

Reproductive Health and Abortion: Convergence and Divergence

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The pitched battles over abortion reflect profound personal and political divisions. They also are a reflection of legal constructs that tend to pit woman against fetus. This legal tension is most apparent in the abortion decisions of the Supreme Court of the United States. *Roe v. Wade*¹ may have set the standard for liberalizing access to abortion. But it also created an intractable legal dichotomy when it stated, “the pregnant woman cannot be isolated in her privacy.”² The Court, by inviting the state into the pregnancy, designated the womb as the battleground between woman and state.

The *Roe* Court’s protection of the right to choose under the rubric of constitutional privacy has been controversial for many reasons, not the least of which is societal ambivalence about recognizing privacy rights of women, particularly when the right is one that challenges deeply entrenched views of woman as mother. The Court’s shift from privacy to liberty in *Planned Parenthood of Southeastern Pennsylvania v. Casey*³, suffers from the same vulnerability – skepticism about women’s liberty to make reproductive choices unencumbered by patriarchal or state control.

Equality as a basis for reproductive choice remains problematic under existing constitutional doctrine in the U.S. The *Casey* decision acknowledges the relationship between reproductive choice and equality, but it does so only as an adjunct to its analysis of liberty, not as a separate, enforceable principle. The ongoing refusal of the Court to recognize pregnancy as a gender-based classification makes a shift to equality analysis unlikely.

In part as a response to the pitfalls of *Roe*, reproductive health has emerged as a human rights model for the protection of reproductive choice. Building on international consensus achieved at the International Conference on Population and Development held in 1994, in Cairo, reproductive health offers both strategy and standard for protecting women’s access to abortion. A number of international and regional human rights documents protect women’s health, including reproductive health. As a human rights principle, reproductive health has both normative and political value. The protection of women’s reproductive health is a critical element of women’s autonomy and dignity; rights protected in numerous human rights documents. Reproductive health also offers an analytical framework for moving beyond the polarization of women’s rights and the protection of the unborn. For example, protection of women’s health has been used by the European Court of Human Rights to find state laws regulating abortion in violation of the European Convention, relieving the Court of confronting

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¹ *Roe v. Wade*, 410 U.S. 113 (1973)

² *Id.* at 159.

³ 505 U.S. 833 (1992).

the question of whether abortion is protected under the European Convention. Evolving definitions of reproductive health encompass the right not to suffer discrimination in health care, the right of access to health care, and a positive obligation on states to protect women's health.

This essay examines how recent U.S. Supreme Court decisions diverge from the trend to protect women's reproductive choice, including abortion, through enhanced protection of women's reproductive health. The Court's decision in *Casey* and its most recent abortion decision, *Gonzalez v. Carhar⁴t*, are notable for weakening constitutional protection for women's reproductive health. U.S. constitutional protection of the right to choose may still be more generous than the protection provided under many other human rights documents. But the U.S. Supreme Court is contracting the right to choose at a time of increasing international recognition of reproductive health as an integral component of human rights.

The Cairo Programme of Action and the Beijing Platform of Action define reproductive health 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."⁵ Reproductive health includes 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..."⁶ Notably, this right of choice extends only to methods that are "not against the law," leaving the legality of abortion to the determination of each state. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) requires states parties to take appropriate measures to eliminate discrimination against women in access to health care, including family planning. Article 16 of CEDAW requires states parties to ensure that men and women have the "same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."⁷ Despite the fact these documents do not explicitly include access to abortion as part of reproductive health, they all rest on a similar principle: women's reproductive rights are human rights. The Cairo and Beijing platforms identify unsafe abortion as a major public health concern, and urge states to take action to address the problem. They stress that where abortion is legal, it should be accessible and safe.

The Protocol on the Rights of Women in Africa, adopted by the African Union in 2003 and entered into force in 2005, offers the most explicit protection of reproductive choice, including abortion, as a human right, the first binding human rights document to do so. The Protocol requires states parties to "take all appropriate measures to...protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother of the

⁴ 550 U.S. 124 (2007).

⁵ 1994 ICPD Programme of Action, Chapter VII (7.2), U.N. Doc. A/CONF.171/13, (Oct. 18, 1994); Beijing Declaration and Platform for Action, Sect. 94, U.N. Doc A/CONF.177/20, (Oct. 17, 1995).

⁶ *Id.*

⁷ CEDAW, Article 16(e).

life of the mother or the foetus.”⁸ This protocol offers significant recognition of reproductive health as a human right.

In April, 2008, the Parliamentary Assembly of the Council of Europe adopted Resolution 1607, “Access to Safe and Legal Abortion in Europe,” advising member states to decriminalize abortion and “guarantee women’s effective exercise of their right to access to a safe and legal abortion.”⁹ The Assembly expressed concern that, even where abortion is legal, “numerous conditions are imposed and restrict the effective access to safe, affordable, acceptable and appropriate abortion services.” These restrictions include requirements for “repeated medical consultations” and extended waiting periods. The Assembly specifically recommended that member states “lift restrictions which hinder, *de jure* or *de facto*, access to safe abortion, and, in particular, take the necessary steps to create the appropriate conditions for health, medical and psychological care and offer suitable financial cover.” The central principle of Resolution 1607 is the statement that “the ultimate decision on whether or not to have an abortion should be a matter for the woman.”¹⁰ Resolution 1607 specifically links effective exercise of the right of choice to the protection of reproductive health and the availability of real access to reproductive health services. Although not legally binding, Resolution 1607 is an important affirmation of reproductive rights, and their key components, protection of health and full access to the complete range of reproductive health services, including abortion.

Recent decisions by courts and treaty-monitoring bodies interpreting international and regional human rights documents show increasing recognition of reproductive health as a human right. In *KL v. Peru*,¹¹ the Human Rights Committee (HRC) held Peru in violation of its obligations under the International Covenant on Civil and Political Rights (ICCPR) for denying a 17-year old girl pregnant with an anencephalic fetus access to an abortion authorized under Peruvian law, which allows limited access to abortion where a woman’s life or health is threatened. The HRC found violations of several provisions of the ICCPR, including Article 7 (freedom from torture and cruel, inhuman and degrading treatment) and Article 17 (right to privacy). The HRC, interpreting health broadly to include mental health, found that KL was legally entitled to an abortion and that Peru violated its obligations by failing to ensure access. *KL v. Peru* is notable both for its emphasis on a broad definition of health and for its finding that denial of right of access to abortion may violate the ICCPR.

The European Court of Human Rights confronted a similar access issue in 2007 in *Tysiac v. Poland*.¹² Polish law authorizes abortion when a pregnancy endangers a woman’s life or health. Tysiac, who suffered from a serious eye condition that could result in blindness from the stress of pregnancy and delivery, was denied the medical certification required to terminate the pregnancy. The European Convention for the Protection of Human Rights and Fundamental

⁸ Article 14. 2(c), African Women’s Protocol.

⁹ Council of Europe Parliamentary Assembly, Resolution 1607 on access to safe and legal abortion in Europe, 16 April 2008.

¹⁰ *Id.*

¹¹ U.N. Doc. CCPR/C/85/D/1153/2003 (2005).

¹² 45 EHRR 42 (2007)

Freedoms, like the ICCPR, protects privacy and prohibits inhuman and degrading treatment. The Court ducked the issue of whether Article 8, protecting the right of privacy, guarantees a right to legal abortion. The Court stressed that privacy under Article 8 should be broadly interpreted to encompass “physical and social identity” and the “right to personal autonomy.” It also reiterated that even though the Convention does not specifically guarantee a right to health, Article 8 protects a person’s “physical and psychological integrity” and the state is under a positive obligation to secure citizens “their right to effective respect for this integrity.” The Court went on to find that Poland had violated the procedural protections of Article 8 by failing to have in place “any effective mechanisms capable of determining whether the conditions for obtaining a lawful abortion had been met.” In short, where abortion is legal, access must be real and procedures must be in place to ensure access is not arbitrary. The European Court of Human Rights, in several cases, has avoided the issue of whether the Convention protects the right to legal abortion, although that may change with the recent referral of *A.B. and C. v. Ireland* to the Grand Chamber. *Tysiack* suggests the Court is far more willing to look at abortion as a health issue.

Several points may be drawn from this brief outline of key documents and decisions addressing reproductive health. Most notably, there is an emerging recognition of reproductive rights in international human rights law. The scope of reproductive rights is evolving; with the exception of the African Protocol, the question of whether reproductive rights include the right to legal abortion is unresolved. However, critical components of reproductive rights have been articulated by courts and treaty-monitoring bodies, primarily the protection of women’s reproductive health and effective access to reproductive health services, including abortion where abortion is legal.

The above decisions address laws far more restrictive than those considered in recent decisions by the U.S. Supreme Court. Nonetheless, the U.S. decisions evince declining constitutional protection for reproductive health and access to reproductive health care at a time when other courts and human rights documents are emphasizing the importance of these principles.

In *Casey*, the Court’s shift from strict scrutiny of laws regulating abortion to the undue burden test, invites additional restrictions on abortion and access to abortion services. The undue burden test not only changes the level of scrutiny, it also shifts the burden from the state to the plaintiff, making it more difficult, and costly, for plaintiffs to prevail. The undue burden test, and the opinion in *Casey*, present particular concerns for women’s access to reproductive health services. The Court has described an undue burden as one that, by purpose or effect, places a substantial obstacle before a woman seeking abortion. *Casey* overrules prior decisions invalidating 24-hour waiting periods and restrictive informed consent requirements. The Court upholds Pennsylvania’s 24-hour waiting period and informed consent procedures, despite evidence that these restrictions impose economic hardship and emotional stress on women seeking abortions. The Court acknowledged the increased costs and delay imposed by the laws but concluded “a state measure designed to persuade her to

choose childbirth over abortion will be upheld if reasonably related to that goal.”¹³ The tension between the Court’s encouragement of laws designed to deter women from abortions and the undue burden standard is problematic. The Court has not articulated a standard for distinguishing permissible laws intended to deter women from abortions from impermissible laws that pose a substantial obstacle. Even more problematic, the Court’s acceptance of laws designed to deter women from choosing abortion is inconsistent with its description of an undue burden as a law that by *purpose* or effect constitutes a substantial obstacle to the right to choose. The impact of *Casey* has been to encourage regulations that impede women’s access to reproductive health services in furtherance of the state’s interest in deterring abortions.

Casey marks an additional diminution in the Court’s protection of reproductive health. Under *Roe*, protection of women’s health was the only justification for regulation of abortion pre-viability. *Casey*, in rejecting the *Roe* trimester approach to evaluating abortion regulation, concluded that one of the most significant flaws in *Roe* was the Court’s failure to accord proper recognition to the state’s interest in protecting potential life throughout the pregnancy, not just post-viability. Thus, under *Casey*, the state’s interest in regulating to protect women’s health will have to compete with measures intended to deter women from choosing abortion to further the state’s interest in protecting potential life.

The warnings that *Casey* would reduce constitutional protection of women’s reproductive health proved accurate in *Gonzales v. Carhart (Carhart II)*, the Court’s most recent abortion decision. The Court upheld the federal Partial-Birth Abortion Ban Act of 2003, despite striking down a similar state law only seven years earlier, in *Stenberg v. Carhart (Carhart I)*. In *Carhart II*, the Court, for the first time, upheld a law restricting abortion that did not include an exception to allow the banned procedure when necessary to protect the health of the woman. Under *Roe*, all laws restricting abortion had to include exceptions when the life or the health of the woman was at risk. In fact, one of the grounds for finding the state law unconstitutional in *Carhart I* was its failure to include an exception to protect the health of the woman, even though the state legislature concluded the exception was not necessary. In *Carhart II*, however, the Court rejected a facial challenge to the law based on the absence of a health exception. The Court found that the legislature need not include a health exception simply because there was “uncertainty over whether the barred procedure is ever necessary to preserve a woman’s health.”¹⁴ The Court concluded, “considerations of marginal safety, including the balance of risks, are within the legislative competence,” even if some procedures “have different risks than others.”¹⁵ The Court’s willingness to allow legislative bodies to evaluate the need for health exceptions eviscerates one of the key principles of *Roe*: women’s reproductive health is a constitutional issue, not a legislative one. With this language as a guide, *Carhart II* is likely to lead to additional erosions in the protection of women’s reproductive health.

¹³ *Casey*, at 878.

¹⁴ *Carhart II* at 1638.

¹⁵ *Id.*

Carhart II further undermines women’s reproductive health and access to health services by accepting a paternalistic, “protective” rationale for the regulation of abortion. The Court finds the ban on certain late-term abortions may help assure that fewer women have an opportunity to regret their decision to choose abortion. Even though the Court admits it has “no reliable data to measure the phenomenon,” it nonetheless concludes, “some women come to regret their choice to abort the infant life they once created and sustained.”¹⁶ The existence of a law banning certain late-term abortions, the Court opines, will help inform women of the consequences of their choice and “encourage” some women to continue the pregnancy. Thus *Carhart II* injects an additional rationale for restricting access to abortion.

Casey and *Carhart II*, in language and in outcome, weaken the constitutional protection of women’s reproductive health that began with *Roe*. This diminution diverges from the trend in international law to recognize reproductive health as a human right. At the same time, the Court’s recent abortion decisions may in fact place U.S. constitutional protection of the right to choose more in line with abortion law in other countries, where access to abortion typically is more heavily regulated than in the U.S. Nonetheless, even if *Casey* and *Carhart II* represent convergence on the regulation of abortion, the Court’s declining protection of reproductive health is likely to reduce further its credibility as a model for preservation of human rights.

¹⁶ *Carhart II* at 1634.