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CONSCIENTIOUS OBJECTION AND ACCESS TO ABORTION IN THE CASE *CGIL V. ITALY* DECIDED BY THE EUROPEAN COMMITTEE OF SOCIAL RIGHTS

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Abstract

The purpose of this article is to analyse the decision rendered by the European Committee of Social Rights in the case *CGIL v. Italy*, published on 11 April, 2016, concerning access to abortion services in Italian hospitals. The decision, which has not received much attention by legal scholarship, is of utmost interest for the affirmation of women's right to reproductive health. I will argue that this decision contributes to the affirmation of States' positive—and not merely negative—obligation to grant women access to safe abortion services.

Keywords: access to abortion, women's autonomy, conscientious objection, human rights

Contents

- I. Introduction
- II. Access to Abortion: An International and Comparative Perspective
- III. The Case *CGIL v. Italy*: Conscientious Objection and Access to Abortion
- IV. Feminist Scholarship on Women's Health and Autonomy
- V. Reflection on the Evolution of States' Positive Obligation to Grant Access to Abortion Services
- VI. Conclusions

I. *Introduction*

This short note¹ aims to analyse the decision rendered by the European Committee of Social Rights in the case *CGIL v. Italy*, published on 11 April, 2016,² regarding access to abortion services in Italian hospitals. The decision, which has received little consideration by legal experts, is relevant for the recognition of women's right to reproductive health.

This note is particularly timely since it refers to women's autonomy in taking fundamental

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¹ The note is part of a broader project of the author on violence against women and the human right to health, forthcoming by Manchester University Press. The article was inspired by a presentation on gender equality in Europe held at Hitotsubashi University on 16 July, 2018, for which my utmost gratitude goes to Prof. Yumiko Nakanishi.

² European Committee on Social Rights, *CGIL v. Italy*, decision of 12 October, 2015, published on 11 April, 2016, Complaint No. 91/2013.

decisions for their reproductive health—an autonomy that is ensured only apparently in our societies, and that is constantly called into question. According to an author, ‘male-gendered’ institutions—both at the political and the religious level—‘have justified intervention in women’s reproductive self-determination, by invoking public order, morality, and public health.’³ In particular, laws that have been construed as male-gendered ‘are enforced at a cost to women’s health.’⁴

The article will first provide the legal background to access to abortion in international human rights law, before analysing the case at issue; it will then provide a few remarks on feminist scholarship on the issue of women’s reproductive autonomy. It will finally reflect on the affirmation of States’ positive obligation in granting access to abortion services.

I will not delve in this article into the concept of ‘personhood’ as related to the foetus. My argument indeed does not exclude the potentiality of the foetus to become a person,⁵ but rather emphasises the fact that, in the name of the foetus, pivotal decisions for women’s health have been left in the hands of ‘others’, therefore perpetrating a stigmatised vision of the woman who cannot but want to become a mother and needs protection to make what society considers the ‘correct’ choice.⁶

II. *Access to Abortion: An International and Comparative Perspective*

The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa is the only legal 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.’⁷ This provision directly ‘situat[es] abortion as a human right that is recognised in the substantive provisions of a regional treaty’.⁸ Without other explicit provisions in regional and international legal instruments, women’s right to have access to abortion services is protected by international human rights law, when denial of abortion amounts to a violation of women’s rights, and to violence against women.

The criminalisation of abortion, particularly criminalisation without exception, can be considered as an example of gender-based violence against women, in the definition that has been consolidated at the international level, because it is a violation of human rights and in that

³ R. J. Cook, ‘Gender, Health and Human Rights’, in M. Grodin, D. Tarantola, G. Annas, and S. Gruskin (eds.), *Health and Human Rights in a Changing World* (Abington: Routledge, 2013), p. 348.

⁴ *Ibid.*, p. 349.

⁵ The ‘gradualist’ perspective tries to respond to the question of whether or not the foetus has a moral status, by acknowledging that ‘at some point late in pregnancy, the fetus [deserves] the very strong moral protection due to newborns’. M. O. Little, ‘Abortion and Margins of Personhood’, *Rudgers Law Journal* 39 (2007-2008), p. 331. This is the view also endorsed by E. Nelson, *Law, Policy and Reproductive Autonomy* (Oxford: Hart Publishing, 2014), p. 115, explaining that it seems aligned with the possibility parents have to take decisions for extremely premature or severely ill newborns even if there is a chance that the newborn’s life could be saved.

⁶ R. Siegel, ‘Reasoning from the Body: A Historical Perspective on Abortion Regulations and Questions of Equal Protection’, *Stanford Law Review* 44 (1992), p. 277.

⁷ Article 14(2)(c).

⁸ C. G. Ngwená, ‘Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa’, *Human Rights Quarterly* (2010), p. 810.

it causes psychological and, when the woman decides to undergo an unsafe procedure, physical harm.

The close relationship between the criminalisation of abortion and the right to health and reproductive health is emphasised by Rebecca Cook, who commented in one of her many contributions on the issue that

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.⁹

The Working Group on the issue of discrimination against women in law and in practice defines the control exercised by the State over decisions taken by women as a form of 'instrumentalisation of women's bodies': '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'.¹⁰ Instrumentalisation includes the discriminatory use of criminal law, such as provisions on termination of pregnancy, the enforcement of which 'generates stigma and discrimination'.¹¹ In the most recent Recommendation No. 35 on violence against women, the CEDAW Committee affirms that criminalisation of abortion is a violation of women's sexual and reproductive health and rights.¹²

Criminal law has been the way governments have used in order to attribute different social meanings to individual conduct.¹³ Abortion laws differ from country to country,¹⁴ and they are highly influenced by religious communities, in particular the Catholic Church,¹⁵ and traditions. According to the study published in 2013 by the UN Department of Economic and Social Affairs, 97 per cent of governments permitted abortion to save a woman's life; two-thirds of countries permitted abortion when the physical or mental health of the mother is endangered, and only half of the countries when the pregnancy resulted from rape or incest or in cases of foetal impairment.¹⁶ Only about one-third of countries permitted abortion for economic or social reasons or on request. On the one hand, countries such as Sweden grant free, safe, and legal abortion for all women to the extent of preventing physicians from invoking conscientious objection;¹⁷ on the other, and opposite, hand, there are countries such as Ireland, who

⁹ R. J. Cook, 'Stigmatized Meanings of Criminal Abortion Law', in R. J. Cook, J. N. Erdman, and B. M. Dickens (eds.), *Abortion Law in Transnational Perspective: Cases and Controversies* (Philadelphia: University of Pennsylvania Press, 2014); p. 347.

¹⁰ A/HRC/32/44, para. 63.

¹¹ A/HRC/32/44, para. 76.

¹² CEDAW/C/GC/35, para. 18.

¹³ R. J. Cook, 'Stigmatized Meanings', p. 348.

¹⁴ <http://worldabortionlaws.com/> and the update database elaborated by WHO and UN, available at <https://esa.un.org/gapp/>.

¹⁵ J. Lemaitre, 'Catholic Constitutionalism on Sex, Women, and the Beginning of Life', in R. J. Cook, J. N. Erdman, and B. M. Dickens (eds.), *Abortion Laws*, p. 239.

¹⁶ United Nations Department of Economic and Social Affairs, *Abortion Policies and Reproductive Health around the World* (UN, 2014), p. 3.

criminalised abortion in 1861 and whose Constitution was amended in 1983 to include a provision giving the unborn equal right to life with the mother.¹⁸ Furthermore, a total ban on abortion is provided by the laws of the Dominican Republic, El Salvador,¹⁹ the Holy See, Malta, and Nicaragua.²⁰ Chile has recently enacted a new law which ensures access to abortion to women in specific situations after 28 years of criminalisation.²¹ In Muslim-majority countries, it has been reported that the approach to abortion varies from State to State, although it is widely accepted when there are risks to the pregnant woman's life or health, and in cases of rape (incest being far less discussed).²² In the Middle East and North Africa, the laws may require the authorisation of more than one practitioner or necessitate the husband's approval.²³ In Africa, it has been reported that 'virtually all member states of the African Union have regulated abortion through a crime and punishment model that has been indifferent to women's reproductive health', and African abortion laws mirrored those in the colonising countries, without respect for women's rights.²⁴ The situation has gradually changed after the adoption of the Maputo Protocol. Ethiopia and South Africa have the most liberal laws, whereas Nigeria and Malawi, the most restrictive ones.²⁵ Several African countries now recognise rape, incest, or foetal malformation, as well as risks to the pregnant woman's health, as grounds for abortion.²⁶ States belonging to a federal system, such as the United States or Australia, may significantly differ in their approach to abortion within the country at the expense of women's rights.²⁷

The need to preserve the pregnant woman's life and severe foetal impairment are in some countries' laws the only few reasons that legitimise abortion. Nonetheless, as Cook has interestingly outlined, when a law allows exceptions to criminal prohibition of abortion to preserve a woman's life only, it considers that 'women's physical existence is alone worthy of protection' and that 'preservation of their health and well-being do not matter'.²⁸ The aim is

¹⁷ The denial of conscientious objection in all circumstances can also be considered a violation of human rights. See the case <http://www.bbc.com/news/world-europe-38756567>.

¹⁸ The evolution of Irish law in I. Bacik, 'Abortion and the Law in Ireland', in A. Quilty, C. Conlon, and S. Kennedy (eds.), *The Abortion Papers Ireland: Volume 2* (Cork: Cork University Press, 2015), p. 104. In 1983, the pro-life clause was included in the Constitution, in Article 40.3.3 (Eighth Amendment). Termination of pregnancy was legal only to save the life of the pregnant mother. Several amendments have been approved following pressure by civil society and several judgments adopted by Irish courts. Finally, in 2013, a new law was approved which provides however several limits to abortion. It is lawful in listed general and maternity hospitals. Two doctors must certify that it is necessary to avert a 'real and substantial risk of loss of the woman's life from a physical illness'; or three doctors, including one psychiatrist, must certify that it is necessary in order to save a woman who would otherwise be at real and substantial risk of losing her life by suicide. Exceptions are made in the case of an emergency. It is a huge step forward, but, as said, 'conservative' (Bacik, p. 116). The debate is still ongoing, and the Council of Europe's Commissioner for Human Rights has recently urged Ireland to change the 2013 law, which has a chilling effect on practitioners (<https://agenda.europe.wordpress.com/2017/04/13/coes-human-rights-commissioner-wants-ireland-to-cancel-unborn-childrens-right-to-life/>). A citizens' assembly composed of 99 people voted in April 2017 to amend rather than repeal the amendment. A referendum took place in 2018 and the majority of Irish people voted in favour of an amendment to the Constitution.

¹⁹ Center for Reproductive Rights, *Marginalized, Persecuted and Imprisoned*, 2014, p. 18, available at <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/El-Salvador-CriminalizationOfAbortion-Report.pdf>.

²⁰ United Nations Department of Economic and Social Affairs, *Abortion Policies*, p. 3.

²¹ The Chilean law, passed by Congress in August 2017, decriminalises abortion if the life of the pregnant woman is at risk; if the pregnancy is the result of rape; or if the foetus will not survive.

²² It is prohibited for economic and social reasons with few exceptions. See G. K. Shapiro, 'Abortion Law in Muslim-majority Countries: An Overview of the Islamic Discourse with Policy Implications', *Health Policy and Planning* 29 (2014), p. 488.

indeed to consider women as agents of their own reproductive health, and their health—meaning also psychological health—at the centre of any decision related to abortion.

Practitioners may refuse to perform abortion by invoking conscientious objection. Conscientious objection means that a person has the right to refuse to perform an action or to provide a service on the grounds that doing so is against his/her conscience.²⁹ The right to conscience is meant to protect 'the right of individuals to differ in thought, belief and opinion for religious, political, philosophical, humanitarian or other reasons'.³⁰ National jurisprudence has determined that conscientious objection cannot be used as justification by judicial officers,³¹ by administrative assistants,³² or by midwives whose only task is to coordinate the work of the labour ward.³³ A paramount case of conscientious objection comes from Italy, where abortion is liberalised in the first trimester of pregnancy, but women still encounter many difficulties in having access to the practice. In Italy, according to Law No. 194 (1978),³⁴ abortion is lawful during the first three months of pregnancy, when 'the continuation of the pregnancy, childbirth, or motherhood would seriously endanger [a woman's] physical or mental health', and also in view of 'their state of health, their economic, social, or family circumstances, the circumstances in which conception occurred, or the probability that the child would be born with abnormalities or malformations'.³⁵ After the first 90 days, voluntary termination of pregnancy 'may be performed ... a) where the pregnancy or childbirth entails a serious threat to the woman's life; b) where the pathological processes constituting a serious threat to the woman's physical or mental health, such as those associated with serious abnormalities or malformations of the fetus, have been diagnosed'. Conscientious objection is recognised, although it does not exempt health personnel from providing care prior to and following the termination of the pregnancy. Nonetheless, access to abortion in Italy is impaired in practice by the high number of conscientious objectors, as the *CGIL v. Italy* case shows.

²³ R. Dabash and F. Roudi-Fahimi, 'Abortion in the Middle East and North Africa', *Population Reference Bureau* (2008), available at <http://www.prb.org/pdf08/MENAabortion.pdf>.

²⁴ C. G. Ngwena, 'Conscientious Objection to Abortion and Accommodating Women's Reproductive Health Rights: Reflections on a Decision of the Constitutional Court of Colombia from an African Regional Human Rights Perspective', *Journal of African Law* 58 (2014), p. 187.

²⁵ E. Brookman-Amisah and T. Kachika, 'Reducing Abortion-related Maternal Mortality in Africa: Progress in Implementing Objective 5 of the Maputo Plan of Action on Sexual and Reproductive Health', in C. G. Ngwena and E. Durojaye (eds.), *Strengthening the Protection of Sexual and Reproductive Health and Rights in the African Region through Human Rights* (Pretoria: Pretoria University Law Press, 2014), p. 33.

²⁶ C. G. Ngwena, 'Conscientious objection', p. 189.

²⁷ See A. Sifris and S. Belton, 'Australia: Abortion and Human Rights', *Health and Human Rights Journal* 19 (2017), p. 211.

²⁸ R. J. Cook, 'Stigmatized Meanings', p. 356.

²⁹ A complete analysis of the topic can be found in M. R. Wicclair, *Conscientious Objection in Health Care. An Ethical Analysis* (Cambridge: Cambridge University Press, 2011).

³⁰ C. G. Ngwena, 'Conscientious Objection', p. 199.

³¹ T-388/09, Colombian Constitutional Court; C. G. Ngwena, 'Conscientious Objection', p. 186.

³² See *Janaway v. Salford Area Health Authority* [1988] 3 All ER 1079 (HL). The claim filed by an administrative assistant on religious grounds to type a letter of referral for an abortion under the Abortion Act 1967 was dismissed.

³³ *Doogan v. Greater Glasgow and Clyde Health Board* [2015] UKSC68. The UK Supreme Court (decision written by Lady Hale) considered that to participate in the procedure means to actually perform 'the tasks involved in the course of the treatment' (para. 37).

³⁴ Norme per la tutela sociale della maternità e sull'interruzione volontaria della gravidanza, Law No. 194 of 22 May, 1978 on the social protection of motherhood and the voluntary termination of pregnancy, *Gazzetta ufficiale* 22 May,

III. *The Case CGIL v. Italy: Conscientious Objection and Access to Abortion*

The case we are analysing in these pages was filed by the Confederazione Generale Italiana del Lavoro (CGIL) and registered on 17 January, 2013 with the European Committee of Social Rights. This Committee operates in the framework of the Council of Europe and its purpose is to consider State Parties' compliance with the provision of the European Social Charter, which was first adopted in 1961 and revised in 1996.³⁶ The Charter supplements the European Convention on Human Rights and Fundamental Freedoms, adopted in 1950 and which entered into force in 1953, in the field of economic and social rights.³⁷ Under a protocol opened for signature in 1995, and which entered into force three years later, the Committee is competent to accept collective complaints regarding violations of the Charter.³⁸ Compared to other systems at the international level regarding the protection of human rights, the Protocol entitles social partners and non-governmental organisations to file collective complaints of violations of the Charter occurring in States that have ratified the Protocol itself.

According to the complainant, the CGIL, an Italian labour union, Article 9 of the Italian law No. 194 of 1978,³⁹ which regulates the conscientious objection of medical practitioners and other medical personnel in relation to abortion services, is not 'properly applied in practice'.⁴⁰ The union contended that the way through which abortion services are offered in practice constitutes a violation of the right to health as enshrined in the Revised European Social Charter, read alone or in conjunction with the principle of non-discrimination (Article E), and of the right to work (Article 1); moreover, it can be a violation of the rights to just conditions of work (Article 2), to safe and healthy working conditions (Article 3), and to dignity at work (Article 26). Only the first part of the complaint is relevant for our purposes. The Italian government replied to the complaint on 30 May, 2013, and the CGIL submitted a response on 29 July, 2013.

Other parties submitted observations regarding the case, including the Movimento per la vita, a national federation of more than six hundred local groups promoting the right to life and care homes, and Giuristi per la vita that argued that the right to conscientious objection cannot be limited in any circumstances. A hearing took place in Strasbourg on 7 September, 2015.

With regard to the law applicable to the case, the Committee reported several articles of the Constitution, including the principle of non-discrimination (Article 3), and some of the provisions of the law at issue, in particular its Article 4:

In order to undergo termination of pregnancy during the first 90 days, women whose situation is such that continuation of pregnancy, childbirth or motherhood would seriously

1978, No. 140.

³⁵ Law No. 194 (1978), Article 5.

³⁶ European Social Charter (ETS No. 35) adopted in 1961 and the Revised European Social Charter (ETS No. 163) adopted in 1996.

³⁷ All 47 Members of the Council of Europe have ratified the European Convention on Human Rights, whereas 43 of the 47 have ratified either the revised Charter or the original Charter.

³⁸ ETS No. 158.

³⁹ Norme per la tutela sociale della maternità e sull'interruzione volontaria della gravidanza, *Gazzetta ufficiale* 22 May, 1978, No. 140.

⁴⁰ *CGIL v. Italy*, cit., para. 2.

endanger their physical or mental health, in view of their state of health, their economic, social or family circumstances, the circumstances in which conception occurred or the probability that the child would be born with abnormalities or malformations, shall apply to a public counselling centre ... or to a fully authorised medical social agency in the region or to a physician of her choice.

Furthermore, according to Article 9 of the law, medical practitioners and other health personnel 'shall not be required to assist ... in pregnancy terminations if they raise a conscientious objection, declared in advance'. However, under the same Article, 'hospital establishments and authorised nursing homes shall be required to ensure that ... pregnancy terminations requested in accordance with the procedures ... are performed. The region shall supervise and ensure implementation of this requirement, if necessary, also by the movement of personnel'. This latter aspect is the one stressed by the CGIL, which complained that, in practice, access to abortion is extremely difficult for women who, in many cases, have to reach other Italian cities to have access to adequate services. In the decision, the Committee also referred to several judgments issued by Italian courts regarding reproductive issues. In 2010, the Tribunale Amministrativo regionale della Puglia (regional administrative tribunal), for example, posited that Article 9 of Law No. 194 does not exempt objecting doctors from assisting the woman before and after the termination of pregnancy.⁴¹

With regard to European and international legal instruments, the Committee referred to the European Convention on Human Rights, which enshrines, on the one hand, the right to respect for private and family life in Article 8, and, on the other hand, freedom of thought, conscience, and religion under Article 9. Relevant in this respect is also the jurisprudence of the European Court of Human Rights, which has acknowledged that States have a margin of appreciation in the determination of the conditions in which abortion should be granted.⁴²

At the United Nations level, we can refer both to the International Covenant on Economic Social and Cultural Rights, adopted in 1966, which includes the right to health (Article 12), and to the Convention on the Elimination of all Forms of Discrimination against Women of 1969 whose Article 12 prohibits discrimination against women in their access to health services. The Committee on the Elimination of Discrimination against Women issued a General Recommendation on Women and Health in 1999, No. 24, in which it is clearly stated that 'if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers'.⁴³

Against this legal backdrop, the Committee first assessed the respect for procedural rules in lodging the complaint, rejected the objection of the Italian government which argued that domestic remedies had not been exhausted, and then analysed the case on its merits.

Starting from Article 11, the right to health, the complainant posited that, despite the legislation, 'in practice, the high number of doctors who are objectors prevents the full implementation of the legislation, [for lack of] tangible means of ensuring that there is a sufficient number of non-objecting doctors within each hospital'.⁴⁴ The Committee stressed that

⁴¹ Judgement 9 September, 2010, No. 3477, deposited on 14 September, 2010.

⁴² ECHR, judgment of 16 December, 2010, *A., B., C. v. Ireland*, Application No. 25579/05, para. 249.

⁴³ Para. 11.

⁴⁴ *CGIL v. Italy*, para. 93.

it is not the right to exercise conscientious objection that is at stake, but rather the women's right to health which can be violated by the limited number of medical practitioners accepting to perform pregnancy termination.⁴⁵ In light of the data provided by the parties and the hearing, the Committee found the following situations:⁴⁶

- a) a decrease in the number of hospitals or nursing homes where abortions are carried out nation-wide;
- b) a significant number of hospitals where, even if a gynaecology unit exists, there are no non-objecting gynaecologists, or there is just one;
- c) a disproportionate relationship between the requests to terminate pregnancy and the number of available non-objecting competent health personnel within single health facilities;
- d) excessive waiting times to access abortion services;
- e) cases of non-replacement of medical practitioners who are not available due to holiday, illness, retirement, etc.;
- f) cases of deferral of abortion procedures due to an absence of non-objecting medical practitioners willing to perform such procedures;
- g) cases of objecting health personnel refusing to provide the necessary care prior to or following abortion.

Despite additional arguments presented by the parties, the Committee concluded that 'the shortcomings which exist in the provision of abortion services in Italy ... remain unremedied and women seeking access to abortion services continue to face substantial difficulties in obtaining access to such services in practice, notwithstanding the provisions of the relevant legislation'.⁴⁷ Furthermore, the fact that health facilities do not adopt the necessary measures to face the deficiencies in the service and that the public authorities do not ensure satisfactory implementation imply that women 'wishing to seek an abortion may be forced to move to other health facilities, in Italy or abroad, or to terminate their pregnancy without the support or control of the competent health authorities, or may be deterred from accessing abortion services which they have a legal entitlement to receive'.⁴⁸ This situation might cause, according to the Committee, 'considerable risks for the health and well-being of the women concerned, which is contrary to the right to the protection of health as guaranteed by Article 11 of the Charter'.⁴⁹

Shifting to the other argument of the complaint, namely the violation of the principle of non-discrimination, the Committee found elements of multiple discrimination, linked to the territorial and/or socio-economic status and to the health status of women. As regards the former, women seeking abortion are forced to travel in order to find a hospital facility capable of performing the termination of pregnancy. As for the second ground of discrimination, the Committee found that there is discrimination between women seeking access to lawful abortion services and women seeking access to other lawful forms of medical procedures, which are not provided on a restricted basis.⁵⁰ The Committee therefore concluded that Italy violated Article

⁴⁵ Ibid, para. 166.

⁴⁶ Ibid, para. 174.

⁴⁷ Para. 190.

⁴⁸ Para. 191.

⁴⁹ Ibid.

⁵⁰ Para. 211.

E of the Social Charter.

IV. *Feminist Scholarship on Women's Health and Autonomy*

Feminist scholarship has extensively dealt with reproductive issues and women's autonomy. In the 1970s, the women's health movement developed and started a debate on sexuality. The key issue was access to abortion, although the movement's position failed to consider black women's needs and the fact that, in some circumstances, they were forced to undergo abortion.⁵¹

Among the outstanding scholars, Lesley Doyal, who deeply analysed the impact of sexuality, fertility control, reproduction, labour, and waged work on women's health, demonstrated how many health problems are reflections of discrimination against women, and emphasised in which sense the reproductive health status of women is affected by who they are and where they live (intersectional discrimination).⁵² In other words, the social environment has a strong impact on how sexuality is perceived. As further argued, 'understanding sexuality includes not only understanding its biological aspects but also deconstructing sexuality within a social framework. This includes analysing the role of culture, values, and politics in sexuality and also in the creation of knowledge about sexuality.'⁵³ Deborah Lupton's research is also useful in order to understand the ways in which the female body has been constructed culturally and historically.⁵⁴ Rebecca Cook, who has extensively written on reproductive health, abortion, and gender stereotyping,⁵⁵ confirms the position that health is influenced by socio-economic factors. With regard to abortion, in particular, she posited that coercion does not only mean forced abortion, but also denial of safe and legal abortion.⁵⁶

Erin Nelson offers an interesting analysis of the concept of autonomy. She clearly posits that to approach reproductive autonomy 'as requiring only that the States do not restrict our ability to make reproductive decisions for ourselves in accordance with our own priorities is to fail to recognise the steps that might be necessary to create the conditions in which reproductive autonomy can meaningfully be exercised'.⁵⁷ With specific regard to abortion, the fact that a woman is free to seek abortion 'does not signify that her decision not to abort is an autonomous one'.⁵⁸ This is what is happening in Italian hospitals. The Italian State has not

⁵¹ H. Amaro, A. Raj, and E. Reed, 'Women's Sexual Health: The Need for Feminist Analyses in Public Health in the Decade of Behavior', *Psychology of Women Quarterly* (2001) 324, pp. 325-326.

⁵² L. Doyal, *What Makes Women Sick* (Basingstoke: MacMillan, 1995); L. Doyal, 'Gender Equality in Health: Debates and Dilemmas', *Social Science & Medicine* (2000) 931; L. Doyal, 'Health', in P. Essed, D. T. Goldberg, and A. Kobayashi (eds.), *A Companion to Gender Studies* (Chichester: Wiley-Blackwell, 2009) 428, p. 433. See also C. F. Sargent and C. B. Brettell, *Gender and Health: An International Perspective* (Prentice Hall: Pearson, 1996).

⁵³ H. Amaro, A. Raj, and E. Reed, 'Women's Sexual Health', pp. 325-326.

⁵⁴ D. Lupton, *Medicine as Culture* (3rd ed., London: Sage, 2012).

⁵⁵ See, among the most relevant works, R. J. Cook (ed.), *Human Rights of Women*, cit.; R. J. Cook and S. Cusack, *Gender Stereotyping. Transnational Legal Perspectives* (Philadelphia: University of Pennsylvania Press, 2010); R. J. Cook and C. G. Ngwena (eds.), *Health and Human Rights* (Aldershot, UK: Ashgate, 2007); R. J. Cook, B. M. Dickens, and E. Kismodi, *Reproductive Health: Case Studies with Ethical Commentary* (Haifa, Israel: UNESCO Chair in Bioethics, 2006).

⁵⁶ R. J. Cook, 'Human rights and reproductive self-determination', *American University Law Journal* (1995), p. 997.

⁵⁷ E. Nelson, *Law, Policy and Reproductive Autonomy*, p. 35.

prevented women from having access to abortion, but it has not adopted any measures to remove barriers to access to abortion services. Autonomous choices are a prerequisite to gender equality, because they can dismantle the belief that women cannot 'make good choices' and that 'male-gendered' institutions are better able to respond to women's needs.

V. *Reflection on the Evolution of States' Positive Obligation to Grant Access to Abortion*

It is useful now to turn to international law in order to understand which legal obligations States have in providing access to abortion services. In its General Comment No. 22, the United Nations Committee on Economic Social and Cultural Rights posits what follows:

Preventing unintended pregnancies and unsafe abortions requires 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.⁵⁹

The protection of women's health requires access to safe abortion services. The lack of access to abortion has indeed proved to be extremely dangerous for women who might decide to undergo unsafe practices. Although the United Nations Committees have not construed a 'right to abortion' in international human rights law, it seems that, at the international level, the right to abortion, at least at the early stage of pregnancy, is 'in a process of evolving'.⁶⁰ As correctly argued, this would constitute a fundamental element of reproductive freedom.⁶¹ Nonetheless, many States have enacted laws that punish those who perform abortion, the women that undergo the procedure, and even the persons that provide the instruments to perform it.⁶² I can contend that, even though a right to abortion has not been consolidated at the international level, its denial in all circumstances has been considered as a violation of women's human rights. The decision under analysis has added a further element, in the sense that it is not enough that a State enacts laws; it is also necessary that these laws be practically applicable. As justly pointed out, coercion also occurs when safe and legal abortion is—as a matter of law or fact—denied.⁶³

I argue that States increasingly have legal obligations at the international level, in

⁵⁸ *Ibid.*, p. 46.

⁵⁹ General Comment No. 22 (2016) on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22, 2 May, 2016, para. 28.

⁶⁰ M. K. Eriksson, *Reproductive Freedom: In the Context of International Human Rights and Humanitarian Law* (The Hague: Martinus Nijhoff, 2000), p. 317.

⁶¹ *Ibid.*

⁶² R. J. Cook, 'Stigmatized Meanings of Criminal Abortion Law', in R. J. Cook, J. N. Erdman, and B. M. Dickens (eds.), *Abortion Law in Transnational Perspective Cases and Controversies* (Philadelphia: University of Pennsylvania Press, 2014), p. 348.

⁶³ R. J. Cook, 'Human rights and Reproductive Self-Determination', *American University Law Review* (1995), p. 997.

particular under the right to health and the principle of non-discrimination, to avoid any form of absolute criminalisation of abortion, and to remove all obstacles to access to abortion services. Here, we can find an innovative perspective. States are required at the international level to repeal laws criminalising abortion because that would cause a violation of women's rights to health and reproductive health. This consists in the negative obligation not to interfere with the enjoyment of the right to health. In addition to this, States are also required to remove all obstacles to access to abortion services, which means that they must act positively in order to grant equal opportunity for all women, where the lack of access to abortion services would constitute a form of violence against women.

VI. *Conclusions*

The decision under analysis must be welcomed as an important achievement, which is paving the way for the affirmation of positive legal obligation of States under international law with regard to access to abortion. Even though it is difficult to affirm that a right to abortion has been consolidated at the international level, it is however possible to argue that there are legal obligations for States to grant access to abortion services in order to avoid the situation that the denial of abortion causes a violation of women's right to health and reproductive health. The proposed argument does not limit conscientious objection, but *does* support women's autonomy and human rights. As a consequence, a conscientious objector should be required to give advice to the patient (e.g., the names of other practitioners), and to provide health services before and after pregnancy termination.