

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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