AMNESTY INTERNATIONAL'S POLICY ON ABORTION

EXPLANATORY NOTE

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LIST OF ABBREVIATIONS

CAT	Committee against Torture
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEDAW Committee	Committee on the Elimination of All Forms of Discrimination against Women
CESCR Committee	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
CRC Committee	Committee on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CRPD Committee	Committee on the Rights of Persons with Disabilities
CSE	Comprehensive sexuality education
FIGO	International Federation of Gynecology and Obstetrics
HRC	Human Rights Committee
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
LGBTI people	Lesbian, gay, bisexual, transgender and intersex people
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UDHR	Universal Declaration of Human Rights
WHO	World Health Organization

GLOSSARY

	DESCRIPTION
ABORTION/ MISCARRIAGE	Abortion is the induced or spontaneous termination of pregnancy. For the purposes of this policy, the term abortion will refer to the induced termination of pregnancy through medical (using abortion medication) or surgical methods, and the term miscarriage will refer to the spontaneous termination of pregnancy.
ABORTION LAWS AND POLICIES	Abortion laws and policies are specific laws and policies put in place to regulate access to and/or provision of abortion services. In most countries, abortion laws and policies involve restrictions on abortion. However, there are some countries where abortion is available without specific regulation and managed as any other health service.
ABORTION METHODS	There are two primary methods of safe abortion: Medical abortion, where medication is used to end a pregnancy, and surgical abortion, which involves a medical procedure performed by a trained professional under sanitary conditions. The World Health Organization (WHO) recommends that women and pregnant people have a choice of abortion methods to respond to their specific needs. (For more information, see Text box 3 below.)
ABORTION MYTHS	Abortion myths refer to biased views and incorrect and/or misleading information on abortion, which are often spread to discourage pregnant people from seeking abortion-related services and evidence-based information. States have an obligation to address abortion-related stigma and provide evidence-based, non-biased abortion-related information.
ABORTION PILL	The abortion pill or abortion medication is in fact two medicines. The first medicine ends the pregnancy and is named mifepristone. It works by blocking the hormone progesterone. Without progesterone, the lining of the uterus breaks down and the pregnancy cannot continue. The second medicine, misoprostol, makes the womb contract, causing cramping, bleeding and the loss of the pregnancy similar to a miscarriage. The WHO's Model List of Essential Medicines includes both misoprostol and mifepristone, which human rights bodies have recognized states are obligated to ensure.
ABORTION-RELATED STIGMA	Abortion-related stigma results from applying negative stereotypes to people involved in seeking, obtaining, providing or supporting abortion. Abortion is often stigmatized because it can challenge a number of social, cultural or religious norms and values. Beliefs and social norms underpinned by gender stereotypes that reduce women to reproductive and social roles of mothers and deny a woman's right to express her sexuality, alongside attribution of human rights to the foetus, are directly linked to abortion-related stigma. Abortion-related stigma can underlie and perpetuate myths around abortion, and lead to shame, bullying, harassment, and physical and mental harm to individuals who undergo abortion, their families and friends who support them, and those who provide abortion services. States have an obligation to combat misinformation around abortion and to address abortion-related stigma, which are key barriers preventing pregnant people from having timely access to safe and high-quality health care.
ABORTION SERVICES	Abortion services may include provision of medical or surgical abortions, post-abortion care, post-abortion contraception, as well as evidence-based abortion-related information and non-directive counselling about pregnancy options.
AUTHORIZATION BY A SPOUSE, PARENT OR	The requirement for a woman, girl or pregnant person to obtain authorization from a husband/parent, medical provider or judge to access an abortion.

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ANOTHER THIRD PARTY	Third-party authorization requirements to obtain an abortion have been criticized by human rights expert bodies for creating barriers to access to abortion services. They violate a pregnant person's right to reproductive autonomy and are discriminatory as they are grounded in harmful gender stereotypes that women cannot be trusted to make responsible decisions about their pregnancies.
BARRIERS TO ABORTION	Barriers to abortion include financial, geographic, social, cultural and detention- and disability-related barriers, and legal and administrative requirements such as mandatory waiting periods and counselling, third-party authorizations and unregulated refusals by health-care providers to provide abortion care, that hinder pregnant persons' access to abortion. States have a legal obligation to remove all barriers which prevent pregnant people from accessing lawful abortion services.
COMPREHENSIVE SEXUALITY EDUCATION (CSE)	Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to realize their health, wellbeing and dignity; develop respectful social and sexual relationships; consider how their choices affect their own wellbeing and that of others; and understand and ensure the protection of their rights throughout their lives. CSE is based on scientifically accurate and rights-based information about sexuality and reproductive health appropriate to children and young people's age.
CONTRACEPTION	Contraception, also known as birth control, fertility control or family planning is a method or device to prevent pregnancy. Birth control has been used since ancient times, but effective and safe methods of contraception only became available in the 20th century. Modern methods of contraception include female and male sterilization, oral hormonal pills, the intra-uterine device, male and female condoms, injectables, implants, vaginal barrier methods, Standard Days Method, lactational amenorrhea method, and emergency contraception. Traditional methods of contraception include abstinence, the withdrawal method, the rhythm method, and other folk methods. Access to a range of modern methods of contraception is a human right.
DECRIMINALIZATION OF ABORTION	Decriminalization of abortion not only requires stopping punishment of women, girls and all pregnant people, health-care providers and others for obtaining, assisting with or providing abortion services, but removal of abortion from criminal laws. Decriminalization of abortion further requires removal of any laws or policies that directly or indirectly punish people for seeking, obtaining, providing or assisting with securing and/or obtaining an abortion. Decriminalizing abortion is not the same as legalizing abortion, which involves introduction of abortion laws and policies regulating abortion. (See Abortion laws and policies above.)
EMBRYO / FOETUS	Embryo (up to week 10 gestation). Foetus (from week 10 gestation onwards).
FOETAL IMPAIRMENT	Foetal impairment refers to a diagnosis that a foetus is developing in a manner different from expected foetal development for various reasons. The term covers a range of conditions that may be diagnosed in utero, either through genetic testing and/or ultrasound screenings, including diagnoses that may not manifest in a disability after birth, diagnoses that would result in the birth of a child with a disability if the pregnancy is carried to term, and diagnoses that are likely to result in miscarriage, stillbirth, or death shortly after birth. As pointed out by Women Enabled International, in the disability rights context, the term "impairment" is perceived as linked to

	DESCRIPTION
	disability, which may create a perception that "abortion on grounds of foetal impairment" is the equivalent of "disability-selective abortion". While foetal impairment includes diagnoses that will lead to a disability following birth, that is not the case for all such diagnoses. Amnesty International will use "foetal impairment" for the purposes of this policy and Explanatory Note as the most neutral term in which to discuss diagnoses of atypical foetal development.
GENDER	Socially constructed characteristics and roles of people commonly predicated on their biological sex. This varies from society to society and can change or be changed. When individuals or groups do not "fit" established gender norms, they often face stigma, discriminatory practices or social exclusion.
GENDER IDENTITY	Each person's deeply felt internal and individual experience of gender, which may or may not correspond with their sex assigned at birth.
GENDER JUSTICE	Gender justice refers to a world where people of all genders are valued equally, can enjoy their human rights without discrimination and on an equal basis, and are able to share equitably in the distribution of power, knowledge and resources.
GENDER STEREOTYPES	Gender stereotypes are generalized views or preconceptions about attributes or characteristics, or the roles that are or ought to be possessed by, or performed by, people of different genders (for example, women and men). A gender stereotype is harmful when it limits individuals' capacity to develop their personal abilities, pursue their professional careers and make choices about their lives and when results it in violations of their human rights.
GESTATIONAL LIMITS	Gestational limits refer to the gestational age by which an abortion is legally permitted. Gestational age is the common term used during pregnancy to describe the stage of development of one's pregnancy. It is generally measured in weeks, from the first day of the woman's last menstrual cycle to the current date. A typical pregnancy can range from 38 to 42 weeks.
ILLEGAL ABORTIONS	Illegal abortions are abortions which do not comply with a country's legal framework. While some illegal abortions may be unsafe when performed by an untrained provider, in unsanitary conditions or without requisite supervision, not all illegal abortions are unsafe. Illegal abortions can be safe when performed by a trained provider in sanitary conditions or when a person has access to high-quality medication, information and support to safely undertake medical abortion outside a medical facility or at home.
IMPAIRMENT AND DISABILITY	Impairment and disability are interrelated but distinct concepts. The Convention on the Rights of Persons with Disabilities (CRPD) in its Preamble defines disability as something that "results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society." Impairment is not defined in the CRPD, but generally refers to a long-term condition that impacts physical, mental, intellectual or sensory capabilities.
INFORMED CONSENT	Informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to health-care providers. Its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and wellbeing. Informed consent requires that information must be provided voluntarily, without coercion, undue influence or misrepresentation.

	DESCRIPTION
	UN Treaty Bodies have made clear that full and informed consent is necessary for all reproductive health services, including abortion services. Full and informed consent requires that a pregnant person be provided with information and counselling, if they so desire, in a way they are able to understand it, both about the procedure (including its risks and benefits) as well as about alternatives to the procedure, so as to ensure that they can make a well-considered and voluntary decision.
INTERSEX PERSONS	Intersex refers to persons whose genital, gonadal, chromosomal or hormonal characteristics do not correspond to the given standard for male or female categories of sexual or reproductive anatomy.
LEGAL GROUNDS FOR ABORTION	Legal grounds describe the circumstances under which abortion is lawful, that is, allowed or not contrary to law, or explicitly permitted as an exception to a law that criminalizes or otherwise prohibits abortion. For example, in some countries, abortion is generally criminalized but permitted on certain circumstances, such as in cases of sexual violence, foetal diagnoses or if the pregnant person's life or health is at risk. In other countries, the range of circumstances under which abortion is lawful is broader, for example for socioeconomic reasons, or abortion is available on request at least in early pregnancy.
PERSONS WITH DISABILITIES	Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.
PREGNANT PEOPLE/ PEOPLE WHO CAN BECOME PREGNANT	Amnesty International's policy on abortion and this Explanatory Note refer to women and girls, people who can get pregnant and pregnant people or individuals. This framing recognizes that while the majority of personal experiences with abortion relate to cisgender women and girls (that is, women and girls whose sense of personal identity and gender corresponds with the sex they are assigned at birth), intersex people, transgender men and boys, and people with other gender identities may have the reproductive capacity to become pregnant and may need and have abortions.
REFUSALS TO PROVIDE ABORTION	The practice of health-care providers refusing to perform abortion services, which they object to on the grounds of their moral or religious views, is sometimes referred to as "conscience-based refusals" or "conscientious objection". We avoid using the latter term as it conflates refusals to provide medical care with "conscientious objection to military service" – a different situation where individuals object to compulsory military service imposed by governments. States have a legal obligation to regulate refusals of care in an adequate way, so they do not undermine pregnant people's right to access abortion services.
REPRODUCTIVE AUTONOMY	The right to make autonomous decisions about one's reproduction including if, when and how to have children, to end or continue a pregnancy, or any other decisions related to a person's body and reproductive health.
REPRODUCTIVE JUSTICE	Reproductive justice is a social justice movement rooted in the belief that individuals and communities should have the resources and power to make sustainable and free decisions about their bodies, genders, sexualities and lives. Reproductive justice means broadening of reproductive health and rights frameworks, expanding the focus from protecting individual rights and choices, to address broader, underlying socioeconomic factors that affect and constrain individuals' reproductive rights, actions and decisions and impact their lives.

	DESCRIPTION
SAFE ABORTION	Abortion is safe when it is performed by a trained provider under sanitary conditions in the case of surgical abortion, or when a person has access to high-quality medication, information and support to undergo a medical abortion. Safe abortion is safer than giving birth.
SEX	The set of biological and reproductive attributes and characteristics of a person.
SEXUALITY	Sexuality is a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.
SEXUAL AND REPRODUCTIVE HEALTH (SRH) INFORMATION AND SERVICES	Sexual and reproductive health (SRH) services, commodities and information include provision of a range of modern contraceptives methods, safe and legal abortion, post-abortion care, maternal health and emergency obstetric care, STIs/HIV voluntary testing, counselling and treatment, diagnostics and treatment of reproductive tract infections and cancers and any other services related to sexual and reproductive health and related information. SRH services should be available, accessible, appropriate and quality health services, and should be provided without discrimination or coercion and with informed consent and respect for a person's privacy and confidentiality. Access to a comprehensive range of quality sexual and reproductive health services is a human right.
SEXUAL AND REPRODUCTIVE RIGHTS	Sexual and reproductive rights are human rights. They allow us to make choices about our lives and personal relationships; to choose if, when and with whom we have sex; to protect ourselves from sexual ill-health and HIV; and to enjoy our sexuality free from the threat of prosecution, discrimination, coercion or violence. They allow us to decide whether and when to become pregnant and who, when or if we marry. They ensure adequate protection from sexual violence and preventable pregnancy-related illness and death.
SOCIAL JUSTICE AND ECONOMIC JUSTICE	Social justice is based on equal rights for all peoples and the possibility for everyone, without discrimination, to benefit from economic and social progress around the world. Social justice flourishes when gender, age, race, ethnicity, religion, culture or disability barriers are struck down. Economic justice is a component of social justice. It is defined as the existence of opportunities for meaningful work and employment and dispensation of fair rewards for the productive activities of all individuals. The concepts of social and economic justice are intertwined and distinguishing between the two can legitimize a false dichotomy between economic and social spheres, which limits the potential for the advancement of justice more broadly. Amnesty International considers that if economic, social and cultural rights recognized in international law are fully implemented, this would ensure a world that is far more socially and economically just than at present.
TRANSGENDER PERSONS	Transgender refers to persons whose gender identity does not correspond to the biological sex assigned to them at birth.
UNSAFE ABORTION	Unsafe abortions are performed by un- or under-trained providers and/or under unsanitary conditions, or in situations where people are unable to safely undergo a medical abortion due to lack of access to high-quality medication, information or support. It is possible to have an unsafe but legal abortion.

	DESCRIPTION
UNWANTED V UNPLANNED PREGNANY	Unwanted pregnancy is a pregnancy that a person decides they do not desire. Unplanned or unintended pregnancies refer to pregnancies that occur when a person is not trying to get pregnant. An unplanned or unintended pregnancy may be either a wanted or unwanted pregnancy. An unwanted pregnancy may not necessarily have started as such.

1. INTRODUCTION

Amnesty International's policy on abortion is based on the recognition that people's ability to exercise their reproductive autonomy, control their reproductive lives and decide if, when and how to have children is essential to the full realization of human rights for women, girls and all people who can become pregnant.[1] The rights particularly at stake in this context include the rights to life, health, privacy, dignity, security of the person, bodily integrity and personal autonomy, equality and non-discrimination, equality before the law, and freedom from torture and other cruel, inhuman and degrading treatment or punishment ("other ill-treatment"). Moreover, the ability to make decisions about one's body, sexuality and reproduction is at the core of gender, economic and social justice.

Amnesty International takes an overarching principle-based approach to abortion laws, policies and practices. The organization will base its analyses of these laws, policies and practices on a set of "key principles" Amnesty International's movement adopted in 2018 (see Annex II: Key Principles – update of Amnesty International's policy on abortion), as well as on existing and evolving international human rights law and standards and foundational human rights legal principles – universality and indivisibility of human rights, fundamental justice, legality, non-arbitrariness, proportionality, non-retrogression, participation, transparency, accountability, equality and non-discrimination, and dignity. Amnesty International positions its approach within the context of working towards gender, social, reproductive and economic justice.

The policy places at its centre the concerns, lived experiences and human rights of women and girls and all those who can become pregnant and who have been subjected to reproductive oppression (both historically and currently) or whose human rights are violated under abortion laws and policies and due to abortion-related stigma and intersecting forms of discrimination.

Amnesty International believes it is important to link sexuality, health, and human rights to social and economic justice by placing abortion and reproductive health issues in the larger context of the wellbeing and health of pregnant people. People's ability to determine their own reproductive lives and to exercise reproductive autonomy is impacted by the conditions of their social and physical environment and states have an obligation to ensure that these conditions enable people to make informed and autonomous decisions that align with their life aspirations and to realize and enjoy their human rights.

Amnesty International's updated abortion policy[2] is aligned with existing international human rights law and standards and their evolution over time. The principle-based approach of the

[1] Amnesty International's policy on abortion and this Explanatory Note refer to women and girls, people who can become pregnant and pregnant people or individuals. This recognizes that while the majority of personal experiences with abortion relate to cisgender women and girls (that is, women and girls whose sense of personal identity and gender corresponds with the sex they are assigned at birth), intersex people, transgender men and boys, and people with other gender identities may have the reproductive capacity to become pregnant and may need and have abortions. For the purposes of this policy, references to 'women and girls' refers to those women and girls who have the capacity to become pregnant, which generally applies to cisgender women.

[2] The International Board adopted the updated policy on 28 September 2020. The policy was developed on the basis of a set of "key principles" (see Annex II), which were consulted on with the Amnesty International movement under the "contentious policy protocol" and adopted by the Global Assembly in June 2018. The key principles were

policy (referenced above) is intended to ensure that it does not become outdated as abortion-related human rights standards continue to evolve. Taking this approach enables the organization to take a broader approach to abortion, with pregnant people as its focus. It helps ensure that the global movement is better placed to advocate for the full protection of the human rights of pregnant people and others affected by abortion in diverse contexts.

informed by a review of Amnesty International's 2007 policy on *Selected aspects of abortion* (abortion policy) (Index: POL 39/005/2007) as required by Decision 15 of the 2017 ICM. The review analysed the impact of the abortion policy on Amnesty International's ability to work on abortion-related human rights violations experienced by women and girls, health-care providers and NGO advocates in a range of countries and contexts, and was based on the experiences of sections and the International Secretariat (IS) in applying the policy in research and campaigning since 2007. It also looked at the policy gaps in the backdrop of the evolving international human rights law and standards around abortion. A Section Working Group comprising representatives of sections and structures and IS researchers and campaigners working on abortion shared experiences and expertise for input into the review. An External Reference Group consisting of 15 leading experts in legal and/or medical and public health aspects of sexual and reproductive health and rights from different regions in the world was also set up to provide feedback and expertise to Amnesty International for the purposes of the review.

2. HUMAN RIGHTS IMPACT OF CRIMINALIZATION OF ABORTION

Amnesty International's policy position on abortion calls for full decriminalization of abortion and universal access to abortion, post-abortion care and evidence-based and non-biased abortion-related information, free of force, coercion, violence and discrimination. This position is based on existing and evolving international human rights law and standards (see Section 3.1) and a set of key principles adopted by Amnesty International's movement in 2018 (see Annex II), a range of fundamental human rights principles, and the organization's long-standing commitment to achieving full gender equality, in particular, substantive equality, and universal human rights.

Research over several decades has shown that being able to control one's reproduction and to exercise reproductive autonomy affects all spheres of the lives of women and girls and all those who can become pregnant. It impacts on their ability to exercise the full range of their human rights, as well as the achievement of gender equality and social, racial, gender and economic justice.[3] Access to safe and lawful abortion services is also firmly rooted in the rights to privacy, personal and bodily autonomy, life, health, liberty and security of person, dignity, equality and non-discrimination and to be free from torture and other ill-treatment. By contrast, criminalizing, restricting and/or otherwise denying access to safe abortion services has a cascading effect on the course of people's lives, as well as on their quality of life.

Amnesty International recognizes that people who are pregnant are best placed to make their own decisions about their reproduction and pregnancy, in the context of their particular life circumstances and trajectory and in accordance with their own views and aspirations. However, people do not make reproductive decisions in a vacuum; their actions and decisions are informed and permeated by the broader context in which they live. Therefore, people facing multiple, intersecting forms of discrimination, in addition to gender discrimination, may feel they have fewer options and that their decision-making autonomy is constrained. Members of marginalized groups may also disparately face violence, oppression and violations of their reproductive rights.

States have an obligation to ensure that people can make decisions about their pregnancies free from coercion, discrimination and violence and that they have access to justice and redress for violations of their sexual and reproductive rights. However, all too often states pass and enforce laws and policies and engage in practices that deny pregnant people's agency and prevent autonomous decision-making. This substitutes the decision-making authority of women, girls and all those who can become pregnant with that of the state, politicians and/or wider communities, who can impose their perceptions of morality and social norms and roles, which are often underpinned by harmful gender stereotypes. Additionally, those who are pregnant face punishment, intense stigma and discrimination under laws, policies and practices that are discriminatory in law or effect. This is contrary to Amnesty International's Key Principles (see Annex II) and international human rights law and standards, as well as foundational human rights principles, including universality and indivisibility of human rights, equality and non-discrimination, legality, non-arbitrariness and proportionality, non-

[3] See for example L.J. Ross and R. Solinger, *Reproductive justice: An introduction*, 1st ed., University of California Press, 2017 (hereinafter: L.J. Ross and R. Solinger, *Reproductive justice: An introduction*).

retrogression and progressive realization, accountability, transparency, and denies pregnant people a range of human rights.

The following sections discuss in more detail the negative human rights impact of criminalization of abortion.

2.1 PERPETUATES STIGMA AND DISCRIMINATION

Criminalization of abortion fosters a "shared understanding that abortion is morally wrong and/or socially unacceptable."[4] One of the foremost human rights impacts of criminal abortion laws and policies, therefore, is to stigmatize those who need, provide or assist with abortion services. They inevitably result in reinforcing abortion-related stigma and resulting in poor care, loss of status, and discrimination, which violate the human rights of women, girls and pregnant people.

Abortion-related stigma or stigmatization has been described as a social process which leads to discrimination and includes the following stages:

> 1) **Labelling**: Abortion is seen as an abnormal event. Women who have abortions and providers who offer abortion care are labelled as deviant. This has the effect of obscuring how frequent and common abortion is.
> 2) **Stereotyping**: Women who have abortions are linked to negative traits such as promiscuity, carelessness, selfishness and a lack of compassion for human life, while abortion providers are portrayed as cold, unfeeling, and motivated by greed or money.
> 3) **Separating**: A false sense of "us and them" is created, viewing or treating women who have abortions as intrinsically different or "othering" them. Silence and fear of exclusion perpetuates this separation and stereotyping.
> 4) **Discrimination**: This social process of stigma leads to overt discrimination against or status loss for women and providers,[5] which is expressed and enshrined in law, policy and practice.

International human rights bodies have analysed the impact of abortion-related stigma on individual women seeking safe abortion services. For example, in *Mellet v Ireland*, the UN Human Rights Committee (HRC) found that Ireland's criminalization of abortion led to Ms Mellet facing shame and stigma and that her suffering was further aggravated by the obstacles she faced in getting information about the appropriate medical options.[6] The HRC also found that "Ireland's criminalization of abortion subjected [the petitioner] to a gender-based stereotype of the reproductive role of women primarily as mothers, and that stereotyping her as a reproductive instrument subjected her to discrimination."[7]

In a document submitted to the HRC, the UN Working Group on the issue of discrimination against women in law and in practice observed: "Ultimately, criminalization does grave harm

[4] K. Kimport, K. Cockrill and T.A. Weitz, 'Analyzing the impacts of abortion clinic structures and processes: A qualitative analysis of women's negative experiences of abortion clinics', *Contraception,* 85, 2012, pp. 204-210.
[5] K.M. Shellenberg, A.M. Moore, A. Bankole, et al. 'Social stigma and disclosure about induced abortion: Results from an exploratory study', *Global Public Health*, 2011; 6 Suppl. 1:S111-S125.
[6] See Human Rights Committee, *Mellet v Ireland,* Comm. No. 2324/2013, UN Doc. CCPR/C/116/D/2324/2013 (2016) (hereinafter: *Mellet v Ireland*).
[7] See Human Rights Committee, *Mellet v Ireland,* supra note 6, para. 7.11.

to women's health and human rights by stigmatising a safe and needed medical procedure."[8] Calling for the decriminalization of abortion actively counters this and implies that women and girls must not be judged (and punished) for deciding to terminate a pregnancy because this is their decision to make.

Amnesty International's 2007 abortion policy, which called for the full decriminalization of abortion, laid the groundwork for the organization to work toward eliminating abortion-related stigma. The updated policy will help the organization to avoid exceptionalizing abortion and to treat it as equivalent to other human rights issues across the full spectrum of its work.

2.2 VIOLATES HUMAN RIGHTS

"The achievement of substantive equality requires States to understand how women, and subgroups of women, are disadvantaged in practice by laws, policies and institutions."[9]

Respect for the autonomous decision-making of women, girls and all those who can become pregnant in laws and policies that affect their lives is a key indicator of the degree of gender equality achieved.[10] Women, girls and people who can become pregnant have the rights to personal and bodily autonomy, liberty and security of person, dignity and equality and non-discrimination, among other rights, which are each implicated by lack of access to abortion. The extent to which these rights are a priority for states is determined by a wide range of laws and policies, not solely those relating to abortion or sexuality and reproduction more broadly. Nevertheless, whether laws, policies and practices respect the right of women, adolescent girls and all those who can become pregnant to make autonomous decisions about their sexualities and reproduction (including whether to carry a pregnancy to term or terminate) is critical.[11] Laws, which do not place pregnant people at the centre and do not respect their autonomous decision-making and human rights, cause harm to all women, girls and others who can become pregnant, and in particular to people who are marginalized and/or otherwise face intersecting forms of discrimination.

2.2.1. The Rights to Autonomy and Privacy

Deciding whether to bear and birth a child falls within the right to privacy that must be respected by state and protected from third-party interference. It entails determining how to use one's body, the form and shape of one's family, and the destination of one's life path, among other things. Such decisions are an essential component to personal and bodily autonomy.

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[8] See UN Working Group on the issue of discrimination against women in law and in practice, *Women's autonomy, equality and reproductive health in international human rights: Between recognition, backlash and regressive trends, Working Group on the issue of discrimination against women in law and in practice* (October 2017), www.ohchr.org/Documents/Issues/Women/WG/WomensAutonomyEqualityReproductiveHealth.pdf

[9] Opening Statement to the Oireachtas Joint Committee on the Eight Amendment to the Constitution, Christina Zampas, J.D., Reproductive and Sexual Health Law Fellow International Reproductive and Sexual Health Law Program, Faculty of Law, University of Toronto, 4 October 2017 (hereinafter: Opening Statement to the Oireachtas Joint Committee on the Eight Amendment to the Constitution, Christina Zampas), data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_the_eighth_amendment_of_the_constitution/submissions/2017/2017-10-04_opening-statement-ms-christina-zampas_en.pdf

[10] R.J. Cook and S. Howard, 'Accommodating women's differences under the Women's Anti-Discrimination Convention', 2007, 56 *Emory Law Journal* 1039, 1050.

[11] Opening Statement to the Oireachtas Joint Committee on the Eight Amendment to the Constitution, Christina Zampas, supra note 9.

Human rights treaty bodies have consistently found that denying access to abortion or imposing barriers to such access undermines women's reproductive autonomy and violates their rights to privacy and equality, alongside their rights to life, health, and freedom from torture or ill-treatment.[12] The HRC has specifically recognized that an individual's decision to pursue a voluntary termination of pregnancy falls within the scope of the right to privacy.[13] The HRC has further found that failure to act in conformity with a woman's decision to undergo a lawful abortion is a violation of the right to privacy, including when the judiciary interferes with such a decision.[14]

Along similar lines, the UN Committee on Economic, Social and Cultural Rights (CESCR Committee) has explicitly stated that the obligation of states to "respect the right of women to make autonomous decisions" about their health encompasses increased access to abortion, as well as other sexual and reproductive health services.[15] UN experts have also noted that restrictive laws and policies on abortion not only contravene human rights law, but also "negate [women's] autonomy in decision-making about their own bodies."[16] Along similar lines, the UN Committee on the Rights of the Child (CRC Committee) has called on states to ensure that the views of pregnant girls are always heard and respected in abortion decisions.[17]

The HRC, in its General Comment 36 on the right to life, has also confirmed that while states can regulate abortion, "such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant. Thus, restrictions on the ability of women or girls to seek abortion must not, among other things, jeopardize their lives, subject them to physical or mental pain or suffering which violates Article 7, discriminate against them or arbitrarily interfere with their privacy."[18] Human rights standards further recognize that extraction of confessions or denunciations, and the mandatory reporting of suspected illegal abortion as a condition of care, whether by legal duty or feared repercussion ("aiding and abetting"), as a form of inhuman and degrading treatment and a violation of the right to privacy.[19]

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[12] See for example, Human Rights Committee, *K.L. v Peru*, Comm. No. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003 (2005) (hereinafter: Human Rights Committee, *K.L. v Peru*); CEDAW Committee, *L.C. v Peru*, Comm. No. 22/2009, UN Doc. CEDAW/C/50/D/22/2009 (2011) (hereinafter: CEDAW Committee*, L.C. v Peru*), para. 8.15.

[13] Human Rights Committee, *Mellet v Ireland*, supra note 6, para. 7.7. See also Human Rights Committee, *L.M.R. v Argentina*, Comm. No. 1608/2007, UN Doc. CCPR/C/101/D/1608/2007 (2011) (hereinafter: Human Rights Committee, *L.M.R. v Argentina*), paras 9.3, 9.4.

[14] See Human Rights Committee, *K.L. v Peru*, supra note 12, para. 6.4; Human Rights Committee, *L.M.R. v Argentina*, supra note 13, para. 9.3.

[15] CESCR Committee, General Comment 22 (2016) on the right to sexual and reproductive health (Article 12 of the ICESCR), UN Doc. E/C.12/GC/22 (2016) (hereinafter: CESCR Committee, General Comment 22), para. 28.

[16] OHCHR, 'Unsafe abortion is still killing tens of thousands women around the world' – UN rights experts warn, 28 Sept 2016, Alda Facio, Chair-Rapporteur of the Working Group on the issue of discrimination against women in law and in practice; Dainius Pūras, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Juan E. Méndez, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; and Dubravka Šimonović, Special Rapporteur on violence against women, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20600&LangID=E

[17] CRC Committee, Concluding Observations: Ireland, UN Doc. CRC/C/IRL/CO/3-4 (2016), para. 58(a); Morocco, UN Doc. CRC/C/OPAC/MAR/CO/1 (2014), para. 57(b); Kuwait, UN Doc. CRC/C/KWT/CO/2 (2013), para. 60; Sierra Leone, UN Doc. CRC/C/SLE/CO/3-5 (2016), para. 32(c); United Kingdom of Great Britain and Northern Ireland, UN Doc. CRC/C/GBR/CO/5 (2016), para. 65(c).

[18] Human Rights Committee, General Comment 36 (Article 6: Right to Life), UN Doc. CCPR/C/GC/36 (2018), para. 8 (hereinafter: Human Rights Committee, General Comment 36).

[19] Human Rights Committee, General Comment 28 (equality of rights between men and women), UN Doc. CCPR/C/21/Rev.1/Add. 10 (2000) (hereinafter: Human Rights Committee, General Comment 28), para. 20; The Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/22/53 (2013), para. 75.

2.2.2. The Rights to Liberty and Security of Person

The rights to liberty and security of person are closely linked with the rights to privacy and autonomy. The right to liberty is not simply a right to not be subjected to arbitrary and unjust detention,[20] which is a common and significant impact of criminal abortion laws, but it also extends to unjust state interference with individuals' personal lives, including with regard to decisions around pregnancy and family life.

Criminal abortion laws significantly contribute to women's imprisonment.[21] As noted by the UN Special Rapporteur on the right to health, "[w]here abortion is illegal, women may face imprisonment for seeking an abortion and emergency services for pregnancy-related complications, including those due to miscarriages. Fear of criminal punishment for 'aiding or abetting' abortions can lead health-care providers to report people suffering from pregnancy complications to authorities."[22] Beyond incarceration, forcing a pregnant person to carry a pregnancy to term amounts to both a physical and psychological invasion of their bodies and lives. Moreover, as criminalization of abortion compels pregnant people to obtain unsafe abortions, it violates their rights to security of person and physical integrity.

The UN Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee), in its General Comment 35, explicitly stated that the criminalization of abortion is a violation of women's sexual and reproductive health and rights and a form of gender-based violence and urged states to repeal all legislation that criminalizes abortion.[23]

At the regional level, the European Court of Human Rights found in *P. and S. v Poland*, that the Polish government violated an adolescent girls' right to liberty by separating her from her mother and detaining her to prevent her from terminating her pregnancy, when less severe measures could have been taken.[24]

At the national level, the Canadian Supreme Court found in *R. v Morgentaler*, that Section 251 of the Criminal Code of Canada, which criminalized abortion except when the woman's life or health was in danger, was unconstitutional because it violated the rights to life, liberty and security of person.[25] The Court relied on a government investigation of Canada's criminal abortion law allowing abortion only on limited grounds. The investigations showed that only allowing abortion on limited grounds delayed access to services to the detriment of some women's physical and mental health and that it was applied arbitrarily across the country, which violated fundamental justice. Notably, the Canadian government has removed abortion from its criminal code.

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[20] See Human Rights Committee, General Comment 35 (Article 9: Liberty and security of person), UN Doc. CCPR/C/GC/35 (2014), paras 3, 5-6 and 10-14.

[21] See Report of the UN Special Rapporteur on the right to highest attainable standard of physical and mental health, UN Doc. A/HRC/38/36 (2018), para. 75 (citing UN Docs A/66/254, A/68/340 and A/HRC/14/20).

[22] See Report of the UN Special Rapporteur on the right to highest attainable standard of physical and mental health, UN Doc. A/HRC/38/36 (2018), para. 75. See also CEDAW Committee, Concluding Observations: El Salvador, UN Doc. CEDAW/C/SLV/CO/8-9 (2017), paras 37-38.

[23] CEDAW Committee, General Recommendation 35 on gender-based violence against women, updating General Recommendation 19, UN Doc. CEDAW/C/GC/35 (2017) (hereinafter: CEDAW Committee, General Recommendation 35).

[24] European Court of Human Rights, *P. and S. v Poland,* App. No. 57375/08 (2012) (hereinafter: European Court of Human Rights, *P. and S. v Poland)*.

[25] Supreme Court of Canada, Morgentaler 1988 decision, 1988 (drawing on evidence from The Report of the Committee on the Operation of the Abortion Law (Ottawa: Minister of Supply and Services, Canada, 1977) showing that the then existing criminal law, allowing abortion on limited grounds, delayed access to services to the prejudice of some women's physical and mental health and was applied arbitrarily across the country).

2.2.3. The Rights to Equality and Non-discrimination and Equal Protection of the Law

States must ensure the right to equality and non-discrimination as a fundamental part of realizing the rights to life and health and other human rights, particularly for women and girls, as well as other marginalized groups. The HRC has stated that interference with women's access to reproductive health care, including failure to ensure that women do not have "to undergo life-threatening clandestine abortions" violates their right to non-discrimination, as well as their right to life.[26] For example, in the case of *Mellet v Ireland,* one of the concurring opinions stated: "The right to sex and gender equality and non-discrimination obligates States to ensure that State regulations, including with respect to access to health services, accommodate the fundamental biological differences between men and women in reproduction and do not directly or indirectly discriminate on the basis of sex."[27]

This stance and reasoning is also supported by the CEDAW Committee, which has explicitly recognized: "Measures to eliminate discrimination against women are considered to be inappropriate if a health-care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a state party to refuse to provide legally for the performance of certain reproductive health services for women."[28] The CEDAW Committee reaffirmed their positions in the cases of *L.C. v Peru*[29] and *Alyne da Silva Pimentel v Brazil,*[30] as well as in their inquiries on the Philippines[31] and on Northern Ireland,[32] that health-care provision should not discriminate on the grounds of sex/gender and guarantee gender equality. The UN Working Group on the issue of discrimination against women in law and in practice has also noted that countries violate women's rights when they "neglect women's health needs, fail to make gender-sensitive health interventions, deprive women of autonomous decision-making capacity and criminalize or deny them access to health services that only women require."[33]

Criminalization of abortion is an overt form of discrimination against women, girls and all people who can become pregnant. In line with the recommendations of the CEDAW Committee and a range of other human rights treaty bodies, states must repeal discriminatory criminal laws, including laws that criminalize abortion,[34] and create the structural conditions in which women, girls and all those who can become pregnant are enabled to make autonomous decisions about

[26] Human Rights Committee, General Comment 28, supra note 19, para. 20.
[27] Human Rights Committee, Mellet v Ireland, supra note 6 (opinion of S. Cleveland, concurring), para. 7; see also Human Rights Committee, *Whelan v Ireland*, Comm. No. 2425/2014, Annex II, UN Doc. CCPR/C/119/D/2425/2014 (2017) (opinion of S. Cleveland, concurring) (hereinafter: Human Rights Committee, *Whelan v Ireland*).
[28] CEDAW Committee, General Recommendation 24 (Article 12: Women and Health), UN Doc. A/54/38/Rev.1, chap. 1 (1999).
[29] CEDAW Committee, *L.C. v Peru*, supra note 12.
[30] CEDAW Committee, *Alyne da Silva Pimentel Teixeira v Brazil*, Comm. No. 17/2008, UN Doc. CEDAW/C/49/D/17/2008 (2011) (hereinafter: CEDAW Committee, *Alyne da Silva Pimentel Teixeira v Brazil*).
[31] CEDAW Committee, Summary of the Inquiry concerning the Philippines under Article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, UN Doc. CEDAW/C/OP.8/PHL/1 (2015) (hereinafter: CEDAW Committee, Summary of the Inquiry concerning the Philippines).
[32] CEDAW Committee, Report of the Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under Article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, UN Doc. CEDAW/C/OP.8/GBR/1 (2018) (hereinafter: CEDAW Committee, Report of the Inquiry concerning the United Kingdom of Great Britain and Northern Ireland).
[33] UN Working Group on the issue of discrimination against women in law and in practice, Report of the Working Group, Human Rights Council (32nd Session), UN Doc. A/HRC/32/44 (2016), para. 14.
[34] See CEDAW, General Recommendation 33 (women's access to justice), UN Doc. CEDAW/C/GC/33 (2015), (hereinafter: CEDAW Committee, General Recommendation 33), para. 51(l); CESCR Committee, General Comment 22, supra note 15, paras 34, 40, 57.

their bodies, sexualities, reproduction and lives and have sufficient economic and social support to raise children, should they choose to do so, in safe and sustainable communities. (See Section 2.3.3 for more discussion).

Human rights treaty bodies have repeatedly condemned laws that prohibit health services that only women need. Human rights experts have also confirmed that "criminalization of or other failure to provide services that only women require, such as abortion and emergency contraception, constitute discrimination based on sex".[35] The CEDAW Committee has explicitly stated that "it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."[36] The Committee has also long recognized that neglecting, overlooking or failing to accommodate women's specific health needs, including in relation to pregnancy, is a form of discrimination against women.[37]

Both criminal abortion laws and legal and practical barriers to safe abortion have a disproportionate and discriminatory impact on the most marginalized groups who are already facing multiple and intersecting forms of discrimination. The CESCR Committee, in its General Comment 22 on the right to sexual and reproductive health, has acknowledged the pernicious nature of intersectional discrimination, identifying groups such as women living in poverty, people with disabilities, migrants, adolescents and people living with HIV/AIDS as more likely to experience multiple discrimination.[38] It has called on states to take measures to specifically address the "exacerbated impact" of such discrimination.[39]

The impact of multiple and intersecting forms of discrimination on the ability of women, girls and others who can become pregnant has to be taken into account in all policies and measures to eliminate discrimination and achieve equality in order to ensure social, economic, gender and reproductive justice.

Finally, punitive and discriminatory abortion laws, policies and practices violate the right to equality and equal protection under the law guaranteed under international and regional human rights treaties and most national constitutions.[40] Under CEDAW Article 15, women and men

[35] Joint Statement by the UN Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, on the situation of human rights defenders, on violence against women, its causes and consequences, and the UN Working Group on the issue of discrimination against women in law and in practice, Rapporteur on the Rights of Women of the Inter-American Commission on Human Rights and the Special Rapporteurs on the Rights of Women and Human Rights Defenders of the African Commission on Human and Peoples' Rights, 'The 2030 Agenda for Sustainable Development and its implementation mark a unique opportunity to ensure full respect for sexual and reproductive health and rights which must be seized', 2015, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16490&LangID=E

[36] CEDAW Committee, General Recommendation 24: Article 12 of the Convention (Women and Health), UN Doc. A/54/38/Rev.1, chap. I, 1999, para. 11.

[37] CEDAW Committee, General Recommendation 24, supra note 28, paras 6, 11, 12; CEDAW Committee, *Alyne da Silva Pimentel Teixeira v Brazil*, supra note 30; R.J. Cook and V. Undurraga, 'Article 12 [Health]', in M. Freeman, C. Chinkin and B. Rudolf (eds.), *The UN Convention on Elimination of All Forms of Discrimination against Women: A Commentary*, 2012, pp. 311-333, pp. 326-327; see also CESCR, General Comment 22, supra note 15, paras 9-10, 28, 34; Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254 (2011), paras 16 and 34; UN Working Group on the issue of discrimination against women in law and in practice, Report of the Working Group, Human Rights Council, UN Doc. A/HRC/32/44 (2016), para. 23; Human Rights Committee, *Mellet v Ireland*, supra note 6, concurring opinions of members: Cleveland, Ben Achour, and Rodríguez Rescia, de Frouville and Salvioli.

[38] CESCR Committee, General Comment 22, supra note 15, para. 30.

[39] CESCR Committee, General Comment 22, supra note 15, para. 30.

[40] See, for example, articles 7 and 8 of the Universal Declaration of Human Rights, articles 2 and 14 of the International Covenant on Civil and Political Rights, and articles 2(2) and 3 of the International Covenant on Economic, Social and Cultural Rights. At the regional level, the Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights), the American Convention on Human Rights and the African Charter on Human and Peoples' Rights all contain relevant provisions.

must have equality before the law and benefit from equal protection of the law. The CEDAW Committee has consistently called on states to adopt appropriate legal and other measures to eliminate all forms of discrimination against women by public authorities and non-state actors (individuals, organizations and enterprises)[41] and to guarantee substantive equality in all areas of life.[42]

2.2.4. The Rights to Health, Life and To Be Free from Torture and Other Ill-treatment

The right to equality and non-discrimination[43] together with the rights to health, to be free from torture and other ill-treatment, to privacy and to access to information, require states to accommodate women's specific health needs and take measures to ensure women are not denied the medical services and information they need.[44]

The CEDAW Committee has explicitly addressed the issue of criminal abortion laws as a form of discrimination against women implicating violence against women.[45] It has stated more generally in its General Recommendation 24 on women and health that "it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."[46] The Committee has also noted: "The obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals" and that barriers to women's access to appropriate health care "include laws that criminalise medical procedures only needed by women and that punish women who undergo those procedures".[47]

The UN Special Rapporteur on the right to health noted in his 2011 report: "Criminal laws and other legal restrictions disempower women, who may be deterred from taking steps to protect their health, in order to avoid liability and out of fear of stigmatisation. By restricting access to sexual and reproductive healthcare goods, services and information these laws can also have a discriminatory effect, in that they disproportionately affect those in need of such resources, namely women. As a result, women and girls are punished both when they abide by these laws, and are thus subjected to poor physical and mental health outcomes, and when they do not, and thus face incarceration."[48] In its General Comment 28 on equality of rights between men

[41] CEDAW, General Recommendation 33, supra note 34, para. 21.
[42] CEDAW, General Recommendation 33, supra note 34, para. 6. The content and scope of CEDAW Article 2 are further detailed in the Committee's General Recommendation 28 on the core obligations of states parties under Article 2 of the Convention, 47th Session, UN Doc. CEDAW/C/GC/28 (2010) (hereinafter: CEDAW Committee, General Recommendation 28). Article 3 of the Convention mentions the need for appropriate measures to ensure that women can exercise and enjoy their human rights and fundamental freedoms on a basis of equality with men.
[43] The prohibition of discrimination in the enjoyment of the rights is set out in the respective instruments such as Article 2 ICCPR, Article 2 ACHPR, Article 1(1) and Article 14 ECHR. The equal treatment provided for in these provisions refers only to the enjoyment of the rights contained in each of the instruments. On the other hand, provisions such as Article 26 ICCPR, Article 3 ACHPR, Article 24 ACHR, and Protocol 12 to the ECHR establish a general equality requirement according to which everyone must be treated equally before the law. In other words, it requires that all laws be applied equally to all people under the jurisdiction of the state without discrimination, prohibiting discrimination in any area regulated and protected by public authorities, and thus constituting an autonomous right to non-discrimination.
[44] See CEDAW Committee, General Recommendation 24 (Article 12: Women and Health), supra note 28, paras 11 and 14; See also CEDAW Committee*, L.C. v Peru*, supra note 12, para. 8.16.
[45] CEDAW Committee, *L.C. v Peru,* supra note 12; CEDAW Committee, General Recommendation 19 (Violence against Women) (1992), UN Doc. A/47/38 at 1 (1993) (hereinafter: CEDAW Committee, General Recommendation 19), para. 24(m). See also CEDAW Committee, General Recommendation 35, supra note 23, para. 18.
[46] CEDAW Committee, General Recommendation 24 (Article 12: Women and Health), supra note 28, para. 11.
[47] CEDAW Committee, General Recommendation 24 (Article 12: Women and Health), supra note 28, para. 14.
[48] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report by the Special Rapporteur, UN Doc. A/66/254 (2011), para. 17.

and women, the HRC stated that interference with access to reproductive health services may violate women's right to equality and non-discrimination.[49] The HRC has also criticized states that fail to provide sexual and reproductive health services, including abortion, thus undermining women's equal participation in social and political life.[50]

TEXT BOX 1: CRIMINALIZATION OF ABORTION INCREASES MATERNAL MORTALITY AND MORBIDITY

Criminalizing abortion creates a "chilling effect" that undermines access to health services and results in an increase in preventable maternal mortality and morbidity. For example, service providers are more reluctant to, or may refuse to, provide abortion services if there is a threat of criminal punishment. This is the case even where abortion is lawful but restricted to particular grounds.[51] Criminalizing abortion also creates barriers to other essential reproductive health services such as post-abortion care; when people know they risk being reported, prosecuted and imprisoned for having miscarriages, this can discourage them from seeking the care they need.[52]

In addition, according to the WHO, over 25 million unsafe abortions are performed each year,[53] sometimes resulting in deaths and life-altering health conditions and/or disabilities.[54] Almost all of these deaths and instances of morbidity occur in countries with restrictive abortion laws (allowing for lawful abortion only on particular grounds).[55]

The HRC has repeatedly expressed concerns about the relationship between restrictive abortion laws, unsafe abortions and maternal mortality and morbidity,[56] and has urged states to amend their abortion laws to ensure

[49] Human Rights Committee, General Comment 28, supra note 19, paras 10, 11, 20.
[50] Human Rights Committee, Concluding Observations: Argentina, UN Doc. CCPR/C/ARG/CO/4 (2010), para. 13; Chile, UN Doc. CCPR/C/CHL/CO/5 (2007), para. 8; Colombia, UN Doc. CCPR/C/79/Add.76 (1997), para. 24; Guatemala, UN Doc. CCPR/C/GTM/CO/3 (2012), para. 20; Ireland, UN Doc. CCPR/C/IRL/CO/3 (2008), para. 13; Mongolia, UN Doc. CCPR/C/79/Add.120 (2000), para. 8(b); Peru, UN Doc. CCPR/C/PER/CO/5 (2013), para. 14; Peru, UN Doc. CCPR/CO/70/PER (2000), para. 20; Senegal, UN Doc. CCPR/C/79/Add 82 (1997), para. 12; Sudan, UN Doc. CCPR/C/79/Add.85 (1997), para. 10; United Republic of Tanzania, UN Doc. CCPR/C/79/Add.97 (1988), para. 15; Zambia, UN Doc. CCPR/C/ZMB/CO/3 (2007), para. 18.
[51] European Court of Human Rights, *Tysiac v Poland*, App. No. 5410/03 (2007) (hereinafter: European Court of Human Rights, Tysiac v Poland), para. 116.
[52] UN Working Group on the issue of discrimination against women in law and in practice, Report of the Working Group, UN Doc. A/HRC/32/44 (2016), para. 79. See also CEDAW Committee, Concluding Observations: El Salvador, UN Doc. CEDAW/C/SLV/CO/8-9 (2017), para. 36(a); Center for Reproductive Rights, 'Marginalised, persecuted and imprisoned: The effect of El Salvador's total criminalization of abortion', (2014), www.reproductiverights.org/sites/crr.civicactions.net/files/documents/El-Salvador-CriminalizationOfAbortion-Report.pdf; E. Guevara-Rosas, 'El Salvador and 'Las 17'', *New York Times*, 2 March 2015, www.nytimes.com/2015/03/03/opinion/el-salvador-and-las-17.html?mcubz=0.
[53] B. Ganatra, et al., 'Global, regional, and subregional classification of abortions by safety, 2010-14: Estimates from a Bayesian hierarchical model', *The Lancet*, 1, 27 September 2017 (hereinafter: B. Ganatra, et al., 'Global, regional, and subregional classification of abortions by safety'), www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31794-4/fulltext
[54] World Health Organization (WHO), 'Safe abortion: Technical and policy guidance for health systems' (2nd ed. 2012) (hereinafter: WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed. 2012)), www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en
[55] See B. Ganatra, et al., 'Global, regional, and subregional classifications of abortions by safety', supra note 53, at 1; WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54, p. 87.
[56] Human Rights Committee, Concluding Observations: Chile, UN Doc. CCPR/C/CHL/CO/6 (2014), para. 15; Costa Rica, UN Doc. CCPR/C/CRI/CO/6 (2016), para. 17 (referring to cases of rape, incest, and fatal foetal impairment); Malawi, UN Doc. CCPR/C/MWI/CO/1/Add.1 (2014), para. 9; Sierra Leone, UN Doc. CCPR/C/SLE/CO/1 (2014), para. 14; Malta, UN Doc. CCPR/C/MLT/CO/2 (2014), para. 13; Sri Lanka, UN Doc. CCPR/C/LKA/CO/5 (2014), para. 10; Paraguay, UN Doc. CCPR/C/PRY/CO/3 (2013), para. 13; Peru, UN Doc. CCPR/C/PER/CO/5 (2013), para. 14; Guatemala, UN Doc. CCPR/C/GTM/CO/3 (2012), para. 20; Mexico, UN Doc. CCPR/C/MEX/CO/5 (2010), para. 10; El Salvador, UN Doc. CCPR/C/SLV/CO/6 (2010), para. 10; Poland, UN Doc. CCPR/C/POL/CO/6 (2010), para. 12; Jamaica, UN Doc. CCPR/C/JAM/CO/3 (2011), para. 14; Dominican Republic, UN Doc. CCPR/C/DOM/CO/5 (2012), para. 15; Nicaragua, UN Doc. CCPR/C/NIC/CO/3 (2008), para. 13; Djibouti, UN Doc. CCPR/C/DJI/CO/1 (2013), para. 9.

that women do not have to resort to illegal and unsafe abortions.[57] For example, in 2016, the Committee urged Argentina to "consider decriminalizing abortion" so that women and girls are not obliged to resort to clandestine abortions.[58] And in its updated General Comment 36 on the right to life, the HRC confirms that while states can regulate abortion, "such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant. Thus, restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardise their lives, subject them to physical or mental pain or suffering which violates article 7, discriminate against them or arbitrarily interfere with their privacy."[59] The HRC further confirmed that states "may not regulate pregnancy or abortion in all other cases in a manner that runs contrary to its duty to ensure that women and girls do not have to undertake unsafe abortions, and it should revise its abortion laws accordingly, and should not introduce new barriers and should remove existing barriers[60] that deny effective access by women and girls to safe and legal abortion,[61] including barriers caused as a result of the exercise of conscientious objection by individual medical providers."[62]

Other human rights treaty bodies have also addressed the issue of abortion criminalization. The CRC Committee, for example, has for several years urged states to decriminalize abortion[63] and recently further elaborated on this by calling for the decriminalization of abortion in "all circumstances."[64] Furthermore, in its General Comment 20 on the implementation of the rights of the child during adolescence, the Committee urged states "to decriminalise abortion to ensure that girls have access to safe abortion and post-abortion services."[65]

The CEDAW Committee has stated that "when possible, legislation criminalising abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion."[66] The Committee explicitly linked this recommendation to reducing maternal mortality. Furthermore, in its General Recommendation 35 on gender-based violence against women, it recognized criminalization of abortion, as well as denial or delay of safe abortion and post-abortion care, not only as violations of women's sexual and reproductive health and rights, but also as "forms of gender-based violence that … may amount to torture or cruel, inhuman

[57] See, for example, Human Rights Committee, Concluding Observations: Jamaica, UN Doc. CCPR/C/JAM/CO/3 (2011), para. 14 (urging the state to "amend its abortion laws to help women avoid unwanted pregnancies and not to resort to illegal abortions that could put their lives at risk. The State party should take concrete measures in this regard, including a review of its laws in line with the Covenant."); Mali, UN Doc. CCPR/CO/77/MLI (2003), para. 14; Djibouti, UN Doc. CCPR/C/DJI/CO/1 (2013), para. 9; Ireland, UN Doc. CCPR/C/IRL/CO/3 (2008), para. 13. See also Human Rights Committee, General Comment 28, supra note 19, para. 10.

[58] Human Rights Committee, Concluding Observations: Argentina, UN Doc. CCPR/C/ARG/CO/5 (2016), para. 12.

[59] Human Rights Committee, General Comment 36 (Right to Life), supra note 18, para. 8.

[60] See Human Rights Committee, Concluding Observations: Jordan, UN Doc. CCPR/C/JOR/CO/5 (2017), para. 21; Mauritius UN Doc. CCPR/C/MUS/CO/5 (2017), para. 16.

[61] Human Rights Committee, General Comment 36 (Right to Life), supra note 18, para. 8 (citing Human Rights Committee, Concluding Observations: Panama, UN Doc. CCPR/C/PAN/CO/3 (2008), para. 9; FYROM, UN Doc. CCPR/C/MKD/CO/3 (2015), para. 11. See also WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54, pp. 96-97.

[62] See Human Rights Committee, General Comment 36 (Right to Life), supra note 18, para. 8. See also Human Rights Committee, Concluding Observations: Jordan, UN Doc. CCPR/C/JOR/CO/5 (2017), para. 21; Mauritius UN Doc. CCPR/C/MUS/CO/5 (2017), para. 16.

[63] CRC Committee, Concluding Observations: Gambia, UN Doc. CRC/C/GAM/CO/2-3 (2015), para. 63(b); Dominican Republic, UN Doc. CRC/C/DOM/CO/3-5 (2015), para. 52(d); Morocco, UN Doc. CRC/C/MAR/CO/3-4 (2014), para. 57(b).

[64] CRC Committee, Concluding Observations: Peru, UN Doc. CRC/C/PER/CO/4-5 (2016), para. 56(b); Kenya, UN Doc. CRC/C/KEN/CO/3-5 (2016), para. 50(b); Haiti, UN Doc. CRC/C/HTI/CO/2-3 (2016), para. 51(c); Senegal, UN Doc. CRC/C/SEN/CO/3-5 (2016), para. 54(d); Ireland, UN Doc. CRC/C/IRL/CO/3-4 (2016), para. 58(a).

[65] CRC Committee, General Comment 20 (2016) on the implementation of the rights of the child during adolescence, UN Doc. CRC/C/GC/20 (2016), (hereinafter: CRC Committee, General Comment 20), para. 60.

[66] CEDAW Committee, General Recommendation 24, supra note 28, para. 31(c).

or degrading treatment."[67] Similar to other treaty bodies, the CEDAW Committee has called on states to decriminalize abortion.[68]

The CEDAW Committee has also ascertained in its Inquiry on Northern Ireland that "[p]ost-abortion medical services, regardless of whether abortion is legal, should always be available."[69] Public health research demonstrates that availability of post-abortion care significantly decreases maternal mortality and morbidity.[70] Along those lines, FIGO recently approved guidelines on post-abortion care, which clarify that health-care providers "bear an ethical responsibility to render prompt assistance to anyone in need of medical care they are able to provide, without discriminating regarding the lawful or other origin of the condition they treat".[71] The guidelines also clarify that "[m]uch of the mortality associated with induced abortion is due to deficient post-abortion care" and that "a refusal or failure to render care appropriately constitutes professional misconduct."[72]

Human rights treaty bodies have also long acknowledged that denial of abortion services through criminalization of abortion or through barriers and delays in access to lawful services, in certain cases constitutes cruel, degrading and inhumane treatment and may also amount to torture.[73] Decriminalization of abortion in these cases has been considered critical for protecting the rights of women and girls in need of therapeutic abortion such as when pregnancy poses a risk to their life or health, in cases of foetal anomalies[74] or sexual violence (including rape and incest).[75]

The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has confirmed that basic standards of medical care and protections against torture and degrading and inhumane treatment apply to prisoners and detainees, including the right to information and medical care relating to sexual and reproductive health.[76] The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has also outlined that for detained women, the lack of gender- and

[67] CEDAW Committee, General Recommendation 35, supra note 23, para. 18.
[68] CEDAW Committee, General Recommendation 35, supra note 23, para. 29(c)(i).
[69] CEDAW Committee, Report of the Inquiry concerning the United Kingdom of Great Britain and Northern Ireland, supra note 32, para. 61.
[70] Guttmacher Institute, 'Abortion worldwide 2017: Uneven progress and unequal access', 2018, www.guttmacher.org/report/abortion-worldwide-2017
[71] FIGO, 'Ethical responsibilities in post-abortion care', 2019, escrh.eu/wp-content/uploads/2019/05/FIGO_Post_abortion_care_documents_final.pdf (hereinafter: FIGO, 'Ethical responsibilities in post-abortion care').
[72] FIGO, 'Ethical responsibilities in post-abortion care', supra note 71.
[73] See for example Human Rights Committee, *K.L. v Peru*, supra note 12; CEDAW Committee, *L.C. v Peru*, supra note 12; Human Rights Committee, *Mellet v Ireland*, supra note 6, paras 7.6, 7.7, 7.8; Human Rights Committee, *Whelan v Ireland*, supra note 27, paras 7.7, 7.8, 7.9, 7.12. See also CAT Committee, Concluding Observations: Peru, UN Doc. CAT/C/PER/CO/5-6 (2012), para. 19; CAT Committee, Concluding Observations: Czech Republic, UN Doc. CAT/C/ CZE/CO/4-5 (2012), para. 12; CEDAW Committee, General Recommendation 35, supra note 23, para. 18.
[74] Human Rights Committee, *K.L. v Peru*, supra note 12; CEDAW Committee, *L.C. v Peru*, supra note 12; Human Rights Committee, *Mellet v Ireland*, supra note 6, paras 7.6, 7.7, 7.8; Human Rights Committee, *Whelan v Ireland*, supra note 27, paras 7.7, 7.8, 7.9, 7.12. See also Inter-American Court of Human Rights, Matter of B, provisional measures with regard to El Salvador, 29 May 2013.
[75] See CEDAW Committee, General Recommendation 30 (women in conflict prevention, conflict and post-conflict situations), UN Doc. CEDAW/C/GR/30 (2013) (hereinafter: CEDAW Committee, General Recommendation 30), para. 36; CESCR, General Comment 22, supra note 15, para. 28; The Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254 (2011), para. 49; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/HRC/35/21 (2017), para. 59.9.
[76] Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. E/CN.4/2004/56 (2003), paras 42, 55-64.

security-appropriate facilities, services and supplies, including pre-, peri-and postnatal care, violate women's rights to sexual and reproductive health and may amount to torture or ill-treatment.[77]

Human rights standards have also long protected against de facto punitive measures for criminal abortion, specifically abuse and mistreatment, and the withholding or conditioning of care within health settings. The UN Special Rapporteur on Torture[78] and the UN Working Group on the issue of discrimination against women in law and in practice[79] have condemned the degrading treatment in health-care facilities. The UN Working Group has explained that "[w]omen face a disproportionate risk of being subjected to humiliating and degrading treatment in health-care facilities, especially during pregnancy … in the name of morality or religion, as a way of punishing what is considered 'immoral' behaviour."[80]

Human rights treaty bodies[81] and UN special procedures[82] have also noted that human rights standards guarantee immediate, confidential and unconditional care for management of post-abortion complications, regardless of the legality of abortion. They further state that health care cannot be withheld for purposes of punishment, nor used to elicit confession or as evidence in any criminal proceedings, or otherwise conditioned on a person's co-operation in a criminal prosecution.[83] Human rights standards recognize extraction of confessions or denunciations, and the mandatory reporting of suspected illegal abortion as a condition of care, whether by legal duty or feared repercussion ("aiding and abetting"), as a form of inhuman and degrading treatment and a violation of the right to privacy.[84]

However, when abortion remains a crime in general, information and services still cannot be offered openly in public facilities, nor can public health information on safe abortion be promoted. The continued criminalization of providers and others who assist in abortion provision also maintains conditions for unsafe practice. Overall partial criminalization does not

[77] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/HRC/38/36 (2018), paras 77-81, 98(c), 98(k). The Special Rapporteur also underlined prisoners' and detainees' continued right to health care, including for women and adolescents; and highlighted discrimination perpetuated in prison environments, including by denial of health care such as sexual health supplies or contraceptives, see paras 28, 38, 71-72, 77-81, 98(c), 98(k).

[78] Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/31/57 (2016), paras 42, 46, 47, 70(k).

[79] The UN Working Group on the issue of discrimination against women in law and in practice, Report of the working group on the issue of discrimination against women in law and in practice, UN Doc. A/HRC/32/44 (2016), para. 17.

[80] The UN Working Group on the issue of discrimination against women in law and in practice, Report of the working group on the issue of discrimination against women in law and in practice, UN Doc. A/HRC/32/44 (2016), para. 17.

[81] See Human Rights Committee, General Comment 36, supra note 18, para. 8. See also CEDAW Committee, General Recommendation 34 (on the rights of rural women), UN Doc. CEDAW/C/GR/34 (2016), para. 39. See also CRC Committee, General Comment 15 (the right of the child to the enjoyment of the highest attainable standard of health), UN Doc. CRC/C/GC/15 (2013) (hereinafter: CRC Committee, General Comment 15), para. 70.

[82] See the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254 (2011), paras 21-36. See also the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/HRC/32/32 (2016), para. 92.

[83] See the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254 (2011), para. 27. See also the report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/31/57 (2016), para. 44.

[84] Human Rights Committee, General Comment 28, supra note 19, para. 20; The Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/22/53 (2013), para. 75.

allow for providers and others to act openly and freely, or for the enactment of positive policy on abortion, to protect the health and lives of pregnant people.

2.2.5. Dignity and Abortion

Criminalization of abortion limits women's rights to decide whether and when to reproduce, a right which human rights authorities recognize as integral to women's physical and mental integrity, and to their dignity and worth as human beings.[85] In criminalizing abortion, a state controls a woman's body and her capacity to reproduce in service of state objectives to protect a public interest. Along these lines, the UN Working Group on the issue of discrimination against women in law and in practice has noted that criminalization of abortion "is one of the most damaging ways of instrumentalising and politicising women's bodies and lives, subjecting them to risks to their lives or health in order to preserve their function as reproductive agents and depriving them of autonomy in decision-making about their own bodies."[86] To gestate and to birth a child is a profound human act, enlisting the whole of a person and the full faculties of mind and body. It is an act that carries consequences for a woman's person and life, reflecting and influencing the way she thinks about herself and her relationship to others and to society. Criminalization of abortion thus implicates not only a woman's physical and mental health, but also respect for her full and equal status as a person.[87]

Furthermore, criminal abortion laws inflict mental or physical suffering, can constitute violence against women, and amount to torture and cruel, inhuman, and degrading treatment. The severity of these harms is fully manifested in the affront to an individual's dignity and conscience and their ability to call their souls and bodies their own.[88] As such, criminalization of abortion is a profound violation of human dignity, which is fundamental to the realization of all human rights.

The Special Rapporteur on the right to health emphasized in his report on criminalization that criminal abortion laws "infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health" and that such laws not

[85] Inter-American Court of Human Rights, *Artavia Murillo et al. ("in vitro fertilization") v Costa Rica*, Preliminary Objections, Merits, Reparations and Costs, Judgment, Inter-Am. Ct. H.R. (series C) No. 257 (28 November 2012), para. 143 ("The scope of the protection of the right to private life has been interpreted in broad terms by the international human rights courts … The protection of private life encompasses a series of factors associated with the dignity of the individual, including, for example, the ability to develop his or her own personality and aspirations, to determine his or her own identity and to define his or her own personal relationships. The concept of private life encompasses aspects of physical and social identity, including the right to personal autonomy, personal development and the right to establish and develop relationships with other human beings and with the outside world … the Court has indicated that motherhood is an essential part of the free development of a woman's personality. Based on the foregoing, the Court considers that the decision of whether or not to become a parent is part of the right to private life."); European Commission of Human Rights, *Brüggemann and Scheuten v Federal Republic of Germany*, App. No. 6959/75 (1981) 3 E.H.R.R. 244, Eur. Comm'n H.R., paras 54-55 ("[L]egislation regulating the interruption of pregnancy touches upon the sphere of private life … The right to respect for private life is of such a scope as to secure to the individual a sphere within which he can freely pursue the development and fulfilment of his personality. To this effect, he must also have the possibility of establishing relationships of various kinds, including sexual, with other persons. In principle, therefore, whenever the State sets up rules for the behaviour of the individual within this sphere, it interferes with the respect for private life and such interference must be justified").

[86] The UN Working Group on the issue of discrimination against women in law and in practice, Report of the Working Group, UN Doc. A/HRC/32/44 (2016), para. 79.

[87] For a detailed discussion see Amnesty International and Prof. Joanna Erdman, Submission to the UN Human Rights Committee on the Comm. No. 2324/2013 *Mellet v Ireland*.

[88] E. Cloatre and M. Enright, Commentary on *McGee v. Attorney General*, 95, citing D. Ferriter, *Occasions of sin: Sex and society in modern Ireland* (London: Profile Books, 2009) 188, in *Northern/Irish Feminist Judgments*, id. 95.

only result in preventable maternal mortality and morbidity but also in "negative mental health outcomes, not least because affected women risk being thrust into the criminal justice system."[89] He also stated that criminal abortion laws may amount to violations of the obligations of states to respect, protect and fulfil the right to health.[90]

The HRC, in its General Comment 28 on the equality of men and women, has called on that states to take measures to eliminate and protect against interference related to women's reproductive functions. It specifically referenced the imposition of a legal duty on doctors or other health providers to report cases of women who have undergone abortion as an example of such an interference, acknowledging that such an imposition jeopardizes women's right to life, as well as their right to be free from torture and other ill-treatment.[91] Furthermore, the Committee has explicitly recommended that a state should "avoid penalising medical professionals in the conduct of their professional duties" in relation to abortion and the right to life.[92]

2.3 VIOLATES FOUNDATIONAL HUMAN RIGHTS LEGAL PRINCIPLES

Criminal abortion laws and policies amount to an unjust infringement on human rights and violate a wide-range of foundational human rights legal principles, including universality and indivisibility of human rights, fundamental justice, legality, non-arbitrariness, proportionality, non-retrogression, participation, accountability, transparency, equality and non-discrimination, and dignity.

While states are obliged under international human rights law to provide a functioning and accountable legal and policy system for individuals' safety and public health, they do not have unlimited power to regulate individuals' lives. States may be permitted to impose restrictions on some human rights only in cases when such restrictions comply with specific criteria to be permissible under international law (see below for further discussion). However, states are prohibited from adopting laws and policies that infringe on certain non-derogable rights, including the rights to life and to be free from torture and other ill-treatment.

Therefore, in addition to demonstrating the human rights impact of criminal abortion laws and policies, such regulations can be challenged as a violation of foundational human rights legal principles. In some contexts, courts and other arbiters of justice may be more amenable to liberalizing abortion laws and policies when considering them through the lens of these principles.[93] For example, in 2006, the Colombian Constitutional Court overturned the country's criminal abortion ban (to permit lawful abortion in some circumstances), based on constitutional and comparative law, human rights law and foundational human rights principles.[94] The Chilean Constitutional Court similarly overturned Chile's long-standing abortion ban in 2017, decriminalizing abortion in certain circumstances.[95] In addition to constitutional analysis, this Court specifically relied on the principles of proportionality,

[89] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254, para. 21.
[90] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254, para. 21.
[91] Human Rights Committee, General Comment 28, supra note 19, para. 20.
[92] Human Rights Committee, Concluding Observations: Nicaragua, UN Doc. CCPR/C/NIC/CO/3 (2008), para. 13.
[93] V. Undurraga, 'Proportionality in the constitutional review of abortion law', *Abortion law in transnational perspectives: Case and controversies* (R. Cook, J. Erdman and B. Dickens, eds.), 2014; J. Erdman and R. Cook, 'Decriminalization of abortion: A human rights imperative', Best Practice & Research: Clinical Obstetrics & Gynaecology, 2019.
[94] See Corte Constitucional de Colombia, Sentencia C-355, 10 May 2006.
[95] See Tribunal Constitucional Chile, Sentencia Rol N° 3729, 28 August 2017.

suitability and necessity to confirm that prosecution and punishment were not ideal mechanisms for protecting foetuses and that denying abortion in cases of rape, fatal foetal impairment, or when a woman's life is in danger has a disproportionate impact on women's lives.[96]

2.3.1. STATES MAY RESTRICT INDIVIDUALS' HUMAN RIGHTS ONLY IN A LIMITED MANNER

While states cannot derogate from certain rights, including the rights to life and freedom from torture and other ill-treatment, in some cases they may be permitted to infringe on individual rights provided that the regulation complies with specific limiting criteria. However, states' use of criminal laws and policies to address particular conduct must be a **"last resort"** (*ultima ratio* principle), as criminal sanctions are one of the most severe forms of state intrusion on individuals' lives.[97] Additionally, any law or policy that impacts human rights must have a **legitimate aim or purpose**.[98] The list of what may constitute a legitimate aim under international human rights law is not open-ended and is restricted to specific purposes, such as protection of national security, public order, public health or morals or the rights and freedoms of others. However, invoking "morality" alone as a reason to restrict human rights is never sufficient.[99]

Any state law or policy impacting human rights must be also **necessary**. In other words, a restriction of an individual's human rights can only be justified when other less restrictive responses would be inadequate and are unable to achieve the legitimate aim or purpose.[100] States' laws and policies must also be **proportionate and suitable to achieve the legitimate**

[96] See Tribunal Constitucional Chile, Sentencia Rol N° 3729, 28 August 2017, paras 113-115.
[97] See N. Jareborg, 'Criminalization as last resort (ultima ratio)', 2 *Ohio State Journal of Criminal Law*, 2005, p. 521; D. Husak, 'The criminal law as last resort', 24 *Oxford Journal of Legal Studies*, 2004, p. 207.
[98] See ICCPR, adopted 16 December 1966, G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, UN Doc. A/6316 (1966), 999 U.N.T.S 171 (entered into force Mar. 23, 1976) Arts. 19, 21 and 22; ICESCR, adopted 16 December 1966, G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, UN Doc. A/6316 (1966), 993 U.N.T.S. 3 (entered into force Jan. 3, 1976) Art. 4; Council of Europe, European Social Charter (revised) signed May 3, 1996, E.T.S. No 163 (entered into force 1 July 1999) Art. 31.1; Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), adopted 17 November 1988, O.A.S.T.S. No 69, O.A.S. Off. Rec. OEA/Ser.L.V/II.82doc.6 rev.1 (1992) (entered into force 16 November 1999) Art. 5.
[99] Human rights law recognizes that states have a legitimate interest in promoting public security, safety or order, public health, morals, or the protection of the rights and freedoms of others. See UN Commission on Human Rights, 41st Session, Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1985/4 (1984), paras 27-28. The Siracusa Principles affirm, however, that states' "margin of discretion" as it relates to morality, does not apply to the rule of non-discrimination as defined under the ICCPR. See also, *Toonen v Australia*, UN Human Rights Committee, UN Doc. CCPR/C/50/D/488/1992 (1994), para. 8.6 (rejecting Tasmania's argument that "moral issues" were "exclusively a matter of domestic concern, as this would open the door to withdrawing from the [Human Rights] Committee's scrutiny a potentially large number of statutes interfering with privacy"); *Naz Foundation (India) Trust v Government of NCT of Delhi and Others*, Writ Petition (Civil) No. 7455/2001, Delhi High Court (2 July 2009), para. 91; *National Coalition for Gay and Lesbian Equality v Minister of Justice,* Constitutional Court of South Africa, CC 11/98 (1998), paras 79 and 86; *Lawrence v Texas,* 539 US 558, 582 (2003) (J. O'Connor, Concurrence*); Ang Ladlad LGBT Party v Commission on Elections*, Republic of the Philippines Supreme Court, 8 April 2010.
[100] Both the Siracusa Principles and the Limburg Principles require that a state's limitation or restriction on human rights be proportionate and no more restrictive than necessary. Read in conjunction with the principle of ultima ratio – states should thus only resort to criminal law if no other less punitive measures suffice. See UN Commission on Human Rights, 41st Session, Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1985/4 (1984), paras 10-14; UN Commission on Human Rights, 43rd Session, 1987, Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/CN.4/1987/17 (1987), paras 60-61.

aim.[101] Finally, any state restriction on human rights **cannot be discriminatory**. This means that laws and policies must be applied equally to all people and not have a discriminatory impact on particular groups of people.[102] Laws and policies that have an unequal impact on particular individuals or groups should be viewed as suspect, requiring specific human rights scrutiny (see below in 2.3.2. **principle of equality and non-discrimination** for further discussion).

While states may purport to have a legitimate aim for criminalizing abortion, for example to protect women and maternal health, evidence confirms that criminal abortion laws are not effective at promoting maternal health and less restrictive measures could better serve that aim without violating human rights. Moreover, as discussed throughout this Explanatory Note, criminal abortion laws are a disproportionate state response, given their wide-ranging human rights impact on the lives of women, girls and all people who can become pregnant and they are explicitly discriminatory and further disparately affect women, girls and pregnant people (see Section 2.2 for additional discussion).

2.3.2. FOUNDATIONAL HUMAN RIGHTS LEGAL PRINCIPLES – ANALYTICAL TOOLS FOR CHALLENGING CRIMINAL ABORTION LAWS

In addition to demonstrating that states' criminal abortion laws and policies unjustly infringe on human rights, foundational human rights principles can be used to challenge states' criminal legal frameworks around abortion. Foremost is the principle of **legality and non-arbitrary application of laws and policies**. The principle of legality is a fundamental aspect of all international human rights instruments, as well as the rule of law.[103] In general, the principle of legality is a basic guarantee against a state's arbitrary exercise of its policing and regulatory powers. One key aspect of legality is the uniform, non-arbitrary application of the law. That is, the law must be transparent, accessible and consistently and fairly applied by governments, including by their health ministries. Lack of transparency around abortion laws and policies, in particular, is a foremost barrier to accessing lawful abortion services. Lack of clarity around pregnant persons' legal entitlement to abortion care leads to delays and denials of care or pregnant persons' avoidance of the formal health system altogether. The precarious legal status of service providers likewise "chills" the provision of abortion services as providers seek to avoid

[101] See UN Commission on Human Rights, 41st Session, Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1985/4 (1984), paras 10(d) and 51; Human Rights Committee, General Comment 31, UN Doc. CCPR/C/21/Rev.1/Add.13 (2004), para. 6 (hereinafter: Human Rights Committee, General Comment 31); CESCR Committee, General Comment 20 (Non-discrimination in economic, social and cultural rights (Article 2, para. 2, of the ICESCR)), UN Doc. E/C.12/GC/20 (2009), para. 13; V. Undurraga, 'Proportionality in the constitutional review of abortion law', *Abortion law in transnational perspectives: Case and controversies* (R. Cook, J. Erdman and B. Dickens, eds.), 2014, pp. 77-97; C. Pulido Bernal, 'El Principo de propporcionalidad y los derechos fundamentals', Centro de Estudios Politicos y Constitucionales, 2007; see also Tribunal Constitucional Chile, Sentencia Rol N° 3729, 28 August 2017, paras 113-115 (relied upon principles of proportionality, suitability and necessity to confirm that prosecution and punishment were not ideal mechanisms for protecting foetuses and that denying abortion in cases of rape, fatal foetal impairment or when a woman's life is in danger has a disproportionate impact on women's lives).

[102] See UN Commission on Human Rights, 41st Session, Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1985/4 (1984), paras 9, 28; UN Commission on Human Rights, 43rd Session, 1987, Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/CN.4/1987/17 (1987), paras 35-41, 49.

[103] The Statute of the International Court of Justice, 18 April 1946, Article 38(1)(c). Statute of the International Court of Justice. (The principle of legality, also understood as the principle of fundamental justice, is a "general principle of law recognized by civilized nations.")

arrest or other legal sanctions. "Without clarity on the law, governments can escape accountability for the adverse effects of their laws on health and human rights."[104]

At the domestic level, the National Supreme Court of Justice of Argentina has explained that a restrictive interpretation of a legal ground for abortion, which leads to women being denied abortion services to which they are legally entitled, violates the principle of legality.[105] Along similar lines, to comply with the principles of fundamental justice, which is comparable in the common law system to the legality principle in the civil law system, the Supreme Court of Canada has held:

"Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person. [Criminal Code] Section 251, therefore, is required by the Charter [Canadian Charter of Rights and Freedoms] to comport with the principles of fundamental justice."[106]

As a result of this decision, abortion in Canada is decriminalized, and is now regulated like any other medical procedure.

With regard to **non-arbitrary application of law**, this concept is intended to guarantee that even interference with human rights provided for by law (that is, through state criminal and regulatory measures) must be in accordance with human rights law and standards. It requires a direct and rational connection between the impact of the law and the objective of the law. For example, a criminal abortion law that limits the human rights of women in a way that bears no connection to, or that undermines, the law's objectives is arbitrary, inflicting harm without need or reason.[107] While the purported aim of a criminal abortion law may be to protect foetal and/or women's health, evidence confirms that such laws do not decrease the rate or number of

104 J.N. Erdman and B.R. Johnson, 'Access to knowledge and the Global Abortion Policies Database, 142, *International Journal of Gynecology & Obstetrics*, 120, 2018, p. 121.

105 F.A.L. (self-executing measure), National Supreme Court of Justice of Argentina, 2012, para 17.

106 Supreme Court of Canada, Morgentaler 1988 decision, 1988 pp. 56-57 (Chief Justice Dickson) (drawing on evidence from The Report of the Committee on the Operation of the Abortion Law (Ottawa: Minister of Supply and Services, Canada, 1977) showing that the then existing criminal law, allowing abortion on limited grounds, delayed access to services to the prejudice of some women's physical and mental health was applied arbitrarily across the country.)

107 Human Rights Committee, *Mellet v Ireland*, supra note 6, at para. 7.8: "[T]the balance that the State party has chosen to strike between protection of the foetus and the rights of the woman in this case cannot be justified. The Committee recalls its *General Comment 16* on article 17, according to which the concept of arbitrariness is intended to guarantee that even interference provided for by law should be in accordance with the provisions, aims and objectives of the Covenant and should be, in any event, reasonable in the particular circumstances. The Committee notes that the author's wanted pregnancy was not viable … The Committee considers that the interference in the author's decision as to how best cope with her non-viable pregnancy was unreasonable and arbitrary in violation of article 17 [the right to privacy] of the Covenant". See also Human Rights Committee, General Comment 16: Article 17 (Right to Privacy) The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation, (1988), para. 4. See also, Human Rights Committee, Whelan v Ireland, supra note 27, at para. 7.9: "The Committee considers that the balance that the State party has chosen to strike between protection of the foetus and the rights of the woman in the present case cannot be justified. The Committee refers in this regard to its Views in *Mellet v Ireland,* which dealt with a similar refusal to allow for termination of pregnancy involving a foetus suffering from fatal impairment.[21] The Committee notes that, like in *Mellet v Ireland,* preventing the author from terminating her pregnancy in Ireland caused her mental anguish and constituted an intrusive interference in her decision as to how best to cope with her pregnancy, notwithstanding the non-viability of the foetus. On this basis, the Committee considers that the State party's interference in the author's decision is unreasonable and that it thus constitutes an arbitrary interference in the author's right to privacy, in violation of article 17 of the Covenant." See also J. Erdman and R. Cook, 'Decriminalization of abortion: A human rights imperative', *Best Practice & Research: Clinical Obstetrics & Gynaecology*, 2019, p. 4.

abortions or promote and protect foetal or maternal health.[108] The WHO, for example, has shown that criminal laws do not decrease the need for abortion, but simply make abortion unsafe.[109] According to the WHO estimates, unsafe abortion is the third leading cause of maternal mortality and morbidity globally, causing about 47,000 deaths per annum, or 13% of all maternal deaths, and an additional 5 million largely preventable disabilities.[110] Research also confirms that criminal abortion laws simply lead pregnant individuals to seek clandestine and/or unsafe abortions and avoid post-abortion care, to the detriment of their health and lives.[111] As such, these laws are arbitrary because they undermine their own purported aim (even when they are seen as serving a legitimate aim) and can lead to rights violations and harm.[112]

In some cases where states attempt to further reduce or eliminate legal grounds for abortion and/or further impede access to abortion, the principle of **non-retrogression** can be relied on. Under international law, states are also prohibited from taking retrogressive measures that further impact and violate human rights. The CESCR Committee has confirmed that in cases where such measures are deliberately taken, the state has the burden of proving that such measures were only introduced "after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources."[113]

Finally, laws and policies that regulate abortion must align with the long-standing **principle of equality and non-discrimination**. That is, they must not be discriminatory in purpose and effect on the basis of sex and gender, or discriminatory in effect on the basis of age, race, ethnicity, geographic location and socioeconomic and other status. As referenced earlier in this Explanatory Note, criminal abortion laws and other laws, policies and practices that impose legal and practical barriers on access to safe abortion have a disproportionate and discriminatory impact on the most marginalized groups, including people on low incomes, people living with HIV, adolescents, people with disabilities and people facing criminalization on other fronts, including sex workers, people who use drugs and refugees and migrants, among others. Such laws and policies further bolster and perpetuate intersectional discrimination and have a disparate impact on those facing multiple and compounded forms of discrimination, as well as multiple barriers to exercising their sexual and reproductive rights.

Biases and prejudices against women often contribute to unjust differences in treatment due to, for example, women's age, poverty, race or ethnicity, thus denying them fair access to

[108] WHO, 'Safe abortion: Technical and policy guidance for health systems', (2nd ed., 2012), supra note 54.
[109] WHO, 'Safe abortion: Technical and policy guidance for health systems', (2nd ed., 2012), supra note 54, p. 90: "Legal restrictions on abortion do not result in fewer abortions nor do they result in significant increases in birth rates. Conversely, laws and policies that facilitate access to safe abortion do not increase the rate or number of abortions. The principle shift of [reforming and clarifying laws] is to shift previously clandestine, unsafe procedures to legal and safe ones. Restricting legal access to abortion does not decrease the need for abortion, but it is likely to increase the number of women seeking illegal and unsafe abortions, leading to increased morbidity and mortality. Legal restrictions also lead many women to seek services in other countries/states, which is costly, delays access and creates social inequities."
[110] WHO and Guttmacher Institute, 'Facts on induced abortion worldwide, in brief', 2012.
[111] See for example Amnesty International, *She is not a criminal: The impact of Ireland's abortion laws* (Index: EUR 29/1597/2015); see also Amnesty International, *On the brink of death: Violence against women and abortion ban in El Salvador* (Index: AMR 29/003/2014); Amnesty International, *The total abortion ban in Nicaragua: Women's lives and health endangered, medical professionals criminalized* (Index: AMR 43/001/2009); Guttmacher Institute, 'Abortion worldwide 2017: Uneven progress and unequal access', 2018, www.guttmacher.org/report/abortion-worldwide-2017
[112] Human Rights Committee, General Comment 16 (right to privacy), UN Doc. CCPR/C/GC/16 (1988); see also J. Erdman and R. Cook, 'Decriminalization of abortion: A human rights imperative', *Best Practice & Research: Clinical Obstetrics & Gynaecology*, 2019, p. 4.
[113] See CESCR Committee, General Comment 14 (right to health), UN Doc. E/C.12/2000/4 (2000), para. 32 (hereinafter: CESCR Committee, General Comment 14).

abortion services.[114] In the criminal justice system, biases and prejudices against women often result in differential access to lawful services and the arbitrary enforcement of the law. A study on the application of criminal abortion laws in several Latin American countries, including Brazil, revealed the selective enforcement of the laws by prosecution of poor, Afro-descendant, young and Indigenous women because they often have no recourse to competent legal defence.[115]

In terms of the broader principle of equality, states are required to accommodate the sex- and gender-based reproductive health differences of women, girls and all people who can become pregnant. In order to comply with its obligations to ensure substantive equality in this regard, states have to treat different cases according to their sex-specific differences in reproduction. Several UN bodies, including the CEDAW Committee,[116] and the CESCR Committee,[117] and the Working Group on the issue of discrimination against women in law and in practice,[118] have explained that where states fail to provide adequate sex-specific health care that only women need, that failure is a form of discrimination that states are obligated to remedy.

[114] WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54: "Protection of persons with special needs: Depending upon the context, unmarried women, adolescents, those living in extreme poverty, women from ethnic minorities, refugees and other displaced persons, women with disabilities, and those facing violence in the home, may be vulnerable to inequitable access to safe abortion services." (p. 68) … "Negotiating authorization procedures disproportionately burdens poor women, adolescents, those with little education, and those subjected to, or at risk of, domestic conflict and violence, creating inequality in access." (p. 95). See also, B. Galli and A.P. Viana, 'O Caso Elineide: Reflexões Sobre as Barreiras Existentes Ao Acesso a Interrupção Legal Da Gravidez Por Risco a Saúde Da Mulher' ('The Case Elineide: Reflections on existing barriers to women's access to legal pregnancy termination due to health risk') (1 October 2013), *Galli et al., O Caso Elineide*.

[115] G. Kane, B. Galli and P. Skuster, 'Cuando el aborto es un crimen: La amenaza para mujeres vulnerables en América Latina', Chapel Hill, Carolina del Norte, Ipas, 2013, www.redsaluddecidir.org/wp-content/uploads/Copia-de-El-aborto-no-es-un-crimen-IPAS.pdf

[116] CEDAW Committee, General Recommendation 24, supra note 28, para. 11; CEDAW Committee, General Recommendation 28, supra note 42. See also R. Cook and S. Howard, 'Accommodating women's differences under the Women's Anti-Discrimination Convention', *Emory Law Journal*, vol. 56, n. 4, 1040-1092, 2007; R.J. Cook and V. Undurraga, 'Article 12 [Health]' in M. Freeman, C. Chinkin and B. Rudolf (eds.), *The UN Convention on the Elimination of All Forms of Discrimination against Women: A comm*entary (Oxford University Press, 2012), pp. 311-333.

[117] CESCR Committee, General Comment 22, supra note 15, paras 24-28.

[118] UN Working Group on the issue of discrimination against women in policy and in practice, Report of the Working Group, UN Doc. A/HRC/32/44 (2016): "Denying women access to services which only they require and failing to address their specific health and safety, including their reproductive and sexual health needs, are inherently discriminatory and prevent women from exercising control over their own bodies and lives." (para. 28); "Equality in reproductive health requires access, without discrimination … to safe termination of pregnancy…" (para. 23).

3. STATES' HUMAN RIGHTS OBLIGATIONS IN THE CONTEXT OF ABORTION

As public health evidence has advanced an understanding of what is at stake when women, girls and all people who can become pregnant cannot control their reproduction, abortion-related human rights standards have evolved. Human rights treaty bodies have increasing called upon states to decriminalize abortion, liberalize abortion laws and create enabling conditions to ensure people are empowered to make autonomous decisions about their sexualities, reproduction, bodies and lives based on accurate and non-biased information and evidence. Set forth below, is an overview of international human rights law and standards that support pregnant individuals' right to access safe abortion and enjoy their sexual and reproductive rights more broadly.

3.1 EVOLVING INTERNATIONAL HUMAN RIGHTS LAW AND STANDARDS

Analysis and recommendations by UN treaty bodies regarding states' legal obligations in the context of abortion have undergone substantial evolution in the past decade.[119] The first to express concern about restrictive abortion laws was the HRC in 1993.[120] Since then, UN treaty bodies, in particular the HRC, the CEDAW Committee, the CRC Committee, the CESCR Committee, the Committee against Torture (CAT), the Committee for the Elimination of Racial Discrimination, and the Committee on the Rights of Persons with Disabilities (CRPD Committee) have consistently expressed concern about unsafe abortion and its consequences for women and girls in hundreds of concluding observations. Furthermore, the focus shifted from calling for access to abortion as a measure to decrease preventable maternal mortality and morbidity due to unsafe abortion, to providing full protection for a range of other women's human rights such as the rights to personal and bodily autonomy, equality and non-discrimination, dignity, privacy, information and the right to be free from torture and other ill-treatment.

UN treaty bodies have consistently expressed concern that in many countries unsafe abortion is the leading cause of high rates of maternal mortality, including among adolescents[121] and

[119] See Human Rights Committee, *Mellet v Ireland*, supra note 6. See also Center for Reproductive Rights, *Breaking ground 2020: Treaty monitoring bodies on reproductive rights,* 2020, reproductiverights.org/document/breaking-ground-2020-treaty-monitoring-bodies-reproductive-rights. See also J.B. Fine, K. Mayall and L. Sepúlveda, 'The role of international human rights norms in the liberalization of abortion laws globally', *Health and Human Rights Journal*, 2017, www.hhrjournal.org/2017/06/the-role-of-international-human-rights-norms-in-the-liberalization-of-abortion-laws-globally/

[120] See Human Rights Committee, Concluding Observations: Ireland, UN Doc. CCPR/C/79/Add.21 (1993), para. 15.

[121] See CRC Committee, Concluding Observations: Colombia, UN Doc. CRC/C/15/ADD.137 (2000); Guatemala, UN Doc. CRC/C/15/Add.154 (2001); Paraguay, UN Doc. CRC/C/15/ADD.166 (2001); Mozambique, UN Doc. CRC/C/15/Add.172 (2002); Canada, UN Doc. CRC/C/PER/CO/3 (2012); Malawi, UN Doc. CRC/C/MWI/CO/2 (2009); Pakistan, UN Doc. CRC/C/PAK/CO/3-4 (2009); Argentina, UN Doc. CRC/C/ARG/CO/3-4 (2010); Burkina Faso, Un Doc. CRC/C/BFA/CO/3-4 (2010); Maldives, CRC/C/MDV/CO/4-5 (2016). See also Human Rights Committee, Concluding Observations: Mongolia, UN Doc. CCPR/C/79/Add.120 (2000); Guatemala, UN Doc. CCPR/CO/72/GTM (2001); Mali, UN Doc. CCPR/CO/77/MLI (2003); Kenya, UN Doc. CCPR/CO/83/KEN (2005). See also CESCR Committee, Concluding Observations: Bolivia UN Doc. E/C.12/1/ADD.60 (2001); Nepal, UN Doc. E/C.12/1/ADD.66 (2001); Benin, UN Doc. E/C.12/1/Add.78 (2002); Trinidad and Tobago, UN Doc. E/C.12/1/ADD.80 (2002); Brazil, Un Doc. E/C.12/1/ADD.87 (2003); Russian Federation, UN Doc. E/C.12/1/ADD.94 (2003); Mexico, UN Doc. E/C.12/MEX/CO/4 (2006); Paraguay, UN Doc. E/C.12/PRY/CO/3 (2006); Brazil, UN Doc. E/C.12/BRA/CO/2 (2009); Argentina, UN Doc. E/C.12/ARG/CO/3 (2011). See also CEDAW Committee, Concluding Observations: Benin, UN

jeopardizes women's health and lives.[122] UN treaty bodies have urged states to address unsafe abortion, remove obstacles to access lawful services and take appropriate measures, legislative or otherwise, to ensure that women and girls do not resort to unsafe abortion.[123] However, increasingly access to safe abortion services is not seen as solely a right to life and/or health issue, but as central to non-discrimination and gender equality, as outlined in Section 2.2.

UN treaties bodies' understanding of the violations caused by denial of safe abortion services has evolved over time.[124] There is a palpable shift away from urging additional exceptions to the criminal law to total decriminalization and guaranteeing access to safe abortion. The consistent message is that grounds-based approaches (where abortion is made legal only in certain circumstances) fall short of protecting *all* women's, girls' and pregnant persons' human rights, and that legal, regulatory, health system and societal barriers to accessing safe abortion must be reformed and removed. The obligation to completely remove the regulation of abortion services from the realms of the criminal legal framework is also clear and resounding. The language and concluding observations of UN treaty bodies also increasingly highlight equality, autonomy and physical and mental integrity as profound concerns in relation to access to abortion.

Human rights bodies and courts have also affirmed that governments must provide access to abortion not just in theory, but in practice. (See Section 5.1: Procedural protections to ensure access to lawful abortion.) In fact, states have a legal obligation to ensure that access to abortion is effectively available to women and girls and others who can become pregnant, free from any barriers, delays or restrictions that violate their human rights.[125] In short, this line of

Doc. CEDAW/C/BEN/CO/1-3 (2005); Cape Verde, UN Doc. CEDAW/C/CPV/CO/6 (2006); Eritrea, UN Doc. CEDAW/C/ERI/CO/3 (2006); Jamaica, UN Doc. CEDAW/C/JAM/CO/5 (2006); Malawi, UN Doc. CEDAW/C/MWI/CO/5 (2006); Philippines, UN Doc. CEDAW/C/PHI/CO/6 (2006); Togo, UN Doc. CEDAW/C/TGO/CO/5 (2006); Venezuela, UN Doc. CEDAW/C/VEN/CO/6 (2006); Belize, UN Doc. CEDAW/C/BLZ/CO/4 (2007); Pakistan, UN Doc. CEDAW/C/PAK/CO/3 (2007); Nigeria, UN Doc. CEDAW/C/NGA/CO/6 (2008); Uruguay, UN Doc. CEDAW/C/URY/CO/7 (2008).

[122] CRC Committee, Concluding Observations: Uruguay, UN Doc. CRC/C/URY/CO/2 (2007). See also CEDAW Committee, Concluding Observations: El Salvador, UN Doc. CEDAW/C/SLV/CO/7 (2008); Morocco, UN Doc. CEDAW/C/MAR/CO/4 (2008); Oman, UN Doc. CEDAW/C/OMN/CO/1 (2011).

[123] See for example CRC Committee, Concluding Observations: Cape Verde, UN Doc. CRC/C/15/Add.168 (2001); Trinidad and Tobago, UN Doc. CRC/C/TTO/CO/2 (2006); Guatemala, UN Doc. CRC/C/15/Add.154 (2001); Haiti, UN Doc. CRC/C/15/Add.202 (2003). See also Human Rights Committee, Concluding Observations: Cameroon, UN Doc. CCPR/C/CMR/CO/4 (2010); Sri Lanka, UN Doc. CCPR/CO/79/LKA (2008). See also CESCR Committee, Concluding Observations: Colombia, UN Doc. E/C.12/1/ADD.74 (2001); Panama, UN Doc. E/C.12/1/ADD.64 (2001); Senegal, UN Doc. E/C.12/1/Add.62 (2001); Benin, UN Doc. E/C.12/1/Add.78 (2002); Albania, UN Doc. E/C.12/ALB/CO/1 (2006); Kosovo, UN Doc. E/C.12/UNK/CO/1 (2008); Kenya, UN Doc. E/C.12/KEN/CO/1 (2008); Dominican Republic, UN Doc. E/C.12/DOM/CO/3 (2010). See also CEDAW Committee, Concluding Observations: Saint Lucia, UN Doc. CEDAW/C/LCA/CO/6 (2006); Brazil, UN Doc. CEDAW/C/BRA/CO/6 (2007); Namibia, UN Doc. CEDAW/C/NAM/CO/3 (2007).

[124] See UN Human Rights Committee, *Mellet v Ireland*, supra note 6. See also Center for Reproductive Rights, 'Breaking ground 2020: Treaty monitoring bodies on reproductive rights', 2020, reproductiverights.org/document/breaking-ground-2020-treaty-monitoring-bodies-reproductive-rights. See also J.B. Fine, K. Mayall and L. Sepúlveda, 'The role of international human rights norms in the liberalization of abortion laws globally', Health and Human Rights Journal, 2017, www.hhrjournal.org/2017/06/the-role-of-international-human-rights-norms-in-the-liberalization-of-abortion-laws-globally/

125 See Human Rights Committee, General Comment 36, supra note 18, para. 8. See also Human Rights Committee, Concluding Observations: Argentina, UN Doc. CCPR/CO/70/ARG (2000), para. 14. See also CESCR Committee, Concluding Observations: Argentina, UN Doc. E/C.12/ARG/CO/3 (2011), para. 22; Poland, UN Doc. E/C.12/POL/CO/5 (2009), para. 28. See also CEDAW Committee, Concluding Observations: India, UN Doc. CEDAW/C/IND/CO/3 (2007) para. 41; Poland, UN Doc. CEDAW/C/POL/CO/6 (2007), para. 25. See also European Court of Human Rights, *Tysiac v Poland,* supra note 51; European Court of Human Rights, *R.R. v Poland,* App. No. 27617/04 (2011) (hereinafter: European Court of Human Rights, *R.R. v Poland*). See also Commissioner for Human Rights of the Council of Europe, Report by Nils Muižnieks, following his visit to Ireland from 22 to 25 November 2016 (29 March 2017), para. 95.

argument affirms that abortion is not only a public health issue but a human rights and social, economic and gender equality issue.

TEXT BOX 2: AMNESTY INTERNATIONAL'S CONTRIBUTION TO THE PROGRESSIVE EVOLUTION OF HUMAN RIGHTS STANDARDS

It is important to note that human rights standards around abortion are constantly evolving and Amnesty International has the potential to play a significant role in contributing to the progressive development of these standards with regard to abortion. Amnesty International works to uphold existing international standards, but many of these (for example, the 1975 UN Convention against Torture) were established in part because of campaigning by Amnesty International. In addition, the organization's policy positions are ahead of international law in several areas (for example, its unconditional opposition to the death penalty and the use of nuclear weapons in all circumstances).[126] Finally, past consultation highlighted the human rights values and principles which underpin the analysis of abortion as a human rights issue and steer the further development of human rights standards: namely, autonomy, bodily integrity, dignity, non-discrimination, participation and accountability.[127]

3.2 STATES' LEGAL OBLIGATIONS IN THE CONTEXT OF ABORTION

3.2.1 DECRIMINALIZE ABORTION

Initially the UN treaty bodies focused on the most extreme regulatory frameworks, expressing concern about states that criminalized abortion in all circumstances[128] or in all but a few limited circumstances.[129] However, over the years, they have come to understand the violations that result from denial of safe abortion services and shifted their recommendations accordingly. They have, therefore, moved away from urging states to partially decriminalize (that is, expand the number of exceptions to the criminal law) and ensure access to safe abortion on certain grounds (around the time Amnesty International's 2007 policy was adopted),[130] and have increasingly called for full decriminalization and access on "at least" certain grounds such as

[126] More recently, Amnesty International took the bold step to adopt a policy on state obligations to respect, protect and fulfil the human rights of sex workers that calls for full decriminalization of sex work, among other things, in order to prevent foreseeable violations of human rights, which goes beyond the position taken by human rights treaty monitoring bodies.

[127] See Amnesty International, *Report of the expert consultation on reproductive rights* (Index: POL 30/006/2005).

[128] See CESCR Committee, Concluding Observations: Nepal, UN Doc. E/C.12/1/ADD.66 (2001); Chile, UN Doc. E/C.12/1/ADD.105 (2004); Malta, UN Doc. E/C.12/1/ADD.101 (2004); Monaco, UN Doc. E/C.12/MCO/CO/1 (2006); El Salvador, UN Doc. E/C.12/SLV/CO/2 (2007); Costa Rica, UN Doc. E/C.12/CRI/CO/4 (2008); Philippines, UN Doc. E/C.12/PHL/CO/4 (2008); Mauritius, UN Doc. E/C.12/MUS/CO/4 (2010); Nicaragua, UN Doc. E/C.12/NIC/CO/4 (2008). See also CRC Committee, Concluding Observations: CRC/C/CHL/CO/3; CRC/C/NIC/CO/4; CRC/C/MLT/CO/2. See also CEDAW Committee, Concluding Observations: Honduras, UN Doc. CEDAW/C/HON/CO/6 (2007); Chile, UN Doc. CEDAW/C/CHL/CO/5-6 (2012); United Arab Emirates, UN Doc. CEDAW/C/AND/CO/2-3 (2015). See also Human Rights Committee, Concluding Observations: Nicaragua, UN Doc. CCPR/C/NIC/CO/3 (2008); Dominican Republic, UN Doc. CCPR/C/DOM/CO/5 (2012); Philippines, UN Doc. CCPR/C/PHL/CO/4 (2012); Sierra Leone, UN Doc. CCPR/C/SLE/CO/1 (2014); Chile, UN Doc. CCPR/C/CHL/CO/6 (2014); Madagascar, UN Doc. CCPR/C/MDG/CO/3 (2007); Madagascar, UN Doc. CCPR/C/MDG/CO/4 (2017). See also CAT Committee, Concluding Observations: Nicaragua, UN Doc. CAT/C/NIC/CO/1 (2009); Sierra Leone, UN Doc. CAT/C/SLE/CO/1 (2014).

[129] See CAT Committee, Concluding Observations: Paraguay, UN Doc. CAT/C/PRY/CO/4-6 (2011). See also CEDAW Committee, Concluding Observations: Afghanistan, UN Doc. CEDAW/C/AFG/CO/1-2 (2013); Bahamas, UN Doc. CEDAW/C/BHS/CO/1-5 (2012). See also CRC Committee, Gambia, UN Doc. CRC/C/GMB/CO/2-3 (2015). See also Human Rights Committee, Jordan, UN Doc. CCPR/C/JOR/CO/5 (2017).

[130] See Human Rights Committee, Concluding Observations: Guatemala, UN Doc. CCPR/CO/72/GTM (2001); Gambia, UN Doc. CCPR/CO/75/GMB (2004). See also CEDAW Committee, Concluding Observations: Indonesia, UN Doc. CEDAW/C/IDN/CO/6-7 (2012).

risk to life, health, for victims of rape and incest, and due to the existence of severe or fatal foetal impairment,[131] or access to safe abortion in a more general manner.[132] Full decriminalization of abortion means that abortion should be removed from the criminal law and that criminal or other punitive laws, policies and practices should not be applied to women, girls and pregnant people for seeking or obtaining an abortion or to health-care providers and others solely for having performed abortions or assisted or facilitated abortion medication or services.[133]

Underlying this shift is a growing recognition among UN treaty bodies of the negative impact of narrow laws framed around exceptions to criminal law. They do not guarantee effective access to lawful abortion. They do not address many of the reasons for which people seek abortions.[134] They have a harmful impact on pregnant people, particularly those who are marginalized;[135] where abortion access is limited to selected grounds, those living in poverty or who are marginalized cannot access abortion services through other routes (for example, in private care or another jurisdiction) and so are forced to opt for unsafe abortions and consequently are at higher risk of prosecution and punishment.

The current approach taken by the CRC Committee is an example of this significant movement. Since 2015, the Committee has consistently recommended that states "decriminalise abortions in all circumstances and review its legislation with a view to ensuring children's access to safe abortion and post-abortion care services. The views of the child should always be heard and respected in abortion decisions."[136]

In 2017, several UN experts called on states to ensure access to safe abortion for all women who need them, recognizing the impact criminal abortion laws can have on particularly vulnerable groups, such as adolescents and poor women, and called on states to decriminalize abortion.[137] In a recent Joint Statement, the CRPD and CEDAW Committees affirmed: "In order

[131] CEDAW Committee, Concluding Observations: Haiti, UN Doc. CEDAW/C/HTI/CO/8-9 (2016); Honduras, UN Doc. CEDAW/C/HND/CO/7-8 (2016). See also CRC Committee, Concluding Observations: Mexico, UN Doc. CRC/C/MEX/CO/4-5 (2015).

[132] See for example, CESCR, General Comment 22, supra note 15, para. 28. See also Joint Statement by CEDAW and CRPD, 'Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities', 29 August 2018, www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDStatements.aspx

[133] Even in cases where exceptions have been added to a criminal abortion law, thus decriminalizing abortion in some circumstances, "partial criminalization" fails to align with existing human rights laws and standards because this legal approach continues to lead pregnant individuals to resort to unsafe, clandestine and/or illegal abortions, reinforces abortion-related stigma and discrimination, and fails to protect to the human rights of women, girls and all people who can become pregnant.

[134] S. Chae, S. Desai, M. Crowell, G. Sedgh, 'Reasons why women have induced abortions: A synthesis of findings from 14 countries', *Contraception,* October 2017; 96(4): 233-241.

[135] Human Rights Committee, Concluding Observations: Poland, UN Doc. CCPR/CO/82/POL (2004), para. 8; CESCR Committee, Concluding Observations: Poland, UN Doc. E/C.12/1/Add.82 (2002), para. 29. See also CEDAW Committee, Concluding Observations: New Zealand, UN Doc. CEDAW/C/NZL/CO/7 (2012), para. 34. See also CRC Committee, Concluding Observations: Zimbabwe, UN Doc. CRC/C/ZWE/CO/2 (2016), para. 60(c); Poland, UN Doc. CRC/C/POL/CO/3-4 (2015), para. 39(b). See also CESCR Committee, Concluding Observations: Poland, UN Doc. E/C.12/POL/CO/6 (2016), paras 46-47.

[136] See CRC Committee, Concluding Observations: Gambia, UN Doc. CRC/C/GMB/CO/2-3 (2015); Honduras, UN Doc. CRC/C/HND/CO/4-5 (2015); Haiti, UN Doc. CRC/C/HTI/CO/2-3 (2016); United Kingdom of Great Britain and Northern Ireland, UN Doc. CRC/C/GBR/CO/5 (2016); Zimbabwe, UN Doc. CRC/C/ZWE/CO/2 (2016); Sierra Leone, UN Doc. CRC/C/SLE/CO/3-5 (2016); Bhutan, UN Doc. CRC/C/BTN/CO/3-5 (2017). See also CRC Committee, General Comment 20, supra note 65, para. 60.

[137] UN Office of the High Commissioner for Human Rights, 'International Safe Abortion Day – Thursday 28 September 2017. Safe abortions for all women who need them – not just the rich, say UN experts', 27 September 2017. The UN experts: Kamala Chandrakirana, Chair-Rapporteur of the Working Group on the issue of discrimination

to respect gender equality and disability rights, in accordance with CEDAW and Convention on the Rights of Persons with Disabilities (CRPD), States parties should decriminalise abortion in all circumstances and legalise it in a manner that fully respects the autonomy of women, including women with disabilities. In all efforts to implement their obligations regarding sexual and reproductive health and rights, including access to safe and legal abortion, the Committees call upon States parties to take a human rights-based approach that safeguards the reproductive choice and autonomy of all women, including women with disabilities."[138]

The CESCR Committee has called on states to "liberalize restrictive abortion laws" and "guarantee access to safe abortion services and quality post-abortion care"[139] and advised states to ensure that sexual and reproductive health care includes access to safe abortion services.[140] The UN Special Rapporteur on the right to health has also noted the importance of decriminalizing abortion, including the decriminalization of the facilitating abortion.[141]

Fully decriminalizing, regardless of reason, is necessary to protect the human rights of women, girls and all people who can become pregnant, including their rights to health and life, by preventing the harmful impact of illegal and unsafe abortions.

3.2.2 ELIMINATE REQUIREMENTS THAT NULLIFY THE AUTONOMY AND AGENCY OF WOMEN, GIRLS AND PREGNANT PEOPLE

UN treaty bodies and independent experts have increasingly criticized abortion laws that restrict and undermine pregnant people's reproductive autonomy and their right to make decisions about their pregnancy. In 2012, the CEDAW Committee expressed concern to New Zealand that the current legal framework and requirements make women "dependent on the benevolent interpretation of a rule which nullifies their autonomy" and recommended that the state "review the abortion law and practice with a view to simplifying it and to ensure women's autonomy to choose."[142] The CESCR Committee has explicitly articulated increased access to abortion, as well as other sexual and reproductive health services as part of states' obligation to "respect the right of women to make autonomous decisions" about their health.[143] UN experts have also noted that restrictive laws and policies on abortion not only contravene human rights law, but

against women in law and in practice; Dubravka Simonovic, Special Rapporteur on violence against women, its causes and consequences; Dainius Pûras, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Ms Agnes Callamard, Special Rapporteur on extrajudicial, summary or arbitrary executions, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=22167&LangID=E

[138] Joint Statement by CEDAW and CRPD Committees, 'Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities', 29 August 2018, www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDStatements.aspx

[139] CESCR Committee, General Comment 22, supra note 15, para. 28.

[140] CEDAW Committee, General Recommendation 30, supra note 75, para. 52 (c); See also CEDAW Committee, Concluding Observations: New Zealand, Un Doc. CEDAW/C/NZL/CO/7 (2012), para. 35(a) (permitting abortion where pregnancy poses a risk to the woman's physical or mental health and in instances of rape or incest to amend its abortion law "to ensure women's autonomy to choose."). See also CEDAW Committee, Concluding Observations: Sierra Leone, UN Doc. CEDAW/C/SLE/CO/6 (2014), para. 32.

[141] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 'Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General', UN Doc. A/66/254 (2011), para. 65(h),(i).

[142] CEDAW Committee, Concluding Observations: New Zealand, UN Doc. CEDAW/C/NZL/CO/7 (2012), paras 34, 35(a).

[143] CESCR Committee, General Comment 22, supra note 15, para. 28.

also "negate [women's] autonomy in decision-making about their own bodies."[144] Along similar lines, the CRC Committee has called on states to ensure that the views of pregnant girls are always heard and respected in abortion decisions.[145]

Women, girls and all pregnant people are the ones who should make decisions about their pregnancies. It should be up to them to decide if they want third parties involved. Third parties have a role to play in the context of abortion – but it is not their role to determine the pregnant person's eligibility for abortion or to make decisions on their behalf or in their stead. Health professionals, social workers, educators and others can support women and girls by offering voluntary, confidential, non-biased and non-directive counselling – both when they are faced with a decision about whether to continue or terminate a pregnancy and in the broader social context through provision of accurate pregnancy-related information and comprehensive sexuality education. To enable full and informed decision-making by women and girls, health professionals, in particular, must provide evidence-based and non-biased information on the health aspects of abortion to women, girls and all pregnant people that takes into account their age, their state of health and the range of available methods.

UN treaty bodies have consistently expressed concerns regarding third-party authorization requirements to obtain an abortion – for example from a spouse or partner[146] or from health-care professionals – and the adverse effect these have on women's ability to access services.[147] The CEDAW Committee noted in its General Recommendation 24 that "States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorisation of husbands, partners, parents or health authorities, because they are unmarried or because they are women."[148]

The CEDAW Committee has specifically recognized spousal consent requirements as a violation of Article 15 of CEDAW (requiring states parties "to accord women equality with men before the law").[149] In its General Recommendation 21 on equality in marriage and family relations, the Committee noted that "[d]ecisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government."[150]

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[144] UN Office of the High Commissioner for Human Rights, 'Unsafe abortion is still killing tens of thousands of women around the world' – UN rights experts warn, 28 Sept 2016. Alda Facio, Chair-Rapporteur of the Working Group on the issue of discrimination against women in law and in practice; Dainius Pūras, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Juan E. Mendez, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; and Dubravka Šimonović, Special Rapporteur on violence against women, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20600&LangID=E

[145] CRC Committee, Concluding Observations: Ireland, UN Doc. CRC/C/IRL/CO/3-4 (2016), para. 58(a); Morocco, UN Doc. CRC/C/MAR/CO/3-4 (2014), para. 57(b); Kuwait, UN Doc. CRC/C/KWT/CO/2 (2013), para. 60; Sierra Leone, UN Doc. CRC/C/SLE/CO/3-5 (2016), para. 32(c); United Kingdom of Great Britain and Northern Ireland, UN Doc. CRC/C/GBR/CO/5 (2016), para. 65(c).

[146] See CRC Committee, Concluding Observations: Pakistan, UN Doc. CRC/C/PAK/CO/5 (2016). See also CEDAW Committee, Concluding Observations: Tunisia, UN Doc. CEDAW/C/TUN/CO/6 (2010); Japan, UN Doc. CEDAW/C/JPN/CO/7-8 (2016); Turkey, UN Doc. CEDAW/C/TUR/CO/7 (2016). See also Human Rights Committee, Concluding Observations: Zambia, UN Doc. CCPR/C/ZMB/CO/3 (2007).

[147] See CEDAW Committee, Concluding Observations: Peru, UN Doc. CEDAW/C/PER/CO/7-8 (2014); Rwanda, UN Doc. CEDAW/C/RWA/CO/7-9 (2017); Timor-Leste, UN Doc. CEDAW/C/TLS/CO/2-3 (2015); New Zealand, UN Doc. CEDAW/C/NZL/CO/7 (2012). See also CAT Committee, Concluding Observations: Kenya, UN Doc. CAT/C/KEN/CO/2 (2013).

[148] CEDAW Committee, General Recommendation 24, supra note 28, para. 14.

[149] See Concluding Observations of the CEDAW Committee: Turkey (1997); Indonesia (1998). The Committee has gone further to recommend that a state party review such a requirement in its abortion law. See Concluding Observations of the CEDAW Committee: Turkey (1997).

[150] CEDAW Committee, General Comment 21 (Equality in Marriage and Family Relations), UN Doc. A/49/38 (1994) (hereinafter: CEDAW Committee, General Comment 21), para. 22.

In Europe, human rights bodies give primacy to women's rights in these circumstances. For example, European Convention case law has dismissed several cases where a male partner/spouse was trying to prevent his partner from undergoing an abortion.[151] In one case (*Boso v Italy*), the European Court of Human Rights considered that any interpretation of a potential "father's rights under Article 8 of the Convention [which guarantees everyone's right to respect for his private and family life] when the pregnant woman intends to have an abortion should above all take into account her rights, as she is the person primarily concerned by the pregnancy and its continuation or termination."[152]

Children and adolescents[153] are entitled to abortion information and services in accordance with their evolving capacities without discrimination on the basis of age. They may want their parents and/or guardians to support them in making a decision about continuing or terminating pregnancy, but blanket requirements of parental authorization are contrary to a human rights-based framework as they stand in the way of realizing the best interests and welfare of children and of recognizing their evolving capacities. What is required, rather, is that children can access support to identify what is in their best interest, including potentially (but not necessarily) consulting parents or other trusted adults about their pregnancy.[154]

The CRC Committee has affirmed the importance of minors having access to health services without parental consent.[155] The Committee has been very clear in its concluding observations to multiple countries that states should review their legislation "with a view to ensuring children's access to safe abortion and post-abortion care services."[156] Its General Comment 20 calls on states to guarantee "the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions."[157] In expressing concern about increased rates of teenage pregnancies, the Committee noted that "various factors, including limited availability of contraceptives, poor reproductive health education and the requirement of parental consent have resulted in an increasing number of illegal abortions among girls."[158] It has also consistently raised concerns about parental consent requirements and states' failure to guarantee the "best interests" of pregnant teenagers and provide them

[151] *See* European Court of Human Rights, *Paton v United Kingdom*, App. No. 8416/78, 3 Eur. H.R. Rep. 408 (1980); *R.H. v Norway*, decision on admissibility, App. No. 17004/90 (1992); *Boso v Italy*, App. No. 50490/99 (2002).

[152] European Court of Human Rights, *Boso v Italy*, App. No. 50490/99 (2002).

[153] Children are defined as peopled below the age of 18 under international law. Children generally develop the capacity to become pregnant before they are 18 and are entitled to abortion-related information and services without discrimination, in accordance with their evolving capacities (an individualized assessment based on the concept that as children mature their ability to exercise their rights increases).

[154] Parents and/or guardians are not always best placed to support children and adolescents in making decisions about pregnancy and abortion. For example, they may have become pregnant through sexual abuse or incest by the parents or guardians. Additionally, stigma around adolescent sexuality may impede children and adolescents from seeking assistance from family or guardians due to fear of punishment or mistreatment. In such cases, health and social service providers should be equipped to assist children and adolescents with determining what is in their "best interest" in their circumstances and in accordance with their evolving capacities.

[155] CRC Committee, General Comment 15, supra note 81, para. III(a) ("States parties shall strive to ensure that no child is deprived of his or her right of access to such health care services").

[156] See CRC Committee, Concluding Observations: Morocco, UN Doc. CRC/C/MAR/CO/3-4 (2014), para. 57(b); Kuwait, UN Doc. CRC/C/KWT/CO/2 (2013), para. 60; Sierra Leone, UN Doc. CRC/C/SLE/CO/3-5 (2016), paras 32(c); United Kingdom of Great Britain and Northern Ireland, UN Doc. CRC/C/GBR/CO/5, para. 65(c); Kenya, UN Doc. E/C.12/KEN/CO/1 (2008), para. 33; Kosovo (UNMIK), UN Doc. E/C.12/UNK/CO/1 (2008), para. 30; Ireland, UN Doc. CRC/C/IRL/CO/3-4 (2016), para. 58(a).

[157] CRC Committee, General Comment 20 (2016), supra note 65, para. 60.

[158] CRC Committee, Concluding Observations: Kyrgyzstan, UN Doc. CRC/C/15/Add.127 (2000), paras 44-45.

with access to sexual and reproductive health services, including safe abortion services.[159] The CRC Committee has stated generally that "there should be no barriers to commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization."[160]

Research shows that in comparison with adults, adolescents are more likely to delay seeking an abortion, resort to unskilled persons to perform it, use dangerous methods and present late when complications arise. Adolescents are also more likely to experience complications.[161] This highlights the higher risk for adolescents of deaths and injuries as a result of unsafe abortions. In his report on adolescents, the UN Special Rapporteur on the right to health recognized that mandatory parental notification and consent laws fail to acknowledge adolescents' capacity to seek out necessary reproductive health needs and that they prevent the full realization of adolescents' sexual and reproductive health and rights. He recommended that states provide for a legal presumption of capacity to consent for adolescents seeking preventive and time-sensitive sexual and reproductive services.[162]

UN treaty bodies have specifically recommended that states remove any requirement for women and girls to obtain judicial/legal authorization in order to access legal, safe abortions, with concerns often related specifically to rape victims.[163] The CAT Committee has called on states to eliminate requirements of judicial consent for abortion, including in the cases of rape.[164]

People with disabilities have a right to equal recognition before the law, which includes the ability to exercise legal capacity, and to make autonomous decisions about their sexuality and reproduction.[165] The CRPD Committee has expressly recognized the right of people with disabilities to exercise their legal capacity.[166] The Committee has also cautioned that "[t]he denial of legal capacity to persons with disabilities has, in many cases, led to their being deprived of many fundamental rights, including … the right to marry and found a family, reproductive rights, parental rights, the right to give consent for intimate relationships and medical treatment, and the right to liberty."[167] Furthermore, the CRPD Committee emphasizes that "[r]estricting or removing legal capacity can facilitate forced interventions, such as sterilization, abortion, contraception, female genital mutilation, surgery or treatment performed on intersex children without their informed consent and forced detention in institutions."[168]

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[159] See CRC Committee, Concluding Observations: Cook Islands, UN Doc. CRC/C/COK/CO/1 (2012); Iraq, UN Doc. CRC/C/IRQ/CO/2-4 (2015); Slovakia, UN Doc. CRC/C/SVK/CO/3-5 (2016); Spain, UN Doc. CEDAW/C/ESP/CO/7-8 (2015); Seychelles, UN Doc. CRC/C/15/Add.189 (2002).

[160] CRC Committee, General Comment 20, supra note 65, para. 60.

[161] A. Olukoya, A. Kaya, B. Ferguson and C. AbouZahr, 'Unsafe abortion in adolescents', *International Journal of Gynecology & Obstetrics,* (2001), 75: 137-147.

[162] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/HRC/32/32 (2016), paras 59 and 60.

[163] See CEDAW Committee, Concluding Observations: Rwanda, UN Doc. CEDAW/C/RWA/CO/7-9 (2017). See also Human Rights Committee, Concluding Observations: Morocco, UN Doc. CCPR/C/MAR/CO/6 (2016); Burkina Faso, UN Doc. CCPR/C/BFA/CO/1 (2016); Bolivia, UN Doc. CCPR/C/BOL/CO/3 (2013); Argentina, UN Doc. CCPR/CO/70/ARG (2000). See also CAT Committee, Concluding Observation: Bolivia, Un Doc. CAT/C/BOL/CO/2 (2013).

[164] See CAT Committee, Concluding Observations: Bolivia, UN Doc. CAT/C/BOL/CO/2 (2013), para. 23.

[165] See CRPD, Article 12.

[166] See CRPD, Article 12; CRPD Committee, General Comment 1 (Article 12: Equal recognition before the law), UN Doc. CRPD/C/GC/1 (2014), para. 8 (hereinafter: CRPD Committee, General Comment 1). It is important to note the difference between legal and mental capacity. According to the CRPD Committee's General Comment 1, "Legal capacity is the ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency). It is the key to accessing meaningful participation in society. Mental capacity refers to the decision-making skills of a person, which naturally vary from one person to another and may be different for a given person depending on many factors, including environmental and social factors."

[167] See CRPD Committee, General Comment 1, supra note 166, para. 8.

[168] See CRPD Committee, General Comment 1, supra note 166.

The CRPD Committee acknowledges that some people with disabilities may require additional support to exercise their legal capacity and calls on states to provide supported decision-making in such cases to enable people with disabilities to exercise their rights and engage in decision-making regarding their lives and bodies.[169] The framework laid out in the CRPD concerning supported decision-making (Article 12) and its specific application areas, including sexual and reproductive health services, are important developments in international human rights law.[170] Along these lines, states have a positive obligation to recognize the legal capacity of women, girls, and other pregnant persons with disabilities to make autonomous decisions about sexuality, reproduction and pregnancy irrespective of mental capacity and to provide any supports necessary to facilitate such informed and autonomous decision-making.[171]

States must not only adopt effective measures to enable women, including women with disabilities, to make autonomous decisions about their sexual and reproductive health, but also ensure that they have access to evidence-based and non-biased information.[172] To this end, the CRPD Committee emphasizes that women with disabilities should not "be denied access to information and communication, including comprehensive sexuality education, based on harmful stereotypes that assume that they are asexual and do not therefore require such information on an equal basis with others."[173] The Committee further clarifies that "[s]exual and reproductive health information includes information about all aspects of sexual and reproductive health, including maternal health, contraceptives, family planning, sexually transmitted infections, HIV prevention, safe abortion and post-abortion care, infertility and fertility options, and reproductive care."[174]

The CEDAW and the CRPD Committees have also confirmed in a joint statement that "States parties should ensure non-interference, including by non-State actors, with the respect for autonomous decision-making by women, including women with disabilities, regarding their sexual and reproductive health well-being … It is … critical that these decisions are made freely and that all women, including women with disabilities, are protected against forced abortion, contraception or sterilization against their will or without their informed consent."[175]

Women and girls with disabilities also need access to abortion services and the necessary unbiased and accurate information to make decisions about their health-care options and pregnancies. While individual assessments can be made around mental capacity, women and girls with disabilities have the same rights under international human rights law as all other women and girls and people who can become pregnant to make autonomous decisions around whether to carry a pregnancy to term and to have access to the necessary support to do so. Supported decision-making models can help empower people with disabilities who require

[169] See CRPD Committee, General Comment 1, supra note 166.
[170] UN, 'Chapter Six: From provisions to practice: Implementing the Convention – legal capacity and supported decision-making', www.un.org/development/desa/disabilities/resources/handbook-for-parliamentarians-on-the-convention-on-the-rights-of-persons-with-disabilities/chapter-six-from-provisions-to-practice-implementing-the-convention-5.html
[171] CRPD Committee, General Comment 1, supra note 166, paras 26, 28, 29.
[172] Joint Statement by CEDAW and CRPD, 'Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities', 29 August 2018, www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDStatements.aspx
[173] CRPD Committee, General Comment 3 (2016), Article 6 (Women and girls with disabilities), UN Doc. CRPD/C/GC/3 (2016), para. 40 (hereinafter: CRPD Committee, General Comment 3).
[174] CRPD Committee, General Comment 3, supra note 173, para. 40.
[175] Joint Statement by CEDAW and CRPD Committees, 'Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities', 29 August 2018, www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDStatements.aspx

assistance to make decisions independently and retain legal authority to make decisions by making available various support options. Such models prioritize the individual's will and preferences and protect their human rights, including rights related to personal autonomy, legal capacity and equal recognition before the law.[176]

All too often, where abortion is criminalized, people with disabilities face additional and multiple barriers in trying to access abortion services. Other restrictive laws can also create additional barriers for people with disabilities. For example, people with disabilities may also require personal assistance both to access information about the services available in another state and for travel, which can drive up the cost of treatment and expose women with disabilities to additional violations of their privacy in their decision-making. People with disabilities may further face additional obstacles in meeting the cost of abortion services, particularly when many are already marginalized and living on low incomes because of the discrimination they face in society.

Finally, in addition to being excluded from receiving critical health services, women and young persons with disabilities can be subjected to disrespectful and abusive treatment and coercive health-care practices and medical procedures such as forced sterilization, forced abortion and forced contraception,[177] which are forms of gender-based violence.[178] The Special Rapporteur on violence against women has also reported that women and girls with disabilities are disproportionately subjected to practices such as forced or coerced sterilization, contraception, and abortion.[179] This occurs through substituted decision-making, often specifically permitted by law, by parents, guardians, spouses/partners, judges or doctors, who make decisions about these reproductive health procedures for women and girls deprived of legal capacity.[180] Substituted decision-making systems, in particular, have been associated with heightened rates of abuse of persons with disabilities, allowing parents or guardians to subject women and young persons with disabilities to medical procedures against their will.[181] Adolescent girls with disabilities are especially at risk of forced sterilizations and forced abortions,[182] and women and adolescent girls with disabilities are more likely to have hysterectomies at a younger age and for a non-medically necessary reason, including by request of a parent or guardian.[183] Such forced practices are frequently based on false and discriminatory assumptions about women with disabilities' sexuality or ability to parent, or on the desire to control their menstrual cycles and growth in contravention to the international human rights law.[184]

3.2.3 ELIMINATE OTHER BARRIERS TO LAWFUL ABORTION SERVICES

[176] CRPD Committee, General Comment 1, supra note 166, para. 29.
[177] See C. Frohmader and S. Ortoleva, 'Issues paper: The sexual and reproductive rights of women and girls with disabilities', 1 July 2013, womenenabled.org/pdfs/ issues_paper_srr_women_and_girls_with_disabilities_final.pdf
[178] See Declaration on the Elimination of Violence against Women, art. 1, G.A. Res. 48/104, UN Doc. A/ RES/48/104 (Dec. 20, 1993).
[179] R. Manjoo, Report of the Special Rapporteur on violence against women, its causes and consequences, UN Doc. A/67/227 (2012), paras 28, 36.
[180] See CRPD Committee, General Comment 3, supra note 173, paras 31-32.
[181] See CRPD Committee, General Comment 3, supra note 173, para. 44.
[182] United Nations Children's Fund (UNICEF), 'The state of the world's children 2013: Children with disabilities' 41 (May 2013), www.unicef.org/publications/files/SWCR2013_ENG_Lo_res_24_Apr_2013.pdf
[183] J.A. Rivera Drew, 'Hysterectomy and disability among US women', 45 *Perspectives on Sexuality and Reproductive Health,* 157, 161 (2013); E. Pendo, 'Disability, equipment barriers, and women's health: Using the ADA to provide meaningful access', Saint Louis University *Journal of Health Law & Policy*, Vol. 2, p. 15, 2008; Saint Louis University Legal Studies Research Paper No. 2008-19. Available at SSRN: ssrn.com/abstract=1435543
[184] R. Manjoo, Report of the Special Rapporteur on violence against women, its causes and consequences, UN Doc. A/67/227 (2012), paras 28 and 36. See also, CRPD Committee, General Comment No. 3, supra note 173, para.40.

States have a legal obligation to ensure that abortion access is effectively available to women and girls and others who can become pregnant, free from any barriers, delays or restrictions that violate their human rights including their reproductive autonomy.[185]

UN treaty bodies have consistently criticized various barriers that states apply to impede or deny safe abortion services, such as cost,[186] unregulated or inadequately regulated refusals by health providers to provide lawful abortion services (see Section 3.2.4),[187] mandatory counselling,[188] mandatory waiting periods[189] and information barriers.[190] They have called on states not only to refrain from introducing barriers to access to lawful abortion services, but to actively eliminate existing barriers.[191] For example, the CESCR Committee has reaffirmed the importance of removing barriers interfering with women's access to sexual and reproductive health services, goods and information.[192] And the HRC has recognized that barriers to abortion services threaten women's right to life and has urged states to remove them.[193]

From a public health perspective, the WHO has recognized that barriers deter women from seeking safe abortions and called for the removal of such barriers.[194] It has also called for expanded access to safe abortion care, including access to affordable services and ensuring that there are more health-care providers and facilities that can lawfully perform abortions.[195] This is particularly important in rural areas where there is a dearth of qualified physicians.

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[185] See for example Human Rights Committee, General Comment 36, supra note 18, para. 8.

[186] See for example, CEDAW Committee, Concluding Observations: Costa Rica, UN Doc. CEDAW/C/CRI/CO/7 (2017); Hungary, UN Doc. CEDAW/C/HUN/CO/7-8 (2013); see also Human Rights Committee, Concluding Observations: Pakistan, UN Doc. CCPR/C/PAK/CO/1 (2017); Ghana, CCPR/C/GHA/CO/1 (2016); see also CRC Committee, Concluding Observations: Slovakia, UN Doc. CRC/C/SVK/CO/3-5 (2016).

[187] See for example CEDAW Committee, Concluding Observations: Romania, UN Doc. CEDAW/C/ROU/CO/7-8 (2017); Italy, UN Doc. CEDAW/C/ITA/CO/7 (2017); Peru, UN Doc. CEDAW/C/PER/CO/7-8 (2014); Poland, UN Doc. CEDAW/C/POL/CO/7-8 (2014); Poland, UN Doc. CEDAW/C/POL/CO/6 (2007); Slovakia, UN Doc. CEDAW/C/SVK/CO/4 (2008); Slovakia, UN Doc. CEDAW/C/SVK/CO/5-6 (2015). See also CRC Committee, Slovakia, UN Doc CRC/C/SVK/CO/3-5 (2016). See also CESCR Committee, Concluding Observations: Italy, UN Doc. E/C.12/ITA/CO/5 (2015), Romania, UN Doc. E/C.12/ROU/CO/3-5 (2014); Poland, UN Doc. E/C.12/POL/CO/6 (2016), Poland, UN Doc. E/C.12/POL/CO/5 (2009). See also Human Rights Committee, Concluding Observations: Argentina, UN Doc. CCPR/C/ARG/CO/5 (2016), CCPR/C/POL/CO/6 (2010). See also CAT Committee, Concluding Observations: Bolivia, UN Doc. CAT/C/BOL/CO/2 (2013); Poland, UN Doc. CAT/C/POL/CO/5-6 (2013). See also HRC, General Comment 36 (right to life), UN Doc. CCPR/C/GC/36 (2018), para. 8.

[188] See CEDAW Committee, Concluding Observations: Hungary, UN Doc. CEDAW/C/HUN/CO/7-8 (2013); Russian Federation, UN Doc. CEDAW/C/RUS/CO/8 (2015).

[189] CEDAW Committee, Concluding Observations: Slovakia, UN Doc. CEDAW/C/SVK/CO/5-6 (2015); Hungary, UN Doc. CEDAW/C/HUN/CO/7-8 (2013); Russian Federation, UN Doc. CEDAW/C/RUS/CO/8 (2015). See also CRC Committee, Concluding Observations, Slovakia, UN Doc. CRC/C/SVK/CO/3-5 (2016).

[190] See CESCR Committee, General Comment 14, supra note 113, para. 34. See also CESCR General Comment 22, supra note 15, para. 34.

[191] Human Rights Committee, General Comment 36, supra note 18, para. 8 ("States parties should not introduce new barriers and should remove existing barriers that deny effective access by women and girls to safe and legal abortion, including barriers caused as a result of the exercise of conscientious objection by individual medical providers.")

[192] CESCR, General Comment 22, supra note 15, para. 28.

[193] Human Rights Committee, Concluding Observations: Bolivia, UN Doc. CCPR/C/BOL/CO/3 (2013), para. 9(b); Zambia, UN Doc. CCPR/C/ZMB/CO/3 (2007), para. 18; Argentina, UN Doc. CCPR/CO/70/ARG (2000), para. 14. See also Human Rights Committee, General Comment 36, supra note 18, para. 8.

[194] These barriers include lack of access to information; requiring third-party authorization; failing to guarantee confidentiality and privacy; and allowing conscientious objection without referrals on the part of health care providers and facilities. See WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), pp. 95-97.

[195] Task shifting involves re-distribution of tasks among the health force work team. In the case of access to abortion, it means allowing health care providers (beyond physicians) to perform abortions, thus increasing its availability and accessibility. See WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54, pp. 95-97; see also WHO, 'Task shifting: Global recommendations and guidelines',

The CEDAW Committee has recommended that states eliminate medically unnecessary waiting periods for abortion.[196] The WHO has also cautioned that "mandatory waiting periods can result in delaying care and thus jeopardize women's ability to access safe, legal abortion services and demeans women as competent decision-makers".[197] Waiting periods can have a disproportionate and discriminatory impact on women, girls and all pregnant people with fewer economic means because of, for example, additional transport costs to reach health-care services, additional child care or absence from work.

UN treaty bodies have consistently emphasized that access to information is a critical element of accessing abortion services[198] and that states should not place criminal sanctions on those who provide information about abortion.[199] Further, the CEDAW Committee has called on states to eliminate information barriers to abortion services, such as mandatory biased counselling requirements,[200] and ensure that information provided is science- and evidence-based and includes both the risks of having an abortion and of carrying a pregnancy to term in order to ensure women's autonomy and informed decision-making.[201] In addressing abortion in its updated General Comment 36, the HRC called on states to "ensure access for women and men, and, especially, girls and boys, to quality and evidence-based information and education about sexual and reproductive health and to a wide range of affordable contraceptive methods, and prevent the stigmatization of women and girls seeking abortion."[202]

Providing accurate, unbiased and non-stigmatizing information and counselling is essential to assist women, girls and all pregnant people to make informed and autonomous decisions about their pregnancies, foetal diagnoses and fertility, free of coercion.[203] The WHO notes that provision of counselling to pregnant individuals who desire it should be voluntary, confidential, non-directive and by trained personnel.[204] The CRC Committee has spoken out against biased counselling, noting it is key for "health care professionals [to] provide medically accurate and non-stigmatizing information on abortion."[205] And both the CEDAW and CRPD Committees have confirmed that "States should adopt effective measures to enable women, including women with disabilities, to make autonomous decisions about their sexual and reproductive health and

www.who.int/workforcealliance/knowledge/resources/taskshifting_guidelines/en/ (for further guidance on task shifting).

[196] CEDAW Committee, Concluding Observations: Hungary, UN Doc. CEDAW/C/HUN/ CO/7-8 (2013), para. 30.

[197] WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54, p. 96.

[198] CEDAW Committee, Concluding Observations: Zambia, UN Doc. CEDAW/C/ZMB/ CO/5-6 (2011), paras 33, 34.

[199] Human Rights Committee, Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/ CO/4 (2014), para. 9.

[200] CEDAW Committee, Concluding Observations: Hungary, UN Doc. CEDAW/C/HUN/ CO/7-8 (2013), para. 30.

[201] CEDAW Committee, Concluding Observations: Slovakia, UN Doc. CEDAW/C/SVK/CO/5- 6 (2015), para. 31.

[202] Human Rights Committee, General Comment 36, supra note 18, para. 8.

[203] See Joint Civil Society Statement, The Nairobi Principles on Abortion, Prenatal Testing and Disability, 2019, nairobiprinciples.creaworld.org/nairobi-principles-on-abortion-prenatal-testing-and-disability/ (Principle 6: "We affirm that the only way of supporting all prospective parents to make informed decisions about continuing or terminating their pregnancies is through affirmative measures, such as combating ableism in prenatal testing and counselling processes, ensuring all parents are operating in an enabling environment and have the social and economic supports they need to raise any child, including a child with disabilities or who is otherwise socially excluded, and promoting the rights and inclusion of persons with disabilities in all spheres of public and private life."; Principle 12: "As prenatal science and technology advance, we recognize that providers should offer evidence-based information to pregnant people neutrally and without bias during the prenatal screening and diagnostic process. We will advocate for professional and ethical standards and medical education that ensures that providers are trained on the rights and lived realities of people with disabilities or are able to refer to relevant people who can provide this information.")

[204] WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54, p. 36.

[205] CRC Committee, Concluding Observations: Slovakia, UN Doc. CRC/C/SVK/CO/3-5 (2016), para. 41(e). See also CESCR, General Comment 22, supra note 15, para. 41.

should ensure that women have access to evidence-based and unbiased information in this regard."[206]

Barriers to abortion must also be removed in prison and detention settings. While people in detention do not relinquish their human rights, all too often imprisoned and detained pregnant women and girls are unable to access abortion care. As confirmed by the HRC in its General Comment 21, states have a positive obligation to persons deprived of liberty to guarantee their dignity "under the same conditions as for that of free persons" apart from "the restrictions that are unavoidable in a closed environment," and that such persons are not "subjected to any hardship or constraint other than that resulting from the deprivation of liberty".[207] With regard to access to sexual and reproductive health care, the CESCR Committee has highlighted states' obligations to effectively monitor and regulate specific sexual and reproductive health-related sectors, and outlining that for "[p]risoners ... [and others with] additional vulnerability by condition of their detention or legal status ... the State [is required] to take particular steps to ensure their access to sexual and reproductive information, goods and health care."[208] In its earlier General Comment 14, the Committee confirmed that states must not impose discriminatory practices relating to women's health status and needs, including for women prisoners and detainees by, for example, "refrain[ing] from limiting access to contraceptives and other means of maintaining sexual and reproductive health, [and] from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information."[209]

States are further required to implement fully and expeditiously the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) which establish appropriate gender-specific conditions of detention.[210] Standard Minimum Rule 24 and Bangkok Rule 10 confirm the overarching principle of prison health care – it should be equivalent to that delivered in the community (outside prison). Bangkok Rule 6(c) recognizes that one of the key gender-specific health-care needs of women is related to their reproductive health. Along these lines, pregnant individuals in prison or other places of detention should be ensured prompt and safe access to critical sexual and reproductive health information and services, including abortion and post-abortion care.

3.2.4 REGULATE REFUSALS BY HEALTH-CARE PROFESSIONALS TO PROVIDE LAWFUL ABORTION SERVICES

Refusals of care based on conscience or religious belief[211] are most often related to the provision of abortion services. Nevertheless, health-care providers and pharmacists also refuse

[206] Joint Statement by CEDAW and CRPD Committees, 'Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities', 29 August 2018, www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDStatements.aspx

[207] Human Rights Committee, General Comment 21, Article 10 (Humane treatment of persons deprived of their liberty), UN Doc. HRI/GEN/1/Rev.9 (Vol. I), 1992, para. 3.

[208] CESCR Committee, General Comment 22, supra note 15, paras 31, 60.

[209] CESCR Committee, General Comment 14, supra note 113, para. 34.

[210] United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), UN Doc. A/RES/65/229 (2011).

[211] The practice of health care providers refusing to perform certain health services, most often in the context of sexual and reproductive health care, which they object to on the grounds of their moral or religious views, is sometimes referred to as "conscience-based refusals" or "conscientious objection." The latter phrase is problematic as it enables conflation of refusals to provide medical care with "conscientious objection to military service" – a different situation where individuals object to compulsory military service imposed by governments. For purposes of clarity and accurate legal and human rights analysis, Amnesty International will use the phrases "refusals of care" or "denial of care" in the context of abortion when refusals of care by health care providers are unregulated or

other care such as the provision of emergency contraception and other forms of contraception, health services for transgender people and sterilization and infertility treatments. Such refusals, if they are not regulated by the state and patients are not provided with alternative care options, can have a significant impact on patients' health and rights and further reinforce discrimination against individuals and groups who are already marginalized and subjected to multiple and intersecting forms of discrimination.

UN and regional human rights bodies have recognized the harmful effects of refusals of care on the health and human rights of women, girls and all pregnant people. They have set out state obligations, under the rights to health, to privacy and to non-discrimination, to ensure that women, girls and all pregnant people can access the reproductive health services that they are lawfully entitled to receive. UN treaty bodies have confirmed that "in cases where abortion procedures may lawfully be performed, all obstacles to obtaining them should be removed," including the unregulated practice of refusing to provide services based on conscience.[212]

UN treaty bodies have repeatedly urged those states that permit refusals of care to adequately regulate it to ensure that it does not limit women's access to abortion services.[213] The CESCR Committee has specifically recommended that an "adequate number of health-care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach."[214]

The former UN Special Rapporteur on health has also recognized that "conscientious objection laws … make safe abortions and post-abortion care unavailable, especially to poor, displaced and young women. Such restrictive regimes, which are not replicated in other areas of sexual and reproductive health care, serve to reinforce the stigma that abortion is an objectionable practice."[215] He has recommended that states "ensure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available" and urged states to ensure that "conscientious objection" cannot be invoked in emergency situations.[216] Medical providers must always provide care, regardless of their personal beliefs or objections, in emergency circumstances when abortion services are necessary to save a woman's life or prevent serious harm, in cases of life-saving post-abortion

inadequately regulated, and pregnant persons are not promptly referred to willing providers and/or not provided care in emergency situations, amounting to a denial of care.

[212] Human Rights Committee, Concluding Observations: Argentina, UN Doc. CCPR/CO/70/ARG (2000), para. 14; see also CESCR Committee, Concluding Observations: Argentina, UN Doc. E/C.12/ARG/CO/3 (2011), para. 22; Poland, UN Doc. E/C.12/POL/CO/5 (2009), para. 28. See also CEDAW Committee, Concluding Observations: India, UN Doc. CEDAW/C/IND/CO/3 (2007), para. 41; Poland, UN Doc. CEDAW/C/POL/CO/6 (2007), para. 25. See also Human Rights Committee, General Comment 36, supra note 18, para. 8.

[213] CESCR Committee, Concluding Observations: Poland, UN Doc. E/C.12/POL/CO/5 (2009), para. 28. See also CEDAW Committee, Concluding Observations: Poland, UN Doc. CEDAW/C/POL/CO/6 (2007), para. 25; Slovakia, UN Doc. CEDAW/C/SVK/CO/4 (2008), para. 29. See also Human Rights Committee, Concluding Observations: Poland, UN Doc. CCPR/C/POL/CO/6 (2010), para. 12.

[214] CESCR Committee, General Comment 22 (right to sexual and reproductive health), UN Doc. E/C.12/GC/22, 2016, paras 14, 43 ("Unavailability of goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, must not be a barrier to accessing services. An adequate number of health-care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach … Where health-care providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone's access to sexual and reproductive healthcare, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought, and that it does not inhibit the performance of services in urgent or emergency situations").

[215] Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254 (2011), para. 24.

[216] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental – Mission to Poland, UN Doc. A/HRC/14/20/Add.3 (2010), paras 50 and 85(k).

care, or where a referral or continuity of care is not possible.[217] Treaty bodies have also affirmed that states must never allow institutional refusals of care.[218]

Medical ethics guidelines also require providers to prioritize patient care over medical providers' individual objections to care.[219] Current guidelines by the International Federation of Gynecology and Obstetrics (FIGO) state that a doctor objecting to abortion based on conscience "has an obligation to refer the woman to a colleague who is not in principle opposed to termination."[220] Additionally, in its "Professional and ethical responsibilities concerning sexual and reproductive rights", the FIGO recommends:

> *"Assur[ing] that a physician's right to preserve his/her own moral or religious values does not result in the imposition of those personal values on women. Under such circumstances, they should be referred to another suitable health care provider. Conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay."*[221]

The current WHO safe abortion guidance further stipulates that the referral must be to someone in the same or another easily accessible health-care facility. If a referral is not possible, the objecting provider is obligated to provide a safe abortion to preserve the woman's life and to prevent risks to her health. Any woman who presents with complications due to abortion must receive professional care with urgency and respect, as with any other emergency case.[222]

States' obligation to regulate health-care provision, including refusals of care, applies to both public and private institutions. It is a well-established human rights principle that, regardless of who provides the health care, the state is responsible for fulfilling the right to health and regulating bodies to ensure health care is provided to everybody free from discrimination, coercion and with respect to human rights. This international legal obligation cannot be transferred. Moreover, states also have a broader obligation to ensure that all health regulation and provision is human rights compliant. According to the CESCR Committee, "[o]bligations to protect include, inter alia, the duties of States … to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services."[223]

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[217] For an overview of international,European and Inter-American regional human rights standards around conscience-based refusals, see Center for Reproductive Rights, 'Conscientious objection and reproductive rights: International human rights standards', 2013, www.reproductiverights.org/sites/crr.civicactions.net/files/documents/_Conscientious_FS_Intro_English_FINAL.pdf

[218] See for example CEDAW Committee, Concluding Observations: Hungary, UN Doc. CEDAW/C/HUN/CO/7-8 (2013), para. 31(d); see also CRC Committee, Concluding Observations: Slovakia, UN Doc. CRC/C/SVK/CO/3-5 (2016), para 41(f).

[219] J. Bueno de Mesquita and L. Finer, 'Conscientious objection: Protecting sexual and reproductive health and rights', University of Essex Human Rights Centre, 2008.

[220] FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, 'Ethical issues in obstetrics and gynaecology' (International Federation of Gynecology and Obstetrics, 2015).

[221] Amnesty International, *Codes of ethics and declarations relevant to the health professions. Fifth edition: 2011 update* (Index ACT 75/002/2011), p. 389, (citing FIGO, 'Professional and ethical responsibilities concerning sexual and reproductive rights', 2003).

[222] WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54.

[223] CESCR, General Comment 14, supra note 113, para. 35.

4. STATE OBLIGATIONS TO CREATE AN ENABLING ENVIRONMENT FOR PEOPLE TO MAKE AUTONOMOUS AND INFORMED DECISIONS

States must comply with international human rights law and standards to ensure pregnant individuals have access to safe abortion. This does not only include permitting and ensuring access to abortion; they also have positive obligations to create an enabling environment for people to make autonomous and informed decisions about their pregnancies. Set forth below is an overview of states' obligations in this regard.

4.1 ELIMINATE HARMFUL STEREOTYPES AND DISCRIMINATION

International human rights treaties recognize that gender equality is essential to the realization of human rights. The principle of substantive equality, as set out in CEDAW, requires not only equality in law, but equality in results or impact. Along these lines, states must do more than just ensure that existing laws do not directly discriminate; they must take additional measures to address the inequalities that women, girls and gender non-conforming people face. For example, states must examine and address the existing patriarchal power structures and dynamics in a society, including within communities, families, at the workplace and in the public sphere, and reform institutions in order to address gender and other, intersecting inequalities. States must also take into account when formulating their policies that women and men experience different kinds of rights violations due to discriminatory social and cultural norms, including in the context of health, and address gender and other, intersecting forms of discrimination. Furthermore, States must ensure equal outcomes for women, including different groups of women, which may require them to introduce policies and other measures to overcome historical discrimination and ensure that institutions guarantee the rights of all people.[224]

The CEDAW Committee has also promoted the notion of "transformative equality" in its General Recommendation 25: "States parties' obligation is to address prevailing gender relations and the persistence of gender-based stereotypes that affect women not only through individual acts by individuals but also in law, and legal societal structures and institutions".[225] The Committee has also emphasized the need for "a real transformation of opportunities, institutions and systems so that they are no longer grounded in historically determined male paradigms of power and life patterns".[226]

[224] For more details see Center for Reproductive Rights, 'Breaking ground 2020: Treaty monitoring bodies on reproductive rights', 2020, reproductiverights.org/document/breaking-ground-2020-treaty-monitoring-bodies-reproductive-rights

[225] CEDAW Committee, General Recommendation 25, on Article 4, para. 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures, para. 7 (hereinafter: CEDAW Committee, General Recommendation 25). See also M. Upreti, 'Toward transformative equality in Nepal: The *Lakshmi Dhikta* Decision', *Abortion law in transnational perspective: Cases and controversies* (J. Erdman, R. Cook, B. Dickens, eds.), 2014.

[226] CEDAW Committee, General Recommendation 25, supra note 225, para. 10.

UN treaty bodies have recognized the need to use a substantive equality approach to ensure gender equality in the context of sexual and reproductive rights. The CRC, CEDAW, CESCR and CRPD Committees and the HRC have urged states to address discrimination in law and in practice in the private and public spheres, adopt measures to eliminate harmful gender stereotypes and address practices that have a disproportionate impact on women.[227] This requires that states take positive measures to create an enabling environment that ameliorates social conditions such as poverty and unemployment and other factors that affect women's right to equality in health care.[228] For example, treaty bodies have called on states to not only ensure access to reproductive health services but to also ensure positive reproductive health outcomes, such as fulfilling unmet need for modern contraceptives, lowering rates of maternal mortality and morbidity, and reducing rates of adolescent pregnancy.[229]

UN treaty bodies have repeatedly condemned laws that prohibit health services that only women need. The CEDAW Committee has stated that "it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."[230] Furthermore, the CESCR Committee has made clear that equality in the context of the right to health "requires at a minimum the removal of legal and other obstacles that prevent men and women from accessing and benefitting from healthcare on a basis of equality."[231]

International human rights bodies have noted that gender discrimination is rooted in social attitudes and perceptions based in prejudices and stereotyped views about the social roles of women and men.[232] The UN Working Group on the issue of discrimination against women in law and in practice has emphasized the vital importance of CEDAW Article 5 in addressing such harmful stereotyping.[233] This requires states to take measures "to modify the social and cultural patterns of conduct of men and women… which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."[234] The HRC has long acknowledged that, "inequality in the enjoyment of rights by women throughout the world is deeply embedded in tradition, history and culture, including religious attitudes."[235] The Committee has called on states to refrain from using references to

[227] See Human Rights Committee, Concluding Observations: Cape Verde, UN Doc. CCPR/C/CPV/CO/1 (2012), para. 8; Jordan, UN Doc. CCPR/C/JOR/CO/4 (2010), para. 7; Canada, UN Doc. CCPR/C/79/Add.105 (1999), para. 20. See also CEDAW Committee, General Recommendation 25, para. 10; CRC Committee, General Comment 15, supra note 15, para. 10. See also CPRD Committee, Concluding Observations: the United Kingdom of Great Britain and Northern Ireland, UN Doc. CRPD/C/GBR/CO/1 (2017).

[228] Human Rights Committee, Concluding Observations: Kyrgyzstan, UN Doc. CCPR/CO/69/KGZ (2000), para. 13. See also CRC Committee, General Comment 15, supra note 81, paras 10 and 24.

[229] CEDAW Committee, Concluding Observations: Argentina, UN Doc. CEDAW/C/ARG/CO/7 (2016), paras 34-35; Thailand, UN Doc. CEDAW/C/THA/CO/6-7 (2017), para. 39; Congo, UN Doc. CEDAW/C/COG/CO/6 (2012), para. 36(f). See also CRC Committee, Concluding Observations: Central African Republic, UN Doc. CRC/C/CAF/CO/2 (2017), para. 55; Nigeria, UN Doc. CEDAW/C/NGA/CO/7-8 (2017), paras 37-38. See also CESCR Committee, General Comment 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Article 3), (34th Session, 2005), para. 29, UN Doc. E/C.12/2005/4 (2005) (hereinafter: CESCR Committee, General Comment 16); See also CESCR Committee, Concluding Observations: Namibia, UN Doc. E/C.12/NAM/CO/1 (2016), para. 65(a).

[230] CEDAW Committee, General Recommendation 24, supra note 28, para. 11.

[231] CESCR Committee, General Comment 16, supra note 229, para. 29.

[232] See OHCHR Commissioned Report, Gender stereotyping as a human rights violation, 2013, www.ohchr.org/EN/Issues/Women/WRGS/Pages/Documentation.aspx

[233] UN Working Group on the issue of discrimination against women in law and in practice, Report of the Working Group, UN Doc. A/HRC/29/40 (2015), para. 15.

[234] CEDAW, Article 5(a).

[235] Human Rights Committee, General Comment 28: Equality of rights between men and women, supra note 19, para. 5.

traditional, historical, religious or cultural attitudes to justify violations of women's equal enjoyment of rights.[236]

The negative impact of harmful gender stereotypes and gender stereotyping on the health of women and girls, in particular on their access to sexual and reproductive health services, has been acknowledged by multiple international human rights bodies.[237] The Special Rapporteur on the right to health has noted, "the causal relationship between the gender stereotyping, discrimination and marginalization of women and girls and their enjoyment of their right to sexual and reproductive health is well documented."[238] The CESCR Committee has also reaffirmed in its General Comment 22 (right to sexual and reproductive health) that states have an obligation to "repeal or reform laws and policies that nullify or impair certain individual's and group's ability to realise their right to sexual and reproductive health. A wide range of laws, policies and practices undermine the autonomy and right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health, for example criminalization of abortion or restrictive abortion laws."[239]

The UN Special Rapporteur on the right to health has also highlighted that gender stereotypes often curtail women's sexual expression and reproductive freedom, resulting in poor health outcomes for women and violations of their right to health.[240] Along similar lines, the UN Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment has noted that discrimination against women and girls often underpins their torture and ill-treatment in health-care settings.[241] He emphasized that "[t]his is particularly true when seeking treatments such as abortion that may contravene socialized gender roles and expectations."[242]

Restrictive abortion laws are grounded in stereotyped views about women's role in society. They reflect the view that due to the fact women's biology is suited to bear children, women's primary social role is destined to be of mothers and child-rearers. The impact of gender stereotypes on women's ability to access safe abortion services has been highlighted in a number of individual cases. In *L.C. v Peru*, the CEDAW Committee found that there had been a violation of CEDAW Article 5 "as the decision to postpone the surgery due to the pregnancy was influenced by the stereotype that protection of the foetus should prevail over the health of the mother."[243] In addition, in *L.M.R. v Argentina*[244] and *K.L. v Peru*[245] gender stereotyping was acknowledged to have negatively affected the ability of the victims to access abortion.

In 2015, the CEDAW Committee issued its second special inquiry report under the Optional Protocol to the Convention. The inquiry addressed states' obligations to ensure access to modern contraceptive methods. The Committee specifically criticized the government of the

[236] Human Rights Committee, General Comment 28: Equality of rights between men and women, supra note 19, para. 5.
[237] See for example CESCR, General Comment 16, supra note 229, para. 29; CRC Committee, General Comment 15, supra note 81, para. 9.
[238] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254 (2011), para. 17.
[239] CESCR Committee, General Comment 22, supra note 15, para. 34.
[240] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254 (2011), para. 16.
[241] Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/31/57 (2016), para. 42.
[242] Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/31/57 (2016), para. 42.
[243] CEDAW Committee, *L.C. v Peru*, supra note 12, para. 8.15.
[244] Human Rights Committee, *L.M.R. v Argentina*, supra note 13, para. 3.6.
[245] Human Rights Committee, *K.L. v Peru*, supra note 12, para. 3.2(b).

Philippines for failing to prioritize women's human rights over religious ideology and cultural stereotypes, which had led to widespread discrimination against women and hindered access to sexual and reproductive health information and services, including access to contraceptives and abortion.[246]

4.2 DESTIGMATIZE ABORTION

Amnesty International's in-depth research on abortion,[247] as well as research conducted by other international NGOs,[248] the WHO,[249] public health institutions[250] and civil society,[251] documents how the vast majority of legal frameworks around the world seek to minimize or eliminate abortions and operate from a harm reduction perspective, as opposed to a health and human rights perspective. Most often abortion is addressed within countries' penal laws, where a few narrow "exceptions" are provided for as "legal" based on particular grounds and gestational limits (see chart below). As such, abortion is largely criminalized and rarely addressed within health, equality and other regulatory frameworks. Even within many health systems, abortion is treated as a phenomenon "apart" from standard health care and as an "exception".

Pic 1. Worldwide abortion regulations (WHO, Global Abortion Policies Database)[252]

As previously discussed, such frameworks are underpinned by harmful stereotypes around gender, race, marital or other status, among others, as well as gender and other intersecting

[246] CEDAW Committee, Summary of the Inquiry concerning the Philippines, supra note 31.
[247] See for example Amnesty International, *She is not a criminal: The impact of Ireland's abortion laws* (Index: EUR 29/1597/2015). See also Amnesty International, On the brink of death: Violence against women and abortion ban in El Salvador (Index: AMR 29/003/2014); Amnesty International, *The total abortion ban in Nicaragua: Women's lives and health endangered, medical professionals criminalized* (Index: AMR 43/001/2009).
[248] See the Center for Reproductive Rights's world abortion laws map, www.reproductiverights.org/document/the-worlds-abortion-laws-map
[249] See WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54. See also WHO global abortion policies database, abortion-policies.srhr.org/
[250] Guttmacher Institute, 'Abortion worldwide 2017: Uneven progress and unequal access', 2018, www.guttmacher.org/report/abortion-worldwide-2017
[251] See for example GIRE, 'Violence without end', 2016, aborto-por-violacion.gire.org.mx/en/assets/pdf/violence-without-end.pdf; GIRE, 'Women and girls without justice: Reproductive rights in Mexico', 2015, gire.org.mx/wp-content/uploads/2016/07/INFORME-GIRE-2015.pdf
[252] See WHO Global Abortion Policies Database, abortion-policies.srhr.org/; see also the Center for Reproductive Rights's world abortion laws map, www.reproductiverights.org/document/the-worlds-abortion-laws-map

forms of discrimination which treat the provision of reproductive health-care services in general, and abortion services in particular, as a form of harm reduction rather as enabling individuals to exercise their right to health and other human rights. By contrast, a human rights-based framework is focused on empowering women, girls and people who can become pregnant to fulfil their sexual and reproductive rights as a core component of their full human rights.

In order to align any abortion regulatory framework with human rights standards, **abortion should not be exceptionalized and should be treated as an essential component of reproductive health care as opposed to regulated under a criminal legal framework.** In a human rights-based framework, there is absolutely no role or justification for punishing people seeking abortion, those who assist them and health providers, or limiting access to abortion. Legitimate regulatory and medical ethics concerns such as guidance on clinical service provision, the licensing of health professionals, protection from medical malpractice and requirements for patients' informed consent can be addressed as part of the overall regulation of (sexual and reproductive) health-care services. The overarching concern of such regulation and the clinical practice flowing from them – as stated in the WHO safe abortion guidelines[253] – must be the rights and wellbeing of all women, girls and others who may seek abortions for a variety of reasons or may need post-abortion care. Once abortion is treated as part of the continuum of sexual and reproductive health care, access barriers can be more clearly identified and eliminated.

To ensure abortion is not exceptionalized, abortion-related stigma must be addressed and abortion-related myths must be debunked. Ending abortion-related stigma is part of states' human rights obligations and means committing to the stance that abortion should be lawful, safe and accessible to *all* women and girls and others who can become pregnant as a matter of their human rights.

Abortion-related stigma can enable myths around abortion to flourish, and lead to shame, bullying, harassment and physical and mental harm to individuals who undergo abortions, their families and friends who support them, and those who provide abortion services. Abortion myths refer to biased views and beliefs around abortion and incorrect or misleading information on abortion.[254] Such misinformation is often provided in order to discourage pregnant people from seeking abortion-related services and evidence-based information.[255] Abortion-related stigma and misinformation are key barriers to pregnant people's timely access to safe abortion. UN treaty bodies have been increasingly drawing attention to states' obligations to address stigma in the context of abortion regulation and provision. In 2013, the CEDAW Committee urged Hungary to "cease all negative interference with women's sexual and reproductive rights, including by ending campaigns that stigmatise abortion and seek to negatively influence the public view on abortion and contraception."[256] In 2019, the CESCR Committee called on Slovakia to prohibit any exposure of pregnant persons to biased or scientifically inaccurate information on the alleged risks of abortion, which may impede their access to services.[257]

The WHO has asserted: "Abortion services should be integrated into the health system … to acknowledge their status as legitimate health services and to protect against stigmatisation and discrimination of women and health-care providers."[258] Positions that differ from that taken by the WHO, and which persist in treating abortion differently from other health-care provision, or

[253] WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54.
[254] For discussion of some of the common abortion myths see International Planned Parenthood Foundation, 'How to talk about abortion: A guide to rights-based messaging', 2018, Appendix 1: Common myths about abortion, p. 22, www.ippf.org/resource/how-talk-about-abortion-guide-rights-based-messaging
[255] See www.opendemocracy.net/en/5050/how-opendemocracy-tracking-anti-abortion-misinformation-around-world/
[256] CEDAW Committee, Concluding Observations: Hungary, UN Doc. CEDAW/C/HUN/CO/7-8 (2013), para. 31.
[257] CESCR Committee, Concluding Observations: Slovakia, UN Doc. E/C.12/SVK/CO/3 (2019), para. 42(b).
[258] WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54, p. 65.

portray it negatively, both stigmatize women and girls and tacitly endorse abortion being regulated in the criminal law or otherwise regulated differently (often in a stigmatizing and obstructive manner). A position that affirms decriminalization of abortion and supports abortion being provided as part of comprehensive sexual and reproductive health care through the health systems and available as self-care, contributes to destigmatizing abortion, affirms the human rights of women, girls and pregnant people, and counters the exceptionalization of abortion.

Health-service providers must be enabled to provide safe abortion services and post-abortion care and evidence-based, non-biased abortion-related information to everyone who needs them, with respect for individuals' human rights and autonomy, privacy and confidentiality, and without discrimination or coercion.[259]

TEXT BOX 3: THE WHO DEFINITIONS OF ABORTION AND ABORTION METHODS

Definitions of abortion vary from source to source and across contexts around the world. Amnesty International does not endorse any particular definition of abortion, which is a medical term, but generally understands and applies it to mean the termination of a pregnancy, whether spontaneous or induced.

Spontaneous abortions are generally what people refer to when talking about miscarriages. Induced abortions are generally what people refer to when talking about abortion. The WHO defines an induced abortion as "the intentional loss of an intrauterine pregnancy due to medical or surgical means." (See the WHO, International Classification of Diseases-11). There are varying methods of abortion, but in general, Amnesty International also uses the WHO's definition of "medical abortion" (use of pharmacological drugs to terminate pregnancy) and "surgical abortion" (use of transcervical procedures for terminating pregnancy, including vacuum aspiration and dilatation and evacuation).

The WHO recommends that a variety of abortion methods (both surgical and medical) should be made available to pregnant people. "If a choice of abortion methods is available, health care providers should be trained to give women clear information about which methods are appropriate, based on the duration of pregnancy and the woman's medical condition, as well as potential risk factors and the advantages and disadvantages of each available method. Women are more likely to find a method of abortion acceptable if they have chosen it themselves. Having a choice of methods is seen as extremely important by the majority of women undergoing abortion."[260]

Medical abortion methods offer a safe treatment alternative, particularly in settings where though abortion is legal, it is performed in unsuitable conditions, such as in a non-sterile environment, with a lack of proper equipment and emergency medicines or by untrained personnel. Medical abortion administration requires little training and a simpler infrastructure compared with surgical procedures and, as such, supports efforts to decentralize services to the primary care level, with referral systems in place for all required higher level care.[261] In addition, misoprostol and mifepristone are on the WHO list of essential medicines for reproductive health to which universal access should be effectively ensured.[262]

[259] See Beijing Declaration and Platform for Action, para. 96, beijing20.unwomen.org/en/about See also Report of the Office of the United Nations 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).
[260] WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54, p. 36.
[261] See Ipas, 'WHO safe abortion guidance: Updates and recommendations', Summary.
[262] See PATH, WHO and UNFPA, 'Essential medicines for reproductive health: Guiding principles for their inclusion on national medicines lists', 2006, Annex 4, www.who.int/medicines/publications/EssMeds_RHealth.pdf See also OHCHR, 'Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical guidance', para. 34.

Self-administration of misoprostol is already common in some countries. Home-based abortion is also increasingly promoted as a safe and effective alternative during public health crises such as the COVID-19 pandemic and is preferred by some who seek to terminate their pregnancies at home with the support of their families.[263] Support from medical providers through telehealth can ensure the safety of the procedure and that women who may suffer from abortion or post-abortion complications receive timely and adequate care. Criminalization creates a barrier for women and girls to receive adequate medical advice and care in cases of these types of complications by causing a "chilling effect" on health-care providers and women themselves, due to the fear of criminal sanctions.

4.3 PROVIDE ACCESS TO COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES, GOODS AND INFORMATION

Ensuring access to a comprehensive range of good-quality sexual and reproductive health information, goods and services, including abortion, post-abortion care, modern contraceptives and evidence-based, non-biased and non-discriminatory information on sexual and reproductive health (including related to pregnancy and abortion), is critical to realizing the rights of women, girls and people who can get pregnant, including their rights to life, health and non-discrimination, and as a means to achieving substantive equality.

One third of health issues for women aged 15-44 are related to sexual and reproductive health.[264] Notably, over 200 million women of reproductive age who want to avoid pregnancy do not have access to modern contraceptive methods.[265] UN treaty bodies have consistently called on states to ensure that a full range of good quality, modern and effective contraceptives, including emergency contraception, are available and accessible to all people.[266] They have also urged states to guarantee substantive equality for women and girls by fulfilling the unmet need for contraceptives and providing access to contraceptive information and services to adolescents to reduce early pregnancies.[267] UN treaty bodies have paid particular attention to emergency contraception, emphasizing that it should be available without a prescription[268] and be free for victims of violence, including adolescents,[269] and special measures should be taken

263 J. Todd-Gher and P. Shah, (2020), 'Abortion in the context of COVID-19: a human rights imperative', *Sexual and Reproductive Health Matters,* 28, 1-4, 10.1080/26410397.2020.1758394

264 WHO, Press Release, Promoting health through the life-course (March 2015), www.who.int/life-course/news/commentaries/2015-intl-womens-day/en/

265 WHO, Factsheet: Family planning/contraception (July 2017), www.who.int/mediacentre/factsheets/fs351/en/

266 See CESCR Committee, General Comment No. 22, supra note 15, paras 13, 28, 45, 57, 62; Human Rights Committee, General Comment 36, supra note 18, para. 8; CEDAW, General Recommendation 24, supra note 28; CEDAW, General Recommendation 34: The rights of rural women, UN Doc. CEDAW/C/GC/34 (2016), paras 38, 39(a); CRC, General Comment No. 15, supra note 81, UN Doc. CRC/C/GC/15 (2013), paras 31, 70; CRC, General Comment No. 20, supra note 65, paras 59, 63; CRC Committee, Concluding Observations: Argentina, UN Doc. CRC/C/ARG/CO/5-6 (2018), para. 32; CEDAW Committee, Concluding Observations: Mozambique, UN Doc. CEDAW/C/MOZ/CO/3-5 (2019), para. 36(c).

267 CRC Committee, General Comment 15, supra note 81, para. 56; CEDAW Committee, General Recommendation 24, supra note 28, para. 17; CRC Committee, Concluding Observations: Kyrgyzstan, UN Doc. CRC/C/KGZ/CO/3-4 (2014), paras 51-52; CEDAW Committee, Concluding Observations: Angola, UN Doc. CEDAW/C/AGO/CO/6 (2013) para. 31(c); Human Rights Committee, Concluding Observations: Malawi, UN Doc. CCPR/C/ MWI/CO/1/Add.1 (2014), para. 9; CESCR Committee, Concluding Observations: El Salvador, UN Doc. E/C.12/SLV/CO/3-5 (2014), para. 23.

268 CEDAW Committee, Concluding Observations: Hungary, UN Doc. CEDAW/C/HUN/CO/7-8 (2013), para. 31(b).

269 CRC Committee, General Comment No. 15, supra note 81, para. 70; CRC Committee, General Comment 20, supra note 65, para. 59; CEDAW Committee, General Recommendation 35, supra note 23, para. 40(c); CESCR Committee, General Comment No. 22, supra note 15, paras 13, 45, 57; CEDAW Committee, Concluding Observations: Peru, UN Doc. CEDAW/C/PER/CO/7-8 (2014), paras 35-36; CRC Committee, Concluding Observations: Costa Rica, UN Doc. CRC/C/CRI/CO/4 (2011), paras 63-64.

to ensure that is available in conflict and post-conflict zones.[270] Failure to ensure accessible emergency contraception to victims/survivors of sexual violence can result in physical and mental suffering that may amount to ill-treatment.[271]

The HRC has recognized the centrality of sexual and reproductive health to women's right to life and health, and has urged states to ensure access to reproductive health services for all women and adolescents.[272] It has explicitly noted the link between reducing maternal mortality and morbidity, and ensuring that women have access to reproductive health services, including safe abortion.[273] Essential sexual and reproductive health services aim to protect women's and girls' rights to health and life, which encompasses their entitlement to enjoy a life with dignity,[274] and is premised on the central importance of personal autonomy and human dignity. Protecting women's and girls' rights to life and health thus requires states to provide pre- and postnatal care, skilled birth attendants, emergency obstetric services, as well as access to contraceptives and information.[275]

Essential health services must be delivered with respect to an individual's human rights and autonomy, informed consent, privacy and confidentiality and without discrimination or coercion.[276] International law has recognized that forced medical treatments are human rights

270 CEDAW Committee, General Recommendation 30, supra note 75, para. 52(c); CEDAW Committee, Concluding Observations: Central African Republic, UN Doc. CEDAW/C/CAF/CO/1-5 (2014), paras 39-40.
271 CEDAW Committee, General Recommendation 35, supra note 23, paras 18, 40(c); CAT Committee, Concluding Observations: Greece, UN Doc. CAT/C/GRC/7 (2018), paras 24, 25.
272 Human Rights Committee, Concluding Observations: Cameroon, UN Doc. CCPR/C/CMR/CO/4 (2010), para. 13 (urging the state to "step up its efforts to reduce maternal mortality, including by ensuring that women have access to reproductive health services."). See also Human Rights Committee, Concluding Observations: Chile, UN Doc. CCPR/C/CHL/CO/6 (2014), para. 15; Costa Rica, UN Doc. CCPR/C/CRI/CO/6 (2016), para. 17; Malawi, UN Doc. CCPR/C/MWI/CO/1/Add.1 (2014), para. 9; Sierra Leone, UN Doc. CCPR/C/SLE/CO/1 (2014), para. 14; Malta, UN Doc. CCPR/C/MLT/CO/2 (2014), para. 13; Sri Lanka, UN Doc. CCPR/C/LKA/CO/5 (2014), para. 10; Paraguay, UN Doc. CCPR/C/PRY/CO/3 (2013), para. 13; Peru, UN Doc. CCPR/C/PER/CO/5 (2013), para. 14; Guatemala, UN Doc. CCPR/C/GTM/CO/3 (2012), para. 20; Jamaica, UN Doc. CCPR/C/JAM/CO/3 (2011), para. 14; Dominican Republic, UN Doc. CCPR/C/DOM/CO/5 (2012), para. 15. See also Human Rights Committee, Concluding Observations: Mali, UN Doc. CCPR/CO/77/MLI (2003), para. 14 (on emergency obstetrics care); Peru, UN Doc. CCPR/C/PER/CO/5 (2013), para. 14 (on emergency contraception).
273 Human Rights Committee, Concluding Observations: Cameroon, UN Doc. CCPR/C/CMR/CO/4 (2010), para. 13 (urging the state to "step up its efforts to reduce maternal mortality, including by ensuring that women have access to reproductive health services."). See also, Human Rights Committee, Concluding Observations: Chile, UN Doc. CCPR/C/CHL/CO/6 (2014), para. 15; Costa Rica, UN Doc. CCPR/C/CRI/CO/6 (2016), paras 17-18; Malawi, UN Doc. CCPR/C/MWI/CO/1/Add.1 (2014), para. 9; Sierra Leone, UN Doc. CCPR/C/SLE/CO/1 (2014), para. 14; Malta, UN Doc. CCPR/C/MLT/CO/2 (2014), para. 13; Sri Lanka, UN Doc. CCPR/C/LKA/CO/5 (2014), para. 10; Paraguay, UN Doc. CCPR/C/PRY/CO/3 (2013), para. 13; Peru, UN Doc. CCPR/C/PER/CO/5 (2013), para. 14; Guatemala, UN Doc. CCPR/C/GTM/CO/3 (2012), para. 20; Jamaica, UN Doc. CCPR/C/JAM/CO/3 (2011), para. 14; Dominican Republic, UN Doc. CCPR/C/DOM/CO/5 (2012), para. 15. See also Human Rights Committee, Concluding Observations: Mali, UN Doc. CCPR/CO/77/MLI (2003), para. 14 (on emergency obstetrics care); Peru, UN Doc. CCPR/C/PER/CO/5 (2013), para. 1 (on emergency contraception).
274 See Human Rights Committee, General Comment 36, supra note 18, paras 3, 8, 26.
275 See WHO, 'Standards for improving quality of maternal and newborn care in health facilities', 2016, apps.who.int/iris/bitstream/10665/249155/1/9789241511216-eng.pdf?ua=1 (for maternal care services); WHO, 'Priority lifesaving medicines for women and children', 2012, http://apps.who.int/iris/bitstream/10665/75154/1/WHO_EMP_MAR_2012.1_eng.pdf?ua=1 (for contraceptives); United Nations Population Fund (UNFPA), 'Sexual and reproductive health', www.unfpa.org/sexual-reproductive-health (for access to SRH information).
276 See CESCR General Comment 22, supra note 15. See also UNAIDS, UNHCR, UNICEF, WFP, UNDP, UNFPA, UN Women, ILO, UNESCO, WHO, OHCHR, IOM – Joint United Nations statement on ending discrimination in health care settings (June 2017), www.unaids.org/sites/default/files/media_asset/ending-discrimination-healthcare-settings_en.pdf

violations, with some forms of coercion constituting violence against women.[277] If services are delivered in a discriminatory manner, without informed consent and without ensuring privacy, women, girls and people who can become pregnant will be less likely to access them to get the care that they need, thus impeding and potentially jeopardising their right to health.

The CESCR Committee has also emphasized that goods and services must be of good quality – evidence-based, scientifically and medically appropriate, and up to date – which requires trained and skilled health-care personnel and scientifically approved and unexpired drugs and equipment. The failure or refusal to incorporate technological advancements and innovations in the provision of sexual and reproductive health services, such as medication for abortion, undermines the quality of care.[278] Furthermore, sexual and reproductive health services and goods should be affordable, with UN treaty bodies increasingly recognizing that such services and goods should be subsidized, covered by public health insurance schemes, or provided free of charge to those who otherwise cannot afford them.[279]

Abortion services and post-abortion care should be integrated into comprehensive sexual and reproductive health services at all levels of the health system (including within prison health systems and detention settings) and that such services should be available, accessible, appropriate and of good quality in line with the standards set forth under international human rights law.[280] In addition to abortion services (including home-based or self-administered medical abortion), access to unbiased, evidence-based abortion-related information should also be available and accessible in line with the understanding that abortion is an integral part of comprehensive sexual and reproductive health care rather than an exception to the criminal law.

States must respect, protect, and fulfil sexual and reproductive health and rights during conflict and humanitarian emergencies too. Human rights law and international humanitarian law are complementary and mutually reinforcing (See Annex I: Abortion in armed conflict situations). The treaty monitoring bodies have provided guidance for states which reinforce and complement state's international humanitarian legal obligations. The CEDAW Committee has called on states to ensure access to maternal health services, including antenatal care, skilled delivery services, and emergency obstetric care in conflict-affected settings.[281] The Committee has also called on states to prioritize the provision of sexual and reproductive health services, including safe abortion services, to mitigate the impact of armed conflict on sexual and reproductive health and maternal mortality.[282] The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) and UNFPA have developed an operational standard of such service provision called the Minimum Initial Service Package (MISP), which outlines a series of crucial actions required to respond to reproductive health needs at the onset of every humanitarian crisis.[283]

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[277] See CEDAW Committee, General Recommendation 35, supra note 23, para. 18. See also CEDAW Committee, General Recommendation 24, supra note 28, para. 22; CRC Committee, General Comment 13 (The right of the child to freedom from all forms of violence), UN Doc. CRC/C/GC/13, 2011, para. 23 (a).
[278] CESCR Committee, General Comment 22, supra note 15, para. 21.
[279] CESCR Committee, General Comment 22, supra note 15, para. 17.
280 See CESCR General Comment 14, supra note 113, para. 12.
281 See CEDAW Committee, General Recommendation 30, supra note 75, para. 52(c).
282 CEDAW Committee, General Recommendation 30, supra note 75; CEDAW Committee, Concluding Observations: Central African Republic, UN Doc. CEDAW/C/CAF/CO/1-5 (2014), para. 40(b); Democratic Republic of the Congo, UN Doc. CEDAW/C/COD/CO/5 (2006), paras 35-36.
[283] See www.unfpa.org/resources/what-minimum-initial-service-package See also www.unhcr.org/uk/4e8d6b3b14.pdf

The CEDAW and CESCR Committees have also urged states to take additional measures to ensure refugees, stateless persons, asylum-seekers and undocumented migrants, who are in a situation of vulnerability due to their legal status, can have access to affordable and quality sexual and reproductive information, goods and services.[284] Provision of sexual and reproductive health services in humanitarian settings requires ensuring available, accessible, adequate and quality services without discrimination; ensuring people who seek services can make informed and autonomous decisions, without spousal, parental or third-party consent; protecting individual's privacy and confidentiality and ensuring access to justice and effective remedies when individual rights are violated.[285]

Access to accurate and timely information, including through comprehensive sexuality education, is essential to exercising autonomy and making informed decisions to undergo sexual and reproductive health care and procedures. People who are pregnant should be provided with unbiased, evidence-based comprehensive information over the course of their pregnancies (as part of their broader sexual and reproductive health and rights), including through voluntary decisions to seek prenatal testing, and respect for the autonomy of pregnant people to make informed decisions about their pregnancies based on that information.[286] Governments must refrain from denying or limiting equal access for all to sexual and reproductive health information and ensure that information is not withheld or intentionally misrepresented. This aligns with international human rights law and principles around patients' right to information, which is strongly embedded in the right to information and the right to health under international law. Limiting people's access to information about their pregnancy is a violation of their right to information among other rights.

4.4 PROVIDE COMPREHENSIVE SEXUALITY EDUCATION (CSE)

Evidence has shown that providing young people with comprehensive sexuality education (CSE),[287] which includes scientifically accurate and rights-based information about sexuality, relationships and sexual and reproductive health appropriate to their age, is effective in improving their health and wellbeing.[288] CSE addresses sexual and reproductive health issues, including, but not limited to: sexual and reproductive anatomy and physiology; puberty and menstruation; reproduction, modern contraception, pregnancy and childbirth; and STIs, including HIV and AIDS. CSE supports young people's empowerment by improving their analytical, communication and other life skills for health and wellbeing in relation to: sexuality,

[284] CESCR Committee, Concluding Observations: Czech Republic, UN Doc. E/C.12/CZE/CO/2 (2014); Slovakia, UN Doc. E/C.12/SVK/CO/3 (2019); CEDAW Committee, Concluding Observations: Lithuania, UN Doc. CEDAW/C/LTU/CO/4 (2008).

[285] See CEDAW Committee, General Recommendation 30, supra note 75; CEDAW Committee, General Recommendation 33, supra note 34. See also www.unfpa.org/resources/what-minimum-initial-service-package, and www.unhcr.org/uk/4e8d6b3b14.pdf

[286] See Joint Civil Society Statement, The Nairobi Principles on Abortion, Prenatal Testing and Disability, 2019, Principle 3, nairobiprinciples.creaworld.org/nairobi-principles-on-abortion-prenatal-testing-and-disability/

[287] Comprehensive sexuality education is defined as age-appropriate and medically accurate information about sexuality and reproductive health. It includes education and counselling for adolescents and young people on gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family planning practices, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention (International Conference on Population and Development Programme of Action, para. 7.47). Comprehensive sexuality education must be rights-based, age appropriate and medically accurate. For more details, see also Center for Reproductive Rights, 'Breaking ground 2020: Treaty monitoring bodies on reproductive rights', 2020, reproductiverights.org/document/breaking-ground-2020-treaty-monitoring-bodies-reproductive-rights

[288] UNESCO, 'International technical guidance on sexuality education: An evidence-informed approach for schools, teachers and health educators', Paris, UNESCO, 2009; see also UNFPA, 'Comprehensive sexuality education: Advancing human rights, gender equality and improved sexual and reproductive health', UNFPA, 2010.

human rights, a healthy and respectful family life and interpersonal relationships, personal and shared values, cultural and social norms, gender equality, non-discrimination, sexual behaviour, violence and gender-based violence (GBV), consent and bodily integrity, sexual abuse and harmful practices such as child, early and forced marriage (CEFM) and female genital mutilation/cutting (FGM/C).[289] CSE also educates about the different ways in which gender norms can influence inequality, and how these inequalities can affect the overall health and wellbeing of children and young people, while also impacting efforts to prevent HIV/STIs, early and unintended pregnancies, and gender-based violence. CSE further contributes to gender equality by building awareness of the centrality and diversity of gender in people's lives, examining gender norms shaped by cultural, social and biological differences and similarities, and by fostering respectful and equitable relationships based on empathy and understanding.

CSE programmes must promote gender equality, consent, non-violence and avoid perpetuating discriminatory stereotypes, including on gender, sexual orientation, gender identity or other status. Such programmes should be age-appropriate, be delivered with respect to the evolving capacity of children and adolescents and provide them with the knowledge and skills to exercise their human rights and make informed and autonomous decisions about their health and lives.[290] Lack of such education leaves young people vulnerable to coercion, abuse, exploitation, unintended pregnancies and HIV/STIs.[291] When CSE is unavailable, this disproportionately impacts adolescent girls, particularly ones from marginalized groups, because they are at higher risk of and bear the long-term consequences of a CEFM, early pregnancy and gender-based violence.[292]

UN treaty bodies have recognized this reality and called on governments to guarantee the rights of all individuals, particularly of adolescents, to health, life, education and non-discrimination by providing them with CSE that is scientifically accurate and objective, age-appropriate and free of prejudice and discrimination.[293] The CEDAW Committee recommends to states to "develop and introduce age appropriate, evidence-based, scientifically accurate mandatory curricula at all levels of education covering comprehensive information on sexual and reproductive health and rights, responsible sexual behaviour, prevention of early pregnancy and sexually transmitted diseases."[294] The CRC Committee emphasizes that all adolescents have the right to access confidential, adolescent-responsive sexual and reproductive health

[289] See UNESCO, UNAIDS, UNFPA, UNICEF, UN WOMEN, WHO, 'International technical guidance on sexuality education: An evidence-informed approach', 2018, unesdoc.unesco.org/ark:/48223/pf0000260770

[290] See CESCR, General Comment 14, supra note 113; CESCR General Comment 22, supra note 15. See also CRC Committee, General Comment 4 (2003): 'Adolescent health and development in the context of the Convention on the Rights of the Child', UN Doc. CRC/GC/2003/4 (2003), paras 3, 7, 16 (hereinafter: CRC Committee, General Comment 4); CRC Committee, General Comment 20, supra note 65.

[291] UNESCO, 'International technical guidance on sexuality education', 2009, foreword.

[292] See CRC Committee, General Comment 20, supra note 65, para. 59. See also M. Campbell, 'The challenges of girls' right to education: Let's talk about human rights-based sex education', *The International Journal of Human Rights*, 20.8 (2016): 1219-1243, www.tandfonline.com/doi/abs/10.1080/13642987.2016.1207627?journalCode=fjhr20. See also Amnesty International, *Coerced and denied: Forced marriages and barriers to contraception in Burkina Faso* (Index: AFR 60/3851/2016); Amnesty International, *Shamed and blamed: Pregnant girls' rights at risk in Sierra Leone* (Index: AFR 51/2695/2015); Amnesty International, *Lost without knowledge: Barriers to sexual and reproductive health information in Zimbabwe* (Index: AFR 46/7700/2018).

[293] CEDAW Committee, Concluding Observations: Italy, UN Doc. CEDAW/C/ITA/CO/7 (2017), para. 35; Nigeria, UN Doc. CEDAW/C/NGA/CO/7-8 (2017), para. 34(e); Ireland, UN Doc. CEDAW/C/IRL/CO/6-7 (2017), para. 39(c); see also CRC Committee, Concluding Observations: Antigua and Barbuda, UN Doc. CRC/C/ATG/CO/2-4 (2017), para. 45(a); see also CESCR Committee, Concluding Observations: Benin, UN Doc. E/C/12/1/Add.78 (2002), para. 42.

[294] CEDAW Committee, General Recommendation 36 (right of girls and women to education), UN Doc. CEDAW/C/GC/36, 2017, para. 69(i).

information, education, and services, irrespective of age and without the consent of a parent or guardian.[295] To ensure access to quality comprehensive sexuality education, states must:

- Make comprehensive sexuality education (CSE) a mandatory part of regular school curriculum, provided throughout schooling in an age-appropriate manner and without the consent of a parent or guardian.[296] The standards set by the state for such sexual and reproductive health education should be in line with guidelines developed by UNESCO, UNAIDS, UNFPA, UNICEF, UN WOMEN and the WHO.[297] Adolescents should be involved in the development of the curriculum[298] and states may not censor, withhold, or intentionally misrepresent sexual and reproductive health information.[299]
- Ensure that the curriculum is based on scientific evidence and human rights standards.[300] In addition to providing information on the biology of reproduction, contraception, responsible sexual behaviour, prevention of early pregnancy,[301] prevention of HIV/AIDS and STIs,[302] the curriculum must also integrate a strong gender perspective and address socialized gender roles and stereotypes, patriarchal attitudes and unequal power dynamics.[303] CSE programmes should also give attention to gender equality, sexual diversity, sexual and reproductive health and rights, and prevention of all forms of gender-based violence.[304]
- Guarantee that comprehensive sexuality education is available to all children and adolescents, both inside and outside educational settings.[305] According to the CRC Committee, unequal access to comprehensive, gender-sensitive sexual and health information, commodities and services amounts to discrimination.[306]

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[295] CRC Committee, General Comment 20, supra note 65, paras 39, 59. The European Court of Human Right has also ruled in two cases that compulsory sexuality education in public schools as such does not violate parental freedom to educate their children according to their religious and philosophical convictions. See European Court of Human Rights, *Kjeldsen, Busk Madsen and Pedersen v Denmark* (App. No. 5095/71; 5920/72; 5926/72), and European Court of Human Rights, *Willi, Anna and David Dojan v Germany and four other applications* (App. No. 319/08).

[296] CRC Committee, Concluding Observations: Saint Vincent and the Grenadines, UN Doc. CRC/C/VCT/CO/2-3 (2017), para. 46(a); see also Human Rights Committee, Concluding Observations: Republic of Moldova, UN Doc. CCPR/C/MDA/CO/3 (2016), para. 18(b); see also CEDAW Committee, Concluding Observations: Switzerland, UN Doc. CEDAW/C/CHE/CO/4-5 (2016), para. 39(b); Italy, UN Doc. CEDAW/C/ITA/CO/7 (2017), para. 36. See also CRC Committee, General Comment 12 (2009): The right of the child to be heard, UN Doc. CRC/C/GC/12 (2009), para. 101.

[297] See UNESCO, UNAIDS, UNFPA, UNICEF, UN WOMEN, WHO, 'International technical guidance on sexuality education: an evidence-informed approach', 2018, unesdoc.unesco.org/ark:/48223/pf0000260770. See also CESCR, General Comment 22, supra note 15, para. 49. See also CEDAW Committee, Concluding Observations: Italy, UN Doc. CEDAW/C/ITA/CO/7 (2017), para. 36.

[298] CRC Committee, General Comment 20, supra note 65, para. 61.

[299] CESCR Committee, General Comment 14, supra note 113, para. 34.

300 CRC Committee, General Comment 20, supra note 65, para. 61; See also CEDAW Committee, Concluding Observations: Sweden, UN Doc. CEDAW/C/SWE/CO/8-9 (2016), para. 33; Iceland, UN Doc. CEDAW/C/ISL/CO/7-8 (2016), para. 28.

301 CRC Committee, General Comment 20, supra note 65, para. 61; see also CEDAW Committee, Concluding Observations: Portugal, UN Doc. CEDAW/C/PRT/CO/8-9 (2015), para. 33.

[302] CEDAW Committee, Concluding Observations: France, UN Doc. CEDAW/C/FRA/CO/7-8 (2016), para. 32 (d).

[303] CESCR Committee, General Comment 22, supra note 15, para. 48; CEDAW Committee, Concluding Observations: Montenegro, UN Doc. CEDAW/C/MNE/CO/2 (2017), paras 30-31; Portugal, UN Doc. CEDAW/C/PRT/CO/8-9 (2015), para. 33; Timor-Leste, UN Doc. CEDAW/C/TLS/CO/2-3 (2015), para. 27; Mongolia, UN Doc. CEDAW/C/MNG/CO/8-9 (2016), para. 25(a). See also CPRD Committee, Concluding Observations: Islamic Republic of Iran, UN Doc. CRPD/C/IRN/CO/1 (2017), para. 49(b).

[304] CRC Committee, General Comment 20, supra note 65, para. 61.

[305] CRC Committee, General Comment 20, supra note 65, para. 61.

[306] CRC Committee, Concluding Observations: Saint Vincent and the Grenadines, UN Doc. CRC/C/VCT/CO/2-3 (2017), para. 46(a).

- Require teachers to be trained on delivering age-appropriate education on sexual and reproductive health and rights.[307] This includes helping teachers deliver CSE programmes in a way that respects children's and adolescents' rights, privacy and confidentially.[308]

TEXT BOX 4: THE IMPACT OF CRIMINALIZATION OF PROVISION OF SEXUAL AND REPRODUCTIVE HEALTH INFORMATION

Many states criminalize the provision of sexual and reproductive health information, an essential component of individuals' enjoyment of their rights to access information and education, health and equality and non-discrimination. For example, overbroad application of anti-pornography or "obscenity" laws or other administrative and public health laws or policies can impede individuals' exercise of their sexual and reproductive rights, stifle discourse around sexual and reproductive health, and fuel stigma and discrimination; often with a disproportionate impact on women, young people and those with non-normative sexual orientations and gender identities.

Information-related restrictions can also make it harder for adolescents to protect themselves from STIs and early and unwanted pregnancies, and to exercise informed and autonomous sexual and reproductive health decision-making, in accordance with their "evolving capacities."[309] Moreover, laws criminalizing sexual and reproductive health information pose grave implications for public health. As noted by the UN Special Rapporteur on the right to health, public health and empowerment programmes, and activities such as educational campaigns on HIV/AIDS and STI prevention, family planning, domestic violence, gender discrimination, female genital mutilation, sexual diversity, overall sexual and reproductive health, may be prohibited or censored under overbroad legislation.[310]

The Special Rapporteur has also noted that "women and girls are most likely to be affected by this gap in available services and programming because they are exposed to a higher risk of HIV/AIDS and sexually transmitted infections, maternal mortality, unsafe abortion and unwanted or unplanned pregnancies."[311] The Special Rapporteur has further confirmed that criminal and other laws restricting access to comprehensive sexual and reproductive health information are incompatible with the full realization of the right to health,[312] and called on states to "decriminalize the provision of information relating to sexual and reproductive health, including evidence-based sexual and reproductive health education …"[313]

TEXT BOX 5: CRIMINALIZATION OF CONSENSUAL ADOLESCENT SEXUALITY

[307] CEDAW Committee, General Recommendation 24, supra note 28, para. 14; CEDAW Committee, Concluding Observations: Thailand, UN Doc. CEDAW/C/THA/CO/6-7(2017), para. 35(a); El Salvador, UN Doc. CEDAW/C/SLV/CO/8-9 (2017), para. 33(b); Bangladesh, UN Doc. CEDAW/C/BGD/CO/8 (2016), paras 28-29; see also CESCR Committee, Concluding Observations: Dominican Republic, UN Doc. E/C.12/DOM/CO/4(2016), para. 65(b); see also Human Rights Committee, Concluding Observations: Republic of Moldova, UN Doc. CCPR/C/MDA/CO/3 (2016), para. 18 (b).

[308] CEDAW Committee, General Recommendation 24, supra note 28, para. 14.

309 CRC Committee, General Comment 20, supra note 65, paras 5, 18, 42; see also CRC Committee, General Comment 4, supra note 290, paras 3, 7, 16.

310 See the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254 (2011), para. 62.

[311] See the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254 (2011), para. 62.

[312] See the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254 (2011), para. 56 (citing CESCR, General Comment 14 (Right to Health), UN Doc. E/C.12/2000/4 (2000), para. 11.

[313] See the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/66/254 (2011), para. 65(e).

Most states set an age at which adolescents are deemed legally capable of consenting to sex through "age of consent" provisions. Often found in penal codes, these provisions generally define consent in the context of sexual violence, including rape and statutory rape. So, while adolescents may freely choose to engage in sexual activity with each other, age of consent provisions generally operate under an assumption of violence and criminality. In many countries, the age of consent is set between 14 and 16, most commonly 16.[314] However, it can range from 12 to 18 years.[315] Many set a lower age of consent for women than for men, which can discriminate against women. Among countries that do not criminalize same-sex sexual activity, at least 16 enforce a higher age of consent for same-sex sexual activity than for heterosexual activity.[316] This discriminates against LGBTI adolescents and can subject them to increased penalties irrespective of consent.[317]

While age of consent provisions may be intended to provide protection from child sexual abuse or early marriage, they can also be used to unfairly suppress, regulate or prosecute consensual sex between adolescents. Additional complications arise when the age of consent to sex or sexual and reproductive health services is different from and/or higher than the age of consent to marriage. Interest in sex is an inherent part of human adolescent development. Having access to information on sex and sexuality and being free to explore and develop one's own sexuality without coercion or discrimination is fundamental to the enjoyment of bodily autonomy, and the rights to freedom of expression, privacy and health.

Where age of consent provisions are discriminatory, vague or overly broad, they can be used to limit or punish adolescents' sexual development and impose criminal sanctions for consensual sexual acts. Young women can be disproportionately punished under these provisions because of social expectations that they curtail their sexual expression and remain "chaste." These concepts are rooted in harmful gender stereotypes about women's and girls' proper roles in society. The consequences on women and girls are compounded by the fact that they often bear the burden of preventing unwanted pregnancies. Thus, age of consent provisions can present particular barriers to girls and young women seeking sexual and reproductive health information and services, contraception and safe abortion services. The CEDAW Committee specifically expressed concern that "the penalization of consensual sexual relations among young people between 15 and 18 years of age may have a more severe impact on young women, especially in the light of the persistence of patriarchal attitudes."[318]

Although states have an obligation under international human rights law to protect children and adolescents from sexual coercion and violence, they are also required to respect, protect and fulfil their human rights, including in the realms of their developing sexualities, and in accordance with their evolving capacities.[319] To that end, human rights bodies have called upon states to recognize that adolescents are rights holders,[320] and (in accordance with the principle of evolving capacities) not to impose a strict age of consent requirement on

[314] See UNICEF, 'Twenty years of the Convention on the Rights of the Child', www.unicef.org/rightsite/433_457.htm#to_have_sex

[315] See UNICEF, 'Twenty years of the Convention on the Rights of the Child', www.unicef.org/rightsite/433_457.htm#to_have_sex

[316] A. Carroll, ILGA, 'State-sponsored homophobia. A world survey of laws: Criminalization, protection and recognition of same-sex love', 11th edition, 2016, ilga.org/downloads/02_ILGA_State_Sponsored_Homophobia_2016_ENG_WEB_150516.pdf Equaldex reports that 82 countries have unequal age of consent law. See Equaldex, 'The collaborative LGBT knowledge base', www.equaldex.com/

[317] UNFPA, 'Harmonizing the legal environment for adolescent sexual and reproductive health and rights: A review of 23 Countries in East and Southern Africa', 2017, esaro.unfpa.org/sites/default/files/pub-pdf/2017-08-Laws%20and%20Policies-Digital_0.pdf

[318] CEDAW Committee, Concluding Observations: Turkey, UN Doc. A/60/38 (2005), paras 363-64.

[319] UN Convention on the Rights of the Child 44/25, www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

[320] See UN General Assembly Resolution, CRC, 44/25, 1989, paras 9, 12, www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

adolescents.[321] The CRC Committee has called on states to "take into account the need to balance protection and evolving capacities [in determining the legal age for sexual consent and to] avoid criminalizing adolescents of similar ages for factually consensual and non-exploitative sexual activity."[322]

The UN Convention on the Rights of the Child (CRC requires states to ensure that adolescents are protected from discrimination on the basis of sex, which requires equalizing age of consent provisions for boys and girls (regardless of the type of sex involved).[323] In 2011, the OHCHR called for the repeal of discriminatory laws that criminalize people on the grounds of their sexuality and gender, specifically laws that criminalize same-sex sexual activity or enforce higher age of consent thresholds for sex between same-sex partners.[324]

For more information, see Amnesty International, Body Politics: Criminalization of sexuality and reproduction – a primer, Annex 4: Criminalizing adolescent sexual activity (Index: POL 40/7763/2018).

4.5 PROMOTE REPRODUCTIVE JUSTICE

Amnesty International's abortion policy is also informed by and will facilitate the application of a reproductive justice framework, which is central for achieving gender, social and economic justice. The term "reproductive justice" has its origins in the struggles for justice, equality and rights of Indigenous women, women from communities that face racial discrimination and trans people and the importance to foreground the needs of the most marginalized women.

Rooted in the international human rights framework,[325] reproductive justice combines reproductive rights and social justice. It provides a framework for activism and for conceptualizing the experiences of reproduction of women belonging to marginalized groups facing multiple and intersecting forms of discrimination.

Reproductive justice demands sexual autonomy and gender equality for everyone.[326] The term reflects the respect, protect and fulfil obligations of the state vis-à-vis individuals' sexual and reproductive rights. The obligation to respect individual's sexual and reproductive rights includes not interfering with individuals' sexual and reproductive decisions (for example, through laws and policies denying people's reproductive autonomy and decision-making such as restrictive abortion laws, or discriminatory policies and practices that result in reproductive oppression of certain communities or individuals such as population control policies or forced sterilization of minority or Indigenous women or transpeople). The obligation to protect includes protecting individuals from third-party interference with their reproductive choices (for example, providing protection from forced pregnancy or medically unnecessary surgeries on

321 See UN General Assembly Resolution, CRC, 44/25, 1989, paras 9, 12, www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx
322 CRC Committee, General Comment 20, supra note 65, para. 40.
323 UN Convention on the Rights of the Child, Article 2.
324 UN Human Rights Council, Annual Report of the United Nations Office of the High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General. Follow-up and implementation of the Vienna Declaration and Programme of Action. Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity. Report of the United Nations High Commissioner for Human Rights, UN Doc. A/HRC/19/41 (2011), para. 84(d). See also CRC Committee, Concluding Observations: Chile, UN Doc. CRC/C/CHL/CO/3, 2007, para. 29; The United Kingdom of Great Britain and Northern Ireland, UN Doc. CRC/C/15/Add.134 (2008), para. 22; Austria, UN Doc. CCPR/C/79/Add.103 (1998), para. 13. Amnesty International also calls for states to harmonize age of consent in its report *Making love a crime: Criminalization of same-sex conduct in sub-Saharan Africa* (Index: AFR 01/001/2013).
325 See CESCR General Comment 14, supra note 113, para. 4; CESCR, General Comment 22, supra note 15 para. 8.
326 L.J. Ross and R. Solinger, 'Reproductive justice. An introduction', supra note 3.

intersex children). The obligation to fulfil includes creating an enabling environment for people to exercise their reproductive autonomy and decision-making as well as their other sexual and reproductive rights (for example, by ensuring access to comprehensive sexual and reproductive health care, information and education or introducing economic and social policies supporting the full realization of individuals' civil, political, economic, social and cultural rights without discrimination).[327]

At the heart of reproductive justice is the claim that all people who can reproduce and become parents require a safe and dignified context for these most fundamental human experiences. Achieving this goal depends on access to specific, community-based resources including high-quality health care and what the WHO has termed the social determinants of health[328] such as adequate housing, education, a living wage, a healthy environment and a safety net for times when these resources fail. Safe and dignified fertility management, childbirth and parenting are impossible without these resources. This is recognized in the CESCR Committee's General Comment 14 on the right to health which acknowledges that "the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."[329]

In its General Comment 22 on sexual and reproductive health, the CESCR Committee notes: "In all countries, patterns of sexual and reproductive health generally reflect social inequalities in society and unequal distribution of power based on gender, ethnic origin, age, disability and other factors. Poverty, income inequality, systemic discrimination and marginalisation based on grounds identified by the Committee are all social determinants of sexual and reproductive health, which also have an impact on the enjoyment of an array of other rights as well. The nature of these social determinants, which are often expressed in laws and policies, limits the choices that individuals can exercise with respect to their sexual and reproductive health. Therefore, to realise the right to sexual and reproductive health, States parties must address the social determinants as manifested in laws, institutional arrangements and social practices that prevent individuals from effectively enjoying in practice their sexual and reproductive health."[330]

The case for reproductive justice makes another basic claim: access to these material resources is justified on the grounds that safe and dignified fertility management, childbirth and parenting together constitute a human right. Reproductive justice uses a human rights framework to draw attention to and resist laws and public and corporate policies grounded in and resulting in racial, gender and class discrimination. These laws and policies deny people the right to control their bodies, interfere with their reproductive decision-making and, ultimately, prevent many people from being able to live with dignity in safe and healthy communities. Furthermore, international human rights standards around abortion are evolving from an exclusive focus on saving women from unsafe abortion to recognizing the broader social effects of criminalization that endanger them.[331] By focusing on the criminal law as a social determinant of health, these human rights standards shift attention away from the simple

[327] L.J. Ross and R. Solinger, 'Reproductive justice. An introduction', supra note 3.
[328] See WHO, 'Social determinants of sexual and reproductive health', 2010, www.who.int/reproductivehealth/publications/social_science/9789241599528/en/
[329] CESCR General Comment 14, supra note 113, para. 4.
[330] CESCR, General Comment 22, supra note 15, para. 8.
[331] Human Rights Committee, General Comment 36, supra note 18, para. 8.

criminal prohibition of the cause of harm toward the broader social effects of criminalization that endanger health and wellbeing.[332]

Experiences of fertility, reproduction and parenthood cannot be understood separately from an understanding of the social and physical contexts in which they occur. There is a relationship between a group or community's access to affordable reproductive health services and social determinants of health, and an individual's reproduction. Therefore, a reproductive justice framework is not solely focused on access to abortion as an individual's right. Abortion access is critical, yet marginalized women and people who can become pregnant also face barriers to accessing contraception, CSE, STI prevention and care, alternative birth options, adequate prenatal and pregnancy care, protection from domestic violence, adequate income to support their families and safe homes. Additionally, even when abortion is lawful, women from marginalized groups, such as women facing racial discrimination, Indigenous or minority women, or women living in poverty, face multiple barriers to accessing services, for example, they cannot afford it, or cannot travel hundreds of miles to the nearest clinic. A reproductive justice lens recognizes that "choice" and autonomous decision-making have to be enabled through ensuring equitable access and affordable services for all pregnant people.

The reproductive justice framework also provides an analysis of and seeks to eradicate the existing power systems, which determine reproductive experiences of individuals and communities they belong to. This includes also an analysis of the intersecting forms of discrimination and structural and systemic inequalities that marginalized women, girls and pregnant people often face and requires acknowledging and addressing them. The reproductive justice framework also aims to prioritise the most marginalized groups based on the understanding that the society as a whole won't achieve social justice and substantive equality until the most marginalized people are able to access the resources and full human rights to live self-determined lives without fear, coercion or discrimination.

In addition to access to sexual and reproductive health services, information and education, pregnant people must also have information about and access to other services and support, including health care and social security, so that they have a real choice as to whether to carry the pregnancy to term and are not forced to seek recourse to abortion due to denial of their economic and social rights. A full range of options and information about how to access them should be available to pregnant individuals in order to empower them to make the best choices for their life circumstances.

To this end, states must ensure that they put human rights-based services in place, allocate adequate resources for their provision and ensure relevant information about these services is made available to pregnant individuals in a sensitive and culturally appropriate manner. States must further combat discriminatory cultural norms and social stereotypes within communities which perpetuate stigma associated with abortion, adolescent sexuality, single parenting and all other sexual and reproductive choices perceived as outside of social norms in order to achieve reproductive justice for all.

4.6 REFRAIN FROM BANNING OR RESTRICTING ABORTION IN THE NAME OF ANTI-DISCRIMINATION

While states have broad international legal obligations to combat and eradicate all forms of discrimination, banning or restricting abortion to supposedly achieve those aims violates

[332] See J.N. Erdman and R.J. Cook, 'Decriminalization of abortion – A human rights imperative', *Best Practice & Research Clinical Obstetrics & Gynaecology*, https://doi.org/10.1016/j.bpobgyn.2019.05.004

international human rights law and long-standing human rights principles and has proven to be ineffective.

Questions have been raised regarding whether abortion in cases of foetal diagnosis or following sex determination amount to discrimination on the basis of disability or sex. This would justify states' efforts to ban or criminalize abortion in those cases to comply with their overarching non-discrimination obligations. However, there are theoretical, practical and principled issues with this type of argumentation. From a theoretical perspective, a foetus is not a separate entity from the pregnant person that sustains it and thus it is not a subject of discrimination (a person cannot discriminate against gametes, zygotes, embryos and foetuses). Additionally, human rights prohibitions of discrimination do not apply as human rights law is clear that human rights protections start at birth (see Section 5.2 below for further discussion). Notably, no human rights body has ever deemed abortion a form of discrimination on any ground.

There may be, however, underlying factors of structural discrimination that lead pregnant people to feel compelled to terminate their pregnancies. For example, in contexts where the biased practice of son preference is common, pregnant women in abusive situations may be forced or coerced to undergo sex-determination procedures and to terminate their pregnancy if the foetus is identified as female. Women may also choose to engage in sex selection rather than deal with the negative consequences that society imposes on them for having a daughter.[333]

Abortion of female foetuses in such contexts can in many cases be as a result of structural discrimination. However, treating abortion of a female foetus as an act of discrimination would also have implications for abortion in cases of foetal diagnoses. Some may argue that deciding to abort a foetus on the basis of foetal impairment or an anticipated future disability is also a form of selective abortion and discrimination against people with disabilities (as a social class). However, as confirmed by the Nairobi Principles on Abortion, Prenatal Testing, and Disability,[334] which were developed jointly by sexual and reproductive rights advocates and disability rights advocates and which Amnesty International endorsed, a woman's decision about her own body cannot be considered discrimination. Principle 3 states:

> "*We affirm that women and all people who can become pregnant have the right to decide whether to become pregnant and whether to continue a pregnancy, and must have the right to all scientific, evidence-based and unbiased information available to make their decisions, regardless of what that decision might be. Individual choices about one's own pregnancy are not eugenics, and nobody exercises discrimination when making choices about their own pregnancies.*"[335]

In cases of foetal diagnosis, a pregnant person may feel compelled to terminate their pregnancy after receiving a diagnosis of foetal impairment that is incompatible with life or in cases where they are given inaccurate or biased information about the foetal potential impairment, and/or do not have access to the resources (financial, social or medical) or family, community or government support to sustain a child with a serious and/or chronic health condition. Long-

[333] R. Bhatia et al., 'Sex selection: New technologies, new gorms of gender discrimination', *Center for Genetic and Society, (*October 2003), www.geneticsandsociety.org/article/sex-selection-new-technologies-new-forms-gender-discrimination

[334] The Nairobi Principles on Abortion, Prenatal Testing, and Disability, 2019, nairobiprinciples.creaworld.org/wp-content/uploads/2019/03/Nairobi-Principles-FINAL-03.pdf

[335] The Nairobi Principles on Abortion, Prenatal Testing, and Disability, 2019, Principle 3, nairobiprinciples.creaworld.org/wp-content/uploads/2019/03/Nairobi-Principles-FINAL-03.pdf

standing stigma and discrimination against people with disabilities may also lead some people to avoid continuing pregnancies that they believe may result in a child with a disability who may face such treatment.

As discussed in Section 4.1 above, States have a positive obligation to address and eliminate structural discrimination and underlying harmful stereotyping, and ensure substantive equality for women and girls.[336] The CEDAW recognizes that the position of women and girls will not be improved as long as the underlying causes of discrimination against them and structural inequality they face are not effectively addressed. States therefore must take all necessary measures, including specific temporary special measures, to advance women's rights and position in society.[337] The CEDAW Committee has further recognized that women's access to sexual and reproductive health services is essential for achieving substantive equality, and that "denial or delay of safe abortion and/or post-abortion care, forced continuation of pregnancy, and abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment."[338] Therefore, restricting or banning abortion as a means to addressing structural discrimination by policing and regulating reproductive decisions of individual women is not a human rights-compliant policy.

A human rights-complaint legal framework for abortion that respects the sexual and reproductive rights and decisions of women and girls, including women and girls with disabilities, must enable all pregnant people to make the best decisions for their life circumstances and ensure access to vital health-care services and information. The best way for governments to combat structural discrimination both on grounds of gender and disability is to put into place laws and policies that support and promote the autonomy and rights of women and people with disabilities, as pointed out by the CEDAW and CRPD Committees.

From a practical and principled point of view, research and public health evidence indicates that restricting access to abortion does not reduce abortion prevalence but rather leads people to seek and obtain unsafe and clandestine abortions (see Text Box 6). Criminalizing or restricting access to abortion in cases of sex determination or foetal diagnoses does not, therefore, achieve the aim of reducing or eradicating abortion in such cases, nor does it effectively address the structural stigma and discrimination on grounds of gender and disability.

TEXT BOX 6: IMPACT OF RESTRICTIVE ABORTION LAWS ON ABORTION INCIDENCE AND SAFETY

[336] CEDAW specifically requires in its Article 5 that "States Parties shall take all appropriate measures: (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women".
[337] See CEDAW, Article 4.
[338] See CEDAW Committee, General Recommendation 35, supra note 23, para. 18.

The WHO and other public health experts have confirmed: "Legal restrictions on abortion do not result in fewer abortions, nor do they result in significant increases in birth rates."[339] However, restrictive abortion laws are likely to result in a rise in the number of women seeking illegal or unsafe abortions and therefore in increased maternal morbidity and mortality.[340]

In contrast, evidence over several decades has shown that removing restrictions on abortion does not lead to an increase in abortion but does reduce unsafe abortions and therefore maternal mortality rates.[341] As the WHO has pointed out, "laws and policies that facilitate access to safe abortion do not increase the rate or number of abortions. The principle effect is to shift previously clandestine, unsafe procedures to legal and safe ones."[342]

When considering laws criminalizing abortion in contexts of sex determination and foetal diagnoses, foundational human rights legal principles can be useful analytical tools. For example, criminalizing or otherwise restricting abortion following sex determination and in cases of foetal diagnosis contravenes the principles of necessity, proportionality and non-discrimination. The human rights principle of necessity requires that restrictions on an individual's human rights can only be justified when other less restrictive responses would be inadequate and are unable to achieve the legitimate aim or purpose of the law or policy.[343] Thus, the criminal law should not be used where other non-punitive measures would equally or better achieve the aim. Additionally, laws and policies must be proportionate and suitable to pursue the legitimate aim.[344] When laws fail to achieve the purported aim, they are *per se*

[339] WHO, 'Safe abortion: Technical & policy guidance for health systems – legal and policy considerations', WHO/RHR/15.04, 2015, 2 (citing G. Sedgh, S. Singh, I.H. Shah, E. Ahman, S.K. Henshaw, A. Bankole, 'Induced abortion: Incidence and trends worldwide from 1995 to 2008, 379 *Lancet,* 625, 2012, dx.doi.org/10.1016/S0140-6736(11) 61786-8; P.B. Levine, D. Staiger, 'Abortion policy and fertility outcomes: The Eastern European experience', XLVII, *Journal of Law and Economics,* 223, 2004.

[340] WHO, 'Safe abortion: Technical & policy guidance for health systems – Legal and policy considerations', WHO/RHR/15.04, 2015, 2 (citing, H.P. David, "Soviet Union", In H.P. David, editor, 'Abortion research: international experience', Lexington (MA): Lexington Books, 1974, 209-16; F. Serbanescu, L. Morris, P. Stupp, A. Stanescu, 'The impact of recent policy changes on fertility, abortion, and contraceptive use in Romania', 26 *Studies in Family Planning,* 1995, 76-87; I.A. Zhirova, O.G. Frolova, T.M. Astakhova, E. Ketting, 'Abortion-related maternal mortality in the Russian Federation', 35 *Studies in Family Planning* 3, 2004, 78-88; UNDP, 'Millennium development goals in Russia: Looking into the future', 2010).

[341] WHO, 'Safe abortion: Technical & policy guidance for health systems – legal and policy considerations', WHO/RHR/15.04, 2015, 2 (citing H.P. David, 'Abortion in Europe, 1920–91: A public health perspective', 23 *Studies in Family Planning* 1, 1992; R. Jewke, H. Brown, K. Dickson-Tetteh, J. Levin, H. Rees, 'Prevalence of morbidity associated with abortion before and after legalisation in South Africa', 324 *British Medical Journal,* 1252, 2002, dx.doi.org/10.1136/bmj.324.7348.1252; R. Jewkes, H. Rees, 'Dramatic decline in abortion mortality due to the Choice on Termination of Pregnancy Act', 95 *South Africa Medical Journal,* 4, 2005, 250; B.K. Suvedi, A. Pradhan, S. Barnett, M. Puri, S.R. Chitrakar, P. Poudel, *et al.,* 'Nepal maternal mortality and morbidity study 2008/2009: Summary of preliminary findings', Family Health Division, Department of Health Services, Ministry of Health, 2009, www.dpiap.org/resources/pdf/nepal_maternal_mortality_2011_04_22.pdf)

[342] WHO, 'Safe abortion: Technical & policy guidance for health systems – legal and policy considerations', WHO/RHR/15.04, 2015, 2 (citing G. Sedgh, S. Singh, I.H. Shah, E. Ahman, S.K. Henshaw, A. Bankole, 'Induced abortion: Incidence and trends worldwide from 1995 to 2008', 379 *Lancet,* 625, 2012, dx.doi.org/10.1016/S0140-6736(11)61786-8; D. Grimes, J. Benson, S. Singh, M. Romero, B. Ganatra, F.E. Okonofua, *et al.*, 'Unsafe abortion: The preventable pandemic', 368 *Lancet,* 1908, 2006, www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)69481-6/fulltext

[343] Both the Siracusa Principles and the Limburg Principles require that a state's limitation or restriction on human rights be proportionate and no more restrictive than necessary. Read in conjunction with the principle of *ultima ratio* – states should thus only resort to criminal law if no other less punitive measures suffice. See UN Commission on Human Rights, 41st Session, "Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights", UN Doc. E/CN.4/1985/4 (1984), paras 10-14; UN Commission on Human Rights, 43rd Sess., 1987, Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/CN.4/1987/17 (1987), paras 60-61.

[344] See UN Commission on Human Rights, 41st Session, "Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights", UN Doc. E/CN.4/1985/4 (1984), paras 10(d) and 51; Human Rights Committee, General Comment 31, supra note 101, para. 6; UN CESCR, General Comment

disproportionate. Finally, criminal laws and policies must not have a discriminatory impact on particular groups of people, which is precisely the case with criminal abortion laws.[345]

The CRPD Committee has expressed concern that including foetal diagnoses among the legal grounds for abortion contributes to a climate of stigma that can lead to discrimination against people with disabilities, particularly because some legal frameworks contain a separate provision (often accompanied by a separate gestational timeframe in which people can access abortion) in cases where pregnant individuals have received a foetal impairment diagnosis.[346] However, the UN CRPD Committee stands behind the principle that pregnant people's reproductive autonomy must be respected and protected and that the decision regarding whether to continue a pregnancy following a diagnosis of foetal impairment should lie with the pregnant person.[347] Moreover, the Committee has consistently refrained from addressing this issue as a violation of Article 10 (the right to life) or Article 5 (the right to equality and non-discrimination) of the CRPD.

In a 2018 Joint Statement, the CEDAW and the CRPD Committees confirmed that states "must address the root causes of discrimination against women and persons with disabilities, including through challenging discriminatory attitudes and fostering respect for the rights and dignity of persons with disabilities, in particular women with disabilities, as well as provide support for parents of children with disabilities".[348] The Committees confirmed that in order to respect gender equality and disability rights in accordance with CEDAW and CRPD, "States parties should decriminalize abortion in all circumstances and legalize it in a manner that fully respects the autonomy of women, including women with disabilities."[349]

As pointed by the group Women Enabled International:[350]

> *"Expanding access to safe abortion without specifically enumerated grounds for legal abortion would help eliminate the abortion-related stigma that pregnant people*

20 (Nondiscrimination in economic, social and cultural rights (Art. 2, para. 2, of the ICESCR)), UN Doc. E/C.12/GC/20 (2009), para. 13.

[345] See UN Commission on Human Rights, 41st Session, "Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights", UN Doc. E/CN.4/1985/4 (1984), paras 9, 28; UN Commission on Human Rights, 43rd Sess., 1987, Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/CN.4/1987/17 (1987), paras 35-41, 49.

[346] See CRPD Committee, Concluding Observations: Spain, UN Doc. CRPD/C/ESP/CO/1 (2011), para. 17; Austria, UN Doc. CRPD/C/AUT/CO/1 (2013), para. 15.

[347] Joint Statement by CEDAW and CRPD, 'Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities', 29 August 2018, www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDStatements.aspx. See also CRPD Committee, Concluding Observations: Poland, UN Doc. CRPD/C/POL/CO/1 (2018), para. 44(e); India, UN Doc. CRPD/C/IND/CO/1 (2019), para. 37(a); Norway UN Doc. CRPD/C/NOR/CO/1 (2019), para. 30; El Salvador, UN Doc. CRPD/C/SLV/CO/2-3 (2019), para. 34; Turkey, UN Doc. CRPD/C/TUR/CO/1 (2019), para. 37(b); Australia, UN Doc. CRPD/C/AUS/CO/2-3 (2019), para. 34(a).

[348] Joint Statement by CEDAW and CRPD, 'Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities', 29 August 2018, www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDStatements.aspx.

[349] Joint Statement by CEDAW and CRPD, 'Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities', 29 August 2018, www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDStatements.aspx.

[350] Women Enabled International, 'Abortion and disability: Towards an intersectional human rights-based approach', 2020, p. 22, womenenabled.org/blog/wei-publication-abortion-and-disability-towards-an-intersectional-human-rights-based-approach/

experience when abortion is criminalized. Full decriminalization of abortion also would help dismantle disability-related stigma that is fueled by legal frameworks that treat abortion on the basis of fetal impairment as "justified." This approach would address the disability community's concerns while strengthening, rather than undermining, reproductive autonomy.

Imposing greater restrictions on reproductive autonomy in the area of abortion law – whether by removing explicit grounds for fetal impairment or banning abortion on the basis of specific prenatal diagnoses – can foster a climate of restrictions on reproductive autonomy writ broadly. As one disability scholar explained:

[W]hile we demand that medicine rethink its pathologization of … forms of difference, we need to be careful not to build a disability stance that vilifies all women whose exercise of their reproductive agency leads to termination. This … is important because logically, we cannot grant agency to exercise a right of autonomy if we insist that only one outcome is correct. Ultimately, the rights we recognize for one person inform the terrain on which we recognize rights for others.[351]

As such, it is imperative that States do not remove existing legal grounds for abortion – including fetal impairment grounds – at this time, unless it is to fully remove the decision to have an abortion from the criminal codes or unless the outcome is an expanded right to exercise reproductive autonomy. To do so would be to legitimize restrictions on autonomy for one group that reverberate to the fundamental rights of others. Instead, States must decriminalize abortion generally and move toward a legal framework that respects the right to access safe abortion without restriction as to reason. To the extent that States maintain gestational limits on abortion access, they must ensure that any gestational limits allow for legal abortion within the timeframe during which pregnant people are able to access essential information about their health and the health of their pregnancy."

Some governments have prohibited prenatal testing for the purposes of sex determination and criminalized revealing the sex of the fetus to prevent this practice.[352] The comparison between abortion following sex determination and abortion after foetal diagnosis have prompted some disability rights advocates to suggest prenatal genetic testing and abortion following foetal diagnosis should similarly be banned. However, as mentioned above, evidence shows that restrictive laws and policies are ineffective in preventing abortions and furthermore have harmful consequences for women's lives and health, restrict women's reproductive autonomy and violate their human rights.[353]

Amnesty International's policy on sexual and reproductive rights affirms that governments must refrain from denying or limiting equal access for everyone to sexual and reproductive health

[351] M. Holms, 'Mind the gaps: Intersex and (re-productive) spaces in disability studies and bioethics', 5 *Journal of Bioethical Inquiry* 169 (2008), cited in Women Enabled International, 'Abortion and disability: Towards an intersectional human rights-based approach', 2020.

[352] See B. Ganatra, 'Maintaining access to safe abortion and reducing sex ratio imbalances in Asia', 2008, in *Reproductive Health Matters,* 16 (31 Supplement): 90-98. See also G. Sen, 'Gender-biased sex selection: Key issues for action', 2009, https://www.dawnnet.org/uploads/documents/Sex%20Selection%20GS%20draft%2008062009_2011-Mar-8.pdf See also United Nations Population Fund (UNFPA), 'Sex imbalances at birth: Current trends, consequences and policy implications', 2012, Bangkok, Thailand.

[353] See OHCHR, UNFPA, UNICEF, UN Women and WHO, 'Preventing gender-biased sex selection', 2011.

information. This aligns with international human rights law and principles around patients' right to information, which is strongly embedded in the right to information and the right to health under international law. Several human rights treaty bodies and courts have stated that access to information is critical to the realization of all human rights, and in the context of health care, including sexual and reproductive health care, states have an obligation, not to censor, withhold, misrepresent or criminalize information to the public in general and to individuals.[354] Therefore, health-related information that is skewed towards or against pregnancy termination is contrary to the right to receive comprehensive sexual and reproductive health information, as well as other human rights principles, including, for example, the CRPD principle (Article 3) respecting human diversity and respect for difference. The WHO also emphasizes that the information given to women who are seeking abortion services must be unbiased, non-directive and provided only on the basis of informed consent.[355]

The CESCR Committee further emphasizes that "[n]ational and donor states must refrain from censoring, withholding, misrepresenting or criminalising information on sexual and reproductive health, both to the public and to individuals. Such restrictions impede access to information and services, and can fuel stigma and discrimination."[356] The Committee further states that "[t]he failure or refusal to incorporate technological advancements and innovations in the provision of sexual and reproductive health services, such as medication for abortion, assisted reproductive technologies, and advancements in the treatment of HIV and AIDS, jeopardises the quality of care."[357] The UN Special Rapporteur on Torture has also affirmed that "access to information about reproductive health is imperative to a woman's ability to exercise reproductive autonomy, and the right to health and to physical integrity."[358]

In conclusion, states must address the underlying social, economic, political and structural conditions that lead to discrimination as a matter of first priority, as opposed to restricting access to abortion or prenatal testing and pregnancy-related information, which might result in punishing pregnant people for larger societal conditions or shifting the burden on providing solutions to structural discrimination to pregnant individuals. Moreover, Amnesty International's abortion policy calls for full decriminalization and opposes bans of any kind on abortion and provision of pregnancy and abortion-related information, necessary to protect their health and rights. As noted throughout this Explanatory Note, states have positive obligations to ensure that all people who can become pregnant can access safe abortion services and information. These should not be undermined by states' legal obligations to combat and prevent discrimination of any kind. These are two co-existing obligations and can be achieved through a range of means. Additionally, sexual and reproductive rights, including the right to access safe abortion, and the right to equality and non-discrimination are not at odds, but rather mutually reinforcing concepts.

4.7 ENSURE PARTICPATION AND ACCOUNTABILITY

[354] See CECSR Committee, General Comment 22, supra note 15, paras 21, 41. See also CESCR Committee, General Comment 14 (2000), supra note 113, para. 34. See also CRPD Committee, General Comment 3, supra note 173, para. 40. See also European Court of Human Rights, *R.R. v Poland*, supra note 125, paras 159-160, 197-198; European Court of Human Rights, *P. and S. v Poland*, supra note 24, paras 108, 167-169. See also Human Rights Committee Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014), para. 9; see also CEDAW Committee, Concluding Observations: Ireland, UN Doc. CEDAW/C/IRL/6-7 (2017), para. 43 (c); CESCR Committee, Concluding Observations: Ireland, UN Doc. E/C.12/IRL/CO/3 (2015), para. 30.
[355] WHO, 'Safe abortion: Technical and policy guidance for health systems' (2012), pp. 36, 97.
[356] See CESCR Committee, General Comment 22, supra note 15, para. 41.
[357] See CESCR Committee, General Comment 22, supra note 15, para. 21.
[358] Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/22/53 (2013), para. 47.

Under international human rights standards, governments have an obligation to ensure the right of individuals to active, informed and effective participation in decision-making that affects them, including on matters related to their sexual and reproductive health and rights.[359]

The OHCHR has noted that "[wh]ile the responsibility and accountability for elaborating laws and policies ultimately rests with public authorities, the participation of various sectors of society allows the authorities to deepen their understanding of specific issues; helps to identify gaps, as well as available policy and legislative options and their impact on specific individuals and groups; and balances conflicting interests. As a consequence, decision-making is more informed and sustainable, and public institutions are more effective, accountable, and transparent. This in turn enhances the legitimacy of States' decisions and their ownership by all members of society."[360]

The participation of women and girls, and people who can become pregnant, in policy-making helps ensure that a gender perspective is integrated into legal and policy frameworks. There is increasing evidence that where such participation is guaranteed, health systems are more responsive to the specific needs of women and girls, and people who can become pregnant, including their reproductive health needs.[361]

In terms of accountability, states have the obligation to ensure that individuals who suffer human rights violations can exercise their right to an effective remedy and to reparations.[362] These are central to the promotion and protection of human rights and providing them is a key component of states' responsibility to ensure human rights.[363] According to the CESCR Committee, any person who has suffered a violation of the right to health, including sexual and reproductive health, should have access to effective judicial and/or other appropriate remedies at both the national and international levels.[364] The Committee has also confirmed that national

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[359] See CESCR Committee, General Comment 14, supra note 113, para. 17. See also CESCR Committee. General Comment 22, supra note 15, para. 49. See also CEDAW Convention, Article 7(b), which requires from states to ensure that women and girls have the right to participate fully and be represented in public policy formulation in all sectors and at all levels.

[360] OHCHR, 'Guidelines for states on the effective implementation of the right to participate in public affairs', available at www.ohchr.org/EN/Issues/Pages/DraftGuidelinesRighttoParticipationPublicAffairs.aspx

[361] See for example Inter-American Commission on Human Rights, 'Access to maternal health services from a human rights perspective', Organization of American States, 7 June 2010. See also the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health A/HRC/17/25 (2011); see also CEDAW Committee, *Alyne da Silva Pimentel v Brazil*, supra note 30; see also CEDAW Committee, *L.C. v Peru,* supra note 12.

[362] See also Article 2(3) International Covenant on Civil and Political Rights (ICCPR); Article 13 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; Article 6 International Convention on the Elimination of All Forms of Racial Descrimination (CERD); Article 8 Universal Declaration of Human Rights; Principles 4-7 of the Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power; Article 27 of the Vienna Declaration and Programme of Action; articles 13, 160-162, 165 of the Programme of Action of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance; Article 9 of the Declaration on Human Rights Defenders; Article 13 European Convention for the Protection of Human Rights (ECHR); articles 7(1)(a) and 25 American Convention on Human Rights (ACHR); Article XVIII of the American Declaration of the Rights and Duties of Man; Article 7 (1) (a) African Charter of Human and Peoples' Rights (ACHPR); and Article 9 Arab Charter on Human Rights.

[363] Article 2 ICCPR; Article 2 CERD; Article 2 CEDAW; Article 2 Convention on the Rights of the Child; Article 1 ACHR, Article 1 ECHR. See General Comment 31 on the Nature of the General Legal Obligation Imposed on States Parties to the Covenant, 26 May 2004, UN Doc. CCPR/C/21/Re v.1/Add.13; para. 16. Inter-American Court of Human Rights: *Loayza Tamayo* Case (Reparations), Judgment of 27 November 1998, Series C No. 42, para. 164; *Suárez Rosero* Case (Reparations), Judgment of 20 January 1999, Series C No. 44, paras 97-99; European Court of Human Rights: *Case X and Y v the Netherlands,* Judgment of 26 March 1985; the African Commission on Human and Peoples' Rights, Case of *The Social and Economic Rights Action Center and the Center for Economic and Social Rights v Nigeria,* Communication 155/96 (30th Ordinary Session, October 2001), paras 44-48.

364 See CESCR Committee, General Comment 14, supra note 113, para. 59. See also CECSR Committee, General Comment 22, supra note 15, para. 64.

ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address such violations.[365]

A remedy can be provided by a court or another institution that acts on complaints. To be effective, all remedies must be accessible, affordable and timely. Reparations should, as far as possible, correct the consequences of the violation and should include restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition.[366] The CECSR Committee has further emphasized that "[t]he effective exercise of the right to remedy requires funding access to justice and information about the existence of these remedies."[367]

Monitoring and accountability in the context of sexual and reproductive health and rights are seriously compromised by significant gaps in data, both at the national and international levels. There are particular gaps in information around issues that are deemed sensitive, carry social stigma, and/or are treated as criminal offences, such lack of access to abortion-related information and services in countries where abortion is criminalized. There is an urgent need to collect statistics and data not just on health interventions, but also on other sexual and reproductive rights issues such as sexual and gender-based violence, FGM/C and child, early and forced marriage. Such information is crucial if governments are to assess accurately the extent to which rights are being denied and to develop targeted interventions.

Disaggregating data helps ensure that discrimination and exclusion are not masked in national statistics. It can also help:

- reveal the different needs and entitlements of specific groups – for instance, adolescents and young people – and assess whether these are met and what further legal and policy measures are required to respect, protect and fulfil human rights;
- establish the need for specific temporary special measures on behalf of certain groups,[368] for instance those for whom historically the experience of state violence and coercion in relation to reproductive health care amounts to an obstacle to accessing health information and services;[369]
- increase accountability at the national level for the provision of services.

Data collection must also respect confidentiality in order to ensure that it does not reinforce discrimination, for instance against lesbian, gay, bisexual, transgender or intersex people.

[365] CESCR General Comment 14, supra note 113, para. 59.
[366] UN Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law, General Assembly Resolution 60/147 of 16 December 2005, para. 18.
[367] CECSR Committee, General Comment 22, supra note 15, para. 64.
[368] CEDAW Committee, General Recommendation 25, UN Doc. A/59/38 Part I; CEDAW/C/2004/I/WP.1/Rev.1
[369] Amnesty International, *Fatal flaws: Barriers to maternal health in Peru* (Index: AMR 46/008/2009).

5. ABORTION REGULATION MUST BE ALIGNED WITH HUMAN RIGHTS

State regulation of abortion has been the topic of human rights analysis for decades given the wide-ranging human rights impact of such laws, policies and practices. As international human rights law and standards continue to evolve, human rights treaty bodies have been increasingly calling on states to fully decriminalize abortion. In many contexts though, women, girls and all people who can become pregnant continue to live under partially criminalized frameworks whereby abortion is lawful only on certain grounds – for example, in cases of sexual violence, foetal impairments and/or a risk to a pregnant person's life or health. Moreover, while in some countries abortion is treated as any other medical procedure and not subject to specific regulation, in most cases governments specifically regulate abortion in a manner that obstructs, delays or otherwise prevents pregnant persons' access to abortion care. While not criminal laws, such regulation can be punitive and similarly violates a range of pregnant persons' human rights. Therefore, it is important that even in these contexts, we advocate for abortion regulation to be aligned with international human rights law and standards around abortion.

To this end, set forth below are some principled positions that need to be taken into account by states with regards to abortion regulation and which we can use in our advocacy, even in partially decriminalized contexts.

5.1 PROCEDURAL PROTECTIONS TO ENSURE ACCESS TO LAWFUL ABORTION

While states worldwide are incrementally liberalizing abortion law, pregnant individuals continue to face arbitrary denials of their right to access lawful abortion. Vague laws and policies, conflict of laws, lack of implementation and knowledge and understanding of abortion laws, as well as bias, stigma and discrimination, can lead to delayed and/or denied access to lawful services.[370] "Human rights standards therefore requires affirmative legal and policy measures to protect against arbitrary denials of lawful care and to ensure access to services under legal grounds. These measures include legal frameworks that articulate clear entitlements to care under lawful grounds or what has been termed 'transparency' in abortion laws."[371]

Other procedural protections around access and entitlement to lawful care, include:

- guarantee timely access to information of the circumstances of pregnancy and the legal grounds for its termination;
- require written reasons for denials of care; and

[370] See J. Erdman and R. Cook, 'Decriminalization of abortion: A human rights imperative', *Best Practice & Research: Clinical Obstetrics & Gynaecology,* 2019, p. 5; see also J. Erdman, 'The procedural turn: Abortion at the European Convention of Human Rights', *Abortion law in transnational perspective: Cases and controversies (*J. Erdman, R. Cook, B. Dickens, eds.), 2014.

[371] J. Erdman and R. Cook, 'Decriminalization of abortion: A human rights imperative', *Best Practice & Research: Clinical Obstetrics & Gynaecology*, 2019, p. 6; see C. Ngwena, 'Reforming African abortion laws and practice: The place of transparency', in Abortion law in transnational perspective: Cases and controversies (J. Erdman, R. Cook, B. Dickens, eds.), 2014.

- establish mechanisms of appeal and review of denials with an opportunity for persons seeking abortions to be heard and to have their views considered.[372]

Human rights standards around procedural protections around access to lawful abortions have been the most developed under the European Court of Human Rights. In the landmark case, *Tysiąc v Poland*, the Court found that the arbitrary application of abortion law in Poland violates women's rights under the European Convention on Human Rights.[373] The Court affirmed that "[o]nce the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it."[374] The jurisprudence under the European system not only affirms women's and girls' substantive right to abortion, but also their procedural rights to access lawful services.[375] Therefore, in the end, states must not only recognize the right to lawful abortion, but also guarantee access to lawful abortion so that the underlying substantive right is not illusory and subject to arbitrary enforcement and application of the law.[376]

5.2 LEGAL PROTECTION OF HUMAN RIGHTS STARTS AT BIRTH

Amnesty International does not take a position on where human life begins; this is a moral and ethical question for individuals to decide for themselves.[377] However, our policy affirms that legal protection of human rights, including the right to life, commences at birth.

Some states across the world have adopted and enforced laws and policies that attempt to accord human right protection to foetuses, embryos, zygotes and gametes, to the detriment of the human rights of women, girls and all people who can become pregnant. However, international human rights law and standards are clear that human rights apply after birth, not before.[378] Terminating a pregnancy is compatible with human rights as discussed throughout this Explanatory Note. By contrast, no human rights body has ever found abortion to be incompatible with human rights, including the right to life. Additionally, no international human

[372] J. Erdman and R. Cook, 'Decriminalization of abortion: A human rights imperative', *Best Practice & Research: Clinical Obstetrics & Gynaecology,* 2019, p. 6; see also Report of the UN Special Rapporteur on extrajudicial, summary and arbitrary executions on a gender-sensitive approach to arbitrary killings, UN Doc. A/HRC/35/23 (2017), para. 103.
[373] See European Court of Human Rights: *Tysiąc v Poland*, supra note 51 (violation of the right to private life); see also European Court of Human Rights, *R.R. v Poland*, supra note 125 (violation of the rights to be free from inhuman and degrading treatment and private life); *P. and S. v Poland*, supra note 24 (violations of the rights to be free from inhuman and degrading treatment, liberty and security and private life).
[374] European Court of Human Rights: *Tysiąc v Poland*, supra note 51, para. 116.
[375] European Court of Human Rights: *Tysiąc v Poland*, supra note 51, para. 116 ("[O]nce the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it.")
[376] European Court of Human Rights, *Tysiąc v Poland*, supra note 51, para. 76; European Court of Human Rights, *R.R. v Poland*, supra note 125 (violation of the rights to be free from inhuman and degrading treatment and private life); European Court of Human Rights, *P. and S. v Poland*, supra note 24 (recognizing the state's systemic failure to enforce its own laws on abortion and to regulate doctors' arbitrary actions to deny access to abortion); see also J.N. Erdman, 'The procedural turn: Abortion at the European Court of Human Rights', *Abortion law in transnational perspective: Cases and controversies,* (J. Erdman, R. Cook, B. Dickens, eds.), 2014, pp. 121-142.
[377] See Amnesty International, 2018 Global Assembly Decisions (Index: ORG 50/8766/2018), UPDATE OF AMNESTY INTERNATIONAL'S POLICY ON ABORTION, p.5.
[378] Human Rights Committee, General Comment 36, supra note 18.

rights body has ever recognized the foetus as a subject of protection under the right to life or other provisions of international human rights treaties, including the CRC.[379]

The HRC likewise has rejected the proposition that the protection of the right to life set out in Article 6(1) of the ICCPR applies before birth.[380] The HRC has repeatedly emphasized the threat to women's and girls' lives posed by abortion prohibitions and restrictions that cause women and girls to seek unsafe abortions, and has called upon states to liberalize laws on abortion;[381] a position that would be problematic if the Covenant's protection of the right to life applied before birth.[382] In addition, in its General Comment 28, the authoritative interpretation of the principle of equality protected by the ICCPR, the HRC has emphasized states' responsibility to reduce maternal mortality due to clandestine abortions and has recognized that restrictive abortion laws could violate women's and girls' right to life.[383] Notably, in 2014, the HRC also criticized the former Irish Constitution, which used to grant the right to life of the "unborn" on an equal footing with a pregnant woman's right to life. The HRC recognized the negative impact this had on women's access to abortion and called for reform of the constitutional provision and liberalization of the abortion law.[384]

To the extent that states attempt to promote foetal health or welfare, UN treaty bodies have recognized that this is best achieved through promoting the health and wellbeing of pregnant women and girls, such as ensuring access to comprehensive safe pregnancy programmes, including nutritional programmes during pregnancy; ensuring safety in childbirth; reducing stillbirths; promoting healthy birth outcomes; and preventing crisis pregnancies.[385]

[379] See R. Copelon et. al., 'Human rights being at birth: International law and the claim of fetal rights', *Reproductive Health Matters* (2005), vol. 13, issue 26, pp. 120-129. An argument to the contrary is erroneously built upon Paragraph 9 of the Convention on the Rights of the Child Preamble, which provides: "Bearing in mind that, as indicated in the Declaration of the Rights of the Child, 'the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth'." The history of negotiations by states on the treaty clarifies that these safeguards "before birth" must not affect a woman's choice to terminate an unwanted pregnancy. As originally drafted, the Preamble did not contain the reference to protection "before as well as after birth," although this language had been used in the earlier Declaration on the Rights of the Child. The Holy See led a proposal to add this phrase, at the same time as it "stated that the purpose of the amendment was not to preclude the possibility of an abortion" (UN Commission on Human Rights, Question of a Convention on the Rights of a Child: Report of the Working Group, 36th Session, E/CN.4/L/1542 (1980)). Although the words "before or after birth" were accepted, their limited purpose was reinforced by the statement that "the Working Group does not intend to prejudice the interpretation of Article 1 or any other provision of the Convention by States Parties." (UN Commission on Human Rights, Report of the Working Group on a Draft Convention on the Rights of the Child, 45th Session, UN Doc. E/CN.4/1989/48, p. 10).

[380] The history of the negotiations on the Covenant indicates that an amendment was proposed and rejected that stated: "the right to life is inherent in the human person from the moment of conception, this right shall be protected by law." UN GAOR Annex, 12th Session, Agenda Item 33, at 96, A/C.3/L.654; UN GAOR, 12th Session, Agenda Item 33, at 113, A/3764, 1957. The Commission ultimately voted to adopt Article 6, which has no reference to conception, by a vote of 55 to nil, with 17 abstentions.

[381] Human Rights Committee, Concluding Observations on Poland, UN Doc. CCPR/CO/82/POL (2004), para. 8. See also Human Rights Committee, General Comment 36, supra note 18, para 8.

[382] Human Rights Committee, Concluding Observations on Poland, UN Doc. CCPR/C/79/Add.110 (1999), para. 11.

[383] Human Rights Committee, General Comment 28, supra note 19, paras 10, 20.

[384] Human Rights Committee, Concluding Observations on Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014), para. 9.

[385] See for example CAT Committee, Concluding Observations on Peru, UN Doc. CAT/C/PER/CO/5-6 (2013), para. 15.

5.3 TIME-BOUND REGULATION OF ABORTION – GESTATIONAL LIMITS

Another common state regulation around abortion is the imposition of "gestational limits" – time-bound restrictions on access to safe and legal abortion.

It is beyond the scope of the mission/mandate of Amnesty International as a human rights rather than a public health or medical organization to develop policy that prescribes specific medical practice, including gestational limits.

Amnesty International acknowledges that states may regulate access to abortion, including by setting gestational limits. Nevertheless, in line with its principled approach, it considers that gestational limits should, like all restriction on abortion access, be subject to human rights scrutiny.

Gestational limits, like other restrictions on abortion, should not be considered reasonable by default. Rather, where appropriate, there should be a human rights analysis of the legal, policy and other regulatory measures on abortion in a particular country and context that is based on human right principles and the impact of the restrictions on the human rights of pregnant people.

For gestational limits to be human rights compliant they must respect and protect the human rights of women and girls and all others who can become pregnant, including their rights to life, health and to bodily integrity and reproductive autonomy. If, for example, a state does not allow abortion after a certain point even if a pregnant person's health is at risk, this would be a human rights violation.

A human rights analysis of restrictions on abortion, including gestational limits, should be conducted when this is deemed an advocacy priority in a particular country. As with all institutional policies, Amnesty International's abortion policy does not require all sections and entities to work on abortion or to challenge gestational limits in any particular country or in any particular way.

This aligns with Amnesty International's principle-based approach to abortion. It also takes into account the fact that over the years public health and social science research has demonstrated that gestational limits may constitute an arbitrary and discriminatory barrier to accessing services, which has a disproportionate impact on the human rights of women and girls. The negative impact of gestational limits on access to quality health care has been recognized by the WHO.[386] Gestational limits can deny people who need abortions access to services, disproportionately impacting those from poorer and/or marginalized backgrounds. Health professionals can also be arbitrarily precluded from considering all medical and clinical options with the best interest of their patient in view and there is a tendency to over apply the legal requirement of gestational limits due to the chilling effect they can have.

It is important to keep in mind regarding discussions of gestational limits that abortions in later pregnancy are quite rare. In the USA, for example, most abortions take place early in pregnancy and only 9% of women who obtain an abortion do so after the first trimester (at 14 weeks or

[386] See WHO, 'Safe abortion: Technical and policy guidance for health systems' (2nd ed., 2012), supra note 54, p. 93-94.

later), and around 1% of abortions are performed at 21 weeks or later.[387] In Canada, where access to abortion is not regulated, 29% of induced abortions are performed before eight weeks; 41% at nine to 12 weeks; 7% at 13 to 16 weeks; and 2% over 21 weeks.[388] In England and Wales, only 8% of abortions occur after 12 weeks; 0.1% occur at or over 24 weeks.[389]

While abortions in later pregnancy are rare, there are many reasons why some people will need them. Many states do not impose any gestational limits in either situations of risk to life or to health (for example, Austria, Denmark, France, Germany, Greece, Iceland, Portugal, Macedonia, New Zealand, Serbia, Slovakia, Slovenia, Sweden and Switzerland). Some states impose gestational limits for risk to health but not in situations of risk to life (for example, Bosnia and Herzegovina, Czech Republic, Finland, Hungary and the United Kingdom). In the final analysis, international human rights law and standards require states to ensure access to safe and legal abortion to protect women's and girls' life and health at all stages of pregnancy without discrimination. For example, the HRC in its General Comment 36 on the Right to Life has prohibited states from regulating abortion in a manner that runs contrary to their duty to ensure that women and girls do not have to undertake unsafe abortions, and has affirmed that "[a]lthough States parties may adopt measures designed to regulate voluntary terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant. Thus, restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardise their lives, subject them to physical or mental pain or suffering which violates article 7, discriminate against them or arbitrarily interfere with their privacy."[390]

[387] See for example Guttmacher Institute, 'Induced abortion in the United States. Fact Sheet', 2019, www.guttmacher.org/fact-sheet/induced-abortion-united-states

[388] *Globe & Mail*, 'Percentage distribution of induced abortions by gestation period', 2012.

[389] Government Statistical Service for the Department of Health (17 May 2016). Abortion statistics, England and Wales: 2018, assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808556/Abortion_Statistics__England_and_Wales_2018__1_.pdf

[390] Human Rights Committee, General Comment 36, supra note 18, para. 8.

ANNEX I: ABORTION IN ARMED CONFLICT SITUATIONS

In conflict-affected areas, there can be a range of factors which may impact pregnant persons' needs to access safe abortion. These include, among others, unwanted pregnancies resulting from sexual violence or the inability to obtain contraception, and the dangers of pregnancy in such precarious environments, including lack of adequate health care.

Both international human rights law and international humanitarian law apply to situations of armed conflict and provide complementary and mutually reinforcing protections.[391] Certain human rights provisions may be derogated from in times of public emergency, in line with Article 4 of the ICCPR. However, as set out in Amnesty International's abortion policy, states' international legal obligation to provide access to safe abortion is grounded in a number of human rights which are non-derogable, including the rights to life, to be free from torture and other ill-treatment, and to minimum core obligations of the right to health – and will therefore continue to be binding.

As a general rule, so long as there is no contradiction across the two bodies of law, the provisions of both international human rights law and international humanitarian law will apply concurrently in contexts of armed conflict.[392] As there is nothing in international humanitarian law that contradicts with states' international human rights obligations to ensure access to safe abortion, those legal obligations (as set out in the abortion policy) equally apply in armed conflict situations. Along these lines, the CEDAW Committee has affirmed women's right to access abortion services in conflict-affected areas by specifically calling on states parties to "ensure that sexual and reproductive health care includes … safe abortion services; post-abortion care…", in these contexts.[393]

In addition to states' legal obligations to ensure access to safe and legal abortion under human rights law, there is an evolving recognition under international humanitarian law that parties to a conflict have an obligation to provide access to safe abortion. This has been most clearly set-out in the context of access to abortion for survivors of rape.

International humanitarian law requires that the wounded and sick be provided with all necessary medical care required by their condition,[394] without any "adverse distinction",

[391] See for example ICJ cases 'Legality of the threat or use of nuclear weapons', para. 25, and 'Legal consequences of the construction of a wall', para. 106.

[392] See for example, Human Rights Committee, General Comment 31, UN Doc. CCPR/C/21/Rev.1/Add.13 (2004), para. 11. Where they would produce inconsistent results the international law principle of *lex specialis derogat legi generali* would apply, according to which, in the case of a conflict of norms, the more specific rule is applied over the more general rule.

[393] CEDAW Committee, General Recommendation 30, supra note 75, para. 52(c).

[394] In relation to international armed conflicts, see: Article 12 of Geneva Convention I, Article 12 of Geneva Convention II, Article 30 of Geneva Convention III, Article 16 of Geneva Convention IV, Article 10 of the Additional Protocol I to the Geneva Conventions. For non-international armed conflicts, see: Common Article 3 of the Four Geneva Conventions, Article 7 of Additional Protocol II. This is customary international humanitarian law in both international and non-international armed conflicts. See International Committee of the Red Cross, Customary International Humanitarian Law, Vol. 1: Rules (ICRC Customary IHL Study), Rule 109.

including on the basis of sex.[395] The "wounded" and "sick" are defined as "persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility".[396]

Experts have highlighted that at least in cases of rape, pregnant persons would fall into the category of "wounded and sick," due to the severe mental, and often physical, trauma suffered.[397] They further argue that any exclusion of abortion services from medical care provided to such persons, when one wants to terminate their pregnancy, is a violation of the party's obligation to provide medical care to the wounded and sick.[398] Moreover, as abortion care is generally only required by women (but can also be required by all persons who can become pregnant), failure to provide such care would can violate the prohibition on making an "adverse distinction" in the delivery of medical care.[399] In certain circumstances, including in cases of rape, the denial of abortion services may also violate the right to be free from torture and other ill-treatment under international human rights law. Along similar lines, it may also violate the prohibition of torture and cruel treatment under international humanitarian law.[400]

This interpretation of international humanitarian law is gaining increasing recognition among states and inter-governmental bodies.[401] A number of states have made affirmative statements – particularly in their humanitarian aid policies – recognizing the international humanitarian law obligation to provide access to abortion, at least in certain circumstances.[402] The European

[395] See for example Article 9 of Additional Protocol I. This is also customary international humanitarian law in both international and non-international armed conflicts. See also ICRC Customary IHL Study, Rule 88.

[396] Article 8 of Additional Protocol I. The Article also explicitly sets out that the term covers "maternity cases" and "expectant mothers".

397 See for example A. Radhakrishnan, E. Sarver and G. Shubin (2017), 'Protecting safe abortion in humanitarian settings: overcoming legal and policy barriers', *Reproductive Health Matters,* 25:51, 40-47, doi.org/10.1080/09688080.2017.1400361; see also L. Doswald-Beck, Open letter to President Barack Obama, 10 April 2013, globaljusticecenter.net/documents/FinalLetter.LDBeck.4.10.2013.pdf; see also Center for Reproductive Rights, 'Ensuring sexual and reproductive rights of women and girls affected by conflict', 2017, www.reproductiverights.org/sites/crr.civicactions.net/files/documents/ga_bp_conflictncrisis_2017_07_25.pdf

[398] See for example A. Radhakrishnan, E. Sarver and G. Shubin (2017), 'Protecting safe abortion in humanitarian settings: overcoming legal and policy barriers', *Reproductive Health Matters,* 25:51, 40-47, doi.org/10.1080/09688080.2017.1400361; see also L. Doswald-Beck, Open letter to President Barack Obama, 10 April 2013, globaljusticecenter.net/documents/FinalLetter.LDBeck.4.10.2013.pdf; see also Center for Reproductive Rights, 'Ensuring sexual and reproductive rights of women and girls affected by conflict', 2017, www.reproductiverights.org/sites/crr.civicactions.net/files/documents/ga_bp_conflictncrisis_2017_07_25.pdf.

[399] See for example A. Radhakrishnan, E. Sarver and G. Shubin (2017), 'Protecting safe abortion in humanitarian settings: overcoming legal and policy barriers', *Reproductive Health Matters,* 25:51, 40-47, doi.org/10.1080/09688080.2017.1400361; see also L. Doswald-Beck, Open letter to President Barack Obama, 10 April 2013, globaljusticecenter.net/documents/FinalLetter.LDBeck.4.10.2013.pdf; see also Center for Reproductive Rights, 'Ensuring sexual and reproductive rights of women and girls affected by conflict', 2017, www.reproductiverights.org/sites/crr.civicactions.net/files/documents/ga_bp_conflictncrisis_2017_07_25.pdf

[400] See for example Common Article 3 of the Four Geneva Conventions, Article 75(2) of AP1, Article 4(2) of AP II. Rule 90 of the Doswald-Beck *et al.* ICRC study.

[401] For an overview, see Global Justice Center, 'International humanitarian law and access to abortions: compilation of citations', 2017, globaljusticecenter.net/blog/30-publications/legal-tools/770-international-humanitarian-law-and-access-to-abortions-compilation-of-citations

[402] See for example United Kingdom Department for International Development, 'Government response: Abortion services in conflict situations' (11 February 2013), www.gov.uk/government/news/abortion-services-in-conflict-situations; France, Statement of Ambassador Araud at the United Nations Security Council, 25 April 2014. See also, Norwegian Agency for Development Cooperation, (2011) 'Sexual violence in conflict and the role of the health sector', p. 12, norad.no/globalassets/import-2162015-80434-am/www.norad.no-ny/filarkiv/vedlegg-til-publikasjoner/sexual-violence-in-conflict-and-the-role-of-the-health-sector.pdf; see also Global

Commission[403] and the EU parliament[404] have likewise recognized such an international humanitarian law obligation in policy papers and resolutions, as has the UN Secretary-General in several reports to the UN Security Council.[405] Furthermore, while not explicitly recognizing a particular international humanitarian law obligation related to abortion services, UN Security Council resolutions have referred to the need for "the full range" of sexual and reproductive health-care services for survivors of conflict-related sexual violence.[406] Recommendations on providing abortion services have also been increasingly incorporated into humanitarian guidance.[407]

Recognizing an international humanitarian law obligation to ensure access to safe abortion is particularly important as this body of law regulates the actions of all parties to a conflict, including both state parties and non-state armed groups (human rights law, in comparison, is primarily directed towards states). It is generally agreed that when parties to the conflict, armed groups are prohibited by international humanitarian law from engaging in any action or behaviour that would prevent the delivery of health care to the civilian population, and are obliged to take the necessary measures to ensure safe access to, and safe delivery of, health care.[408] Accordingly, as part of their obligations, armed groups must also refrain from preventing the delivery of abortion services and must take active steps to ensure safe access and delivery of such services, at least in certain circumstances.

International criminal law also applies to both state and non-state actors. Certain serious violations committed in the context of armed conflict are war crimes, for which individuals, whether military or civilian, may be held criminally responsible.[409] Additionally, individuals can be criminally liable for crimes against humanity – certain acts, carried out as part of a widespread or systematic attack on the civilian population, whether committed in armed conflict or peacetime.[410] Unlawfully confining an individual forcibly made pregnant in order to deny them access to abortion may constitute the crime of forced pregnancy, a war crime or crime against humanity.[411] In some circumstances, denial of abortion may also constitute the crimes against humanity of torture, persecution or other inhumane acts; or the war crimes of torture or of inhuman treatment.

Justice Center, Press Release, 'Netherlands affirms right of women raped in armed conflict to abortions as part of necessary medical care under international law' (9 April 2013), globaljusticecenter.net/press-center/press-releases/223-netherlands-affirms-right-of-women-raped-in-armed-conflict-to-abortions-as-part-of-necessary-medical-care-under-international-law-223

[403] Policy Position of the European Commission, September 2015. The position states that "where a pregnancy threatens a woman or girl's life or causes unbearable suffering, international humanitarian law and/or human rights law may justify the offering of a safe abortion rather than perpetrating what amounts to inhumane treatment".

[404] See for example European Parliament resolution of 9 July 2015 (2014/2229(INI)).

[405] See for example Report by the Secretary-General on Women, Peace and Security, UN Doc. S/2017/861 (16 October 2017) and UN Doc. S/2013/525 (4 September 2013).

[406] See UN Security Council Resolution 2122, preamble, UN Doc. S/RES/2122 (18 October 2013) and UN Security Council Resolution 2106, para. 19, UN Doc. S/RES/2106 (24 June 2013).

[407] See for example, the 2018 revisions of the *Sphere handbook* and the 2018 *Inter-Agency field manual on reproductive health*, the latter of which specifically recognizes international humanitarian law on p. 60, iawg.net/wp-content/uploads/2019/01/2018-inter-agency-field-manual.pdf

[408] ICRC, (2015), 'Safeguarding the provision of health care: Operational practices and relevant international humanitarian law concerning armed groups', 15, shop.icrc.org/les-groupes-armes-et-la-protection-des-soins-de-sante-2144.html

[409] For a list of war crimes see the Statute of the International Criminal Court, Article 8; see also ICRC Customary IHL, rule 156.

[410] Statute of the ICC, Article 7.

[411] For Amnesty International's legal commentary on the crime of forced pregnancy see Amnesty International, *Forced pregnancy. A commentary on the crime in International Criminal Law* (Index IOR 53/2711/2020).

Amnesty International therefore:

- Emphasizes that state obligations under international human rights law to decriminalize abortion and ensure access to safe abortion remains fully applicable in armed conflict contexts.
- Welcomes an evolving recognition that international humanitarian law also provides all parties to an armed conflict with a complementary duty to ensure access to safe abortion, at least in certain circumstances.
- Stresses that, in some circumstances, denial of abortion may also constitute a crime under international law for which individuals may be criminally liable.

ANNEX II: KEY PRINCIPLES – UPDATE OF AMNESTY INTERNATIONAL'S POLICY ON ABORTION (2018 AMNESTY GLOBAL ASSEMBLY DECISION 2)

The Global Assembly:

Requests the International Board to adopt a policy that seeks to guarantee the human rights of women and girls, and all people who can get pregnant,[412] based on the following principles:

1. **Rights holders at the centre.** Amnesty International will affirm pregnant persons' reproductive autonomy, and that laws, policies and practices must not restrict their ability to make decisions related to their pregnancies. All legal, policy and other regulatory measures on abortion should respect, protect and fulfil the human rights of pregnant persons, not force them to undertake unsafe abortions or prevent them from obtaining a safe abortion.
2. **Non-discrimination and equality.** Amnesty will focus on the discriminatory impact of abortion-related laws and policies and advocate that no one's status as a rights holder and equal subject of the law may be suspended, diminished or mandatorily set aside because of pregnancy or having had an abortion.
3. **A comprehensive approach to abortion rather than solely focusing on selected aspects of abortion.** Amnesty International's policy will approach abortion in a comprehensive manner to enable us to fully respond to the lived realities of all those whose rights are affected by abortion laws, policies and practices, and the stigma, discrimination and stereotyping that they manifest in various contexts
4. **Legal protection of human rights**. Amnesty International's policy will be grounded in international human rights law and principles, and affirm that the legal protection of human rights, including the right to life, commences at birth.
5. **Acknowledgement of the range of beliefs around abortion**. Amnesty International will not contribute to or promote judgement or disrespect of individuals' moral, ethical or religious beliefs around abortion, in line with the organization's policy on impartiality and independence from any political ideology or religion. Amnesty International does not take a position on when a human life begins – which is a moral and ethical issue for each individual to decide for themselves in line with their conscience.
6. **States' obligations to provide comprehensive health services and information.** The provision of abortion-related information and services is part of comprehensive health care and requires functioning health-care systems. Human rights law further requires that people enjoy the benefits of scientific progress, can access quality health information, facilities, goods and services, including comprehensive sexual and reproductive health services, modern methods of contraception, information

[412] Throughout this motion we refer sometimes to "women and girls" and sometimes to "people who can get pregnant." The updated policy should recognize that whilst the majority of personal experiences with abortion relate to cisgender women and girls (women and girls who were assigned the female sex at birth), intersex people, transgender men and boys, and people with other gender identities may have the reproductive capacity to become pregnant and may need and have abortions.

and comprehensive sexuality education, and that barriers to abortion access are removed.

7. **Full realization of economic, social and cultural rights of all people.** States must ensure pregnant people have information about and access to services and support, including health care, social security and means to obtain an adequate standard of living, so that they are empowered to make their own choices about whether to carry their pregnancy to term, and that they are not compelled to seek recourse to abortion due to denial of their economic and social rights.
8. **Challenging the root causes of discrimination.** Amnesty will challenge social systems that discriminate, deny personal and bodily autonomy and impose unequal burdens based on individuals' reproductive capacities and their pregnancy status. We will emphasize the importance of challenging these social systems and that tackling criminalization of abortion and abortion-related human rights violations is central to that challenge.
9. **Opposing biased and discriminatory practices and calling for transformative equality.** We will challenge, rather than reinforce, gender stereotyping and discrimination, abortion-related stigma and attacks on scientific evidence. We will promote transformative equality and challenge social norms and attitudes that shape discriminatory and harmful abortion laws, policies and practices.
10. **Addressing intersectional discrimination.** Those who face human rights violations due to their pregnancy status and barriers to abortion services include cisgender women and girls, intersex people, transgender men and boys, and people of other gender identities who have the reproductive capacity to become pregnant. Amnesty's policy will take into account the impact of intersectional discrimination faced by certain groups and individuals.[413]
11. **Contributing to the evolution of international human rights law.** We will seek to contribute to the progressive development of international human rights law and standards and combat retrogressive normative developments. Our work will be guided by the fundamental principles on which international human rights law is founded, such as bodily integrity, autonomy, privacy, equality, dignity, social and gender justice, participation and accountability.

[413] For example, children, people living with disabilities, lesbian, bisexual, transgender and intersex people, gender non-conforming individuals, those living in rural areas and/or in poverty, Indigenous peoples and racial and ethnic minorities, among others, are often differently impacted by abortion laws, policies and practices.