is now widely accepted that many of the factors that increase a person's vulnerability to TB or reduce their access to services to prevent, diagnose, and treat TB are strongly linked to human rights. It goes without saying, therefore, that a human rights-based approach is the condition *sine qua non* to an effective TB response and that without placing human rights at the heart of the response, no meaningful progress can be achieved. It is also now widely understood that TB is rooted in poverty, as well as legal, structural, and social barriers that together collide and collude to deny patients access to TB services of the highest quality.

Yet despite the above understanding, the policy frameworks and national TB programs of most countries are not generally geared toward addressing human rights violations. In fact, most of the time, the focus tends to be biomedical and pays lip service to human rights, if at all. This is so despite the increasing realization that the promotion and enforcement of human rights is essential to overcome many barriers that stand in the way of

TB patients' access to critical services.

A number of policies in our countries discriminate against marginalized people, such as prisoners, preventing them from accessing care and treatment. In addition, there is a lack of an integrated approach to TB and HIV.

Most policy frameworks appear oblivious to a number of documented challenges or barriers that hinder access to TB services, such as economic, geographical, socio-cultural, and health system barriers.

Economic and financial barriers relate to the direct or indirect costs of TB care, including costs related to travel, diagnosis, and treatment, as well as the opportunity costs of lost employment. Physical barriers relate to distance to the nearest health facilities and concomitant transportation challenges. And issues of stigma relate to community and individual prejudice that militates against access to services.

In my 14 years' experience as a judge, I have discovered that there is a plethora of policies governing issues of TB in many of our countries but that such policies are devoid of significant human rights content. This, accompanied with underdeveloped legal frameworks, makes the job of a judge extremely difficult.

To give but one example, I presided over an HIV-related case many years ago. At the time, I was serving as a judge of the Industrial Court, and there was no specific legislation governing the case at hand. At the end of the day, and having found no local legislative guidance—but only policy, which is not law—I had to invoke the aid of international law in a country where international law is not automatically part of the law, opening the court to charges of judicial activism and back-door legislating.

The question has often been debated as to whether we need TB-specific legislation. This is an issue in which there is no consensus—some experts support broader health legislation, while others think there is merit in enacting specific TB legislation.

Whatever the case may be, the absence of legislation that comprehensively entrenches human rights with respect to TB is a matter of grave concern because it may lead to situations where the courts may simply say there is no law governing the situation at hand and therefore their hands are tied. This has happened in my jurisdiction in the context of HIV/AIDS.

There is an urgent need to sensitize countries on the importance of legislating on TB, whether specifically or as part of the broader health law. This legislation must be inspired by international human rights law and best practices on TB and human rights. Bringing human rights to the center of the TB response is the imperative of our time.

In order to bring human rights to the center of the TB response, we firstly need additional evidence to underscore the link between TB and human rights and to highlight how human rights violations or disregard for human rights-based approaches prevents people with TB (and often HIV and TB co-infection) from accessing services they need. For too long, TB has been a stigmatizing disease—this state of affairs is unsatisfactory and is clearly not helpful if we are to diagnose, treat, and cure those with TB.

Currently, in most countries, the country-level platform for TB control and management is through national TB control programs. These tend to be located within ministries of health and therefore tend to look at the national response to TB through a public health approach devoid of human rights.

TB patients are bearers of rights. These rights are universal, interdependent, inalienable, and non-negotiable. Our governments must understand that as duty bearers they have a duty—not an option—to protect, respect, and fulfill rights and must be willing to account for failing to do so. In order to give effect to this obligation, they must legislate comprehensively on TB so that there is little room for guesswork when it comes to human rights.

The right to health is one of the many rights implicated in the TB response. It comprises the right to access health facilities and protection against epidemic diseases. The right to health requires the realization of a number of underlying determinants, such as safe drinking water, food, adequate nutrition, housing, healthy occupational and environmental conditions, education, and so on.

The law, in its various forms, must underwrite and guarantee human rights. This is so because the

ultimate objective of law is the welfare of society.

The legal enforcement of laws on TB is invariably a balancing act. On the one side are patients' rights. These include the rights to not to be discriminated against, to human dignity, to liberty, to freedom of movement, to privacy and autonomy, to access medical records, and to refuse medical treatment, to mention but a few. On the other hand, there are public health considerations, which include the obligation to prevent disease transmission and protect the public.

As a general rule, TB treatment should be provided on a voluntary basis, with the patient's informed consent and cooperation; and as part of respect for patients' autonomy, health professionals must explain the medication they are dispensing, including any side effects, to patients. This has a bearing on adherence. It is generally accepted that non-adherence is often the direct result of failure to engage the patient fully in the treatment process.

Coercive measures such as detention should never be routinely utilized unless they are strictly necessary in the interest of public health. Involuntary isolation must be used only as a last resort—and since having TB is not a crime, any isolation must be linked to the legitimate purpose of preventing disease transmission and must take place in a health facility and not a penal institution.

Where it is considered necessary to effect involuntary isolation, the manner in which the isolation is done must comply with human rights as set out in international human rights instruments and guidelines, such as the Siracusa Principles, which require that measures must, among other things, be in accordance with the law, be based on a legitimate objective, be strictly necessary, and be the least restrictive possible.

We need to come up with laws that strike the correct balance between individual rights and the public interest. South Africa's National Health Act balances the confidentiality of a patient's health information against an allowance for the disclosure of such information to prevent a "serious threat to public health." In Zambia, the Public Health (Infectious Diseases) Regulation 8 restricts individual hardship to that which is necessary and unavoidable, which helps ensure that the government is limited in its authority to isolate and report people with communicable diseases.

This balancing of public interest and civil liberties is paramount in public health law, given the costs of excluding people from school, isolating them from social contacts, and disclosing their disease status.

In South Africa, a complex assortment of acts, regulations, and other policies governs TB infection control. The highest law governing health in South Africa, which may be cited as a good example, is Section 27 of the Constitution, which states in part that "everyone has the right to have access to: (a) health care services."

In Botswana, the Public Health Act authorizes the isolation of persons certified to have communicable diseases on the order of a registered medical practitioner until such persons are determined to be free from infection or no longer pose a danger to public health.

The Public Health Act also addresses the reporting of TB, listing TB as a notifiable disease and requiring health officers to notify cases to the minister of health. Furthermore, Botswana's TB infection control guidelines call for the routine screening of all health care workers for TB and HIV infection. These guidelines use mandatory language (for example, "must"), raising the possibility of the guidelines being an instrument of coercion.

In conclusion, I reiterate the importance of strengthening the evidence on linkages between human rights, law, and effective national TB responses. While policies are good, legislation is far better. We need to involve people infected with and affected by TB in the planning, implementation, monitoring, and reviewing of TB programs—to ensure that the TB programs are based on human rights and sensitive to people's rights.

We also need to assemble a group of experts to work together with infected and affected people and other critical stakeholders to develop a guidance document on mainstreaming human rights into national TB programs. This can be carried out together with the development of tools, guidance documents, and policy briefs for key stakeholders,

such as judges, parliamentarians, policy makers, and law enforcement officers.

It may also be a good idea to mobilize and support the idea of developing an international TB control framework similar to the Framework Convention on Tobacco Control. This may be a long-term vision, but it needs to be pursued with vigor and determination. This will ensure a strong political commitment to addressing TB. There are four distinct advantages to the development of an international framework. First, having a framework akin to the tobacco framework will institutionalize the strategy at the international level and make it obligatory for countries to sign it. Second, such a convention provides a point of reference for civil society organizations, the bar, and the bench for strategic litigation. Third, ratification of such a convention may make resources available for additional research and studies in the context of TB medication and so forth. Lastly, there is a link between smoking, chest infections, and TB prevalence—so a convention linked to the tobacco framework may be a possible way to further advance global TB control.

It seems to me that the Nairobi Strategy is a timely and welcome intervention that seeks, among other things, to develop rights-based legislation and sensitize all critical stakeholders, including legislators, lawyers, and judges, on the development of a jurisprudence that is based on reasonableness and proportionality and is informed by empirical evidence and scientific advancement. It may therefore be a good idea for the Global Fund to encourage countries to include activities such as the above in their concept notes being developed this year.

I hope I have not exaggerated the value of law and given the impression that law is the panacea of all ills. On the contrary, what I sought to convey is that law in the hands of men and women of integrity and good will can be a force for good; but in the wrong hands, it can occasion serious harm. In the right hands, law can help fight and dislodge stigma and wanton violations of human rights that ultimately endanger public health.

My very last parting word is this: for human rights to take root and endure, we need more than good constitutions, treaties, lawyers, and judges. We also need a vigilant and active civil society. Constitutions and treaties are just promissory notes. It is all of us—judges, lawyers, and civil society—who can ensure that the promise of constitutions and treaties is kept.