

# Gender inequalities and violence against women's health during the CoViD-19 pandemic: an international law perspective

Sara De Vido\*

GENDER INEQUALITIES AND VIOLENCE AGAINST WOMEN'S HEALTH DURING THE COVID-19 PANDEMIC: AN INTERNATIONAL LAW PERSPECTIVE

**ABSTRACT:** This article explores the impact of the CoViD-19 pandemic, and the measures adopted in response to it, on women's rights to health and reproductive health. It will argue that the pandemic has exacerbated systemic and deeply entrenched gender inequalities, and that it has been used as an excuse to restrict women's rights to health and reproductive health through policies and laws whose declared purpose was to address the health emergency. It will provide examples of State practice in the field of access to abortion and maternal health and contend that States have legal obligations under international human rights law to guarantee access to these rights, also during emergencies.

**KEYWORDS:** Reproductive health; abortion; obstetric violence; violence against women; pandemic

**SUMMARY:** 1. Introduction – 2. Why women's rights to health and reproductive health - 2.1. Feminist approaches to the rights to health and reproductive health – 2.2. Definitional framework: Health, sexual and reproductive health rights, family planning and fertility regulation – 2.3. Violence against women's health and reproductive health: Challenges in times of pandemic – 3. Access to abortion and post-abortion services in times of COVID-19 – 3.1. Access to abortion at the international level: Introductory notes – 3.2. When abortion is not considered as "essential": The pandemic as an excuse to limit women's access to the procedure – 3.3. When chemical abortion is performed in hospital only and restricted in times of pandemic – 3.4. States' obligations in times of emergency with regard to access to abortion services – 4. Obstetric violence in times of pandemic – 4.1. Obstetric violence in international human rights law: Introductory notes – 4.2. Examples taken from the practice – 4.3. States' obligations in times of emergency with regard to obstetric violence prevention – 5. Concluding remarks.

## 1. Introduction

The United Nations (UN) Secretary General Antonio Guterres issued a policy brief on 9 April 2020 in which he particularly stressed the multiple impacts of the CoViD-19 pandemic on women and girls, and that these impacts have been further amplified in contexts of fragility, conflicts, and emergency<sup>1</sup>. The United Nations Entity for Gender Equality and the Empowerment

\* Sara De Vido, Associate Professor of International Law, Ca' Foscari University of Venice, Italy; affiliate, Manchester International Law Centre, UK. Mail: [sara.devido@unive.it](mailto:sara.devido@unive.it). The article was subject to a double-blind peer review process.



of Women (UN Women) reported that 243 million women and girls globally (aged 15-49) have been subjected to sexual or physical violence by an intimate partner in the last twelve months, and that data available regarding the last months have shown that, since the outbreak of the pandemic, violence against women (VAW) and girls has intensified<sup>2</sup>. The UN Women Director has defined the disproportionate impact of CoViD-19, and the measures in response to it, as a «shadow pandemic»<sup>3</sup>, an expression that was also used by the Council of Europe in a seminar held on 20. May 2020<sup>4</sup>. In Italy, for example, the National Institute of Statistics (ISTAT) has recently published new data regarding the lockdown period, from March to June 2020, demonstrating that the number of calls to 1522, the free number aimed at helping victims of violence and stalking, has doubled compared to the same period of last year (+119,6%), shifting from 6.956 to 15.280 calls<sup>5</sup>. In the UK, femicides within the households have more than doubled between 23 March and 12 April 2020, compared to the average rate of the previous decade<sup>6</sup>. In China, a police department in Jianli County, Hubei, declared that the number of domestic cases tripled in February 2020, compared to the same month of the previous year<sup>7</sup>. In India, the National Commission for Women reported an increase by 94 percent of complaints for domestic violence during the lockdown<sup>8</sup>. These are a few illustrative examples of the increase in intimate partner violence abuses within the household in times of pandemic.

Other data presented by international bodies and non-governmental organisations have demonstrated the disproportionate impact of the measures adopted in times of pandemic on migrant women, women that have been trafficked, and girls forced into child marriages and to drop school to take care of the family<sup>9</sup>. This data represents the «intersectional» impact of the COVID-19 pandemic

<sup>1</sup> UN SG, *The Impact of COVID-19 on Women*, 9 April 2020, <https://www.unwomen.org/en/digital-library/publications/2020/04/policy-brief-the-impact-of-covid-19-on-women> (last accessed on 26. August 2020).

<sup>2</sup> COVID-19 and Ending Violence Against Women and Girls, <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006> (last accessed on 26. August 2020).

<sup>3</sup> P. MLAMBO-NGCUKA, *Executive Director of UN Women, Violence against Women and Girls: The Shadow Pandemic*, 6 April 2020, <https://www.unwomen.org/en/news/stories/2020/4/statement-ed-phumzile-violence-against-women-during-pandemic> (last accessed on 26. August 2020).

<sup>4</sup> Webinar of 20. May 2020, available here <https://www.coe.int/en/web/istanbul-convention/webinar> (last accessed on 26. August 2020).

<sup>5</sup> <https://www.istat.it/it/archivio/246557> (last accessed on 26. August 2020).

<sup>6</sup> J. GRIERSON, *Domestic Abuse Killings «more than double» amid COVID-19 Lockdown*, in *The Guardian*, 15 April 2020, <https://www.theguardian.com/society/2020/apr/15/domestic-abuse-killings-more-than-double-amid-covid-19-lockdown> (last accessed on 26. August 2020).

<sup>7</sup> B. ALLEN-EBRAHIMIAN, *China's Domestic Violence Epidemic*, in *Axios*, 7 March 2020 <https://www.axios.com/china-domestic-violence-coronavirus-quarantine-7b00c3ba-35bc-4d16-afdd-b76ecfb28882.html> (last accessed on 26. August 2020).

<sup>8</sup> See, also, in India, S. NIGAM, *COVID-19: India's Response to Domestic Violence Needs Rethinking*, 14 May 2020, <http://southasiajournal.net/covid-19-indias-response-to-domestic-violence-needs-rethinking/> (last accessed on 26. August 2020).

<sup>9</sup> See, for example, IOM, *Covid 19 and Women Migrant Workers*, Geneva, 2020; UNODC, *Impact of the COVID-19 Pandemic on Trafficking in Persons. Preliminary Findings and Messaging Based on Rapid Stocktaking*, Vienna, 2020; *COVID-19 and Women's Rights*, conference panel, <https://bit.ly/33REmWS> (last accessed on 26. August 2020); *COVID-19 & The Increase in Gender Based Violence & Discrimination Against Women*, Joint call by the EDVAW Platform of independent United Nations and regional expert mechanisms on violence against

and related lockdowns, which have had a disproportionate impact on women and girls, intersecting multiple forms of discrimination.

The «shadow pandemic» is even shadier when it comes to the impacts of the measures adopted in response to CoViD-19 on women's health and reproductive health, though. We are not referring here to the mortality rate of women affected by the CoViD-19, which is generally lower than men<sup>10</sup>, but, as the Special Rapporteur on Violence against Women acknowledged, to «restrictions on the provision of health-care services that are essential to women and girls»<sup>11</sup>. This contribution will specifically approach this latter – less explored by legal scholarship – topic, reflecting from an international human rights law perspective on how the measures adopted in response to the pandemic have affected women's rights to health and reproductive health. It will argue that the pandemic has exacerbated systemic and deeply entrenched gender inequalities, and it has been used as an excuse to restrict women's rights to health and reproductive health. It will also contend that States have legal obligations under international human rights law to guarantee access to these rights, in times of peace as well as in times of emergency. This article will first explain the reason underlying the choice of focusing on women's rights to health and reproductive health, stressing on one hand the intersectional elements of patterns of discrimination persistent in the recognition of those women's rights and, on the other hand, their complex evolution. It will then delve into specific forms of «violence against women's health»<sup>12</sup>, as it will be explained below, in times of pandemic, namely lack of access to abortion and obstetric violence. This article will investigate State practice during the lockdown months with regard to these two forms of violence and highlight obligations States must abide by, referring to relevant human rights jurisprudence and quasi-jurisprudence<sup>13</sup>.

## 2. Why women's rights to health and reproductive health

It was 1994 when Mahmoud Fathalla, a professor of obstetrics and gynaecology and Chair of the World Health Organisation (WHO) Advisory Committee on Health Research, acknowledged that «society is not neutral with regard to reproductive rights», and that in many societies, «the predominant objection against contraceptive use was directed at contraceptive control by women, rather than

---

women and women's rights on combating the pandemic of gender based violence against women during the COVID-19 crisis, 14 July 2020, <https://bit.ly/3iQts89> (last accessed on 26. August 2020).

<sup>10</sup> In Italy, for example, according to ISTAT, the female mortality rate is 42 per cent, [https://www.istat.it/it/files/2020/07/Rapp\\_Istat\\_Iss\\_9luglio.pdf](https://www.istat.it/it/files/2020/07/Rapp_Istat_Iss_9luglio.pdf), 6.

<sup>11</sup> Report of the Special Rapporteur on violence against women, its causes and consequences, Dubravka Šimonović, *Intersection between the coronavirus disease (COVID-19) pandemic and the pandemic of gender-based violence against women, with a focus on domestic violence and the "peace in the home" initiative*, 24 July 2020, A/75/144, para. 73. See also UN SG, *The Impact*, cit., 10. He also added that «the diversion of attention and critical resources away from these provisions may result in exacerbated maternal mortality and morbidity, increased rates of adolescent pregnancies, HIV and sexually transmitted diseases. In Latin America and the Caribbean it is estimated that an additional 18 million women will lose regular access to modern contraceptives, given the current context of COVID-19 pandemics».

<sup>12</sup> The concept was coined in the book S. DE VIDO, *Violence Against Women's Health in International Law*, Manchester, 2020, open access here <https://bit.ly/3IDKKqY>. See also below, para. 2.3.

<sup>13</sup> With the words 'quasi-jurisprudence', we refer to the non-binding decisions taken by UN treaty bodies, such as the Human Rights Committee and the CEDAW Committee.

against contraception itself»<sup>14</sup>. The same year, Rebecca Cook published a paper commissioned by the WHO on *Women's health and human rights*, in which she emphasised the «pervasive neglect of women's health»<sup>15</sup>. In 1995, Aart Hendriks contended that «woman's right to sexual and reproductive health is not only threatened by current expressions of deep-rooted, harmful practices-including sexual violence against women and girls, forced marriage, and female genital mutilation-but is also challenged by progress in reproductive medicine»<sup>16</sup>. It is noteworthy that almost twenty years after these outstanding contributions, Erin Nelson, in her work on reproductive autonomy, reflected on the fact that the «history of reproductive regulation is a history of attempting to enforce a traditional view of women as child-rearers»<sup>17</sup>. In 2016, the Working Group on the issue of discrimination against women in law and in practice, established at UN level, confirmed this view, by stating in its report that: «women's bodies are instrumentalized for cultural, political and economic purposes rooted in patriarchal traditions. Instrumentalization occurs within and beyond the health sector and is deeply embedded in multiple forms of social and political control over women. It aims at perpetuating taboos and stigmas concerning women's bodies and their traditional roles in society, especially in relation to their sexuality and to reproduction»<sup>18</sup>.

In other words, women's rights to health and reproductive health should not be taken for granted, since their acknowledgment faces enormous obstacles, most importantly in a time when these rights are being put into question and limited more than ever while invoking reasons of public health.

Reproductive rights are not only a component of the right to health<sup>19</sup> but also a major health topic of global concern and also a development and a human rights issue<sup>20</sup>. Yet the interest for the right to reproductive health only gained momentum in the 90s. The right to health indeed, as originally conceived in human rights legal instruments, «reflect[ed] a male-oriented conception of health», where issues related to reproductive health were «conspicuously absent»<sup>21</sup>. In particular, feminists have been concerned about the role of «paternalistic medicine», which assumes the incapacity of women to make choices on their own without professional recommendations<sup>22</sup> and have highlighted the fact

<sup>14</sup> M.F. FATHALLA, *The Impact of Reproductive Subordination on Women's Health Family Planning Services*, in *American University Law Review*, 44, 1994-1995, 1181-1182.

<sup>15</sup> R. COOK, *Women's Health and Human Rights*, Geneva, 1994, 5.

<sup>16</sup> A. HENDRIKS, *Promotion and Protection of Women's Right to Sexual and Reproductive Health under International Law: The Economic Covenant and the Women's Convention Conference on the Interventional Protection of Reproductive Rights: The Right to Health*, in *American University Law Review*, 44, 1995, 1127.

<sup>17</sup> E. NELSON, *Law, Policy, and Reproductive Autonomy*, Oxford, Portland, 2013, 66.

<sup>18</sup> Report of the Working Group on the issue of discrimination against women in law and in practice, A/HRC/32/44, 8 April 2016, para. 18.

<sup>19</sup> COMMISSION ON HUMAN RIGHTS, Resolution No. 2003/28, para. 6: «sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health».

<sup>20</sup> R.J. COOK, B.M. DICKENS, M.F. FATHALLA (eds), *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law*, Oxford, 2003, 9.

<sup>21</sup> A.R. CHAPMAN, *Conceptualizing the Right to Health: A Violation Approach*, in *Tennessee Law Review*, 65, 1998, 397.

<sup>22</sup> R.J. COOK, *Women's Health and Human Rights*, cit., 26.

that many health problems specifically related to women have not received specific attention<sup>23</sup>. Ruth Anna Putnam argued that medical research, in taking men's bodies to be the basic human bodies, has neglected women's health<sup>24</sup>. Commenting on this author's thought, Christine Korsgaard contended that «this of course is not because either developing or developed societies have ignored gender. It is because they have ignored women. That is another matter altogether»<sup>25</sup>. This argument is true, although it should be acknowledged that the subordinated status of women in almost all countries in the world facilitated, after World War II, State interventions «rendering the ordinary female body as a key political resource: available, malleable, and potent material to deploy in the biopolitical project of shaping the state's size, character, and place in the world»<sup>26</sup>. Hence, women were not ignored when the so-called «Reproductive States» decided to centre their reproductive health policies on female instrumentalised bodies at the expense of women's autonomy. According to Cook, «male-gendered' institutions – both at the political and religious level – have justified intervention in women's reproductive self-determination, by invoking public order, morality, and public health»<sup>27</sup>. When Cook wrote about the «pervasive neglect of women's health», and Virginia Leary affirmed that «women's health issues have been given less attention in medical research»<sup>28</sup>, they described a situation during the 1990s where the interest on reproductive rights started to raise, and still is present today, despite (or maybe also because of) the evolution of technology, and despite the change of habits, women's attitudes, and/or women's consciousness of their bodies and their autonomy. In times of pandemic, it has been clear how women's bodies can be instrumentalised under the guise of necessary actions against CoViD-19.

### 2.1. Feminist approaches to the rights to health and to reproductive health

The female body has been perceived in different ways over time. As stressed by Carole Bunch, «the importance of control over women can be seen in the intensity of resistance to laws and social changes that put control of women's bodies in women's hands: reproductive rights, freedom of sexuality whether heterosexual or lesbian, laws that criminalize rape in marriage, etc.»<sup>29</sup>. As anticipated above, States have exploited women's bodies to define their population policies, transforming into law the societal subjugation of women<sup>30</sup>.

The Women's Health Movement in the 60s and 70s in the US and Canada first challenged the biased view of women's health, denouncing «the medical profession's authority to control women's repro-

<sup>23</sup> A.R. CHAPMAN, *Monitoring Women's Right to Health under the International Covenant on Economic, Social and Cultural Rights*, in *American University Law Review*, 44, 1995, 1174.

<sup>24</sup> R.A. PUTNAM, *Why not a Feminist Theory of Justice?*, in M.C. NUSSBAUM, J. GLOVER (eds), *Women, Culture, and Development: A Study of Human Capabilities*, Oxford, 1995, 313.

<sup>25</sup> C.M. KORSGAARD, *A Note on the Value of Gender-Identification*, in M.C. NUSSBAUM, J. GLOVER (eds), *Women, Culture, and Development*, cit., 402.

<sup>26</sup> R. SOLINGER, M. NAKACHI, *Introduction*, in R. SOLINGER, and M. NAKACHI (eds), *Reproductive States*, Oxford, 2016, 3.

<sup>27</sup> R.J. COOK, *Gender, Health and Human Rights*, in *Health and Human Rights*, 1(4), 1995, 362.

<sup>28</sup> V. LEARY, *The Right to Health in International Human Rights Law*, in *Health and Human Rights*, 1(1), 1994, 38.

<sup>29</sup> C. BUNCH, *Women's Rights as Human rights: Toward a Re-Vision of Human Rights*, in *Human Rights Quarterly*, 12(4), 1990, 491.

<sup>30</sup> On the instrumentalisation of women's bodies, see also A/HRC/32/44, cit., para. 61.



ductive lives by regulating access to abortion and contraceptives»<sup>31</sup>. Women told stories, gathered in the volume *Our Bodies, Ourselves*, of «condescending, judgmental treatment, and of being lied to, sexually abused, overtreated, and ignored by their doctors»<sup>32</sup>. Gender biases led – and to some extent lead also today – to missed or inaccurate diagnoses. On the one hand, physicians considered that health complaints were attributable to emotional causes and not to physical ones<sup>33</sup>. On the other hand, female behaviours that conflicted with well-established rules in society were often attributed to various physical or mental illnesses<sup>34</sup>. Societal perceptions regarding women’s health statuses and women’s bodies often disadvantaged women. Hence, as it was pointed out, «the female body is a biological body, but it is also a gendered body and as such has a history»<sup>35</sup>. In other words, biology is *one* factor that shapes differences in male and female patterns of morbidity and mortality but not the only one. In a study regarding the United Kingdom dating back to 2003, it was clarified that gender differences in living and working conditions, including the woman being in charge of the household, «put males and females at differential risk of developing some health problems, while protecting them from others»<sup>36</sup>.

Issues regarding women’s reproductive health gained momentum during the UN Women’s Decade 1975-1985, when groups of women organised the International Tribunal on crimes against women in Brussels in 1976,<sup>37</sup> and the International Tribunal and Meeting on Reproductive Rights in Amsterdam in 1984.<sup>38</sup> Another wave of women’s health activism emerged in the 90s, led by women’s health advocacy groups and women who had attained positions of influence in the government, medical profession, academia, and health care delivery organisations. Their purpose was to promote equality for women in biomedical research and in health care delivery<sup>39</sup>. They adopted a broad view of women’s

<sup>31</sup> C.S. WEISMAN, *Changing Definitions of Women’s Health: Implications for Healthcare and Policy*, in *Maternal and Child Health Journal*, 1(3), 1997, 181.

<sup>32</sup> M. OBERMAN, M. SCHAPS, *Women’s Health and Managed Care*, in *Tennessee Law Review*, 65, 1998, 564, quoting the Boston Women’s Health Book Collective, the New *Our Bodies, Ourselves* (rev. ed. 2011). In May 1969, 12 women from 23 to 39 years old met during a women’s liberation conference at Emmanuel College in Boston, where they organised the workshop on Women and their Bodies. They published in 1970 the booklet *Women and their Bodies*, reprinted the next year with the title *Our bodies, Ourselves*. In the same direction, the Montreal Women’s Health Book Collective of 1972.

<sup>33</sup> M. OBERMAN, M. SCHAPS, *Women’s Health and Managed Care*, cit., 565.

<sup>34</sup> M. FOX, T. MURPHY, *The Body, Bodies, Embodiment: Feminist Legal Engagement with Health*, in M. DAVIES, V.E. MUNRO (eds), *The Ashgate Companion to Feminist Legal Theory*, Fernham, 2013, 253.

<sup>35</sup> W. MITCHINSON, *Agency, Diversity and Constraints: Women and their Physicians, Canada 1850-1950*, in S. SHERWIN (ed.), *The Politics of Women’s Health*, Philadelphia, 1998, 126.

<sup>36</sup> L. DOYAL, S. PAYNE, A. CAMERON, *Promoting Gender Equality in Health, Research and Resources Unit*, Equal Opportunities Commission, 2003, 9.

<sup>37</sup> See, for example, in the final report of the Tribunal, a woman’s testimony: «When R. tells us about her abortion, when she confesses the fears and inhibitions which she still has, when she talks about her constant sexual dissatisfaction, and when she reveals her state of submission, she also discloses the plight of each woman, dispossessed of her own body, submitting to the rules of a system which reduces her to a reproductive function or an object of pleasure» (*Crimes Against Women: Proceedings of the International Tribunal*, compiled and edited by D. E. H. RUSSELL, N. VAN DE VEN, 1976, 23).

<sup>38</sup> J.M. JOACHIM, *From the Margins to the Center—Women’s Rights, NGOs, and the United Nations*, in J.M. JOACHIM (ed.), *Agenda Setting, the UN, and NGOs. Gender Violence and Reproductive Rights*, Washington DC, 2007, 4.

<sup>39</sup> C.S. WEISMAN, *Changing Definitions of Women’s Health*, cit., 181.

health, focusing on issues beyond reproduction: women have a womb, but they cannot be identified with their womb. As posited by Catherine MacKinnon, women's capacity for and their role in childbearing have determined «the social disadvantages to which women have been subjected»<sup>40</sup>. A broad view of health was also endorsed by Fathalla, Cook and Dickens, who included in the notion of reproductive health the ability of women to enjoy mutually fulfilling relationships, freedom from sexual abuse, coercion or harassment: «health for women is more than reproductive health. Being a woman has implications for health. Women have specific health needs related to their sexual and reproductive functions, collectively expressed in the reproductive health package. Women have an elaborate reproductive system that is vulnerable to dysfunction or disease, even before it functions or after it ceases to function. Women are subject to the same diseases of other body systems that can affect men, but their disease patterns often differ from those of men because of women's genetic constitution, hormonal environment, or gender-evolved lifestyle behaviour [...] Because women are women, they are subject to social dysfunctions that impact on their physical, mental, or social health»<sup>41</sup>.

As pointed out by Purdy, women's bodies are socially determined<sup>42</sup>. Once «produced», the body «can then be invested with legal characteristics»: ownership, property, autonomy.<sup>43</sup> Granting women's autonomy is not merely ensuring freedom from interference<sup>44</sup>: it means to adopt measures aimed at effectively allowing women to exercise this autonomy. Susan Sherwin argued that «the institution of medicine has been designed in ways that reinforce sexism»<sup>45</sup>. She then elaborated a relational notion of autonomy, which is «socially situated or contextualized», meaning that «specific decisions are embedded within a complex set of relations and policies that constrain (or ideally promote) an individual's ability to exercise autonomy with respect to any particular choice»<sup>46</sup>. This view departs from the one elaborated by liberal feminists, who focused on the importance of personal autonomy and privacy, but also from the one of Carol Gilligan, who concentrated on interpersonal relations<sup>47</sup>. In her study on autonomy, Erin Nelson centred in on reproduction, placing women's bodily integrity at the centre; she stressed that decisions on bodily integrity «require the State to provide conditions which optimally permit the exercise of this aspect of reproductive autonomy»<sup>48</sup>. These conditions include, *inter alia*, the provision of basic obstetric services, access to abortion and post-

<sup>40</sup> C. MACKINNON, *Reflections on Sex Equality under Law*, in *Yale Law Journal*, 100, 1991, 1308.

<sup>41</sup> R.J. COOK, B.M. DICKENS, M.F. FATHALLA, *Reproductive Health and Human Rights*, cit., 9-10.

<sup>42</sup> L. PURDY, *Medicalization, Medical Necessity, and Feminist Medicine*, in *Bioethics*, 15(3), 2001, 253.

<sup>43</sup> C.F. STYCHIN, *Body Talk: Rethinking Autonomy, Commodification and the Embodied Legal Self*, in S. SHELDON, M. THOMSON (eds), *Feminist Perspectives on Health Care Law*, London, Sidney, 1998, 216.

<sup>44</sup> The right to health was earlier conceived as a right to be free from medical abuse and it was then transformed as a right to research on high-tech intervention for ailments particular to women. See in that respect N. JACOBSON, *The Feminist Critique of Medicine, Medicalization, and the Making of Breast Implant Policy*, in C. MAKHLOUF OBERMEYE (ed.), *Cultural Perspectives on Reproductive Health*, Oxford, 2001, 223.

<sup>45</sup> S. SHERWIN, *No Longer Patient: Feminist Ethics and Health Care*, Philadelphia, 1992, 18.

<sup>46</sup> S. SHERWIN, *A Relational Approach to Autonomy in Healthcare*, in S. SHERWIN (ed.), *The Politics of Women's Health*, Philadelphia, 1998, 32.

<sup>47</sup> C. GILLIGAN, *In a Different Voice: Psychological Theory and Women's Development*, Cambridge, 1982. See also L. MCLENNAN BROWN, *Feminist Theory and the Erosion of Women's Reproductive Rights: The Implications of Fetal Personhood Laws and In Vitro Fertilization*, in *Journal of Gender, Social Policy & the Law*, 13(1), 2005, 89.

<sup>48</sup> E. NELSON, *Law, Policy*, cit., 70.

abortion services, and the prohibition of medical practices that endanger women's health<sup>49</sup>. Laws that limit or prevent women from having access to reproductive health services should be challenged before national and regional courts, as well as before UN treaty bodies, as violating women's rights<sup>50</sup>.

## 2.2. Definitional framework: Health, sexual and reproductive health rights, family planning and fertility regulation.

A thorough analysis of the different terms – health, reproductive health, reproductive rights, sexual health, sexual rights – is beyond the scope of the research here, but language matters, especially when it is necessary to identify the content of human rights and legal obligations States must abide by. According to the 1946 WHO Constitution, health is «a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity». The definition is extremely broad, since it includes the concept of social well-being<sup>51</sup>. Two years later, Article 25 of the Universal Declaration of Human Rights stated that «everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing». There was no reference to reproductive health and the gender-neutral language of provisions in international legal instruments was far from being achieved at that time (the use of *himself* and *his* was recurrent). The right to health was then included in Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR), which requires States to «recognize the right of everyone to the enjoyment of the highest standard of physical and mental health». This article includes, among States' obligations, «the provision for the reduction of the stillbirth rate and of infant mortality», which contains an indirect reference to women in their societal role as mothers. The «highest attainable standard of health» is also contemplated in Article 24(1) of the 1989 Convention on the Rights of the Child, and Article 25 of the Convention on the Rights of Persons with Disabilities of 2006. Regional instruments have contemplated the right to health referring to the «highest level of physical, mental and social well-being» (Protocol of San Salvador, Article 10(1)), the «effective exercise of the right to protection of health» (Article 11 of the European Social Charter), and the «best attainable state of physical and mental health» (African Charter on Human and Peoples' Rights, Article 16). A specific article of the ICESCR is devoted to the protection of mothers «before and after childbirth» (Article 10(2))<sup>52</sup>. CEDAW is the first human rights treaty which obliges States parties to ensure access to family planning, under Articles 12(1), 10(h), 14(2)(b), and 16(1)(e), as a measure against discrimination.<sup>53</sup> The right to health is enshrined in Article 12 CEDAW:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

<sup>49</sup> A.R. CHAPMAN, *Conceptualizing the Right to Health*, cit., 413-415.

<sup>50</sup> R. COOK, *International Human Rights and Women's Reproductive Health*, in *Studies in Family Planning*, 24(2), 1993, 74.

<sup>51</sup> A.R. CHAPMAN, *Global Health, Human Rights and the Challenge of Neoliberal Policies*, Cambridge, 2016, 36.

<sup>52</sup> B. SAUL, D. KINLEY, J. MOWBRAY, *The International Covenant on Economic, Social and Cultural Rights. Commentary, Cases and Materials*, Oxford, 2014, 796.

<sup>53</sup> R.J. COOK, V. UNDURRAGA, *Article 12*, in M.A. FREEMAN, C. CHINKIN, B. RUDOLF (eds), *The UN Convention on the Elimination of All Forms of Discrimination against Women*, Oxford, 2012, 320.



2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

As anticipated, reproductive health has been basically relegated to the fields of population and development, and «the pillars of reproductive rights – the rights to reproductive health care and to reproductive self-determination» – were excluded from the human rights framework, hence revealing «the biased lens with which human rights have traditionally been interpreted»<sup>54</sup>. Reproductive health was first conceived as a new paradigm in the Programme of Action elaborated during the International Conference on Population and Development (ICPD) held in Cairo in 1994 and defined as «a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes»<sup>55</sup>. It marked the emergence of the connection between human rights and health and linked health to objectives of social justice and respect for human dignity<sup>56</sup>. According to the programme, reproductive health entails individuals' «capability to reproduce and the freedom to decide if, when and how often to do so» and two rights are «implicit in this last condition», namely: a) the right of men and women «to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law»; b) the «right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant»<sup>57</sup>. Reproductive rights are based on the recognition of the basic right of all couples and individuals to «decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health»<sup>58</sup>. In the definition included in the Programme of Action, reproductive health «also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases»<sup>59</sup>. The WHO later elaborated a working definition of sexual health as «a state

---

<sup>54</sup> L. CABAL, J.M. TODD-GHER, *Reframing the Right to Health: Legal Advocacy to Advance Women's Reproductive Rights*, in A. CLAPHAM, M. ROBINSON (eds), *Realizing the Right to Health*, Zurich, 2009, 121; J. KAUFMAN, *Measuring Reproductive Health: From Contraceptive Prevalence to Human Development Indicators*, in L. REICHENBACH, M.J. ROSEMAN (eds), *Reproductive Health and Human Rights*, Pennsylvania, 2009, 74.

<sup>55</sup> Programme of Action adopted at the International Conference on Population and Development Cairo, 5–13 September 1994, para. 7.2. See also the Vienna World Conference, which, in 1993, considered for the first time women's rights as human rights. C. ROMANY, *On Surrendering Privilege: Diversity in a Feminist Redefinition of Human Rights Law*, in M. SCHULER (ed.), *From Basic Needs to Basic Rights: Women's Claims to Human Rights*, Washington D.C., 1995, 544.

<sup>56</sup> C. SHALEV, *Rights to Sexual and Reproductive Health – the ICPD and the Convention on the Elimination of all Forms of Discrimination against Women*, paper presented by the then CEDAW expert at the International Conference on Reproductive Health, Mumbai (India), 15-19 March 1998, <https://bit.ly/3nFFGE8> (last accessed on 26. August 2020).

<sup>57</sup> Cairo Program of action, cit., para. 7.2.

<sup>58</sup> Cairo Program of action, cit., para. 7.3.

<sup>59</sup> Ibid.

of physical, emotional, mental and social well-being in relation to sexuality»<sup>60</sup>. However, as correctly pointed out by the then Special Rapporteur on the right to health, Paul Hunt, «since many expressions of sexuality are non-reproductive, it is misguided to subsume sexual rights, including the right to sexual health, under reproductive rights and reproductive health»<sup>61</sup>. Scholars agree on the fact that the Programme of Action determined a shift from a narrow focus on population policies and birth control to a broader notion of sexual and reproductive health relevant for the lives of men and women.<sup>62</sup>

As stated in the 1994 ICPD Declaration, family planning is placed within the framework of reproductive health care<sup>63</sup>. The following year, the Platform of Action adopted at the World Conference on Women held in Beijing stressed that women's health involves «their emotional, social and physical well-being» and that it is determined «by the social, political and economic context of their lives, as well as by biology»<sup>64</sup>. In other words, women's health was subject to social determinants<sup>65</sup>. The Platform also acknowledged that women and men are affected by the same health conditions, but «women experience it differently», owing to the social context in which they live, characterised by a limited power many women have over their reproductive lives<sup>66</sup>. The Beijing Platform, building on the previous ICPD in Cairo, identified the human rights encompassed in the notion of reproductive rights as follows: a) the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; b) the right to attain the highest standard of sexual and reproductive health; c) the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents<sup>67</sup>. These rights «should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning»<sup>68</sup>. Family planning and fertility regulation are meant to be two distinct notions, the former concerning the number, spacing and timing of their children, the latter including «a comprehensive range of contraceptive means»<sup>69</sup>.

Reproductive health is conceived as broader than «fertility regulation» and «family planning», and it expands «beyond a focus on controlling births, since it incorporates an awareness of the social and

<sup>60</sup> WHO, *Sexual Health, Human Rights and the Law*, 2015, sect. 1.1. On sexual autonomy as the right to choose to have a sexual intercourse and the right to refuse it, see S. SCHULHOFER, *Unwanted Sex: The Culture of Intimidation and the Failure of Law*, Cambridge, Mass. and London, 1998.

<sup>61</sup> Special Rapporteur on the right to health, Paul Hunt, E/CN.4/2004/49, 16 February 2004, para. 55.

<sup>62</sup> M.J. ROSEMAN, L. REICHENBACH, *International Conference on Population and Development at 15 years: Achieving sexual and reproductive health and rights for all?*, in *Am J Public Health*, 100(3), 2010, 403-406; L.P. FREEDMAN, *Human Rights and the Politics of Risk and Blame*, in S. GRUSKIN, M. GRODIN, G. ANNAS, and S.P. MARKS (eds.), *Perspectives in Health and Human Rights*, New York, 2005, 532-533.

<sup>63</sup> Cairo Declaration on Population & Development, ICPD, 4 September 1994, para. 5.

<sup>64</sup> Beijing Platform of Action, 1995, para. 89.

<sup>65</sup> See A. E. YAMIN, *Women's Health and Human Rights: Struggles to Engender Social Transformation*, in J.M. ZUNIGA, S.P. MARKS, L.O. GOSTIN (eds.), *Advancing the Human Right to Health*, Oxford, 2013, 277.

<sup>66</sup> Beijing Platform of Action, cit., para. 92.

<sup>67</sup> Ivi, para. 95.

<sup>68</sup> Ibid.

<sup>69</sup> Cairo Program of action, cit., para. 7.10. On the evolution of the concepts, see M.K. ERIKSSON, *Reproductive Freedom in the Context of International Human Rights and Humanitarian Law*, The Hague, 2000, 175 ss.

economic context in which reproduction and child bearing is carried out, and puts it in the context of gender equality and the empowerment of women»<sup>70</sup>. In turn, sexual health can be considered as broader than reproductive health, since it includes, for example, the choice of the sexual partner but also the right to sexual pleasure<sup>71</sup>. Reproductive health and sexual health are realised through the promotion and protection of sexual and reproductive rights. In particular, dealing with reproductive health issues means – Maja Eriksson argued – to «address the reproductive rights of women and men and the social behavior and cultural practices that affect reproductive health outcomes»<sup>72</sup>.

### 2.3. Violence against women's health and reproductive health: challenges in times of pandemic

In a recent book, we have coined the expression «violence against women's health» (VAWH), which is meant to grasp two dimensions of violence linked to women's rights to health and reproductive health: the violation of the right to health is a consequence of violence (horizontal, inter-personal dimension), as much as (State) health policies might cause – or create the conditions for – VAW (vertical dimension). The horizontal dimension aims to consider interpersonal relations, whereas the vertical dimension encompasses state health policies and laws. Violence against *women's health* constitutes a violation of *women's right to health* and *right to reproductive health*<sup>73</sup>. VAWH is a form of discrimination against women *because* they are women and/or it affects women disproportionately, and it is structural, meaning that this form of violence is rooted in society, and based, as explained by the 2011 Council of Europe Istanbul Convention, on the «crucial social mechanisms by which women are forced into a subordinate position compared with men». From a legal point of view, the structural aspect of VAWH can be seen in «patterns of discrimination», which mean not just social and cultural patterns that are rooted in society, but also the persistence of and the «tolerance» States demonstrate towards VAW, and in particular to VAWH. The «societal» pattern of discrimination and the «State» pattern of discrimination are, needless to say, interconnected and mutually reinforcing. This distinction is pivotal in terms of States' obligations: the State has legal obligations to prevent VAWH by changing cultural patterns that consider the woman as subordinated to the man, but it also has obligations to disrupt the «pattern of discrimination» represented by laws and policies in the health field that, directly or indirectly, perpetuate the stereotyped gender roles of women and men in society, and thereby cause violence.

VAWH is a form of «intersectional» discrimination against women, intersecting multiple forms of discrimination. As it is known, the concept of «intersectionality» was first introduced by Kimberlé Crenshaw in the late 1980s, to stress the specific conditions of Black women in US society. It is not a concept that applies to marginalised groups only, it is rather «an aspect of social organisation that shapes our lives» with the consequence that «groups may be advantaged or disadvantaged by struc-

---

<sup>70</sup> M.K. ERIKSSON, *Reproductive Freedom*, cit., 174. An author has used the expression right to reproductive choice as «a composite right including the rights to found a family, to decide the number and spacing of one's children and to seek and obtain family planning information and services»: C. PACKER, *Defining and Delineating the Right to Reproductive Choice*, in *Nordic Journal of International Law*, 67, 1998, 94-95.

<sup>71</sup> L. REICHENBACH, M.J. ROSEMAN, *Global Reproductive Health and Rights: Reflecting on ICPD*, in R. REICHENBACH, M.J. ROSEMAN (eds), *Reproductive Health and Human Rights*, Philadelphia, 2009, 5.

<sup>72</sup> M.K. ERIKSSON, *Reproductive Freedom*, cit., 174.

<sup>73</sup> S. DE VIDO, *Violence against Women's Health*, cit., 134.

tures of oppression»<sup>74</sup>. Intersectionality has not had much attention in legal scholarship, though. Defined as an «analytical tool»<sup>75</sup>, it has rarely been invoked in court. Lorena Sosa considered intersectionality «a tool for interpreting human rights in general, and for violence against women in particular, consisting of an explicit interdisciplinary approach to the study of race, gender, class and other social categories of distinction»<sup>76</sup>. This concept, she argues, captures the «socio-structural nature of inequality». From a legal point of view, intersectionality can be used as «interpretative methodology» for exploring international legal norms on VAW<sup>77</sup>, and for «empowering these norms»<sup>78</sup>. Never sufficiently explored, not even by the most advanced human rights courts, intersectionality could shape the way in which the violation of human rights is assessed and against which related reparations can be measured. Patterns of discrimination have exacerbated during the pandemic, showing the rooted causes of discrimination against women and girls and their intersectional character<sup>79</sup>. We will see how and to what extent in the forms of VAWH that we will propose in the next paragraphs.

### 3. Access to abortion and post-abortion services in times of CoViD-19

This paragraph, after a short introduction on access to abortion services in international human rights law (3.1), will discuss the executive orders adopted in several American states in response to the pandemic which have jeopardised women's access to abortion services (3.2), and the policies followed in Italian hospitals with regard to abortion procedures in the past months (3.3), before reflecting on States' obligations in times of health emergency. In the following sub-paragraphs, we are neither discussing foetal personhood nor the compatibility of laws that criminalise or decriminalise abortion with international human rights law, which go beyond the scope of this article<sup>80</sup>. We are rather focusing on those States where abortion is legal under certain circumstances, but policies and laws adopted (or reinforced) during the pandemic have prevented women from having access to abortion and post-abortion services during the lockdown.

<sup>74</sup> S. LAUREL WELDON, *Intersectionality*, in G. GOERTZ and A.G. MAZUR (eds), *Politics, Gender, and Concepts*, Cambridge, 2008, 195.

<sup>75</sup> J.C. NASH, *Re-Thinking Intersectionality*, in *Feminist Review*, 89, 2008, 1.

<sup>76</sup> L. SOSA, *Intersectionality in the Human Rights Legal Framework on Violence Against Women*, Cambridge, 2017, 15. See also B.G. BELLO, *Intersezionalità. Teorie e pratiche tra diritto e società*, Milano, 2020.

<sup>77</sup> See the analysis of legal instruments in L. SOSA, *Intersectionality*, cit.

<sup>78</sup> L. SOSA, *Intersectionality*, cit., 33, referring to the work by M. SATTERTHWAIT, *Women Migrants' Rights under International Human Rights Law*, in *Feminist Review Labour Migrations: Women on the Move*, 77, 2004, 170.

<sup>79</sup> In this sense, see the Special Rapporteur on Violence against Women, *Intersections*, cit., paras. 81-88.

<sup>80</sup> Cfr. M.O. LITTLE, *Abortion and Margins of Personhood*, in *Rudgers Law Journal*, 39, 2007-2008, 331; A. MADRAZO, *Narratives of Prenatal Personhood in Abortion Law*, in R.J. COOK, J.N. ERDMAN, B.M. DICKENS (eds), *Abortion Law in Transnational Perspective: Cases and Controversies*, Philadelphia, 2014, 327; S. DE VIDO, *Violence against Women's Health*, cit., 59.

### 3.1. Access to abortion at the international level: Introductory notes

At the international level, it is hard to argue that abortion is a stand-alone right<sup>81</sup>. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) is the only legally binding instrument which openly acknowledges «the reproductive rights of women» and authorises medical abortion «in cases of sexual assault, rape, incest, and where continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus»<sup>82</sup>. This provision directly «situat[es] abortion as a human right that is recognised in the substantive provisions of a regional treaty»<sup>83</sup>. Where other explicit provisions are not present in regional and international legal instruments, women's right to have access to abortion services is protected by international human rights law, under which denial of abortion amounts to a violation of women's rights. The criminalisation of abortion, in particular a criminalisation without exceptions, is an example of VAW, and, we argue, also of VAWH, that originates from a State health policy. The close relation between the criminalisation of abortion and the rights to health and reproductive health has been clearly caught by Rebecca Cook: «when a state criminalizes induced abortion[...], it is constructing its social meaning as inherently wrong and harmful to society. Through criminal prohibition, a state is signalling conditions in which abortion is criminally wrong, reflecting the historical origin of crime in sin that can and should be punished. In contrast, the legal framing of abortion as a health issue constructs meanings of preservation and promotion of health. A state is signalling that abortion is a public health concern, and should be addressed as a harm reduction initiative»<sup>84</sup>.

The Working Group on the issue of discrimination against women in law and in practice has correctly categorised the control exercised by the State over decisions taken by women as a form of «instrumentalization of women's body»: «patriarchal negation of women's autonomy in decision-making leads to violation of women's rights to health, privacy, reproductive and sexual self-determination, physical integrity and even to life»<sup>85</sup>. Instrumentalisation includes the discriminatory use of criminal law, such as provisions on termination of pregnancy, the enforcement of which «generates stigma and discrimination»<sup>86</sup>. Even though there is no right to abortion clearly encapsulated at the international level as human right, States have legal obligations to provide abortion and post-abortion services to women in need. These obligations have been identified by regional human rights jurisprudence and the quasi-jurisprudence of UN treaty-based bodies. Hence, for example, human rights courts and UN treaty bodies have contended that States must decriminalise abortion at least when it

<sup>81</sup> R. SIFRIS and S. BELTON, *Australia: Abortion and Human Rights*, in *Health and Human Rights Journal*, 19, 2017, 210.

<sup>82</sup> Article 14(2)(c).

<sup>83</sup> C.G. NGWENA, *Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa*, in *Human Rights Quarterly*, 32(4), 2010, 810.

<sup>84</sup> R.J. COOK, *Stigmatized Meanings of Criminal Abortion Law*, in R.J. COOK, J.N. ERDMAN, B.M. DICKENS (eds), *Abortion Law in Transnational Perspective*, cit., 347.

<sup>85</sup> A/HRC/32/44, para. 63.

<sup>86</sup> Ivi, para. 76.



follows rape, sexual violence and/or incest<sup>87</sup>, and in cases of severe malformation of the foetus and risks to the life or health (including mental health) of the pregnant woman. States maintain room to manoeuvre, the «margin of appreciation» as defined by the jurisprudence of the European Court of Human Rights (ECtHR), in deciding to what extent abortion can be legally limited, provided that denial of abortion does not cause VAWH, in terms of intense suffering, specifically a «high level of mental anguish», connected to an «intense stigma and loss of dignity» for the pregnant woman<sup>88</sup>. In terms of negative obligations, States must also refrain from adopting laws that oblige practitioners to give «false, misleading, and irrelevant» information to a woman seeking access to abortion<sup>89</sup>. Informed consent is a «process [...] intended to ensure that a patient is left alone to make decisions based on a set of medical facts free from direct coercion»<sup>90</sup>. Laws must ensure appropriate and objective counselling, in order to allow women to make free decisions, without coercion, and ensure confidentiality. In *L.C. v. Peru*, the CEDAW Committee argued that, when it comes to State intervention in a personal decision, «such intervention should be legal and regulated in such a way that, following due process, the person affected has the right to be heard», and added that «the contrary situation constitutes a violation of the right of protection from arbitrary interventions in decisions that, in general, are based in the intimacy and autonomy of each human being»<sup>91</sup>. In terms of access to abortion services, the *L.C.* decision paves the way for an in-depth consideration of what positive obligations to provide access to health services entail in the context of abortion. The Committee acknowledged that *L.C.*, a girl that was raped and, after attempting suicide and being severely injured denied a timely abortion, had been the victim of «exclusions and restrictions in access to health services based on a gender stereotype that understands the exercise of a woman's reproductive capacity as a duty rather than a right»<sup>92</sup>. The Committee considered that, since therapeutic abortion was legalised, the State must establish «an appropriate legal framework that allows women to exercise their right to it under conditions that guarantee the necessary legal security, both for those who have recourse to abortion and for the health professionals that must perform it»<sup>93</sup>. Furthermore, in the recommendations included in the decision, the Committee required the State to: «[r]eview its laws with a view to establish[ing] a mechanism for effective access to therapeutic abortion under conditions that protect women's physical and mental health and prevent further occurrences in the future of violations similar to the ones in the present case<sup>94</sup>. »

<sup>87</sup> See, for example, *L.C. v. Peru*, CEDAW/C/50/D/22/2009 (2011), Communication No. 22/2009 (CEDAW), para. 8.18. See also General Comment (GC) No. 36 on the Right to Life (Human Rights Committee), 30 October 2018, para. 8.

<sup>88</sup> *Amanda Jane Mellet v. Ireland*, CCPR/C/116/D/2324/2013 (2016), Communication No. 2324/2013 (HRC), and GC No. 36 (HRC), cit., para. 8.

<sup>89</sup> S. DE VIDO, *Violence against Women's Health*, cit., 141.

<sup>90</sup> P. LAUFER-UKELES, *Reproductive Choice and Informed Consent: Fetal Interests, Women's Identity, and Relational Autonomy*, in *American Journal of Law and Medicine*, 37, 2011, 578. See also the special issue in *BioLaw Journal*, 1, 2019.

<sup>91</sup> *L.C.*, cit., para. 7.13.

<sup>92</sup> *L.C.*, cit., para. 7.7.

<sup>93</sup> *L.C.*, cit., para. 8.17.

<sup>94</sup> *L.C.*, cit., para. 9(b)(i).

Access to abortion services must also encompass post-abortion services, including counselling, medical care and psychological support.<sup>95</sup> In Ireland, at the time of *Mellet*, women could get access to abortion abroad, but no protection and coverage from the public healthcare system, no paid leave of absence, nor support from public or private insurance. Once back in Ireland, Amanda Mellet could obtain medical care, but no form of public-funded post-abortion counselling, which was eventually granted by an association. When denial of access to abortion causes VAWH, there is an obligation on the State not only to abstain from certain behaviours – in this case abstain from interfering if the woman decided to travel abroad to get access to the service – but also to provide services in order to avoid physical and psychological consequences for the woman<sup>96</sup>.

### 3.2. When abortion is not considered as «essential»: The pandemic as an excuse to limit women's access to the procedure

In times of pandemic, there have been several restrictions to women's access to abortion and post-abortion services. For example, in the United States, where the right to abortion is constitutionally granted as a consequence of the famous *Roe v. Wade* judgment rendered in 1973 by the US Supreme Court<sup>97</sup>, several US states have declared that abortion is a non-essential or elective health procedure, banning abortion procedures until the end of the emergency<sup>98</sup>. Ohio and Texas started, soon after the first coronavirus cases in the US, to declare that abortion is an elective medical procedure, and that it can be suspended in times of emergency. Other US states joined, including Mississippi, Louisiana, Oklahoma, and Alabama; these states being known for their restrictive abortion laws<sup>99</sup>. Some courts unequivocally stopped the attempt to jeopardise women's right to abortion, such as in Oklahoma<sup>100</sup>. The case of Texas is particularly interesting because it led to a series of (somewhat contradictory) decisions by the District court and the Court of Appeals challenging the legitimacy of the executive order issued by the governor of Texas. On 30 March 2020, the District Court for the Western District of Texas entered a temporary restraining order against the governor's executive order postponing non-essential surgeries and procedures until 21. April as applied to abortion procedure.<sup>101</sup> The decision was later considered «patently erroneous» by the 5th Circuit Court of Appeals, which applied the «Jacobson test»<sup>102</sup>, contending that «the bottom line is this: when faced with a society-threatening epidemic, a state may implement emergency measures that curtail constitutional rights

<sup>95</sup> *Mellet*, cit., para. 9.

<sup>96</sup> For further examples of States obligations, S. DE VIDO, *Violence against Women's Health*, chapter 3.

<sup>97</sup> 410 U.S. 113 (1973).

<sup>98</sup> In Alabama, Ohio and Tennessee, federal district courts have allowed clinics to provide abortion services. In Alaska, Arkansas, Iowa, Kentucky, Louisiana, Mississippi, West Virginia and Texas, the initially imposed restrictions have been withdrawn. See the updated cases in L. SOBEL, A. RAMASWAMY, B. FREDERIKSEN, A. SALGANICOFF, *State Action to Limit Abortion Access During the COVID-19 Pandemic*, 10 August 2020, <https://www.kff.org/coronavirus-covid-19/issue-brief/state-action-to-limit-abortion-access-during-the-covid-19-pandemic/> (last accessed on 26. August 2020).

<sup>99</sup> See, for example, US Supreme Court in *Whole Woman's Health et al. v. Hellerstedt, Commissioner, Texas Department of State Health Services, et al.*, Certiorari to the United States Court of Appeals for the Fifth Circuit No. 15–274. Argued March 2, 2016—Decided June 27, 2016.

<sup>100</sup> *South Wind Women's Center LLC v. Stitt*, No. CIV-20-277-G, 2020 WL 1677094, 2 (W.D. Okla., 6. April 2020)

<sup>101</sup> *Planned Parenthood Ctr. for Choice et al. v. Abbott*, 2020 WL 1502102, 4 (W.D. Tex. 30. March 2020)

<sup>102</sup> *Jacobson*, 197 U.S. at 31, 38.

so long as the measures have at least some «real or substantial relation» to the public health crisis» and are not «beyond all question, a plain, palpable invasion of rights secured by the fundamental law»<sup>103</sup>. The Court was not convinced that the bottom line had been reached because «all constitutional rights may be reasonably restricted to combat a public health emergency»<sup>104</sup>, and the order issued by the Governor of Texas only constituted a «temporary postponement» of non-essential medical procedures<sup>105</sup>. According to the Governor's executive order, an abortion in times of emergency could have been considered as legitimate only inasmuch as it was necessary to preserve the life or health of the pregnant woman. As Judge James L. Dennis contended, however, dissenting from the majority, «it is painfully obvious that a delayed abortion procedure could easily amount to a total denial of that constitutional right» and «in a time where panic and fear already consume our daily lives, the majority's opinion inflicts further panic and fear on women in Texas by depriving them, without justification, of their constitutional rights, exposing them to the risks of continuing an unwanted pregnancy, as well as the risks of travelling to other states in search of time sensitive medical care»<sup>106</sup>. The issue was tackled by the District court and the 5<sup>th</sup> Circuit Court of Appeals multiple times. In the order of 13 April 2020, the upper Court eventually confirmed the temporary restrictive order issued by the District Court with regard to the decision of the Governor as applied to *all* abortion procedure, hence denying the enforcement of this decision against medication abortions but kept the criticism against the legal reasoning followed by the lower court<sup>107</sup>.

Another controversial issue consists in having a negative CoViD-19 test within 48 hours prior to the beginning of the procedure. This requirement, which sounds *prima facie* reasonable to contain the pandemic, has posed enormous obstacles to women seeking abortion, owing to a lack of available rapid tests and the refusal to test asymptomatic individuals. In Arkansas, the Department of Health first ordered Little Rock Family Planning, the only clinic providing surgical abortions in the state, to cease the performance of abortions, unless they were necessary to protect the life or health of the patient<sup>108</sup>. The decision was challenged on trial, and then changed, allowing elective procedures subject to a negative CoViD-19 test within 48 hours prior to the beginning of the procedure. The state, as many others, was facing shortage of tests, tests were not rapid, and it proved to be very difficult to find a clinic testing asymptomatic patients. Hence, the problem was not the need for a CoViD-19 test but rather the *de facto* impossibility to have access to it. The American Civil Liberties Union filed a request with the District Court for a preliminary injunction aimed at protecting three patients close to the legal limit to obtain abortion. The association showed the difficulties encountered by several

<sup>103</sup> *Abbott*, 954 F.3d, No. 20-50264 (US Court of Appeals for the Fifth Circuit, 7 April 2020) <https://reproductiverights.org/sites/default/files/2020-04/5th%20cir%20granting%20mandamus%204-7-20.pdf> (last accessed on 26. August 2020), 12.

<sup>104</sup> *Ivi*, 15.

<sup>105</sup> *Ibid*, 18-19.

<sup>106</sup> *Ibid*, 46.

<sup>107</sup> [https://www.washingtonpost.com/context/5th-circuit-abortion-order-texas-4-13-20/15751fb0-1503-46e2-a119-3c36b1a5e9a1/?itid=lk\\_interstitial\\_manual\\_8](https://www.washingtonpost.com/context/5th-circuit-abortion-order-texas-4-13-20/15751fb0-1503-46e2-a119-3c36b1a5e9a1/?itid=lk_interstitial_manual_8) (last accessed on 26. August 2020). See also the concurring opinion by Judge Dennis: «The petitioners' stated desire to enforce GA-09 against medication abortions despite the executive order's apparent inapplicability is a strong indication that the enforcement is pretextual and does not bear a «real or substantial relation to the public health crisis» we are experiencing».

<sup>108</sup> L. SOBEL, A. RAMASWAMY, B. FREDERIKSEN, A. SALGANICOFF, *State Action*, cit.

Jane Does, two of them travelling from Texas and Louisiana, in having access to abortion procedures. On 7 May, the Court denied the request, recalling the Jacobson test and arguing that the directives issued as a response to the pandemic were not openly aimed at limiting abortion and that they were reasonable given the emergency. Despite acknowledging the limitations of constitutional freedoms, the judge showed that the measures were not disproportionate and that other comparable measures restricting fundamental rights had been adopted. The proposed examples were not comparable, though, because nothing can replace access to a timely abortion and the guarantee of the respect for the rights to health and reproductive health: the judge mentioned measures such as «threatening criminal prosecutions against people of faith, so that they cannot exercise their First Amendment right to freedom of religion», or «closing gun shops (*sic!*) so that people cannot exercise their Second Amendment right to own firearms»<sup>109</sup>. How these measures can be comparable to a medical procedure that is necessary within a certain period of time is hard to say. In a quite paternalistic way, which shows how women's autonomy is deemed as secondary, and how women are stereotypically treated with pity and sympathy, the judge concluded that «there is a strong urge to rule for them because they are extremely sympathetic figures, but that would be unjust»<sup>110</sup>. The Arkansas Department of Health later modified the timeframe to within 72 hours, then again to 120 hours, and, as of 1 August, the requirement for a negative test was removed.

### 3.3. When chemical abortion is performed in hospital only and restricted in times of pandemic

Even though access to abortion is not directly hampered by laws and orders specifically issued for the health emergency, its *de facto* access might be limited owing to the strain on the health systems caused by the pandemic. Social distancing, limited access to hospitals and health services, along with the obligation to self-declare during lockdowns the scope of one's journey, impair women's right to health and reproductive health. We will not delve here into the debate of conscientious objection because it is not specifically relevant for the times of emergency, being persistent at *all* times<sup>111</sup>. We will rather focus on the practice that was specifically adopted during the emergency. Hence, for example, during the lockdown, some Italian hospitals suspended abortion procedures, arguing that this action was in conformity with the Decrees of the Italian President of the Council of the Ministers adopted in times of pandemic, «illegitimately considering [abortion] as non-essential, even though the Italian Law No. 194 includes the voluntary termination of pregnancy among the essential medical

<sup>109</sup> *Little Rock Family Planning Plaintiffs Services et al. v. Leslie Rutledge, in her official capacity as Attorney General of the state of Arkansas et al.* Case No. 4:20-CV-00470 BSM (US District Court for the Eastern District of Arkansas, 7 May 2020).

<sup>110</sup> *Ivi*, 16.

<sup>111</sup> In that sense, see European Committee of Social Rights, *CGIL v. Italy*, decision of 12 October 2015, published 11 April 2016, complaint No. 91/2013; on this decision, in particular, see S. DE VIDO, *Conscientious Objection and Access to Abortion in the Case CGIL v. Italy Decided by the European Committee of Social Rights*, in *Hitotsubashi Journal of Law & Politics*, 47, 2019, 45 ss., and, on conscientious objection in Italy, I. DOMENICI, *Obiezione di coscienza e aborto: prospettive comparate*, in *BioLaw Journal*, 3, 2018, 19 ss.; I. PELLIZZONE, *Obiezione di coscienza nella legge 194 del 1978: considerazioni di diritto costituzionale a quarant'anni dall'approvazione della legge n. 194 del 1978*, in *BioLaw Journal*, 3, 2018, 111 ss.

procedures»<sup>112</sup>. This partial interruption of the service, which was not decided by the law but by public and private hospitals, has exacerbated the already difficult situation for women willing to having access to legal abortions<sup>113</sup>. The related issue that emerged in Italy during the lockdown was chemical abortion: it was legal in Italy up until the seventh week of pregnancy, and, according to the national guidelines, the drugs had to be administered during a three-day hospital stay. At the time in which the debate spread in Italy, only five regions out of 20 allowed women to have access to chemical abortion on an outpatient basis<sup>114</sup>. Chemical abortion became almost impossible. The Pro-choice Italian Network (Pro-choice RICA), Libera Associazione Italiana Ginecologi per l'Applicazione legge 194 (LAIGA), Associazione Medici Italiani Contraccezione e Aborto (AMICA), and Associazione Vita Di Donna ONLUS requested the President of the Council of the Ministers and the Ministry of Health to adopt urgent measures to guarantee access to voluntary termination of pregnancy, preferring abortion on an outpatient basis (abortion at home, common in European Countries) with one access only to the hospital or the family counselling<sup>115</sup>. The Italian government eventually adopted the new guidelines on chemical abortion, which allow women to have access to the procedure up until the ninth week of pregnancy, in authorized clinics or family counselling or on day hospital<sup>116</sup>.

### 3.4. States' obligations in times of emergency with regard to access to abortion services

At the international level, even though States maintain discretion in the adoption of laws regulating abortion – a total ban on abortion has been considered contrary to women's human rights<sup>117</sup> – they do have legal obligations under international human rights law to grant women access to abortion and post-abortion services. The question is whether abortion can be considered as an «essential» procedure, which cannot be limited in times of emergency, when it is legal under domestic law. It should be noted that the WHO has considered abortion as «essential» to realise women's right to reproductive health<sup>118</sup>. Furthermore, the American College of Obstetricians and Gynecologists (ACOG) has recently issued a statement defining abortion as a time sensitive and «essential component of comprehensive health care» and that a delay, even days, «may increase the risks or potentially make

<sup>112</sup> C. MURATORI, L. DI TOMMASO, *Dall'obiezione di coscienza alla violenza domestica, come e perché le crisi hanno effetti negativi sulle donne e questa non farà eccezione*, in *InGenere*, 15 April 2020, <http://www.ingenere.it/articoli/i-segni-della-crisi-sui-corpi-delle-donne> (last accessed on 26. August 2020).

<sup>113</sup> See, above, note 111.

<sup>114</sup> <https://www.hrw.org/it/news/2020/07/30/375941> (last accessed on 26. August 2020).

<sup>115</sup> <https://prochoice.it/2020/04/04/facilitare-accesso-ad-aborto-farmacologico-durante-emergenza-covid-19/> (last accessed on 26. August 2020).

<sup>116</sup> Update of «Linee di indirizzo sulla interruzione volontaria di gravidanza con mifepristone e prostaglandine», 4 August 2020, <https://bit.ly/3jW6ZYA> (last accessed on 26. August 2020). In September 2020, however, the Region Piemonte announced to be willing to depart from the guidelines and to require hospitalisation for chemical abortions.

<sup>117</sup> See, in that respect, General comment (GC) No. 22 (2016) on the right to sexual and reproductive health (Economic Social and Cultural Rights Committee), E/C.12/GC/22, 2 May 2016, para. 57.

<sup>118</sup> [https://www.who.int/health-topics/abortion#tab=tab\\_1](https://www.who.int/health-topics/abortion#tab=tab_1) (last accessed on 26. August 2020).



it completely inaccessible»<sup>119</sup>. What about international human rights law? In its General Comment No. 22 (2016), the Economic Social and Cultural Rights (ESCR) Committee contended that «denial of abortion often leads to maternal mortality and morbidity, which in turn constitutes a violation of the right to life or security, and in certain circumstances can amount to torture or cruel, inhuman or degrading treatment»<sup>120</sup>. The Committee also considered medicines for abortion and post-abortion care among «essential medicines» that should be available<sup>121</sup>. Among States' obligations, the Committee identifies the obligation of States to adopt: «legal and policy measures to guarantee all individuals access to affordable, safe and effective contraceptives and comprehensive sexuality education, including for adolescents; to liberalize restrictive abortion laws; to guarantee women and girls access to safe abortion services and quality post-abortion care, including by training health-care providers; and to respect the right of women to make autonomous decisions about their sexual and reproductive health»<sup>122</sup>.

The Human Rights Committee, in its General Comment No. 36 on the right to life, clearly construed a «duty to ensure that women and girls *do not have* to undertake unsafe abortions», and acknowledges that «States parties should ensure the availability of, and effective access to, quality prenatal and post-abortion health care for women and girls, in *all circumstances*»<sup>123</sup>. The examples that we provided in the previous paragraphs also demonstrate how relevant the intersection of forms of discrimination are in having access to abortion and post-abortion services. The Jane Does that had to travel from one American state to another seeking access to abortion services and finding closed doors were socially disadvantaged<sup>124</sup>. Poor women, women with disabilities, migrant women, women belonging to indigenous or ethnic minorities, trafficked women, face the major difficulties in all times. As well as an interesting case at the national level, *Lakshmi Dhikta v. Nepal*, decided by the Supreme Court of Nepal<sup>125</sup>, the economic issue has been addressed by the Human Rights Committee in the views of the *Mellet* and *Whelan* cases<sup>126</sup>. The Committee stressed that discrimination based on social and economic conditions had occurred because to gain access to abortion both *Mellet* and *Whelan* had to go abroad without any form of support: «the differential treatment to which the author was subjected in relation to other women who decided to carry to term their unviable pregnancy created a legal distinction between similarly-situated women which failed to adequately take into account her medical needs and socioeconomic circumstances and did not meet the requirements of reasonableness, objectivity and legitimacy of purpose. Accordingly, the Committee concludes that the failure

<sup>119</sup> <https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak> (last accessed on 26. August 2020).

<sup>120</sup> GC No. 22, cit., para. 10.

<sup>121</sup> GC No. 22, cit., para. 13.

<sup>122</sup> Ivi, para. 28.

<sup>123</sup> GC No. 36, cit., para. 8. Emphasis added.

<sup>124</sup> See above, para. 3.2.

<sup>125</sup> *Lakshmi Dhikta v. Nepal* (2009), Writ petition number WO-0757, 2067 (2007) Supreme Court of Nepal, [www.reproductiverights.org/sites/crr.civactions.net/files/flash/LBS\\_LAKSHMI%20DHIKTA\\_FINAL%20NOV2010.pdf](http://www.reproductiverights.org/sites/crr.civactions.net/files/flash/LBS_LAKSHMI%20DHIKTA_FINAL%20NOV2010.pdf)

<sup>126</sup> *Siobhán Whelan v. Ireland*, CCPR/C/119/D/2425/2014 (2017), Communication No. 2425/2014 (HRC), and *Mellet*, cit.

of the State party to provide the author with the services that she required constituted discrimination<sup>127</sup>.»

Discrimination was therefore within the same gender, between women that miscarried and those who sought abortion abroad. Nonetheless, as argued by two members of the Committee in their concurring opinions, there had also been discrimination on the basis of gender because the prohibition of access to abortion services «par son effet contraignant, indirectement punitif et stigmatisant, vise les femmes *en tant que telles* et les place dans une situation spécifique de vulnérabilité, discriminatoire par rapport aux personnes de sexe masculine»<sup>128</sup>. Another expert, Sarah Cleveland, added that State regulations must «accommodate the fundamental biological differences between men and women in reproduction and [...] not *directly or indirectly* discriminate on the basis of sex», hence they require States to protect «on an equal basis, in law and in practice, the unique needs of each sex»<sup>129</sup>. One can argue that General Comments and views belong to *soft law* and that legal obligations depend on the consent of the States to ratify a specific international convention. In particular, it should be noted that the US has ratified neither the ICESCR, which contains a clear reference to the right to health, nor the CEDAW. However, the prohibition of discrimination, which is encapsulated in all binding international human rights law instruments, and the rights to life, privacy and the prohibition of torture, enshrined in the International Covenant on Civil and Political Rights, have obtained wide recognition at the international level and consolidated as international customs. Most importantly, the prohibition of torture, inhuman or degrading treatment, has the status of a *jus cogens* norm, to which non-derogation is admitted<sup>130</sup>. The lack of access to abortion may affect all these rights. Hence, for example, at regional level, the ECtHR applied Article 8 (right to respect for private and family life) of the European Convention on Human Rights (ECHR), in the *Tysiak v. Poland* case and concluded that Poland had violated Tysiak's right to respect for private and family life because it did not provide «any effective mechanisms capable of determining whether the conditions for obtaining a lawful abortion had been met in her case»<sup>131</sup>. The Court referred to her health in terms of the «severe distress and anguish» that Tysiak suffered and stressed the absence of compensation granted by the Polish authorities to cover «the irreparable damage to her health»<sup>132</sup>. In *R.R. v. Poland*, the Court applied Article 8 ECHR, ruling that Poland had violated R.R.'s right to respect for private and family

<sup>127</sup> *Whelan*, cit., para. 7.12, and *Mellet*, cit., para. 7.11.

<sup>128</sup> Individual opinion of Committee member Yadh Ben Achour, in *Mellet*, cit., para. 4.

<sup>129</sup> Individual opinion of Committee member Sarah Cleveland (concurring), in *Mellet*, cit., para. 7.

<sup>130</sup> The prohibition of torture is included, for example, in Article 5 of the Universal Declaration of Human Rights; Article 7 of the International Covenant on Civil and Political Rights; Article 3 of the European Convention on Human Rights; Article 7 of the Statute of the International Criminal Court; and in specific conventions, such as the UN Convention of 1984, the Inter-American Convention on the Prevention and Repression of Torture of 1985, the European Convention on the Prevention of Torture of 1987. On the *jus cogens* nature of the norm, see, ex multis, A. ORAKHELASHVILI, *Peremptory Norms in International Law*, Oxford, 2006, 54 ss.; E. DE WET, *The Prohibition of Torture as an International Norm of jus cogens and its Implication for National and Customary Law*, in *EJIL*, 2004, 97 ss.; A. MARCHESI, *Implementing the UN Convention Definition of Torture in Criminal Law*, in *JICJ*, 2008, 195 ss.; ID., *Il divieto di tortura nel diritto internazionale generale*, in *RDI*, 1993, 979 ss.; J. BRUNNÉE, *The Prohibition of Torture: Driving jus cogens Home?*, in *Proceedings of the ASIL Annual Meeting*, 104, 2010, 454 ss.

<sup>131</sup> ECtHR, *Tysiak v. Poland* (Appl. No. 5410/03), 20 March 2007, para. 124.

<sup>132</sup> *Tysiak*, cit., para. 125.

life by not providing «any effective mechanisms that would have enabled the applicant to seek access to a diagnostic service, decisive for the possibility of exercising her right to take an informed decision as to whether to seek abortion or not»<sup>133</sup>. The Court, «in an unprecedented move»<sup>134</sup>, also found Poland in violation of Article 3 ECHR, since R.R. had «suffered acute anguish» and «humiliation», as a consequence of the fact that her concerns «were not properly acknowledged and addressed by the health professionals dealing with her case»<sup>135</sup>. Furthermore, delays in the provision of services had prevented her from making an informed decision within the time limit provided by the law. Article 3 ECHR was also applied in *P. and S. v. Poland*, along with the rights enshrined in Articles 8 and 5 ECHR. The Court in Strasbourg concluded that Poland had been responsible for violating the applicants' rights. In particular reference to Article 8, P. and her mother had received «misleading and contradictory information, » and been deprived of «appropriate and objective medical counselling»<sup>136</sup>. Furthermore, civil courts could not provide them an effective remedy because no case law featured compensation for the damage caused to a woman by «the anguish, anxiety and suffering entailed by her efforts to obtain access to abortion»<sup>137</sup>. In *A., B., C. v. Ireland*, specifically C.'s case which fell within the provisions of the Irish law at the time, the ECtHR acknowledged the existence of guidelines for practitioners, which should have helped identify the legitimate grounds for abortion, but considered that they did not provide clear criteria for doctors in assessing the risks related to the pregnancy. This uncertainty had a chilling effect on practitioners' acceptance of permission to perform abortion, owing to the risk of «a serious criminal conviction and imprisonment in the event that a decision taken in medical consultation, that the woman was entitled to an abortion in Ireland given the risk to her life, was later found not to accord with Article 40.3.3 of the Constitution»<sup>138</sup>. Furthermore, C.'s interests could not have been said to be protected by the availability of judicial proceedings, since, according to the Court, «constitutional courts [a remedy also invoked by the government] are [not] the appropriate forum for the primary determination as to whether a woman qualifies for an abortion which is lawfully available in a State»<sup>139</sup>. As a consequence, Ireland had no effective and accessible procedures in place, demonstrating a «striking discordance» between the provisions of the law and its practical implementation<sup>140</sup>. Ireland was consequently found in violation of Article 8 ECHR. Therefore, it can be argued that abortion, when it is legal in a country, must be granted as an essential procedure at *all* times because its denial or postponement directly or indirectly jeopardises women's right to health and reproductive health. In the systems which do not openly recognise these rights (ECHR), it limits the women's right to respect for private and family life and, under certain circumstances, reaches the «level of severity» to trigger the prohibition of torture, inhuman, degrading treatment or punishment. All the cases which regional human rights courts and UN treaty

<sup>133</sup> ECtHR, *R.R. v. Poland* (Appl. No. 27617/04), 26 May 2011, para. 208.

<sup>134</sup> F. FABBRINI, *Fundamental Rights in Europe*, Oxford, 2014, 235. See also the partly dissenting opinion of Judge Bratza.

<sup>135</sup> *R.R.*, cit., para. 159.

<sup>136</sup> ECtHR, *P. and S. v. Poland* (Appl. No. 57375/08), 30 October 2012, para. 108.

<sup>137</sup> *P. and S.*, cit., para. 110.

<sup>138</sup> ECtHR, *A.B.C. v. Ireland* (Appl. No. 25579/05), 16 December 2010, para. 254.

<sup>139</sup> *A.B.C.*, cit., para. 258.

<sup>140</sup> *A.B.C.*, cit., para. 264.

bodies have decided deal with situations that have occurred in «normal» times. Nonetheless, the legal findings can be applied to the situations of emergency, since States' obligations with regard to the provision of «essential services» can be included among the «core obligations» as identified by the ESCR Committee<sup>141</sup>. Furthermore, in the most severe cases, when denial to access to abortion services amounts to torture, inhuman or degrading treatment, derogations are never admitted.

#### 4. Obstetric violence in times of pandemic

Compared to abortion, the number of cases of obstetric violence that have reached courts in «normal» times is relatively small and limited to those cases entailing the most severe consequences for the woman and the newborn leading to malpractice litigation. The following sub-paragraphs will illustrate what obstetric violence is and which human rights violates (4.1), before moving to the worsening of the situation for pregnant women in times of pandemic (4.2). The article will then enucleate obligations States must abide by to prevent obstetric violence, arguing that these obligations must be respected also in times of pandemic (4.3).

##### 4.1. Obstetric violence in international human rights law: Introductory notes

Obstetric violence occurs in all countries in the world even though it is not yet fully recognised<sup>142</sup>. In 2014, the WHO eventually issued a statement in which it acknowledged that «many women across the globe experience disrespectful, abusive or neglectful treatment during childbirth in facilities»<sup>143</sup>. It stressed that «abuse, neglect or disrespect during childbirth can amount to a violation of a woman's fundamental human rights»<sup>144</sup>. In 2015, UN and regional human rights experts, the Rapporteur on the rights of women of the Inter-American Commission of Human Rights and the Special Rapporteurs on the rights of women and human rights defenders of the African Commission on Human and Peoples' Rights issued a joint statement explicitly calling on States to address «acts of obstetric and *institutional* violence»<sup>145</sup>. Mistreatment and abuse during childbirth include physical, verbal and sexual abuse, discrimination and neglect, denial of privacy or of confidentiality and poor-quality care. More than fifty years ago, the *Ladies' Home Journal* in the USA published a shocking article under the title «Cruelty in maternity wards», which reported the stories of nurses and women about inhuman treatment in labour and delivery<sup>146</sup>. In 1958, a Society for the Prevention of Cruelty to Pregnant Women was established in the United Kingdom. The situation has not improved in recent years, despite the gigantic improvements in medical technology<sup>147</sup>. In a report of 2011 by the *Perseu*

<sup>141</sup> GC No. 22 (2016), cit., para. 49, in particular letter c), d), e), and g).

<sup>142</sup> F. DIAZ-TELLO, *Invisible Wounds: Obstetric Violence in the United States*, in *Reproductive Health Matters*, 24, 2016, 57.

<sup>143</sup> WHO statement 2014, <https://bit.ly/3doQAJN>.

<sup>144</sup> WHO statement 2014, cit.

<sup>145</sup> Available at <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16490&LangID=E> (last accessed on 26. August 2020).

<sup>146</sup> G.D. SCHULTZ, *Cruelty in Maternity Wards*, in *Ladies' Home Journal*, 44–5, 1958, 152–5.

<sup>147</sup> See the study by H. GOED, *Cruelty in Maternity Wards: Fifty Years Later*, in *Journal of Perinatal Education*, 19, 2010, 33.

*Abramo* Institute in Brazil, 25 percent of the 2,365 women interviewed reported some form of violence during childbirth, including verbal abuses<sup>148</sup>. In September 2017, the *Osservatorio sulla violenza ostetrica Italia* (Ovo), published a report on obstetric violence, based on interviews of 5 million Italian women aged 18 to 54 with at least one child aged 14 or less<sup>149</sup>. The inquiry, which was followed by the protest of thousands of women through the campaign «#Basta tacere» on Twitter, showed that four in ten women considered their child's birth as harmful to their dignity and psycho-physical integrity. Approximately 1 million women in Italy – 21 percent – claimed to have been victim of a form of physical or psychological OV during their first child's birth.

Experts from different countries have documented cases of beatings, hitting, slapping, kicking, pinching, the use of mouth gags and bed restraints, of harsh or rude language, of judgmental or accusatory remarks<sup>150</sup>. Coercive or unconsented medical procedures, such as forced caesarean surgery (sometimes through a court order), episiotomy, the Kristeller manoeuvre and induced labour – when they are not clinically justified – and also detention of women and their new-borns in facilities after childbirth for inability to pay constitute other examples of obstetric violence. Obstetric violence also consists in the refusal to provide relief for pain during labour, if this refusal entails negative consequences for the woman's health. It has been argued that obstetric practices «inadvertently perpetuate VAW by using coercion»<sup>151</sup>. In the most severe cases, obstetric violence leads to the woman's death. As emphasised by an author, «this is a problem that resides at the intersection of astonishing progress in medical technology on the one hand, and regressive attitudes about the rights and responsibilities of pregnant women on the other»<sup>152</sup>. Obstetric violence has found legal recognition in few countries. Hence, for example, Venezuela's 2007 Organic Law on women's right to a life free from violence, first defined obstetric violence as «the appropriation of a woman's body and reproductive processes by health personnel, in the form of dehumanizing treatment, abusive medicalization and pathologisation of natural processes, involving a woman's loss of autonomy and of the capacity to freely make her own decisions about her body and her sexuality, which has negative consequences for a woman's quality of life<sup>153</sup>.»

<sup>148</sup> S.G. DINIZ, A.F. PIRES LUCAS D'OLIVEIRA, S. Lansky, *Equity and Women's Health Services for Contraception, Abortion and Childbirth in Brazil*, in *Reproductive Health Matters*, 20, 2012, 97.

<sup>149</sup> The report is available, in Italian, at <https://ovoitalia.wordpress.com/> (last accessed on 26. August 2020).

<sup>150</sup> M.A. BOHREN, J.P. VOGEL, E.C. HUNTER et al., *The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review*, in *PLoS Medicine*, 12, 2015, <https://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1001847&type=printable>. R. KHOSLA et al., *International Human Rights and the Mistreatment of Women During Childbirth*, in *Health and Human Rights Journal*, 18, 2016, 132. For Venezuela, see P. TERÁN et al., *Violencia obstétrica: percepción de las usuarias*, in *Revista de Obstetricia y Ginecología de Venezuela*, 73, 2013, 171; for Nigeria, I.I. OKAFOR, E.O. UGWU and S.N. OBI, *Disrespect and Abuse During Facility-Based Childbirth in a Low-Income Country*, in *International Journal of Gynaecology and Obstetrics*, 128, 2015, 110.

<sup>151</sup> S. CHARLES, *Obstetricians and Violence against Women*, in *American Journal of Bioethics*, 11, 2011, 51.

<sup>152</sup> E. NELSON, *Reconceiving Pregnancy: Expressive Choice and Legal Reasoning*, in *McGill Law Journal / Revue De Droit De McGill*, 49, 2004, 596.

<sup>153</sup> *Ley orgánica sobre el derecho de las mujeres a una vida libre de violencia*, available at [www.acnur.org/fileadmin/Documentos/BDL/2008/6604.pdf](http://www.acnur.org/fileadmin/Documentos/BDL/2008/6604.pdf). R. PÉREZ D'GREGORIO, *Obstetric Violence: A New Legal Term Introduced in Venezuela*, in *International Journal of Gynaecology and Obstetrics*, 3, 2010, 201.



Article 51 of the same law contemplated some examples of obstetric violence, such as incapacity to respond to obstetric emergencies, forcing women to deliver lying on their backs with their feet in stirrups, preventing the mother and child from staying together after birth, altering the natural process of delivery by using induced labour without «voluntario, expreso e informado» consent, performing a coerced caesarean section when the conditions for a natural childbirth were present, without fully informed consent. The law requires the perpetrator («al responsable o la responsable», irrespective of gender) to pay a fine and a copy of the judgment to be sent to the professional association, which can decide whether to proceed against its member.

Obstetric violence violates the women's rights to health and reproductive health and restricts one's autonomy. From a feminist point of view, it is possible to argue that a male-centred society underestimates the harm caused to women during childbirth. If women are conceived as reproductive objects, and childbirth as a «normal» part of every woman's life, it is easier to understand why obstetric violence has only recently attracted interest. Women's suffering has always had a purpose: to serve society by giving birth to a child.<sup>154</sup>

Obstetric violence is also hardly detectable and rarely reported, unless it leads to the most serious consequence, namely the death of the woman in labour. Few cases of obstetric violence have been dealt with at regional and domestic level as violation of human rights<sup>155</sup>, the most relevant one being related to maternal mortality. In *Alyne da Silva Pimentel Teixeira (deceased) v. Brazil*, the CEDAW Committee, deciding a case of a young woman of Afro-Brazilian descent aged 28 who died because of the delay she experienced in receiving medical support after giving birth to a still-born foetus, rejected the argument presented by the state that Teixeira's death was non-maternal and that the probable cause of her death was digestive haemorrhage. The Committee was convinced that Teixeira's death had been linked to obstetric complications related to pregnancy, and that there was a link between gender and the possible medical errors committed<sup>156</sup>. It found Brazil responsible for failure to control private institutions providing medical services, and that this was in violation of Article 2(e) CEDAW providing for the elimination of discrimination by any organisation or enterprise<sup>157</sup>. According to the Committee, appropriate maternal health services in the State party had failed to meet «the specific, distinctive health needs and interests of women», which constituted a violation of Article 12 (2) CEDAW but also discrimination against women under Articles 12(1) and 2 CEDAW. It is interesting to note the emphasis put on the intersecting forms of discrimination that Teixeira suffered, «not only on the basis of sex, but also on the basis of her status as woman of African descent and her socio-economic background»<sup>158</sup>. The convergence or association of the different elements – posited the Committee – «may have contributed to the failure to provide necessary and emergency care to her

<sup>154</sup> A. RICH, *Of Woman Born – Motherhood as Experience and Institution*, New York, 1976, 152–62.

<sup>155</sup> See, in that respect, S. DE VIDO, *Violence against Women's Health*, cit., 91 ff.

<sup>156</sup> *Alyne da Silva Pimentel Teixeira (deceased) v. Brazil*, CEDAW/ C/49/D/17/ 2008, 25 July 2011, Communication No. 17/2008 (CEDAW), para. 7.3. See the analysis in L. CABAL and S. PHILLIPS, *Reproductive Rights Litigation: From Recognition to Transformation*, in M. LANGFORD, C. RODRÍGUEZ-GARAVITO and J. ROSSI (eds), *Social Rights Judgments and the Politics of Compliance: Making It Stick*, Cambridge, 2017, 418–19.

<sup>157</sup> *Pimentel Teixeira*, cit., para. 7.5.

<sup>158</sup> *Pimentel Teixeira*, cit., para. 7.7.

daughter, resulting in her death»<sup>159</sup>. Rebecca Cook contended that this was the first time that a UN treaty body considered discrimination in a country's healthcare system from the perspective of a poor woman belonging to a minority, and the first time that maternal death was declared to be preventable, «and when governments fail to take the appropriate preventive measures, that failure violates women's human rights»<sup>160</sup>. The Committee concluded that the State had violated the principle of non-discrimination by failing to accommodate sex-specific health care<sup>161</sup>. The Committee presented several recommendations to Brazil, including ensuring «women's right to safe motherhood and affordable access for all women to adequate emergency obstetric care»; providing «adequate professional training for health workers, especially on women's reproductive health rights»; and ensuring that private health care facilities comply with relevant national and international standards on reproductive health care. The State was asked to provide adequate financial compensation to the relatives of Teixeira, «commensurate with the gravity of the violations against her»<sup>162</sup>. After ten years, in 2013, the Rio de Janeiro Trial Court eventually awarded moral damages and a pension to Teixeira's daughter, retroactively from her mother's death until she turned 18.

#### 4.2. Examples taken from the practice

Women in all countries in the world, no matter how advanced these countries are, have experienced obstetric violence, and this form of gender-based violence has exacerbated in times of pandemic, as reported by *OpenDemocracy*<sup>163</sup>. Women have told to *OpenDemocracy* their experiences of: birth companions banned from hospitals – in some cases even after other lockdown restrictions have been lifted; forcible separation from newborns and being prevented from breastfeeding – despite no evidence that breast milk can transmit coronavirus; pain medication withheld because hospital resources including anaesthesiologists were diverted to the COVID-19 response; procedures performed without their consent, including caesarean sections, induced labour and episiotomies, to speed up labour<sup>164</sup>. The map of cases of obstetric violence prepared by *OpenDemocracy* is the most complete available and zooms in on a problem that is often underestimated. Even though it is constantly updated, it will not be able to take into account all cases of obstetric violence women have suffered.

The pandemic, or, more importantly, the measures adopted during the lockdown, have worsened obstetric violence in a way that goes beyond hospital premises. Hence, for example, in Uganda it was reported that at least three pregnant women died because they could not reach the hospital owing to transport restrictions<sup>165</sup>. The probably unique (at least so far) research that has been elaborated connecting obstetric violence to the pandemic has shown that some of the restrictions and interven-

<sup>159</sup> *Pimentel Teixeira*, cit., para. 7.7.

<sup>160</sup> R.J. COOK, *Human Rights and Maternal Health: Exploring the Effectiveness of the Alyne Decision*, in *Journal of Law, Medicine & Ethics*, 2013, 108–9.

<sup>161</sup> On State compliance, see also K.L. CALDWELL, *Health Equity in Brazil: Intersections of Gender, Race, and Policy*, Champaign, 2017, chap. 5.

<sup>162</sup> *Pimentel Teixeira*, cit., para. 8.1.

<sup>163</sup> <https://www.opendemocracy.net/en/5050/womens-rights-during-childbirth-help-us-track-globally/> (last accessed on 26. August 2020).

<sup>164</sup> *Ibid.*

<sup>165</sup> N. ARCHER, C. PROVOST, *Global Investigation – Disturbing Treatment of Women in Childbirth During COVID-19*, in <https://bit.ly/3jSQ2yk> (last accessed on 26. August 2020).

tions being implemented in childbirth due to the CoViD-19 outbreak were not necessary, not based on scientific evidence, disrespecting human dignity and not proportionate to achieve the objective of limiting the spread of the virus<sup>166</sup>. Thus, for example, the choice without adequate informed consent of caesareans or instrumental deliveries, the prohibition of companionship during labour, immediate separation and isolation from the newborn, and the prevention of breastfeeding, can be all considered examples of obstetric violence in times of pandemic<sup>167</sup>. In China, it was reported that «all babies were delivered by caesareans without giving convincing reasons for such intervention»<sup>168</sup>.

#### 4.3. States' obligations in times of emergency with regard to obstetric violence prevention

The question is which obligations States must abide by under international human rights law to prevent obstetric violence, and whether maternal health services are «essential». With regard to the first aspect, it is striking to see how law has provided «little significance to pregnancy as a source of rights worthy of consideration or as a special status needing of protection. In recent jurisprudence and quasi-jurisprudence, however, State obligations have evolved»<sup>169</sup>. An obligation to adopt laws that supply a legal framework for the provision of services to which women can have access can be identified, though: for example, a law that allows free access for poor women to prenatal, natal and post-natal services. An Indian Court required the state to provide access to hospital to women in labour, so they would not be obliged to give birth in the streets<sup>170</sup>. There is no coherent State practice or jurisprudence on home birth, regulation of which is left within the State's margin of appreciation, as emerged in the *Dubská and Krejzova v. Czech Republic* case decided by the ECtHR<sup>171</sup>. It is worth mentioning, however, the opinion of five dissenting judges in *Dubská* who, although recognising that States have a wide margin of appreciation in regulating home births, concluded that the interference in *Dubská's* right to respect for private and family life had been unnecessary in a democratic society<sup>172</sup>. The dissenting judges explained that the single-option birth model, which stemmed from a regulation imposing strict requirements on maternity clinics, was *per se* problematic with regard to Article 8 ECHR. In cases of low-risk pregnancies in women who were not first-time mothers, the interference was not considered to be justified<sup>173</sup>. One might argue that, in times of pandemic, home birth might have its advantages for the protection of the woman's and the newborn's health.

In *Xákmok Kásek Indigenous Community v. Paraguay*, the Inter-American Court of Human Rights contended that «States must *design* appropriate health-care policies that permit assistance to be provided by personnel who are adequately trained to attend to births, policies to prevent maternal mortality with adequate prenatal and post-partum care, and legal and administrative instruments for

<sup>166</sup> M. SADLER, G. LEIVA, I. OLZA, *COVID-19 as a Risk Factor for Obstetric Violence*, in *Sexual and Reproductive Health Matters*, 28(1), 2020, 1 ss.

<sup>167</sup> *Ivi*, 1.

<sup>168</sup> *Ibid*.

<sup>169</sup> P. LAUFER-UKELLES, *The Disembodied Womb: Pregnancy, Informed Consent and Surrogate Motherhood*, in *North Carolina Journal of International Law and Commercial Regulation*, 43, 2018, 4.

<sup>170</sup> *Court of its own motion v. Union of India*, Judgment of 12 January 2011, W.P. (C) 5913/2010. Delhi High Court.

<sup>171</sup> ECtHR, *Dubská and Krejzová v. Czech Republic* (Appl. No. 28859/11 and 28473/12), 15 November 2016.

<sup>172</sup> Dissenting opinion of judges Sajó, Karakaş, Nicolaou, Laffranque and Keller, para. 25.

<sup>173</sup> Dissenting opinion, para. 35.

health-care policies that permit cases of maternal mortality to be documented adequately,» and added that «pregnant women require special measures of protection»<sup>174</sup>. Special measures of protection are *a fortiori* needed during health emergencies.

In the ground-breaking decision *Alyne da Silva Pimentel Teixeira*, concerning the death of the applicant's daughter as a consequence of complications during childbirth, the CEDAW Committee presented several recommendations to the State. For example, the State was required to ensure to pregnant women access to «safe motherhood and affordable access for all women to adequate emergency obstetric care», and «that adequate sanctions are imposed on health professionals who violate women's reproductive health rights»<sup>175</sup>. «Affordable» might mean, in certain circumstances such as emergency maternal care, that the service, at least a minimum service, must be provided free of charge. This «minimum level» was evoked by the High Court of Delhi, which, in *Laxmi Mandal*, reflected on the «minimum standard of treatment and care in public health facilities, and in particular the reproductive rights of the mother»<sup>176</sup>.

It can be argued that there are obligations stemming from international human rights law regarding the provisions of services for maternal health. What is missing, however, is a decision by a regional human rights court on obstetric violence. This practice, as anticipated, is seen more as an issue of malpractice than as a violation of human rights. However, forms of obstetric violence, often «normalised» and considered as part of the experience of childbirth, even when they do not lead to the most severe consequence, can be said to amount to torture, inhuman or degrading treatment.

Concerning the second aspect, namely whether maternal health services are «essential», the ESCR Committee, in its General Comment No. 22, even though it did not specifically address emergency situations, explained that «special measures, both temporary and permanent, are necessary to accelerate the *de facto* equality of women and to protect maternity»<sup>177</sup>. The provision of maternal health services, despite not being explicitly among the core obligations identified in the General Comment, can fall within the recommendation to «guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services, goods and facilities», and to «provide medicines, equipment and technologies essential to sexual and reproductive health»<sup>178</sup>. On the level of «essentiality» linked to maternal health services in times of COVID-19 pandemic, in the interim guidance *Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected*, published on 13 March 2020, the WHO clearly addressed the need for caring pregnant women with CoViD-19<sup>179</sup>. Explaining that there is no evidence of mother-to-child transmission when infection manifests in the third trimester, the WHO recommended that:« pregnant women with suspected, probable, or confirmed CoViD-19, including women who may need to spend time

<sup>174</sup> Inter-American Court of Human Rights, *Xákmok Kásek Indigenous Community v. Paraguay*, 24 August 2010, para. 233. Emphasis added.

<sup>175</sup> *Pimentel Teixeira*, cit., para. 8.

<sup>176</sup> *Laxmi Mandal v. Deen Dayal Harinagar* (2010) 172 D.L.T. 9 (High Court in Delhi, India), para. 2.

<sup>177</sup> GC No. 22 (2016), cit., para. 27.

<sup>178</sup> Ivi, para. 49, letters c) and g).

<sup>179</sup> WHO, *Clinical Management of Severe Acute Respiratory Infection (SARI) when COVID-19 Disease is Suspected*, 13. March 2020 <https://apps.who.int/iris/bitstream/handle/10665/331446/WHO-2019-nCoV-clinical-2020.4-eng.pdf> (last accessed on 26. August 2020).

in isolation, should have access to woman-centred, respectful skilled care, including obstetric, fetal medicine and neonatal care, as well as mental health and psychosocial support, with readiness to care for maternal and neonatal complications<sup>180</sup>.»

With regard to breastfeeding, the WHO suggested that «infants born to mothers with suspected, probable, or confirmed CoViD-19 should be fed according to standard infant feeding guidelines, while applying necessary precautions», and that «symptomatic mothers who are breastfeeding or practising skin-to-skin contact or kangaroo mother care should practice respiratory hygiene, including during feeding (for example, use of a medical mask when near a child if the mother has respiratory symptoms), perform hand hygiene before and after contact with the child, and routinely clean and disinfect surfaces with which the symptomatic mother has been in contact»<sup>181</sup>.

## 5. Concluding remarks

This article has zoomed in on a neglected aspect of the pandemic and of the measures adopted to respond to it, namely the impact on women's health and reproductive health. Using the health emergency as an excuse, States have adopted policies – or have not prevented the adoption of certain practices by the hospitals – which have jeopardised women's reproductive health, exacerbating already existing patterns of discrimination rooted in societies. One can counter-argue that everyone is asked to suffer some limitations as a consequence of the pandemic. However, we cannot agree with the American judge that compared the limitations for people to have access to a gun shop to the ones women have suffered because they could not have access to abortion services<sup>182</sup>. The situations are not comparable because, as we argued in this article, States bear legal obligations under international human rights law to provide access to maternal health services and to abortion and post-abortion services and this access must be granted at all times to protect women's right to health and reproductive health. In some cases, as the jurisprudence of human rights courts and the quasi-jurisprudence of UN treaty bodies have determined, a denial that causes «severe anguish» can amount to torture, inhuman or degrading treatment. In times of emergency, essential services, including access to abortion services and maternal health services, must be granted. The objection that all medical supplies must be devoted to addressing the emergency and that practitioners are forced to use them to save the lives of those affected by the coronavirus is quite misplaced. It should not be whom practitioners are going to save, but rather who bears the responsibility for having to make this choice as a consequence of the failure of States in the adoption of measures of preparedness to possible pandemics, and as a consequence of the inefficient, discriminatory and not affordable access to basic health services and medicines<sup>183</sup>. The pandemic has exacerbated, not created *ex novo*, constraints in the provision of health services, and, with specific regard to women, it has reproduced forms of systemic discrimination on the basis of gender. It is striking to see how women's right to re-

<sup>180</sup> *Ivi*, 10.

<sup>181</sup> *Ivi*, 12.

<sup>182</sup> See above, para. 3.2.

<sup>183</sup> On this specific aspect, see S. DE VIDO, *Health as a Tipping Point*, in J. D'ASPREMONT and J. HASKELL (eds), *Tipping Points in International Law*, Cambridge, forthcoming.

productive health, whose evolution has been briefly reported in these pages, still faces enormous difficulties to be recognised as worthy of protection at all times.

*Focus on*

