Who is the "Woman" in Human Rights Law:

Narratives of Women's Bodies and Sexuality in Reproduction Jurisprudence

Liiri Oja

Thesis submitted for assessment with a view to obtaining
the degree of Doctor of Laws of the European University Institute

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European University Institute
Department of Law

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Researcher declaration to accompany the submission of written work
Department of Law – LL.M. and Ph.D. Programmes

I Liiri Oja certify that I am the author of the work *Who is the "Woman" in Human Rights Law: Narratives of Women's Bodies and Sexuality in Reproduction Jurisprudence* I have presented for examination for the Ph.D. at the European University Institute. I also certify that this is solely my own original work, other than where I have clearly indicated, in this declaration and in the thesis, that it is the work of others.

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I confirm that chapters 1, 2, 3, 4, 5, 6 draw upon an earlier article:

OJA, L., YAMIN, A. E., "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?", *Columbia Journal of Gender and Law*, Vol. 32, No. 1 (2016)

Statement of language correction (if applicable):

This thesis has been corrected for linguistic and stylistic errors.

I certify that I have checked and approved all language corrections, and that these have not affected the content of this work.

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20 August 2018

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When I was in secondary school 15 years ago I wrote a research paper titled (in a rough translation) “Dance parties and get-togethers during 100 years” for a school project and also a national competition. My only source of information was my mother who would sit down and tell me for hours which dance party traditions my great grandmother, my maternal grandmother and my mother herself had had, and I would diligently write it all down. In hindsight it must have been a somewhat surprising choice of topic for my teachers and the jury members of the competition because in early 2000s most Estonian students were trying to record the horrors their grandparents and other family members had suffered during the years of Soviet Occupation. Although I obviously did not win the competition I learned to love stories and storytelling. If I went back to that paper today, I could see how these stories of women were not just stories about what they wore to a party and which music they danced to, but these are also telling a lot about what it meant to be a woman in Estonia during these moments.

That school paper was not, however, the start of my feminist writings – although I wish I could say so as it would be fairly elegant and fitting to have a beginning like that. But my journey to this PhD research has been less linear and much longer. Someone once asked which is more important – the doctoral thesis or the person who has taken the PhD journey. For me it is an easy question. Although this manuscript is a labour of love, a result of hard work and means a lot to me, the journey itself comes first. In fact, there is a whole second story behind the thesis and its socio-legal analysis of jurisprudence. There is the story of six different countries and nine different cities. There is the story of meeting people who have made me cry, made me angry, made me feel frustrated, but more so the stories of people who have taught me about kindness, patience and support, have made me a good writer, a more critical thinker, a better person.

When I was unhappy about a “B” in Physics and my teacher told me “*Girls don’t need to get an ‘A’ in hard sciences*” I knew he was wrong. When my undergraduate law professor commented after a moot court speech that I should “*smile more and appear softer*” I knew that *also* he was wrong. When my drunken graduate school classmate did not accept my “no” and harassed me at the back of a taxi I knew that he was *wrong*, too.

I knew and it made me angry, but it has taken me some years of feminist research, many books and those inspiring people – a whole journey – to find the suitable language for my anger. So my story is a common one, full of unlearning and unpacking what has been

presented as “natural” and “cultural”. I am not alone in this learning. I also know that despite some negative experiences I have been able to be healthy, live without fear and pursue education, professional and personal fulfilment – things many girls and women are not able to do. Although I do not know great harm and violence I know how debilitating being powerless is, even if just for a moment. Creating a supportive space for that anger and translating it into actions and change is possible with the help of people who sometimes see light before I do and who remind me to breathe.

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I would like to thank my first boss Aaro Mõttus for trusting me, allowing me to grow, swim against the flow and not expecting me to ask for permission to do so. I am grateful to my two professors at Georgetown: Susan L. Crockin who introduced me to reproductive rights and judge Dennis Davis who was the first person to tell me to go for a PhD.

A very special thanks goes to my *chosen* family. You remind me that there is a space for me not despite, but exactly *because* of my many strong opinions and stubbornness. Eva for being the best cheerleader – your love is always felt every step of the way even when I do not say so, Marie for being the very reason I am in this field now, Triin for giving me advice over the best cups of coffee, for the over 20 years of friendship and showing a new perspective when no-one else could. Esther for providing me with a safe haven in London and welcoming me to the UK with such care and warmth. I thank Saskia for inspiring me to refocus and read more, Kaire for offering a home and never minding my early morning trains or late night planes – your resilience, commitment and patience are admirable.

I thank my Brighton family – Tam and Arran, you made me feel at home during what was a rather intense time. I am always grateful to my Sussex people – Ben and Ebru, everything was better because of you. I thank my Spanish teacher and friend Edurne for creating little spaces of happiness with her language classes and dinner parties– muchísimas gracias! I would like to thank Benedikt, Birgit, Björn, Christian, Dieneke, Elena, Greg and Maria for brightening up my days at the EUI (and beyond, of course).

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I thank my brothers Tajo and Kaspar – men who call themselves feminists and who fight for a better world in their own way. Aitäh!

I am grateful to my parents – Eia and Urmas Oja – who are the masters of magical childhoods and storytelling. Thank you, dad, for reading us Astrid Lindgren's *Pipi Longstocking* and *Ronja the Robber's Daughter* so that I knew when the time came that yes, GIRLS can do anything and everything. Thank you for the hundred times you picked me up from different stations, patiently printed & scanned thousands of pages, sent me relevant books-articles-films, stocked up on sweets, organised office spaces for me. Thank you, mum, for the hundred times you helped me pack/unpack, urged me to be a dreamer and taught me about education, people, forgiveness. Aitäh, isa ja emme! Sigrid Undset on kirjutanud: "Head

päevad langevad osaks mõistlikele inimestele, parimad aga neile, kes julgevad olla meeletud". Ma olen saanud olla (natuke) meeletu tänu teile mõlemale.

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SUMMARY OF THESIS

This thesis asks who is the *woman* in human rights law and explores how transnational human rights law forums are contributing to women's silencing by reinforcing harmful stereotypes. It constructs a special analytical frame – a reproductive rights-based approach – to show the emerging narratives about women, their bodies and sexuality when jurisprudence concerning abortion, birth, reproductive violence and assisted reproduction is connected and read together. By using feminist approaches to law and understanding human rights through power relationships to analyse a total of 35 cases (between 2003-2017) from the European Court of Human Rights, the United Nations Human Rights Committee, the United Nations CEDAW Committee and the Inter-American Court of Human Rights, the thesis shows how despite good examples of anti-stereotyping done by courts or committees, by an large, women are still given fixed roles that are all primarily connected to the idea of women as *mothers* and women's bodies as *reproductive* bodies. Thus, the human rights law forums are still not putting women's lived experiences at the centre of their analysis and are not doing an effective *listening* work. Instead, there is still a resistance – especially in the European Court of Human Rights – against taking women's lived realities, life plans and what *they* say about violence, suffering, disadvantages *seriously*.

ACRONYMS & ABBREVIATIONS

ARTs	Assisted reproductive technologies
CAT	The Committee Against Torture
CEDAW	United Nations Convention on the Elimination of All Forms of Discrimination against Women
Convention of Belem Do Para	Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women
DEVAW	United Nations Declaration of Violence against Women
ECtHR	European Court of Human Rights
FGM	Female genital mutilation
GA	General Assembly
GC	General Comment
IACtHR	Inter-American Court of Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
Istanbul Convention	Council of Europe Convention on preventing and combating violence against women and domestic violence

IVF	*In vitro* fertilisation
SDG	United Nations Sustainable Development Goal
UDHR	Universal Declaration of Human Rights
UNCAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
WHO	World Health Organisation

LIST OF CASES

A, B and C v. Ireland	Application no. 25579/05 (2010)
A.S. v. Hungary	CEDAW/C/36/D/4/2004 (2006)
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I.V. v. Bolivia	Preliminary Objections, Merits, Reparations, and Costs, Judgment, IACtHR (ser. C) No. 329 (2016)

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1. INTRODUCTION: RESEARCH QUESTION, METHODOLOGY & OUTLINE

The problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story.

Chimamanda Ngozi Adichie

1.1 THE SEARCH FOR STORIES STARTS – THE RESEARCH QUESTION

Stories matter – it is through storytelling that people create communal, national, transnational narratives that help to explain and make sense of the world. Importantly, this goes beyond the reading of bedtime fairy-tales – stories are everywhere and come in all different forms: they can be written down as letters, poetry, novels, or rules and regulations, fixed in paintings, sculptures and photographs, narrated in films and cartoons, subtly proposed through landmarks and buildings, passed on as songs and music, or kept only in people's minds, hearts and dreams. Stories about *women* have for example been captured in stories as different as the mythological folk tales of women as wolves, in the trilogy of Kristin Lavransdatter by the Nobel laureate Sigrid Undset, in Virginia Woolf's ground breaking feminist essays, in the award-winning contemporary novels with strong female lead characters written by Elena Ferrante and Elif Shafak, in the speeches on gender equality by the novelist Chimamanda Ngozi Adichie and actress-activist Emma Watson, in the paintings of Frida Kahlo and Judy Chicago's installation "Dinner Party", in the music of Aretha Franklin and Beyoncé, in the poetry of Maya Angelou and Nayyirah Waheed.

In all of these stories there are signalling moments that implicitly or explicitly (through the plot of the book, choice of colours, angle of the viewer, building material) reflect something about women's experiences: their status in the society, struggles, successes, and losses in their own time and specific geographic location, socio-legal, economic and cultural space – and about the limitations of the very terms "gender", "femininity", "woman". Equally salient is to consider, how the stories that *do not* talk about women, are nevertheless stories about women as the silences and exclusions speak volumes too. Whichever the form of the story, the crucial aspect is that stories have the power to change the way a human being experiences the world. Therefore, it is imperative to a person's life what kind of stories she can tell about herself, and what kind of stories *others* are telling about her.

Playing an active role in one's own life story means having a voice, and having a voice is in turn a pre-requisite for a life lived with human dignity. Consequently, stories and voices are essential to human rights, and silencing is a path to human rights breaches through denying people from taking up space and making them small and insignificant. Rebecca Solnit argues: "Having a voice is crucial. It's not all there is to human rights, but it's central to them, and so you can consider the history of women's rights and lack of rights as a history of silence and breaking silence".[1] Solnit explains further, how silence is the "universal condition of oppression", and "who is heard and who is not defines the status quo".[2]

Solnit's idea of women's voices forms the foundation for this thesis as an investigation into how acts of silencing play out in the narratives about women, power and reproduction that human rights law forums create through high-level transnational legal interpretation. Thus, the main research question of this thesis asks: *Who is the "Woman" in human rights law*? To answer, I show through six chapters, which narratives of women's bodies and sexuality are constructed in the 21st century in the jurisprudence concerning reproduction of the selected transnational human rights law forums.

Aimee Carrillo Rowe and Sheena Malhotra challenge the assumption in the Western culture that "locates silence as a site of reform and privileges voice as the ultimate goal of and means to achieve empowerment", and presumes that "for an individual or group who is silenced to gain power, they must activate voice in order to resist and transform the conditions of their oppression".[3] They explain, how the "lacuna within this formulation is that the burden of social change is placed upon those least empowered to intervene in the conditions of their oppression", thus shifting the focus away from the "labor that might be demanded of those in positions of power to learn to listen".[4] I am taking this challenge into account as with this thesis I focus on how the human rights law forums are *silencing* women, and show how in order to stop that they need place their analysis in the context of power dynamics, in societies, and put women's lived experiences in the centre of their analysis – *i.e* using Carrillo Rowe and Malhotra's words the human rights law forums need to *listen* and do the *labour*.

[1] R. Solnit, *The Mother of All Questions* (2017), p. 20.
[2] R. Solnit, *The Mother of All Questions* (2017), p. 24.
[3] A. Carrillo Rowe, S. Malhotra, "Still the Silence: Feminist Reflections at the Edges of Sound", in: *Silence, Feminism, Power*, A. Carrillo Rowe, S. Malhotra (eds.) (2013), pp. 1-2.
[4] A. Carrillo Rowe, S. Malhotra, "Still the Silence: Feminist Reflections at the Edges of Sound", in: *Silence, Feminism, Power*, A. Carrillo Rowe, S. Malhotra (eds.) (2013), pp. 1-2. They also challenge Audre Lorde's work on silence and voice – see A. Lorde, "The Transformation of Silence into Language and Action", in: *Sister Outsider: Essays and Speeches* (1984).

In summer 2017, just before I started writing up this thesis in its full length the European Court of Human Rights decided a case against Portugal that in light of its other previous cases concerning women, reproduction and sexuality stood out. Namely, it concerned a woman in her 50s who had been discriminated by the Portuguese judiciary based on her gender and age as the amount of damages awarded to her had been decreased based on the stereotype that "for a woman in her age, sex is not that important". The Strasbourg Court found Portugal in breach of the right to non-discrimination and right to privacy rooting its conclusions in the anti-stereotyping approach. I introduce the case in detail later, but to set up the thesis I highlight one striking sentence from the court's analysis. Namely, the European Court of Human Rights argued that the assumption that sexuality is not as important for a fifty-year-old woman and mother of two children as for someone of a younger age reflected "a traditional idea of female sexuality as being essentially linked to child-bearing purposes and ignores its physical and psychological relevance for the self-fulfillment of *women as people*".[5] Indeed, in the context of all the jurisprudence regarding reproduction I use in this thesis such an explicit challenge to stereotyping seems something to celebrate. However, if put in the context of broader jurisprudence over the years that I have included into this piece of research and taking into account the feminist scholarly works that have been pointing out such limiting and harmful stereotypes for decades, my stronger sentiment is exasperation. Accordingly I do not see that a human rights case affirming "women as *people*" with desires beyond reproduction should be the benchmark for appraisal.

Before I unpack the research question by outlining my methodology, the structure of the arguments, and the analytical frame I have constructed for the search and critique of the narratives, I proceed with two paramount disclaimers.

[5] Emphasis added. *Carvalho Pinto de Sousa Morais v. Portugal,* Application no. 17484/15 (2017), para. 52.

our work should equip
the next generation of women
to outdo us in every field
this is the legacy we'll leave behind
– progress
(rupi kaur)

1.2 THE DISCLAIMERS: A FEMINIST THESIS IN HUMAN RIGHTS LAW

The following two disclaimers mark the theoretical frames of the arguments in this thesis as I position my work in feminist approaches and human rights law.

1.2.1 "Questioning everything": a feminist thesis

First, this thesis is grounded in, and guided by feminist analysis. There are many ways to look at ideas and the world – or stories, for this matter, – and consequently, different approaches are also analytically productive in distinct ways. Furthermore, choosing a theoretical frame for a PhD thesis is inevitably also a statement about much broader questions surrounding knowledge production, and power within and beyond scholarship.[6] I agree with Griselda Pollock who argues that demanding women to be considered not only "changes what is studied and what becomes relevant to investigate", but also challenges the existing disciplines politically as "women have not been omitted through forgetfulness or mere prejudice".[7] Thus, in this way my thesis becomes a demand for a space in which transnational reproduction jurisprudence is considered through *feminist approaches to law*.

What are feminist approaches? I side with Christine Littleton who explains, how feminist method "starts with the very radical act of taking women seriously, believing that what we say about ourselves and our experience is important and valid, even when (or perhaps especially when) it has little or no relationship to what has been or is being said *about us*".[8] This "act of taking women seriously" also means that consequently there is no

[6] See e.g.: G. K. Bhambra, (ed.), *Current Sociology Special Issue: Knowledge production in global context: Power and coloniality*, Vol. 62, Issue 4 (2014), M. do Mar Pereira, *Power, Knowledge and Feminist Scholarship: An Ethnography of Academia* (2017).
[7] G. Pollock, *Vision and Difference: Feminism, femininity and the histories of art*, (2003), p. 1.
[8] C. A. Littleton, "Feminist Jurisprudence: The Difference Method Makes", *Stanford Law Review,* Vol. 41, No. 3 (1989), p. 764.

one single feminist approach.[9] Instead, like Hilary Charlesworth, Christine Chinkin and Shelley Wright explained in their ground-breaking article on feminist approaches to international law, different feminist writers can occasionally have conflicting views, which however, does not undermine feminist inquiries, but is on the contrary essential to them and enriching as conflicting views add diversity.[10] For example, this diversity has called for intersectional feminisms that invite a rigorous analysis of power distribution and silencing by acknowledging women's different identities *within* the constructed group of "women".[11]

In summary, this means that feminist approaches are not tools for uncovering "ultimate truth": instead, feminist methods emphasise conversations and dialogue rather than the production of "a single triumphant truth".[12] Thus, as Sandra G. Harding summarises, there is a "permanent partiality" to the feminist inquiry.[13] Methodologically this leads to what Heather Ruth Wishik has called "questioning everything".[14]

This "permanent partiality", however, seems to construct an immediate clash with the legal discipline and the legal method as it is traditionally understood and taught within the discipline. Namely, Ruth Fletcher explains how combining the legal method and feminism can seem impossible as law claims to be objective and neutral – and not differentiate between people.[15] Charlesworth, Chinkin and Wright add that although the central feature of many Western theories about law is the "law's autonomous character and the argument that law is distinct from the society it regulates, operates on the basis of abstract rationality and is consequently capable of achieving neutrality and objectivity", the feminist approaches to law challenge this.[16] Accordingly, feminist methods must question the traditional "fundamentals

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[9] See further on feminist approaches e.g: C. Ramazanoglu, J. Holland*, Feminist Methodology: Challenges and Choices* (2002), C. Hemmings, *Why Stories Matter: The Political Grammar of Feminist Theory* (2011), *Feminist Research Practice: A Primer,* 2nd edition, S. Nagy Hesse-Biber (ed.) (2013).

[10] H. Charlesworth, C. Chinkin, S. Wright, "Feminist Approaches to International Law", *American Journal of International Law*, Vol. 85, Issue 4 (1991), p. 613.

[11] The term "intersectionality" was coined by Kimberle Crenshaw in 1989 as a critique of the single-axis-approach to discrimination. See: K. Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," *University of Chicago Legal Forum*, Vol. 1989, Article 8. Crenshaw was not the first person to draw attention to the too narrow definition of discrimination, but she is regarded as the person who theorised intersectionality. See also: P. Hill Collins, S. Blige, *Intersectionality (Key Concepts)* (2017).

[12] H. Charlesworth, "Feminist methods in international law", in: *The Methods of International Law*, S. R. Ratner and A.-M. Slaughter (eds.) (2003), p. 159. Charlesworth is referring to J. Ann Tickner.

[13] H. Charlesworth, C. Chinkin, S. Wright, "Feminist Approaches to International Law", *American Journal of International Law,* Vol. 85, Issue 4 (1991), p. 613.

[14] H. R. Wishik, "To Question Everything: The Inquiries of Feminist Jurisprudence", *Berkeley Women's Law Journal*, Issue 4 (1985).

[15] R. Fletcher, "Feminist Legal Theory", in: *An Introduction to Law and Social Theory, R. Banakar, M. Travers* (eds.) (2002), p. 136.

[16] H. Charlesworth, C. Chinkin, S. Wright, "Feminist Approaches to International Law", *American Journal of International Law,* Vol. 85, Issue 4 (1991), p. 613.

of the legal persuasion", e.g the language, the acceptance of abstract concepts as somehow "valid" or "pure", and the commitment to male, hierarchical structures in all legal and political organisations.[17] Further, Fletcher underscores how feminists have argued that legal ideas of full objectivity and neutrality are not only impossible, but also problematic for people who have been historically marginalised, thus, much feminist work focuses on deconstructing these claims of objectivity and neutrality.[18]

As Hilary Charlesworth writes – maybe as a pre-emptive supportive warning for scholars applying feminist approaches – since feminist methodologies challenge many accepted scholarly traditions, they are regularly seen as "unscholarly, disruptive, or mad".[19] Thus, just as Charlesworth once wrote in her response to an invitation to participate in a symposium on international law methods: "I also hope that one day I will stop being positioned always as a feminist and will qualify as a fully fledged international lawyer", I would hope too that one day feminist methods become so obvious and natural that one does not need to spell out that a thesis is a *feminist thesis* – as if there could be a thesis that was not.[20] Until that time comes, however, this thesis is explicitly a feminist thesis.[21]

1.2.2 Overcoming the tension: the power and limitations of the "rights framework"

The second disclaimer is connected to the first one. I employ feminist approaches to "question everything", and therefore criticise the ways in which human rights law forums are failing to recognise women's voices, and offer a better protection of their reproductive rights. Furthermore, my work is aware of the many broader challenges that are not only pointing out the missing gender perspectives in human rights law, but also questioning whether the human rights project as such should be abandoned. However, although I do argue for a better and more reflective human rights analysis, I do not call for a complete rejection of human rights law.[22]

To repeat, human rights law frameworks are not free from stark criticism, doubt or

[17] H. Charlesworth, C. Chinkin, S. Wright, "Feminist Approaches to International Law", *American Journal of International Law*, Vol. 85, Issue 4 (1991), p. 634.
[18] R. Fletcher, "Feminist Legal Theory". In: An Introduction to Law and Social Theory, R. Banakar, M. Travers (eds.) (2002), p. 136.
[19] H. Charlesworth, "Feminist methods in international law", in: *The Methods of International Law*, S. R. Ratner and A.-M. Slaughter (eds.) (2003), p. 160.
[20] H. Charlesworth, "Feminist methods in international law", in: *The Methods of International Law*, S. R. Ratner and A.-M. Slaughter (eds.) (2003), p. 159.
[21] See also further: *Feeling Academic in the Neoliberal University Feminist Flights, Fights and Failures*, Y. Taylor, K. Lahad, (eds.) (2018).
[22] Some scholars are more pessimistic. See e.g.: E. Posner, *The Twilight of Human Rights Law* (2014).

scepticism (beyond feminist enquiries).[23] For example, Stephen Hopgood, Jack Snyder and Leslie Vinjamuri refer to critics who call for a better and more straightforward analysis of where rights came from, whose interests they serve, and how they will fare in a rapidly changing world in which the "hegemony of Western and liberal concepts is under challenge in new ways".[24] This "rights vs. justice (or some other alternative to rights)" division is familiar to the rights critique within feminist legal theory proposing that the rights-approach and the rights-language are in fact disempowering (for women).[25] Namely, some scholars have argued that the rights-language oversimplifies gender-based power relations, or that rights are indeterminate, receptive for manipulation, empty, or more generally, asking whether it is possible to "dismantle the master's house with the master's tools" as famously written by Audre Lorde.[26]

Moreover, Andrea Cornwall and Maxine Molyneux for example outline four "feminist dilemmas" regarding rights (and international development).[27] One of them is the relationship between *rights* and *realities*, as Cornwall and Molyneux explain it: "It is the gulf that exists between elegant laws and the indignities of women's everyday realities, and between being accorded a right and being in any position at all to make use of it".[28] Another dilemma relevant here is the very relationship between rights, feminisms and the state. Namely, Cornwall and Molyneux argue that since the state is the guarantor of rights the state also becomes the focus of feminist advocacy.[29] In other words, framing something as a right essentially and fundamentally means *including* the state, *inviting* the state to intervene. And that in itself can be potentially counter-productive or even dangerous as governance through laws, regulations, guidelines defines the rules of the game which might not be in sync with people's lived experiences.

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[23] See e.g.: *Human Rights Futures,* S. Hopgood, J. Snyder, L.Vinjamuri (eds.) (2017), S. Marks, "Human rights and root causes", *Modern Law Review*, Vol. 74, Issue 1 (2011), S. Moyn, *The Last Utopia: Human Rights in History* (2012), M. W. Mutua, "Savages, Victims, and Saviors: The Metaphor of Human Rights", *Harvard International Law Journal*, Vol. 42, No. 1 (2001).

[24] S. Hopgood, J. Snyder, L.Vinjamuri, "Conclusion: Human Rights Futures", in: *Human Rights Futures*, S. Hopgood, J. Snyder, L.Vinjamuri (eds.) (2017), p. 313.

[25] N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights*, K. Knop (ed.) (2004), pp. 38-53. See also: H. Charlesworth, C. Chinkin, *The boundaries of international law. A feminist analysis* (2000), pp. 208-247.

[26] H. Charlesworth, C. Chinkin, *The boundaries of international law. A feminist analysis* (2000), pp. 208-212; A. Lorde, *Sister Outsider*: *Essays and Speeches* (1984).

[27] A. Cornwall, M. Molyneux, "The Politics of Rights: Dilemmas for Feminist Praxis: An introduction", *Third World Quarterly*, Vol. 27, No. 7 (2006).

[28] A. Cornwall, M. Molyneux, "The Politics of Rights: Dilemmas for Feminist Praxis: An introduction", *Third World Quarterly*, Vol. 27, No. 7 (2006), p. 1183.

[29]A. Cornwall, M. Molyneux, "The Politics of Rights: Dilemmas for Feminist Praxis: An introduction", *Third World Quarterly*, Vol. 27, No. 7 (2006), p. 1185.

This thesis is a "reconstructive project" as I do not reject the framework of human rights, but instead opting to show what the transnational human rights law forums are missing in their human rights analysis.[30] Throughout this thesis I criticise, re-consider and re-define the rights framework, but I also simultaneously argue that there is positive (transformative and protective) power potential in the human rights protection systems. Instead of rejecting transnational human rights bodies as too distant from the "local" or too elitist, ethnocentric, neo-colonial I again propose that a strong critique of the rights systems and regional human rights bodies is not mutually exclusive with using these very systems to advance human lives.

I strongly side with scholars Alicia Ely Yamin, who understands rights as "bundles of relationships that are supported by the state's monopoly on force", Maya Unnithan, who maintains that "human rights are not simply discrete legal instruments but concepts whose meaning is interpretive, relationally constituted, experientially based, and historically shaped", and Alison Brysk, who argues that human rights can move beyond binaries of local/global, protection/empowerment, and insiders/outsiders by "introducing new voices, new rights, and new pathways to fulfillment".[31] An allergy to fixed either/or binaries, and critical reconsideration of human rights as power systems is part of the "disorderly" feminist approach that as Hilary Charlesworth describes is seen as "unscholarly, disruptive, or mad".[32]

My aim therefore is to submit the "demand" for a rights-based thinking that challenges the legal discipline *within* the discipline itself by calling out stereotyping that hides behind the "neutral" legal method, harmful language and terminology constructing limiting narratives about women, and applying critical reading to some "untouchable" ideas. Consequently in this thesis I draw material from other disciplines (i.e. sociology, anthropology, medical science) because many questions have been under-researched by legal scholars. Nevertheless, I am deliberately carving a space for criticism and change *within* and not outside law.

Catharine MacKinnon's uses the "butterfly effect" metaphor (originally coined by Konrad Lorenz in 1972) according to which "some extremely small simple actions that are

[30] About "reconstructive projects" see: N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights*, K. Knop (ed.) (2004), p. 43.
[31] A. E. Yamin, "Taking the Right to Health Seriously: Implications for Health Systems, Courts, and Achieving Universal Health Coverage", *Human Rights Quarterly*, Vol. 39, No. 2 (2017) p. 346, M. Unnithan, "What Constitutes Evidence in Human Rights-Based Approaches to Health? Learning from Lived Experiences of Maternal and Sexual Reproductive Health", *Health and Human Rights*, Vol. 17, No. 2 (2015), p. 54, A. Brysk, *Contesting regression: citizen solidarity vs. the decline of democracy*, October 5, 2017, available at: https://www.openglobalrights.org/Contesting-regression-citizen-solidarity-vs-the-decline-of-democracy/?lang=English (accessed 7 February, 2018).
[32] H. Charlesworth, "Feminist methods in international law", in: *The Methods of International Law*, S. R. Ratner and A.-M. Slaughter (eds.) (2003), p. 160.

properly targeted can come to have highly complex and large effects in certain contexts", and explains how even small critical interventions can affect how the system behaves and thus bring along transformation in the gender system.[33] MacKinnon believes that the butterfly metaphor can encourage multidimensional political thinking, inspire interventions ("even tiny ones") and open discussions/debate.[34] I borrow from MacKinnon's thinking and treat this thesis as a version of a flap of a butterfly's wings that challenges some of the thinking about women, reproduction, infertility and violence that the transnational human rights law forums do.

1.3 METHODOLOGY AND OUTLINE OF THE THESIS

I have now positioned this project as a *feminist thesis in human rights law*. In this last part of the introduction I outline my methodology for answering the research question – to recall, this thesis asks: *Who is the "Woman" in human rights law*? I have chosen to answer this question through investigating transnational jurisprudence concerning reproduction.[35] Furthermore, I have picked a specific way of analysing the case-law. Namely, in the first pages of this thesis I sketched out the connections between stories, having a voice, silencing, and human rights. I argued that for a life lived with dignity one needs to have a voice, and be able to tell and live her story, and if that voice is systematically silenced, then this silencing could lead to human rights breaches.

Firstly, I describe my case-law selection – in other words, which specific cases regarding reproduction from which transnational (and why) I have included as objects of my investigation. Secondly, I explain, how I am reading the case-law as *stories* which when brought together into one analytical framework form *narratives*. Accordingly, the methodology part more specifically explains, how I extract narratives about women, their bodies and sexuality to conclude who women are in the reproduction jurisprudence of the transnational human rights law forums (*i.e* which roles they have been given).

1.3.1 Case-selection: overview and limitations

I have included case-law of the treaty monitoring bodies of the European Convention on Human Rights (the European Court of Human Rights, hereafter the ECtHR), the United Nations Convention on the Elimination of All Forms of Discrimination against Women (the

[33] C. A. MacKinnon, *Butterfly Politics* (2017), pp. 1-8.
[34] C. A. MacKinnon, *Butterfly Politics* (2017), p. 8.
[35] In this thesis I understand "transnational" as *not* domestic/national (courts/jurisprudence).

CEDAW Committee), the International Covenant on Civil and Political Rights (the United Nations Human Rights Committee, hereafter the HR Committee), and American Convention on Human Rights (the Inter-American Court of Human Rights, hereafter the IACtHR).[36]

Based on a systematic review of the available jurisprudence from 2003 to 2017 I consider a total of 35 cases (see Appendix 1). From the case-law of the regional human rights court in Europe (the ECtHR) I have chosen five cases concerning abortion,[37] five cases concerning birth,[38] six cases on assisted reproduction,[39] four forced sterilisation cases,[40] five forced gynaecological examination cases[41] and one case concerning women's sexuality during their life course.[42]

From the IACtHR, the ECtHR's American counterpart, I have two cases: one case concerning assisted reproduction,[43] and one case concerning forced sterilisation.[44] And lastly, from the UN treaty monitoring bodies I have picked seven cases: one abortion case,[45] one forced sterilisation case[46] and one maternal mortality case from the UN CEDAW Committee[47], and four abortion cases from the UN Human Rights Committee.[48]

My focus when choosing the relevant cases was the transnational space. This does not mean that domestic courts are unimportant. On the contrary, human rights protection is a construction with many vital parts that all need critical attention from scholarship. For the

[36] The Human Rights Committee (on the basis of the First Optional Protocol to the ICCPR), the Committee on the Elimination of Discrimination Against Women (on the basis of the Optional Protocol to the CEDAW).
[37] *Tysiac v. Poland*, Application no. 5410/03 (2007), *A, B and C v. Ireland*, Application no. 25579/05 (2010), *R.R. v. Poland*, Application no. 27617/04 (2011), *P. and S. v. Poland*, Application no. 57375/08 (2013), *Annen v. Germany*, Application no. 3690/10 (2016).
[38] *Ternovszky v. Hungary*, Application no. 67545/09 (2011), *Konovalova v. Russia*, Application no. 37873/04 (2015), *Hanzelkovi v. the Czech Republic*, Application no. 43643/10 (2015), *Korneykova and Korneykov v. Ukraine*, Application no. 56660/12 (2016), *Dubska and Krejzova v. Czech Republic*, Applications nos. 28859/11 and 28473/12 (2016).
[39] *Dickson v. United Kingdom*, Application no. 44362/04 (2007), *Evans v. United Kingdom*, Application no. 6339/05 (2007), *S.H. and Others v. Austria*, Application no. 57813/00 (2011), *Costa and Pavan v. Italy*, Application no. 54270/10 (2013), *Mennesson v. France*, Application no. 65192/11 (2014), *Paradiso and Campanelli v. Italy*, Application no. 25358/12 (2017).
[40] *K.H. and Others v. Slovakia*, Application no. 32881/04) (2009), *N.B. v. Slovakia*, Application no. 29518/10 (2012), *VC v. Slovakia*, Application no. 18968/07 (2012), *I.G. and Others v. Slovakia*, Application no. 15966/04 (2013).
[41] *Y.F. v. Turkey*, Application no. 24209/94 (2003), *Juhnke v. Turkey*, Application no. 52515/99 (2008), *Salmanoğlu and Polattas v. Turkey*, Application no. 15828/03 (2009), *Yazgül Yilmaz v. Turkey*, Application no. 36369/06 (2011).
[42] *Carvalho Pinto de Sousa Morais v. Portugal*, Application no. 17484/15 (2017).
[43] *Artavia Murillo et al. ("In vitro fertilization") v. Costa Rica*, Preliminary Objections, Merits, Reparations, and Costs, Judgment, IACtHR (ser. C) No. 257 (2012).
[44] *I.V. v. Bolivia,* Preliminary Objections, Merits, Reparations, and Costs, Judgment, IACtHR (ser. C) No. 329 (2016).
[45] *L.C. v. Peru*, CEDAW/C/50/D/22/2009 (2011).
[46] *A.S. v. Hungary*, CEDAW/C/36/D/4/2004 (2006).
[47] *Alyne da Silva Pimentel v. Brazil*, CEDAW/C/49/D/17/2008 (2011).
[48] *K.L. v. Peru*, CCPR/C/85/D/1153/2003 (2005), *LMR v. Argentina*, CCPR/C/101/D/1608/2007 (2011), *Mellet v. Ireland*, CCPR/C/116/D/2324/2013 (2016), *Whelan v. Ireland*, CCPR/C/119/D/2425/2014 (2017).

purposes of this thesis, however, I am limiting my analysis to the transnational space. Irrespective of the actual compliance and execution of these specific cases I argue that transnational reproduction jurisprudence has a special function beyond the applicant and respondent state.

Firstly, the nature and function of transnational jurisprudence is different from domestic case-law as access to transnational courts and committees is restricted, e.g. there is the requirement of exhaustion of local remedies. Moreover, transnational litigation is more expensive and time-consuming, thus the cases that do reach the European Court of Human Rights for example are usually examples of systematic or structural problems with legislation, policies or practices. Secondly, compared to other human rights cases, there is only a moderate number of reproductive rights related cases. The low number does not mean that reproductive rights violations are not common (in fact the exact contrary is true), or that these cases can be overlooked and disregarded, but quite the opposite – each of these cases has a huge potential to call out systematic injustices, change socio-legal thinking about reproduction and women, set new standards. Consequently, this thesis is tracing the narratives about women flowing from the selected reproduction jurisprudence.

I recognise that my choice of case-law could raise a critical question whether capturing women's stories exclusively through reproduction jurisprudence could be described as essentialising in itself – as if women's stories could not be told without talking about their bodies and reproductive systems. My response to this is pragmatic: conversations about reproduction in the majority of these cases still take place in male-dominated power spaces (governments, courts, parliaments), and only *seem* to be conversations about women when they actually circumvent women as full citizens and rights-holders, and delve into defining right/wrong, good mothers/bad mothers, motherhood, proper sexual behaviour etc. To balance that reality, I indeed look at reproduction and women, but under terms I have defined with the help of centuries-long feminist critique and by borrowing from other social science disciplines that have more experience with analysing, theorising and contextualising reproduction.

1.3.2 Human Rights Forums as Storytellers

Many social scientists collect personal stories through interviews and these narratives feed into their scholarship. My thesis focuses on stories and narratives, but in this work the storytellers are transnational human rights law forums. In this thesis I understand the stories

that emerge, when a human rights law forum (whether a tribunal, court, commission, or a committee) brings together the human experience (factual circumstances of a case), and the relevant treaty provision (the legal source) as *narratives*. I have gathered cases that all focus on some aspect of reproduction – whether on forced sterilisations, assisted reproductive technologies, maternal mortality, forced gynaecological examinations, obstetric care, surrogacy, or access to abortion. Such storytelling by courts or committees through transnational jurisprudence has a specific character, and is different for example from semi-structured interviews with litigators, NGO-s or even judges from these forums. In fact, the storytelling I investigate is so specific that it sparks the question, whether calling these cases *stories* is accurate at all.

Namely, framing these cases as stories may seem to disregard that a case reaching a transitional human rights law forum is more likely than not a result of strategic and well-crafted litigation as the stories that reach for example the European Court of Human Rights, or the UN CEDAW Committee are already someone's summaries of life experiences, designed and contextualised in a certain way.[49] As Katherine M. Franke observes "the translation of human suffering into vocabulary and a form that is acceptable and appropriate to a judicial proceeding can be a dehumanizing experience".[50] She argues that the translation of human suffering into the "language of law and rights" serves the interests of legal authorities more than those "who are called to narrate their pain".[51] I do not disagree with Franke's argument, but the focus of this thesis is specifically the analysis (definitions, concepts, framings) produced by transnational courts or committees – I am not looking these cases from the perspective of the applicants, as I am not following up whether for example they were satisfied with the outcome.

How do I read the chosen cases? The classic methodology for close reading and analysis of case-law follows usually a two-question-structure used by most judicial bodies and tribunals. Firstly, which human rights are involved in the case? This means identifying relevant human rights provisions and specific dimensions, or the "attributes" that they carry. The second question the courts, committees or tribunals ask is, what is the threshold for the violation *i.e* has the limitation (interference) been permissible, or has there been a breach of the particular human right. For this thesis, however, this two-question-structure is

[49] Regarding individual narratives see e.g: D. Tietjens Meyers, *Victims' Stories and the Advancement of Human Rights* (2016).
[50] K. M. Franke, "Gendered subjects of transitional justice", *Columbia Journal of Gender & Law*, Vol. 15, No. 3 (2006), p. 818.
[51] K. M. Franke, "Gendered subjects of transitional justice", *Columbia Journal of Gender & Law*, Vol. 15, No. 3 (2006), p. 821.

insufficient. Firstly, as I explain in more detail later on, reproductive rights do not appear in the main human rights texts in the same explicit way other human rights do. In other words, human rights treaty texts are silent on reproductive autonomy, abortion, maternal mortality, surrogacy, or home birth. However, as I show in Chapter 2 there is a growing international consensus that reproductive rights should be constructed through already recognised human rights, and can be read into the existing human rights frameworks. Therefore the so-called "entry points" of reproductive rights into human rights law vary: whether it is through the right to health, right to privacy, or through the prohibition of torture/degrading treatment and non-discrimination. Consequently, this means that human rights law forums have to move beyond the labels of "abortion", "surrogacy", and "forced sterilisation". This in turn requires a deep knowledge of all aspects of women's reproductive lives, and how the latter are impacted by women's socioeconomic status and by how much power they have in the society. Secondly, questions regarding a violation threshold are similarly problematic if not accompanied by critical questions about the missing gender perspectives in (human rights) law – *i.e* if degrading treatment or torture is understood through masculine experiences, and/or the violation threshold is rooted in (gender) stereotypes.[52] I explain how I overcome these shortcomings by adding different questions to the "classic" two-question-structure in Chapter 2.

1.3.3 Outline of the thesis: a reproductive rights-based approach and the narratives

After this introductory chapter my thesis proceeds with four core chapters (Chapter 2-5) and finishes with a concluding chapter (Chapter 6). As I set out above I am interested in storytelling, voices and silencing and that I am looking at these notions and processes in the space of transnational jurisprudence by employing feminist approaches, unpacking power relations, and tracing narratives. Thus, Chapter 2 titled "*Constructing the analytical frame – from "questioning everything" to a reproductive rights-based approach*" builds upon the theoretical frames I have already introduced (feminist approaches to law and human rights

[52] My methodology has similarities with different "rewriting projects". See for example: *The Women's Court of Canada, Rewriting Equality*: http://womenscourt.ca/; H. Douglas, F. Bartlett, T. Luker, R. Hunter (eds.), *Australian Feminist Judgments. Righting and Rewriting Law* (2014); J. Balkin (ed.), *What Brown v. Board of Education Should Have Said: The Nation's Top Legal Experts Rewrite America's Landmark Civil Rights Decision* (2002); J. Balkin (ed.), *What Roe v. Wade Should Have Said: The Nation's Top Legal Experts Rewrite America's Most Controversial Decision* (2005); The US Feminist Judgments Project, http://sites.temple.edu/usfeministjudgments/; R. Hunter, C. McGlynn, E. Rackley (eds.), *Feminist Judgments: From Theory to Practice* (2010); *Integrated Human Rights in Practice Rewriting Human Rights Decisions,* E. Brems, E. Desmet (eds.) (2017).

framework) and sketches additional layers and tools by borrowing elements from feminist legal theory, human rights-based approaches to health, and the existing reproductive rights discourse.

Specifically, I firstly explain, how feminist approaches have penetrated international law/human rights law, and how anti-stereotyping within legal analysis is the available tool for revealing power dynamics. Secondly, I show through the example of global health rights discourse, how the power relations-based analysis already exists in law – there is a growing emphasis on the *human rights-based approaches to health* that understand health through social determinants. Thirdly, I explain the development of reproductive rights discourse. More specifically, I arrive fairly late to the debates and discussions on the efforts of conceptualising people's reproduction experiences and reproductive lives through the human rights discourse – the term "reproductive rights" was coined and substantiated within the international human rights law already in the 1990s. Therefore it is important to connect my thesis to that part of scholarship, and build on from what has been achieved and theorised.

I bring all these elements together under an analytical framework that I term as *a reproductive rights-based approach* to help me trace, demonstrate and systematise the emerging narratives about women's bodies, reproduction and sexuality. The way women are portrayed in cases concerning reproduction – whether as victims, empowered agents, villains, or something else – plays an essential role in women's human rights in general. In other words, narratives matter: how a human rights court, commission or a committee conceptualises and understands women's bodies and gender roles in the reproduction context lays the foundation for substantive gender equality, and full citizenship of women. This understanding has also been expressed in 2016 General Comment (GC) on the Right to Sexual and Reproductive Health issued by the UN Committee on Economic, Social and Cultural Rights. The General Comment provides: "Due to women's reproductive capacities, the realization of women's right to sexual and reproductive health is essential to the realization of the full range of their human rights".[53]

Furthermore, as noted by Alicia Ely Yamin, judicial and quasi-judicial interventions can play an important role in the larger accountability circle that aims at "transforming discriminatory and exclusionary health systems and practices that bear on women's maternal

[53] UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 22 on the Right to sexual and reproductive health (Article 12). UN Doc. E/C.12/GC/22 (2016).

and reproductive health and well-being".[54] In this thesis I too am guided by this belief in the transformative power of rights-based approaches changing the power relations governing women's life experiences in the context of reproduction. Eva Brems argues that the interpretation of treaty provisions by the monitoring bodies through the individual complaints mechanism is very important as a model for domestic courts that may wish to apply the relevant treaty in their own jurisprudence.[55] Sally Engle Merry supports my argument when she writes, how "human rights are difficult for individuals to adopt as a self-definition in the absence of institutions that take these rights seriously".[56] Accordingly, I underscore that the human rights law forums must be much more conscious of their crucial role in creating new transformative narratives that are rooted in women's lived experiences, and not generalised assumptions (stereotypes). Further, Andrea Cornwall and Alice Welbourn (like R. Solnit in the introduction of this thesis) write how real participation is about "having a voice", and it is also about "being able to make choices, including whether to participate, and on what terms".[57] Therefore, Cornwall and Welbourn argue similarly to Engle Merry and Yamin that changes in gendered power relations and deeply rooted norms-values require *more* than "working with those who are deemed most vulnerable", as "contextual factors such as poverty and discrimination" need to be tackled, too.[58]

Accordingly, my focus on power relations is of course not revolutionary (in scholarship), as evidenced by feminist approaches highlighted above. Maria Sjöholm's recent book also looks at transnational case-law (reproduction issues included) through gender-sensitive norm interpretation.[59] However, she does not focus only on reproduction jurisprudence, and does not set up to look at narratives and processes of silencing as I do here.

Chapters 3, 4 and 5 are dedicated to case-law and the emerging narratives. I have divided the narratives into three themes. In Chapter 3, "*Women, birth and pregnancy narratives*", I show how motherhood, birth and pregnancy are understood and defined by the human rights law forums in abortion, maternal mortality and birth cases. The narrative that

[54] A. E. Yamin, "Towards transformative accountability: applying a rights-based approach to fulfill maternal health obligations", *SUR*, Vol. 7, No. 12 (2010), p. 108.
[55] E. Brems, "Developing the full range of state obligations and integrating intersectionality in a case of involuntary sterilization: CEDAW Committee, 4/2004, AS v Hungary", in: *Integrated Human Rights in Practice Rewriting Human Rights Decisions,* E. Brems, E. Desmet (eds.) (2017), pp. 238-239.
[56] S. Engle Merry, *Human Rights and Gender Violence* (2009), p. 192.
[57] A. Cornwall, A. Welbourn (eds.), *Realizing Rights: Transforming Approaches to Sexual and Reproductive Well-being: introduction* (2002), p. 7.
[58] A. Cornwall, A. Welbourn (eds.), *Realizing Rights: Transforming Approaches to Sexual and Reproductive Well-being: introduction* (2002), p. 9.
[59] M. Sjöholm, *Gender-Sensitive Norm Interpretation by Regional Human Rights Law Systems* (2017).

emerges from this chapter portrays women as a homogeneous group of people whose identity is constructed through motherhood, and who have a duty to reproduce under circumstances determined by the state or other entities. In Chapter 4, "*Women and violence narratives*", I present who the "woman" is in cases concerning forced sterilisations and forced gynaecological examinations ("virginity testing"). I reveal that the human rights framework on prohibition of torture and ill-treatment has failed to respond to the unique experiences of women in the context of reproduction, and that there is a strong narrative telling women that the violence deriving from over-medicalisation, obstetric mistreatment, forced "virginity testing" and forced sterilisations is just an unavoidable *misfortune* that happens to women and girls. Thus, a reproductive rights-based analysis must call out that these forms of violence stem "from socially determined roles and expectations" and also that "gender stereotypes are downplaying the pain and suffering that certain practices inflict".[60] Finally, in Chapter 5, "*Women and (in)fertility narratives*", I put forth the stories that emerge in case-law concerning surrogacy, *in vitro* fertilisation and embryo freezing: how women – whether as surrogates or egg donors, or patients receiving infertility treatment – become almost invisible and also how assisted reproduction regulations are used to maintain "traditional" ideas about procreation, families and power distribution.

[60] *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, (A/HRC/31/57) (5 January 2016).

2. CONSTRUCTING THE ANALYTICAL FRAME – FROM "QUESTIONING EVERYTHING" TO A REPRODUCTIVE RIGHTS-BASED APPROACH

2.1 SETTING THE COURSE: OUTLINE & AIM OF THE CHAPTER

I start unfolding my analysis from the fundamental idea of how, for a life lived with human dignity, having a voice is pivotal. In simple terms, having a voice in one's life story means having power over one's life course, and vice versa – being silenced leads to a state of powerlessness. In this thesis I understand voices and silencing in a broad sense, not restricting it just to a person's freedom to speak, or to verbal expressions exclusively. Having a voice means determining one's life course irrespective of one's identity and background. Thus, I see silencing as a societal phenomenon; as a systematic and structural process that may happen through instances of violence, discrimination, and exclusion.

Specifically I am looking at voice, power and silencing of women in the transnational reproduction jurisprudence. How are transnational human rights law forums contributing to these processes of silencing-empowering with their case-law? Which narratives about women's bodies and sexuality emerge – are women's experiences at the heart of the reproduction jurisprudence I am considering? With this investigation into narratives I am engaging with two simultaneous tasks. Firstly I answer my research question about the emerging narratives: who is the "woman" in reproduction jurisprudence. Second, I also challenge the legal discipline by carving a space in which I consider jurisprudence through the narrative approach that prioritises unpacking power dynamics over more traditional tools of analysis.

Chapter 2 explains the essence and origins of what I term as *a reproductive rights-based approach*, which I use as a frame in this thesis to make sense of the selected reproduction jurisprudence; trace and extract the narratives about women, their bodies and sexuality. As I said above, a reproductive rights-based approach is constructed with mainly already existing critical approaches, thus it is not revolutionary *per se*. However, it is a toolbox that sharpens human rights analysis, and – as the jurisprudence analysed in this thesis demonstartes – is unfortunately still to date largely missing from the legal analysis apparatus of the international human rights law forums. A *reproductive rights-based approach* serves as a lens through which I discover sometimes explicit, but often hidden broader conversations about gender, power, and reproduction in different reproduction cases ranging from abortion

to surrogacy – thus, throughout this piece I see reproductive rights through power relationships, not as specific exhaustive lists of services or/and entitlements.[61]

I have divided Chapter 2 into three sections: firstly, I explain feminist approaches to human rights law (2.2), the second section is dedicated to health: the definitions and dimensions of health and reproductive health, the right to health in human rights law, and most importantly, human rights-based approaches to health (2.3). And lastly, in the third section I give an overview of the development of the reproductive rights discourse as part of the international human rights law, and explain how reproductive rights have been defined (2.4).

2.2 FEMINIST APPROACHES TO HUMAN RIGHTS LAW

As I explained in the introduction throughout this thesis I am employing feminist approaches. Generally, this means "questioning everything" (including different feminist viewpoints), and engaging with how power distribution impacts people's lives. In the following part (2.2) I explore this idea further and establish, how feminist approaches have specifically penetrated legal theory, international law and human rights. I end the section by showing anti-stereotyping as a specific tool that courts or committees could use to analyse, how harmful stereotypes impact women's lived experiences, and can act as short-cuts to human rights breaches. The aim of this part is three-fold: firstly, as promised, I add layers to the analytical frame of this thesis; secondly I lay the groundwork for the narrative tracing in the following chapters as I introduce here the language and main arguments of feminist approaches to human rights; last but definitely not least I am showcasing how much resistance there has been and continues to be in law against feminist approaches and critical questions about power distribution. As I demonstrate in Chapters 2, 3 and 4 of this thesis, the same resistance feeds into, and fuels the resistance of the transnational human rights courts or committees to call out sexism and harmful stereotypes. Thus, I go back to Griselda Pollock's argument underscoring that women have not been omitted "through forgetfulness or mere prejudice".[62] Instead, it has been a conscious choice, a resistance to accept that law can be a tool of oppression or stagnation for some groups in the society; that international human

[61] I have referred to a *reproductive rights-based approach* also in my previous work. See: L. Oja, "Why is a 'Good Abortion Law' Not Enough? The Case of Estonia, *Health and Human Rights Journal* , Vol. 19, No. 1 (2017), L. Oja, A. E. Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?", *Columbia Journal of Gender and Law* , Vol. 32, No. 1 (2016).
[62] G. Pollock, *Vision and Difference: Feminism, femininity and the histories of art*, (2003), p. 1.

rights law, like most economic, social, cultural, and legal constructs can also contribute to silencing, and thus reinforce powerlessness.[63]

2.2.1 Feminist legal theory

Nicola Lacey gives an excellent overview of the development of feminist legal theory.[64] The aim of describing these different stages here is to highlight how reluctant the legal discipline has been to the idea of "questioning everything", and furthermore, to underscore once again, how there does not exist one *single* "feminist critique". The latter is also evident throughout this thesis as I showcase how in the context of reproductive rights some feminist authors take completely opposite views of what is for example empowering or disempowering (for women).

Lacey explains that despite the common perception that legal feminism is the creation of the late 20th century, the *feminist thought about law* actually stretches back for many centuries.[65] However, Lacey also notes that it was the second wave women's movement in the 1960s and 1970s that gave "a fresh impetus to feminist thought", and importantly also stimulated the "gradual entry of feminist ideas" into scholarship and academia – in other words, feminist movement not only affected societal awareness and culture, but also put on the intellectual agenda issues that had been ignored – e.g questions about sexual violence, equal pay, gender discrimination.[66]

As expected, Lacey notes that these developments were however slow to reach legal scholarship: the earliest feminist legal scholarship focused on the *absence* of women from the

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[63] H. Charlesworth, "What Are 'Women's International Human Rights'?" in: *Human Rights of Women: National and International Perspectives*, R. J. Cook (ed.) (1994), p. 60.

[64] N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights,* K. Knop (ed.) (2004). See also e.g: *The Oxford handbook of transnational feminist movements*, R. Baksh, W. Harcourt (eds.) (2015).

[65] N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights,* K. Knop (ed.) (2004), p. 13.

[66] N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights*, K. Knop (ed.) (2004), p. 14. It is important to acknowledge that just as there is no one single feminism, there also does not exist *one* feminist movement. For example, the Eastern and Central European feminist movements were different from USA, the UK. See further: R. Koobak, R. Marling, "The decolonial challenge: "Framing post-socialist Central and Eastern Europe within transnational feminist studies", *European Journal of Women's Studies*, Vol. 21, Issue 4 (2014), and e.g, B. Havelková, *Gender equality in law: uncovering the legacies of Czech State socialism*, (2017) where Havelková describes feminism in Czech Republic: "What is not seen is the structural nature of the underlying causes. By contrast, Western feminism has from the 1970s onwards brought about a paradigmatic shift, largely intellectually internalised, at least by the elites, including large parts of the legal communities in the West, that inequality is not the problem of women but the problem of patriarchy". Furthermore, on Latin America see e.g: Y. Espinosa Miñoso*, Aproximaciones críticas a las prácticas teórico-políticas del feminismo latinoamericano*, Volumen 1 (2010).

agenda of legal study, and gradually the "woman question" started to make its way into family law, criminal law and labour law.[67] The problem with that approach, however, was that it did not question patriarchy's categories, stereotypical assumptions, but simply suggested that there had been an error: "the failure to include women".[68] The "women and law" work that was concerned with the "woman-centredness" of feminism (term used by J. Conaghan) was however criticised for being essentialist and rendering the targets of feminist critique to something that was exclusively a "woman problem".[69] Thus, there was another shift to "gender and law", but also this move did not come about without criticism, either.[70]

Feminist legal theory has also developed by virtue of other disciplines. Namely, Ruth Fletcher notes that feminist thought has made law's location within humanities and social sciences more explicit, and thus the parameters of legal research have broadened: "Although the term "socio-legal" is problematically broad. Its use does signify an acknowledgement that law is a social phenomenon which cannot be understood by attention to internal technical detail alone".[71]

I have already explained through the voices of several feminist scholars, how although there is a plurality in feminist approaches, the common elements at the heart of these approaches are "questioning everything" and "permanent partiality". As Joanne Conaghan explains:

> *First, feminist legal scholars seek to highlight and explore the gendered content of law and to probe characterizations positing themselves as neutral and, more specifically, ungendered. Secondly, they are part of a cross-disciplinary feminist effort to challenge traditional understandings of the social, legal, cultural, and epistemological order by placing women, their individual and shared experiences, at the centre of their scholarship. Thirdly, feminist legal scholars seek to track and expose law's implication in women's disadvantage with a view to bringing about transformative social and political*

[67] N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights*, K. Knop (ed.) (2004), p. 14.
[68] H. R. Wishik, "To Question Everything: The Inquiries of Feminist Jurisprudence", *Berkeley Women's Law Journal*, Issue 1 (1985), p. 68.
[69] J. Conaghan,"Reassessing the Feminist Theoretical Project in Law", *Journal of Law and Society*, Vol. 27, No. 3 (2000), p. 363, and N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights*, K. Knop (ed.) (2004), p. 15.
[70] N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights*, K. Knop (ed.) (2004), p. 15.
[71] R. Fletcher, "Feminist Legal Theory", in: *An Introduction to Law and Social Theory*, R. Banakar, M. Travers (eds.) (2002), p. 137.

change.[72]

Nicola Lacey goes into more methodological details about feminist legal theories and explains that feminist legal theories aspire to produce a critical interpretation of legal practices.[73] She then spells out main theoretical points of distinction between feminist theorists. Firstly, there is a differentiation in methodology and style – whether more rhetorical, polemical, classically academic or metaphorical.[74] Lacey underscores that this is, however, not just a question of personal style of writing, but rather a *strategic choice* as new forms of expression can challenge "the way in which particular intellectual disciplines and discourses have developed makes it impossible to conceptualize certain types of harm or wrong, or to reveal certain kinds of interest or subject position" - in other words, this means that different methodologies in style can conceptualise certain things that would otherwise be left to the margins, or "fall between a number of existing social and legal concepts".[75]

The second important differentiation is grounded in the variety of underlying theories of sexual difference: e.g whether the maintenance of sexual difference lies in "domination grounded in the abuse of sexual power and the exercise of sexual violence", or the sexual difference is rooted in women's distinctive bodily experiences and relationships that generate a "particular female culture" (for example some radical or cultural feminists).[76]

The third axis of differentiation comes from the extent to which different feminist theories exhibit substantive or methodological continuities with other legal and social theories: some theorists would insist that feminist theory is autonomous as a method, but some would argue that feminist legal theory is not an autonomous theoretical or methodological approach, but rather it is "an interpretive approach which seeks to get beyond the surface level of legal doctrine and legal discourse, and which sees traditional jurisprudence as ideological" - accordingly, there are different political versions of feminist

[72] J. Conaghan "Reassessing the Feminist Theoretical Project in Law" , *Law and Society*, Vol. 27, No. 3 (2000), p. 359.
[73] N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights*, K. Knop (ed.) (2004), p. 17.
[74] See Lacey giving examples in: N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights,* K. Knop (ed.) (2004), p. 17
[75] N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights*, K. Knop (ed.) (2004), p. 18. See additionally e.g: *The Oxford handbook of feminist theory* (electronic resource), L. Disch, M. Hawkesworth (eds.) (2015-2016), *The Ashgate research companion to feminist legal theory* (electronic resource), M. Davies, V. E. Munro (eds.) (2013), C. Hughes, *Key concepts in feminist theory and research* (2002).
[76] N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights*, K. Knop (ed.) (2004), p. 18.

theory – liberal feminism, radical feminism, Marxist and Socialist feminism, and difference feminism.[77]

In my thesis I borrow freely from all of these differentiations where justified and necessary. More important than a theoretical label is how a specific element of a critique can be useful for an analytical exercise in practice. Such "mixed approach" has been endorsed by Hilary Charlesworth who writes that although there is a tendency within feminist scholarship to "pigeonhole" theorists into fixed categories as "liberal" or "radical", a range of feminist theories are actually needed to "excavate" different issues.[78]

2.2.2 From feminist legal theory to women's rights in human rights law

I now move on from the general overview of feminist legal theory to human rights and feminism more specifically. Feminist legal theory has indeed inspired a vast and a growing literature about the intersection of gender and international (human rights) law.[79] Again, Hilary Charlesworth's work is essential. Charlesworth asks what "women's international human rights" are, why is there a need to emphasise the "women" part, and consequently, how can women be taken seriously across the entire spectrum of human rights.[80] Charlesworth explains how the very common response to women's human rights is a reference to law's universality and accordingly how human rights are universally applicable, therefore making the term women's human rights a "distracting redundancy" – again this response showcases the reluctance to acknowledge that the development of human rights law has been partial and androcentric privileging a masculine worldview.[81] Anne Hellum and Henriette Sinding Aasen, too, reflect how for most of human history, men have been assigned a superior status in law, this started to change only in the 20th century as with the "drafting of international and regional human rights conventions, and with the emerging women's

[77] N. Lacey, "Feminist Legal Theory and the Rights of Women", in: *Gender and Human Rights,* K. Knop (ed.) (2004), pp. 19-26. See also: H. Charlesworth, C. Chinkin, *The boundaries of international law. A feminist analysis* (2000), pp. 23-59.
[78] H. Charlesworth, "Feminist methods in international law", in: *The Methods of International Law*, S. R. Ratner and A.-M. Slaughter (eds.) (2003), p. 161.
[79] For example: H. Charlesworth, C. Chinkin, *The boundaries of international law. A Feminist Analysis* (2000); *Women's rights. Human Rights. International Feminist Perspectives*. J. Peters, A. Wolper (eds.) (1995); *Human Rights of Women. National and International Perspectives,* R. J. Cook (ed.) (1994).
[80] H. Charlesworth, "What Are 'Women's International Human Rights'?", in: *Human Rights of Women: National and International Perspectives*, R. J. Cook (ed.) (1994), p. 59.
[81] H. Charlesworth, "What Are 'Women's International Human Rights'?", in: *Human Rights of Women: National and International Perspectives*, R. J. Cook (ed.) (1994), p. 60.

movement the political and legal atmosphere changed and discrimination based on sex an gender became a human rights concern".[82]

Hilary Charlesworth underscores, how the problem is structural powerlessness, and international human rights law, like most economic, social, cultural, and legal constructs, reinforces this powerlessness.[83] With this, Charlesworth as other feminist scholars contests the idea of law being something inherently neutral, and also acknowledges that the powerlessness and marginalisation of women is not accidental or incidental, but actually institutionalised. Susan Marks also writes that indeed, "flaws have been illuminated at the level of law, procedure and policy", but these flaws have been made to seem like "simple misunderstandings or oversights, deficiencies of leadership or accountability, or quirks of local history or culture" not "man-made" and consequential to "some wider systemic context".[84]

Karen Engle maps the development of feminist critiques of human rights law, and identifies three eras: liberal inclusion critique (1985-1990), structural bias critique (1987-1995) and third world feminist critique (since 1992).[85] According to Engle, the liberal inclusionists argued that women should and could be included in international human rights and humanitarian law, which for structural bias critics was a simple "add women and stir" strategy that did not address how the "structure of international law prevented women's assimilation".[86] And lastly, the "third world feminist critiques" (as Engle terms them) suggested that the effects of international law on women must be examined in the light of class, culture and race, and that "Western feminism" has misrepresented women and disregarded issues that have the greatest importance to women in the third world.[87]

Indeed, there are many things that have changed and improved, and some of these

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[82] *Women's human rights. CEDAW in International, Regional and National Law*, A. Hellum, H. Sinding Aasen (eds.) (2013).
[83] H. Charlesworth, "What Are 'Women's International Human Rights'?", in: *Human Rights of Women: National and International Perspectives*, R. J. Cook (ed.) (1994), p. 60.
[84] S. Marks, "Human rights and root causes", *Modern Law Review*, Vol. 74, Issue 1, (2011), p. 78.
[85] K. Engle, "International Human Rights and Feminisms: When Discourses Keep Meeting", in: *International Law: Modern Feminist Approaches,* D. Buss, A. Manji (eds.) (2005). Engle builds on her earlier article: K. Engle, "International Human Rights and Feminism: When Discourses Meet", *Michigan Journal of International Law*, Vol. 13, Issue 3 (1992).
[86] K. Engle, "International Human Rights and Feminisms: When Discourses Keep Meeting", in: *International Law: Modern Feminist Approaches,* D. Buss, A. Manji (eds.) (2005), pp. 51-52.
[87] K. Engle, "International Human Rights and Feminisms: When Discourses Keep Meeting". In: *International Law: Modern Feminist Approaches,* D. Buss, A. Manji (eds.) (2005), p. 61. See further on postcolonial criticisms of feminisms, e.g.: C. Talpade Mohanty, *Feminism without borders: decolonizing theory, practicing solidarity* (2003), S. de Jong, *Complicit Sisters: Gender and Women's Issues across North-South Divides* (2017) and A. Sisson Runyan, (guest ed.), *International Feminist Journal of Politics:* "Decolonizing knowledges in feminist world politics", Vol. 20, Issue 1 (2018).
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reflect also in the cases introduced in later chapters of this thesis. However, the "feminist project" has definitely not lost its momentum and relevance. Chinkin, Wright and Charlesworth were reflecting almost 15 years after their revolutionary article what has changed in the feminist approaches to international law. They respond to criticism about how the feminist project of reconceiving international law might contribute to the latter's "fragility": "Our argument is, however, that international law does not provide even a momentary distance from subjectivity. It is intertwined with a sexed and gendered subjectivity, and reinforces a system of male power".[88] Chinkin, Wright and Charlesworth conclude that although conventions, declarations and challenges before international forums are not enough to protect and enhance the international standing and rights of women, they are nevertheless important for "both theorising difference and putting that difference into practice in a way that empowers women, men and children".[89]

2.2.3 Toolbox: Tackling stereotypes in (human rights) case-law

The challenges that feminist legal theory and feminist approaches present to law, human rights, legal thinking and legal education can express and manifest themselves in many ways. I have chosen in this thesis to look at narratives of power, and ask who the women in these narratives are. Thus, I have chosen to communicate the emerging narratives about women in the reproduction jurisprudence through *stereotypes*. The United Nations CEDAW, the *Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women* (the Convention Of Belem Do Para), and the *Council of Europe Convention on preventing and combating violence against women and domestic violence* (the Istanbul Convention) are transnational human rights treaties that explicitly legally bind countries to take measures against harmful stereotyping.[90]

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[88] C. Chinkin, S. Wright, H. Charlesworth, "Feminist Approaches to International Law Reflections from Another Century", in: *International Law: Modern Feminist Approaches,* D. Buss, A. Manji (eds.) (2005), p. 44. See also: *Feminist perspectives on contemporary international law: between resistance and compliance?* S. Kouvo, Z. Pearson (eds.) (2011).

[89] C. Chinkin, S. Wright, H. Charlesworth, "Feminist Approaches to International Law Reflections from Another Century", in: *International Law: Modern Feminist Approaches,* D. Buss, A. Manji (eds.) (2005), p. 44.

[90] CEDAW: *Article 2* States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:
(...) (f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;Article 5 States Parties shall take all appropriate measures:(a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women; Article 10 States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure

Rebecca J. Cook and Simone Cusack explain that stereotype is a "generalised view or preconception of attributes or characteristics possessed by, or the roles that are or should be performed by, members of a particular group".[91] Cook and Cusack emphasise that in reality it does not even matter whether all members of that group actually correspond to these stereotypes (for example, if they possess certain characteristics), but the "key consideration is that, because a particular group is presumed to possess those attributes or characteristics or perform those roles, an individual, simply by virtue of membership in that group, is believed to conform to the generalised view or preconception".[92] Lourdes Peroni and Alexandra Timmer add a "typology of stereotypes", which explains different forms of stereotypes – e.g. descriptive, prescriptive, role-typing, negative, positive stereotypes.[93]

Stereotyping helps people make sense of the world – they act as shortcuts, and not all stereotypes have harmful effects, or lead to human rights breaches.[94] However, if stereotypes define what roles people can (are allowed to) take in their life projects, and lead to silencing and penalties when people reject these stereotypical roles , then stereotypes have become harmful. Harmful stereotypes can in turn set people up for human rights violations. Thus, this is the problem and danger of "a single story" as explained above by Sandra G. Harding and Chimamanda Ngozi Adichie. Here intersectionality is also important, as Raphaële Xenidis explains: "Every individual is in fact embedded into a complex network of social memberships and identity groups, potentially cumulating disadvantage".[95] Xenidis refers to

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to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women: (...)
(c) The elimination of any stereotyped concept of the roles of men and women at all levels and in all forms of education by encouraging coeducation and other types of education which will help to achieve this aim and, in particular, by the revision of textbooks and school programmes and the adaptation of teaching methods;
Istanbul convention
Article 12 – General obligations
1 Parties shall take the necessary measures to promote changes in the social and cultural patterns of behaviour of women and men with a view to eradicating prejudices, customs, traditions and all other practices which are based on the idea of the inferiority of women or on stereotyped roles for women and men.
Convention of Belem do Para
Article 8 – b, Article 6 – b.

[91] R. J. Cook and S. Cusack, *Gender Stereotyping: Transnational Legal Perspectives*, (2010), p. 9. See also insights into whether anti-stereotyping has been taken on by transnational human rights law forums in: *Stereotypes and human rights law*, E. Brems, A. Timmer (eds.) (2016).

[92] R. J. Cook and S. Cusack, *Gender Stereotyping: Transnational Legal Perspectives*, (2010) p. 9.

[93] L. Peroni, A. Timmer, "Gender Stereotyping In Domestic Violence Cases An Analysis Of The European Court Of Human Rights' Jurisprudence", in: *Stereotypes and human rights law*, E. Brems, A. Timmer (eds.) (2016), pp. 40-41.

[94] See: E. Brems, A. Timmer, "Introduction", in: *Stereotypes and human rights law*, E. Brems, A. Timmer (eds.) (2016), pp. 2-3.

[95] R. Xenidis, "Multiple Discrimination in EU Equality Law", in: U. Belavusau, K. Henrard (eds.), *EU Anti-Discrimination Law Beyond Gender: Achievements, Flaws, and Prospects* (Hart Publishing, forthcoming).

situations where for example a woman is disadvantaged due to her gender *and* race, or gender, religion *and* sexual orientation, or gender, refugee status *and* disability etc.

Nevertheless, Cook and Cusack note how, regrettably, despite the progress made in finding that the application of gender stereotypes violates women's and men's rights, "courts and human rights treaty bodies are still generally reluctant to find that resort to gender stereotypes constitutes discrimination or violates other human rights".[96] Thus, as a cure they propose a step-by-step methodology to address gender stereotyping within legal interpretation work. The first step is naming (gender) stereotypes: identifying their forms and describing how they harm women. They explain that "naming is an important tool for revealing otherwise hidden harm, explaining its implications, and labelling it as a human rights concern, grievance, or possible human rights violation", and underscore how law is an effective and powerful tool for the "naming" process precisely because it can "publicly and authoritatively proclaim and transform an unacknowledged harmful experience into an experience, or wrong, that is recognized at law as one that is harmful and that requires legal redress".[97] How does one recognise a stereotype, i.e know that a stereotype is, indeed, a stereotype? Cook and Cusack explain how there is no "single correct way" to determine whether a law, policy, or practice applies, enforces, or perpetuates a gender stereotype and thus a variety of approaches might be employed.[98] They continue to list different "symptoms or indicators of stereotyping" and also suggest that some feminists have relied on asking the "woman question" which aims to expose the gendered nature of a law/practice by directing attention to what a law, policy, or practice implies about women.[99]

I echo Cook and Cusack's view that there is no one single recipe because identification of stereotypes requires many things such as understanding different sociolegal and historic contexts, how power dynamics impact people's lived experiences, the structural nature of human rights violations etc. Therefore asking the "woman question" has many necessary layers to it that go beyond gender. In any case, the key point of departure is that women's experiences are taken seriously and what they say about their lived experiences is sought after and regarded as evidence by courts or committees.

[96] R. J. Cook and S. Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (2010).
[97] R. J. Cook and S. Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (2010), p. 39.
[98] R. J. Cook and S. Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (2010), p. 46.
[99] R. J. Cook and S. Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (2010), p. 47.

The second step requires "articulating normative obligation to eliminate the stereotypes", and the third step devises appropriate remedies.[100] In this thesis I focus on the first and second step: through the jurisprudence analysis I demonstrate *stereotypes* regarding women's reproductive roles, bodies and their sexuality that led to human rights breaches and when left unchallenged are influencing the analysis of the human rights law forums.[101] I show how stereotypes are feeding into harmful narratives about women.[102] Lourdes Peroni and Alexandra Timmer note that their argument for anti-stereotyping does not mean that they think the European Court of Human Rights can eliminate gender stereotypes, however, they do see the Strasbourg Court as "one actor in a larger effort".[103]

Barbara Havelková also investigates, how courts – specifically the European Court of Human Rights – consider stereotypes. Havelková notes how "several European judges in recent years have made a number of statements in discrimination cases that are striking in their forthright and blatant hostility towards anti-discrimination and equality law".[104] Similarly to feminist approaches to law discussed above Havelková too underscores how anti-discrimination law, and indirect discrimination especially depend on "several acknowledgements about social reality" – one of them being the awareness that discrimination is a consequence of socio-economic and socio-cultural structures that disadvantage certain groups, and accordingly it is vital to recognise how seemingly "neutral"

[100] R. J. Cook and S. Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (2010), p. 177.

[101] Other scholars have argued for anti-stereotyping as a tool/method for courts. See e.g: A. Timmer, "Toward an Anti-Stereotyping Approach for the European Court of Human Rights" *Human Rights Law Review*, Vol. 11, Issue 4 (2011), L. Peroni, "Deconstructing 'Legal' Religion in Strasbourg", *Oxford Journal of Law and Religion*, Vol. 3, Issue 2 (2014) and "Religion and Culture in the Discourse of the European Court of Human Rights: The Risks of Stereotyping and Naturalizing", *International Journal of Law in Context*, Vol. 10, Issue 2 (2014); S. Fredman, "Emerging from the Shadows: Substantive Equality and Article 14 of the European Convention on Human Rights", *Human Rights Law Review*, Vol. 16, Issue 2 (2016); L. Clerico, C. Novelli, "The Inclusion of the Social Question within the Gender Perspective: Notes to Rewrite Cotton Fields", *Inter-American and European Human Rights Journal*, Vol. 9, Issue 2 (2016).

[102] I used similar approach with Alicia Ely Yamin in our co-authored article: L. Oja, A. E. Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?", *Columbia Journal of Gender and Law* , Vol. 32, No. 1 (2016). L. Peroni and A. Timmer use a similar method of spelling out stereotypes in their chapter "Gender Stereotyping In Domestic Violence Cases An Analysis Of The European Court Of Human Rights' Jurisprudence", in: *Stereotypes and human rights law*, E. Brems, A. Timmer (eds.) (2016).

[103] L. Peroni and A. Timmer, "Gender Stereotyping In Domestic Violence Cases An Analysis Of The European Court Of Human Rights' Jurisprudence", in: *Stereotypes and human rights law*, E. Brems, A. Timmer (eds.) (2016), p. 40.

[104] B. Havelková, "Judicial Scepticism of Discrimination at the ECtHR", in: H. Collins, T. Khaitan (eds.) *Foundations of Indirect Discrimination Law* (2018), p. 83. Havelková refers to the European Court of Human Rights' *Ladele* case (2013). Ms Ladele was a registrar who refused to officiate civil partnerships on the grounds of her religion and conscience, which led to disciplinary proceedings against her and loss of job. The European Court of Human Rights ruled that the UK had not exceeded margin of appreciation. However, two dissenting judges noted how "gay rights" had been "clearly favoured over fundamental human rights". Havelková writes how the judges' "contrast of anti-discrimination rights with fundamental rights, along with their use of inverted commas, betrays an unusually conspicuous hostility towards gay rights".

rules will impact the advantaged and disadvantaged groups differently.[105] She offers a useful analytical frame when she writes that the judges' or governments' objections to effects-based and substantive doctrine of indirect discrimination can be categorised into three: first the "belief in the existence of a fair world based on a confidence that existing institutional set-ups are fair and neutral", second, how anti-discrimination law should target only "hostile animus", and therefore not implicit bias – which leads to the third: the burden of overcoming the disadvantage is put on the person who is discriminated.[106] These positions, however, "seriously impede the formation and the application of an effects-based and substantive doctrine of indirect discrimination".[107]

There are many incredibly strong and persistent stereotypes about women, their roles in the society and all aspects about their life projects and experiences with reproduction, e.g. "all women desire to become mothers", "women seeking abortions are careless", "women desiring to give birth at home are dangerous", "women's sexuality is a question of her dignity and honour". Putting stereotypes at the heart of my analysis allows me to trace narratives about women and their bodies, draw conclusions about the processes of silencing, and consequently answer the research question: *Who is the "Woman" in human rights law?*

2.3 HEALTH AND HUMAN RIGHTS: FROM SOCIAL DETERMINANTS TO HUMAN RIGHTS-BASED APPROACHES

Feminist legal theory is challenging the idea that *law* is a neutral and objective space, free of power dynamics otherwise present in the society. In my thesis the spirit of this challenge translates more specifically into critical approaches to the definitions courts, or committees adopt for *science*, *medicine*, *violence*, *access*, *autonomy*, *harm*. In the fields of global health, and health & human rights scholars and activists are facing similar challenges. Namely, although the acknowledgment of *social dimensions* of health is penetrating international (but also consequently domestic) laws regarding health, and general thinking about health rights this has not happened without resistance. Reproductive health is included into these developments and discussions as I show below. Thus, in the following sections I

[105] B. Havelková, "Judicial Scepticism of Discrimination at the ECtHR", in: H. Collins, T. Khaitan (eds.) *Foundations of Indirect Discrimination Law* (2018), pp. 85-86, and the further references therein to the works of S. Fredman and T. Khaitan.
[106] B. Havelková, "Judicial Scepticism of Discrimination at the ECtHR", in: H. Collins, T. Khaitan (eds.) *Foundations of Indirect Discrimination Law* (2018), p. 88.
[107] B. Havelková, "Judicial Scepticism of Discrimination at the ECtHR", in: H. Collins, T. Khaitan (eds.) *Foundations of Indirect Discrimination Law* (2018), p. 92.

demonstrate, how in the context of global health critical analysis of power and rights has developed and been termed as *human rights-based approaches to health*. These processes have not been easy successes, facing no resistance. Therefore, there are obvious similarities between what *human rights based approaches to health* and *feminist approaches* are both trying to achieve. However, it nevertheless emerges that when the obvious *gender* component of reproduction (reproductive health) is added into the discussion on health, rights and power, the resistance increases and strengthens. Consequently, arguing for *a reproductive rights-based approach* carries a double challenge.

2.3.1 Understanding health within societal power systems

Iris Borowy explains in her work two different approaches to health. First, a biomedical view that defines health primarily as a function of disease – thus, according to this view, improving health requires fighting diseases by improving medical therapy, which essentially means more and better doctors and medicine, biomedical prevention, therefore this approach is "marked by its seemingly apolitical character, devoid of moral connotations".[108] Borowy adds, how the biomedical view perceives diseases as "regrettable but natural" events for which nobody bears responsibility, and which call for "technical fixes", rather than social or political change; its main strategies are thus "vertical" policies "designed to fight a specific disease until its incidence declines substantially or, ideally, it disappears".[109] It is impossible to miss the similarities between this understanding of health, and the idea that human rights violations can be cured with approaches that do not address the connection of power distribution and the rights breaches. In simple terms, as long as the law applies to *everyone* the same way, and is blind of a person's identity, inequalities should not occur.

The second approach to health as Borowy describes has a social dimension that perceives health not as a medical, but a social phenomenon – therefore, requiring policies that redistribute power, resources and opportunities in contrast to mere extensions of modern medical technology.[110] As Ritu Sadana writes, the underlying causes are complex – often reflecting systematic social, political, historical, economic, and environmental factors that

[108] I. Borowy, "Shifting Between Biomedical and Social Medicine: International Health Organizations in the 20th Century", *History Compass*, Vol. 12, Issue 6 (2014), pp. 517-518.
[109] I. Borowy, "Shifting Between Biomedical and Social Medicine: International Health Organizations in the 20th Century", *History Compass*, Vol. 12, Issue 6 (2014), p. 518.
[110] I. Borowy, "Shifting Between Biomedical and Social Medicine: International Health Organizations in the 20th Century", Vol. 12, Issue 6 (2014), p. 526.

indeed interface with biological factors, are often accumulated during a lifetime, and could be trans-generational.[111] Many if not most scholars who build their work on this understanding use Amartya Sen's scholarship.[112] Accordingly, Tim Evans describes the social dimension as the "social patterning of health".[113] Ritu Sadana writes that the term often used as shorthand for all different factors is "social determinants". [114] Michael Marmot explains how acknowledging the impact of the social gradient "changes the discussion fundamentally" as it implies that the central issue is inequality, not simply poverty [115] Therefore, he argues that "tackling disempowerment" is crucial for improving health.[116] Norman Daniels agrees when he argues, how "social justice in general is good for population health and its fair distribution".[117]

Furthermore, scholars have applied this thinking to global development context: Ashley M. Fox and Benjamin M. Meier argue for a collective human right to development that could reconceptualise public health systems as "core social institutions that define the very experience of poverty and development, scaling up the provision of underlying determinants of health to realize the highest attainable standard of health".[118] Thus, again we witness that the challenge to biomedical view of health is in sync with the challenge to neutrality and objectivity of *law*. Another important take-away that sets the context for the following part is the idea that although a social dimension of health (*i.e* seeing health through power relations) is not an abstract concept, but an evidence-based understanding, it is still not given, but something scholars, advocates, policy-makers need to push for.

2.3.2 Health as a human rights issue

Just like feminist approaches to law the story of connecting human rights and health is also complicated and uneven, – full of successes and failures. I explained above the different

[111] R. Sadana, "Reflections on Global Monitoring of Social Determinants of Health and Health Equity", in: N. Eyal *et al* (eds.), *Inequalities in Health: Concepts, Measures, Ethics* (2013), p. 4.
[112] See e.g.: A. Sen, *Development as freedom* (2000), *The Idea of Justice* (2009).
[113] T. Evans, "Global Health", in: *International Development: Ideas, Experience, and Prospects*, B. Currie-Alder *et al* (eds.) (2014), p. 4.
[114] R. Sadana, "Reflections on Global Monitoring of Social Determinants of Health and Health Equity", in: *Inequalities in Health: Concepts, Measures, Ethics*, N. Eyal *et al* (eds.) (2013), p. 4.
[115] M. Marmot, *The Health Gap: The Challenge of an Unequal World* (2015), p. 28.
[116] M. Marmot, *The Health Gap: The Challenge of an Unequal World* (2015), p. 46.
[117] N. Daniels, *Just Health: Meeting Health Needs Fairly* (2008), p. 82.
[118] A. M. Fox, B. M. Meier, "Health as freedom: addressing social determinants of global health inequities through the human right to development", *Bioethics*, Vol. 23, Issue 2 (2009), p. 122.

concepts of health and I continue now by looking at the difficult process of confirming the links between *social dimension of health and human rights*.[119]

Benjamin Mason Meier writes, how human rights are heralded as a modern guide for public health, but "it was not always so". [120] After the United Nations Charter (the first international legal document that recognised the concept of human rights) came into force in 1945, the participating countries also signed the World Health Organisation's Constitution in 1946. John Tobin comments that the World Health Organisation's Constitution was the *first* document in international law where the idea of the right to the highest attainable standard of health was expressed: "*The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition*".[121] The World Health Organisation was officially founded in spring 1948, which made it the United Nations first specialised agency.[122]

The issue of health also found its way to the first document of the International Bill of Human Rights – the Universal Declaration of Human Rights (UDHR) was proclaimed in 1948, and the declaration made an explicit reference to health in its Article 25.[123] Indeed, although the right to health was not included as a specific right, it was also not abandoned – it was bundled together with a series of economic and social rights in Article 25 (1).[124] It is important to note how this first framing of the right to health already took into account the underlying social determinants of health.[125] Meier and William Onzivu comment, how with the Universal Declaration of Human Rights and World Health Organisation coming into existence, there was a great promise that these two institutions would complement each other, and the World Health Organisation would also support the great human rights project with its own programmes and policies.[126]

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[119] See also: *Health and human rights in a changing world*, M. Grodin *et al*. (eds.) (2013).
[120] B. M. Meier, "The World Health Organization, the evolution of human rights, and the failure to achieve Health for All", in: *Global Health and Human Rights. Legal and philosophical perspectives*, J. Harrington, M. Stuttaford (eds.) (2010), p. 163.
[121] *Constitution of the World Health Organisation* (New York, 22 July 1946, entered into force 7 April 1948, 14 UNTS 185).
[122] B. M. Meier, W. Onzivu, "The evolution of human rights in World Health Organization policy and the future of human rights through global health governance", *Public Health*, Vol. 128, Issue 2 (2013), p. 2.
[123] *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*
[124] J. Tobin, *The Right to Health in International Law* (2012), p. 17.
[125] B. M. Meier, "The World Health Organization, the evolution of human rights, and the failure to achieve Health for All", in: *Global Health and Human Rights. Legal and philosophical perspectives*. J. Harrington, M. Stuttaford (eds.) (2010).
[126] B. M. Meier, W. Onzivu, "The evolution of human rights in World Health Organization policy and the future of human rights through global health governance", *Public Health*, Vol. 128, Issue 2 (2013), p. 2.

Unfortunately the reality was different: the first phase full of great promise of upholding human rights was followed by a period where the World Health Organisation intentionally neglected the right to health, and projected itself as "a technical organisation above legal rights".[127] During the neglect-period the World Health Organisation adopted a medicalised view of health, shifted from its previous emphasis on global health priorities for the disadvantaged groups in the society, and took no specific actions to explain broadly defined human rights for health promotion: e.g it did not respond to requests for comments on the final drafts of the International Covenant on Economic, Social and Cultural Rights (ICESCR) adopted in 1966, and consequently did not object when the definition of health and references to social well-being were deleted.[128]

The World Health Organisation tried to change the course in the early 1970s – "after twenty years shunning human rights law", and sought to re-engage with human rights.[129] Iris Borowy explains that the social approaches to health made a really strong comeback in the early 21st century.[130] For example, in 2005 the World Health Organisation set up the *Commission on Social Determinants of Health* to investigate inequities in health. The Commission published its final report in 2008.[131] It took a holistic view of social determinants of health and noted, how an unequal distribution of health-damaging experiences is not a 'natural' phenomenon but the result of "a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics".[132]

Although Audrey R. Chapman calls the 2008 report "unequivocal in its condemnation of the disparities in life opportunities and health status between rich and poor countries and between the rich and poor within the country", she criticises it for its lack of a human rights dimension.[133] Paul Hunt also argues that the report's rights-based analysis remained unfortunately weak: "Despite the multiple, dense connections between social determinants

[127] B. M. Meier, "The World Health Organization, the evolution of human rights, and the failure to achieve Health for All", in: *Global Health and Human Rights. Legal and philosophical perspectives*, J. Harrington, M. Stuttaford (eds.) (2010), p. 163.
[128] B. M. Meier, "The World Health Organization, the evolution of human rights, and the failure to achieve Health for All", in: *Global Health and Human Rights. Legal and philosophical perspectives*, J. Harrington, M. Stuttaford (eds.) (2010), p. 173.
[129] B.M. Meier, W. Onzivu, "The evolution of human rights in World Health Organization policy and the future of human rights through global health governance", *Public Health*, Vol. 128, Issue 2 (2013), p. 3.
[130] I. Borowy, "Shifting Between Biomedical and Social Medicine: International Health Organizations in the 20th Century", *History Compass*, Vol. 12, Issue 6 (2014), p. 525.
[131] "Closing the gap in a generation: Health equity through action on the social determinants of health", Final Report of the WHO Commission on Social Determinants of Health (2008), available at: http://www.who.int/social_determinants/thecommission/finalreport/en/ (accessed 8 February 2018).
[132] The Final Report, p. 1.
[133] A. R. Chapman, "Missed Opportunities: The Human Rights Gap in the Report of the Commission on Social Determinants of Health", *Journal of Human Rights*, Vol. 10, Issue 2 (2011), p. 133.

and human rights, the report's human rights content is disappointingly muted. The human rights analysis is not absent, but underdeveloped and understated".[134] Chapman's criticism is more particular, and she explains how the "justice claims" in the report rely principally on the "persuasiveness of its ethical reasoning", and *not* on internationally recognised human rights principles and norms, which made the report weaker, and additionally, it did not link the findings of the report to existing the international, regional, and national human rights institutions that monitor and evaluate the implementation of human rights.[135]

Chapman argues that although the report does borrow principles of empowerment and participation from human rights, it does not incorporate the conceptual foundation of the human rights-based approach, thus resulting in an outcome that is "an uncomfortable hybrid in which advocacy of community empowerment is grafted onto a report that focuses primarily on top-down initiatives through changes in government policy" – which is for Chapman "a weak conception of empowerment".[136] Meier wrote in 2012, how, "given WHO's inconstant commitment to human rights, it remains to be seen whether WHO will adhere to this evolving rights-based imperative or revert to its previous institutional neglect of human rights for the public's health".[137] Paul Hunt has commented in 2016 that in the development of the international right to health there is "a drive towards its 'real-life' implementation for the benefit of individuals, communities, and populations, and a movement from short, general, abstract, legal treaty provisions towards specific, practical human rights guidance".[138] It is fair to say that the WHO is part of that movement, and has fortunately not reverted again to a complete "neglect of human rights", but rather makes continuous efforts to translate health concerns into the language of human rights.[139]

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[134] P. Hunt, "Missed opportunities: Human Rights and the Commission on Social Determinants of Health", *Global Health Promotion*, Vol. 16, Issue 1 (2009) p. 36.

[135] A. R. Chapman, "Missed Opportunities: The Human Rights Gap in the Report of the Commission on Social Determinants of Health", *Journal of Human Rights*, Vol. 10, Issue 2 (2011), p. 135. For example, Chapman describes how although the report calls the governments, international organisations and the civil society to increase and strengthen political commitment and also add resources to sexual and reproductive health services, it makes no mention of the CEDAW, and the work and case-law of the CEDAW Committee (p. 136).

[136] A. R. Chapman, "Missed Opportunities: The Human Rights Gap in the Report of the Commission on Social Determinants of Health", *Journal of Human Rights* Vol. 10, Issue 2 (2011), p. 142.

[137] B. M. Meier, "The World Health Organization, the evolution of human rights, and the failure to achieve Health for All", in: *Global Health and Human Rights. Legal and philosophical perspectives. J. Harrington, M. Stuttaford* (eds.) (2010), p. 183.

[138] P. Hunt, "Interpreting the International Right to Health in a Human Rights-Based Approach to Health", *Health and Human Rights Journal* Vol. 18, No. 2 (2016).

[139] For example, the WHO has published several guidelines regarding reproductive health that give recommendations for good practices, and entail explicit references to relevant human rights: the "*WHO recommendations on antenatal care for a positive pregnancy experience*" (2016), "*WHO guidelines on the management of health complications from female genital mutilation*" (2016), and "*Technical Guidance on the*

Nevertheless, the United Nations Sustainable Development Goals 2030 have for example again been criticised for a lack of human rights language. Namely, Audrey R. Chapman writes that although the declaration part of the Sustainable Development Goals references to human rights, the goals do not adopt a human rights approach: "None of the SDGs are framed as a human rights entitlement guaranteeing that all people having a right to the services and benefits with governments accountable for its availability and for equal access". [140]

2.3.3 Human rights-based approaches to health

The last part of this section explains *human rights-based approaches to health*, which serves as an inspiration for what I term as a reproductive rights-based approach.

What human rights-based approaches to health mean is best articulated in Alicia Ely Yamin's work: she argues, how "we understand the reason for people's suffering is crucial to enabling us to apply transformative human rights frameworks to health".[141] Yamin gives an example of morphine being a cheap and effective pain medicine, thus the question is not whether there are resources and means to relieve the pain, but whether the relief is distributed to everyone because they have a right to it – in other words, we do not accept suffering as natural and inevitable.[142] Sara Bennett *et al* also point out that across the world 100 million people are pushed into poverty each year because of health care expenditures, but "this is an avoidable tragedy".[143] Human rights advocates have expressed their concern for treating health as a commodity subject to a person's ability to pay for it as "when access to health

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Application of a Human Rights Based Approach to the Implementation of Policies and Programmes for Reduction of Preventable Maternal Mortality and Morbidity" (2014).

[140] A. R. Chapman, "Evaluating the health-related targets in the Sustainable Development Goals from a human rights perspective", *International Journal of Human Rights*, Vol. 21, Issue 8 (2017), p. 1099. Chapman acknowledges that there is indeed one exception – target 5.6 to ensure universal access to sexual and reproductive health and reproductive rights does use the *rights* language. Chapman notes two things however – first, the reproductive health targets in the Sustainable Development Goals "refrain from taking a rights-based approach", and focus on a technical approach instead. Second, the Sustainable Development Goal 5 to achieve gender equality and empower all women and girls could potentially fill the gap and as Chapman writes: "If even some of these objectives are met, it would strenghten women's status in society and their likelihood of achieving control of their sexual and reproductive health" (p. 1104).

[141] A. E. Yamin*, Power, Suffering, and the Struggle for Dignity Human Rights Frameworks for Health and Why They Matter* (2016), p. 41.

[142] A. E.Yamin, *Power, Suffering, and the Struggle for Dignity Human Rights Frameworks for Health and Why They Matter* (2016), p. 41.

[143] S. Bennett *et al*, "*Which Path to Universal Health Coverage? Perspectives on the World Health Report* 2010" *PLoS Med*, Vol. 7, Issue 11 (2010).

care is dependent on income, it explicitly legitimates inequalities and the exclusion of the poor.[144]

In the context of human rights-based approaches to health Yamin sews together three elements: the strength of human rights, the social dimension of health, and the need to take into account how power is divided in a society. The rights-based framework will shape the way we see suffering and shift the blame from "destiny, natural causes, and individual behaviour and blame" to state accountability: "Taking seriously the suffering of women, children, sexual minorities, and others requires a shift in the conception of rights and ensuing state obligations from the way in which they were set out in theories of the traditional liberal state."[145] More specifically, as Yamin argues, human rights-based approaches can be deployed to open medical and other institutions that are cloaked in "technical authority" to scrutiny their reasoning, and thereby challenge hierarchies of knowledge and power that have historically been used against women.[146] Further, Yamin together with Leslie London both emphasise the role of agency and participation in rights-based approaches.[147] Yamin explains: "A fundamental distinction of a human rights approach to development and policy-making that affects health is that it aims to enable those who are most impacted by poverty, patriarchy, and disease to be active participants in constructing the solutions to their problems".[148] Thus, human rights-based approaches that tackle powerlessness are in sync with my understanding of how having a voice and being able to use one's own lived experience as evidence are antidotes against silencing.

Audrey R. Chapman echoes Yamin's arguments and adds that unfortunately many countries see the requirements in the human rights treaties they have ratified in the sphere of economic, social and cultural rights to be more in the nature of "aspirational goals or perhaps 'even optional'", whereas human rights actually differ from other types of ethical claims by conferring specific claims or entitlements on right holders and assuring a standard of

[144] A. R. Chapman, *Global Health, Human Rights and the Challenge of Neoliberal Policies* (2016), p. 75.
[145] A. E. Yamin, *Power, Suffering, and the Struggle for Dignity Human Rights Frameworks for Health and Why They Matter* (2016), p. 43.
[146] A. E. Yamin, "Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care", *Health and Human Rights*, Vol. 10, No. 1 (2008). See further: A. E. Yamin, *Power, Suffering, and the Struggle for Dignity Human Rights Frameworks for Health and Why They Matter* (2016).
[147] See: L. London, "Issues of equity are also issues of rights: Lessons from experiences in Southern Africa", *BMC Public Health*, Vol. 7 (2007); A. E. Yamin, "Suffering and powerlessness: The significance of promoting participation in rights-based approaches to health", *Health and Human Rights Journal,* Vol. 11, No. 1 (2009).
[148] A. E. Yamin, "Suffering and powerlessness: The significance of promoting participation in rights-based approaches to health", *Health and Human Rights Journal*, Vol. 11, No. 1 (2009), p. 6.

accountability".[149] Chapman expands this point by arguing, that the political, social and economic environment in which rights are to be implemented sets extra challenges (i.e resistance): "the increasing hegemony of market-based approaches" that is inspired by neoliberalism makes rights-based approaches far more difficult to implement.[150] That is because for a human rights-based approach to health a high state interference is necessary, whereas in the market-based approach promoted by neoliberalism the role of the state is minimal:

> *A human rights approach rests on a conception of health and health care as social or public goods of special moral importance that are designed to benefit whole populations. In contrast, neoliberalism tends to promote a view of health care as a commodity whose cost, price, availability, and distribution, like other consumer goods, should be left to the marketplace*.[151]

Audrey Chapman is not the only scholar who has been critical of the compatibility of neoliberalism and human rights. Paul O'Connell also argues that there is an "irreducible tension" between neo-liberal globalisation and protection of human rights in their ideological premises, in the different roles the two assign to the state, and in practice.[152] O'Connell similarly to Chapman agrees that neoliberalism does embrace certain framings of rights, but "with respect to subsistence rights, such as housing, health-care, etc., the neo-liberal outlook simply cannot countenance such matters as being human rights or general entitlements", and instead of seeing structural denial of human rights, neo-liberals see "failures by individual consumers to make adequate provision for their own health-care needs".[153]

Although as Chapman notes, all human rights confront challenges and resistance, she agrees with Yamin who describes health as perhaps the most radical of subjects – in part because a rights-based approach to health challenges our assumptions about justice, society, and humanness itself.[154] As I already noted above, reproductive rights and reproductive

[149] A. R. Chapman, *Global Health, Human Rights and the Challenge of Neoliberal Policies* (2016), p. 6.
[150] A. R. Chapman, *Global Health, Human Rights and the Challenge of Neoliberal Policies* (2016), p. 19.
[151] A. R. Chapman, *Global Health, Human Rights and the Challenge of Neoliberal Policies* (2016), p. 85.
[152] P. O'Connell, "On Reconciling Irreconcilables: Neo-liberal Globalisation and Human Rights", *Human Rights Law Review*, Vol. 7, Issue 3 (2007). A discussion fuelled by this article between O'Connell and R. E. Howard-Hassmann can be found in: R. E. Howard-Hassmann, "Reply to Paul O'Connell's Article on Neo-liberal Globalisation and Human Rights", *Human Rights Law Review*, Vol. 9, Issue 1 (2009), and in P. O'Connell, "Not Seeing the Forest for the Trees: A Reply to Rhoda Howard-Hassmann", *Human Rights Law Review*, Vol. 9, Issue 1 (2009).
[153] P. O'Connell, "On Reconciling Irreconcilables: Neo-liberal Globalisation and Human Rights", *Human Rights Law Review,* Vol. 7, Issue 3 (2007), p. 497, and D. Harvey, *Neoliberalism: A Brief History* (2005).
[154] A. R. Chapman, *Global Health, Human Rights and the Challenge of Neoliberal Policies* (2016), pp. 17-18.

health are even more challenging as reproduction itself is a highly loaded issue for states, and reproductive rights are strongly impacted by gender biases and harmful stereotyping. Yamin also recognises this resistance and argues: "No area more dramatically illustrates the importance of human rights frameworks in expanding understandings of health as well as how contested challenging of the power relations that determine health can be than sexual and reproductive health".[155]

Maya Unnithan underlines that a human rights focus puts the spotlight not only on "who is disadvantaged and who is not", but draws the attention "toward *process* (mechanisms) as much as outcome, and to the workings of *power*".[156] Consequently, Unnithan highlights another essential dimension of human rights-based approaches – they require additional ways of thinking what constitutes as evidence since quantitative forms of evidence and random controlled trials are unable to capture the lived experience of a person in a evolutionary, historical, environmental, social and cultural context.[157]

In summary a human rights-based approach transforms not only the way we understand health, but how we approach and understand human rights institutions as it draws attention to power relations that are formed, reinforced or institutionalised by these human rights systems. Consequently, new challenges emerge within the ways we understand and define science, medical space, violence and harm. In other words, thinking along the frame of challenge/resistance, a rights-based approach to health penetrates many of the existing power dynamics and the idea of law being objective and neutral within it – just as feminist approaches.

2.4 THE REPRODUCTIVE RIGHTS DISCOURSE

In the last part of Chapter 2 I add the final layer to my analytical frame. So far I have engaged with broader ideas about feminist challenges to power, the social dimension of health and human rights-based approaches to health that spill over to and set up this section. The aim now in the following paragraphs is to look at *reproduction* and *rights* more

[155] A. E. Yamin, *Power, Suffering, and the Struggle for Dignity Human Rights Frameworks for Health and Why They Matter* (2016), p. 91.
[156] M. Unnithan, "What Constitutes Evidence in Human Rights-Based Approaches to Health? Learning from Lived Experiences of Maternal and Sexual Reproductive Health", *Health and Human Rights*, Vol. 17, No. 2 (2015), p. 46.
[157] M. Unnithan, "What Constitutes Evidence in Human Rights-Based Approaches to Health? Learning from Lived Experiences of Maternal and Sexual Reproductive Health", *Health and Human Rights*, Vol. 17, No. 2 (2015), pp. 46-47.

specifically. However, instead of viewing reproduction and reproductive rights as *narrow* questions, I emphasise again that when unpacked layer-by-layer reproduction issues offer a fundamental snapshot of how law approaches violence, autonomy, kinship, gender and citizenship broadly. I come to the scholarship on reproductive rights matters at the moment when a lot has already been argued, (re-)considered, and achieved. Therefore, in order to conceptualise what I term as *a reproductive rights-based approach*, I first give an overview of the relevant discourse specific developments.

2.4.1 From feminist movements to the global United Nations recognition

The concept of reproductive rights has gained some, (admittedly somewhat limited and contested) global acceptance.[158] Freedoms and rights regarding women's reproductive lives have been – and most crucially continue to be – important struggles for feminist movements in all parts of the world – however exasperated women themselves and scholars-advocates might be.[159] The high rates of maternal mortality, limited or completely restricted access to safe and legal abortion, denial of sex education, obstetric violence, and evidence of forced sterilisations have not caused among important stakeholders – governments, communities, law-makers, doctors, courts, policy-makers – an outrage significant enough to motivate them to take women's experiences seriously. As also I show in this thesis through case-law analysis the human rights analysis of reproduction matters is not completely absent, but using Paul Hunt's words, it is underdeveloped and understated to say the least. As Adrienne Germain comments, women's reproductive rights issues are "still on the side burner because of the imbalance of power between men and women", and although "women have mobilised in virtually every country, we are still very often marginalised when it comes to

[158] A. M. Miller, "Sexual but not Reproductive: Exploring the Junction and Disjunction of Sexual and Reproductive Rights" *Health and Human Rights*, Vol. 4, No. 2, *Reproductive and Sexual Rights* (2000). On the differentiation between reproductive and sexual rights see also: A. M. Miller, M. J. Roseman. "Sexual and reproductive rights at the United Nations: frustration or fulfilment?", *Reproductive Health Matters,* Vol. 19, Issue 38 (2011). Miller and Roseman explain on p. 104: "While both sexual and reproductive rights claims have a common grounding in these other rights [privacy rights, economic rights etc.], they have been theorised differently: reproduction (and heterosexuality) in the last two decades have been more "naturalised" and less theorised today *as a question of social production*. Sexuality, on the other hand, being more recent in its appearance, has been explicitly addressed in the last decade as being socially produced – with advocates joining the scholars to argue about "naturalness" and social construction".

[159] See e.g: J. Orr, *Abortion wars: the fight for reproductive rights* (2017), S. Combellick-Bidney, *Reproductive rights as human rights: stories from advocates in Brazil, India and South Africa* (2017), A. Frank, A. Betül Çelik, "Beyond Islamic versus Secular Framing A Critical Analysis of Reproductive Rights Debates in Turkey", Journal of Middle East Women's Studies, Vol. 13, No. 2 (2017), J. Mishtal, *The politics of morality: the church, the state, and reproductive rights in postsocialist Poland* (2015).

budgets, laws and policy-making".[160]

Historically, the language of reproductive health, gender and sexuality used to almost exclusively belong in the academic milieu and social movements before it underwent a process of legitimisation in the 1990-s.[161] The etymology of the term "reproductive rights" is mostly to be found among women's groups and in non-institutional framework: its conceptualisation was directly linked to the struggle for the right to safe, legal abortion and contraception in industrialised countries in the 1970-1980-s.[162] Thus, it can be stated that the reproductive rights concept began to emerge from the very practical concerns around women's reproductive health.

Veronique Mottier emphasises three features of reproduction that explain its importance to feminist theory and praxis: firstly, reproduction is traditionally considered as something that belongs to the "woman's domain", secondly, normative femininity is defined in relation to reproduction and motherhood, and thirdly, the fact that reproduction involves the engendering of future generations turns it into an object of collective interest and anxiety – it was in the context of such struggles a new vocabulary of *reproductive rights*, *reproductive health* and *reproductive justice* emerged.[163]

As explained above, feminist movements are not identical, and thus women's struggles are also different – for example, framing the notion of "reproductive freedom" primarily through Western feminists' calls for access to abortion has been criticised for being "a luxury concern of privileged women" by advocates from developing countries where women are subjected to forced abortions or coerced sterilisations, and similarly also the questions around genital mutilation can be seen as an expression of Western ethnocentrism.[164] Essentially these challenges were targeting not "reproductive freedom" *per se*, but existing global and local power divisions and biases against "the other".[165] Such

[160] S. Corrêa, A. Germain, R. P. Petchesky, "Roundtable: Thinking Beyond ICPD+10: Where Should Our Movement Be Going?",*Reproductive Health Matters*, Vol. 13, Issue 25 (2005), p. 113.
[161] S. Corrêa, "From Reproductive Health to Sexual Rights: Achievements and Future Challenges*",* *Reproductive Health Matters*, Vol. 5, No. 10, *The International Women's Health Movement* (1997), p. 107.
[162] S. Corrêa, "From Reproductive Health to Sexual Rights: Achievements and Future Challenges*",* *Reproductive Health Matters*, Vol. 5, No. 10, *The International Women's Health Movement* (1997), p. 108.
[163] V. Mottier. "Reproductive rights", in: *The Oxford Handbook of Gender and Politics*, G. Waylen, K. Celis, J. Kantola, S. Laurel Weldon (eds.) (2013), p. 215.
[164] V. Mottier. "Reproductive rights", in: *The Oxford Handbook of Gender and Politics*, G. Waylen, K. Celis, J. Kantola, S. Laurel Weldon (eds.) (2013), p. 215. I come back to this theme in this thesis in chapter on *"Women and violence narratives"* where I discuss "virginity testing".
[165] See further: J. Silliman, M. Gerber Fried, L. Ross, E. Gutiérrez, *Undivided Rights: Women of Color Organizing for Reproductive Justice*, 2nd edition (2016), J. Nelson, *Women Of Color And The Reproductive Rights Movement* (2003), S. Combellick-Bidney, A. Genis, "Only Through the Body: Reproductive Justice and the Practice of Embodied Theory", *Women's studies*, Vol. 47, No. 1 (2018), L. J. Ross, "Reproductive Justice as

critique led to the emergence of *reproductive justice*, which was claimed to be different from reproductive rights as it "aims to shed light to the gap between legal rights, and the actual usage of such rights", thus making a connection between reproductive rights and social justice".[166] Other authors also emphasise the need for a more comprehensive understanding of how to theorise structural injustices that are present in the sexual and reproductive lives of women and men, and how a rights-based approach could be substituted with alternative approaches: Maya Unnithan and Stacy Leigh Pigg explain how "rights are salient in a legal domain, justice engages with morality in a broader sense and challenges power inequalities, which makes reproductive justice distinct from rights in its function as a moral indicator".[167] They give an overview of some of the scholarly work criticising the limitations of rights and argue, how applying rights analysis on the "messiness of everyday life" requires a closer (re)-examination of how rights are framed, not just operationalised.[168]

Rosalind Pollack Petchesky similarly emphasises how "as part of collective feminist efforts to reclaim a property in our bodies" there is a need to redefine all essential health care and services as common property to which all people are entitled access. [169] Petchesky writes how the language of reproductive freedom is "burdened with 300 years of the dominant Euro-American model of dichotomization between the self and community, body and society", and hopes that the idea of women owning their bodies could be seen as not "an individualistic, exclusionary interest", but rather a fundamental condition for women's development and strength as a social group and thus for their full participation as citizens.[170] In addition to a call for re-consideration and more nuance there is also a stronger criticism that suggests that the rights approach is simplistic and excludes and marginalises certain people and agendas, and thus enabling new forms of inequalities to arise.[171]

The first stage of international legitimisation happened at a relatively marginalised feminist gathering – the 4th International Women and Health Meeting in Amsterdam in 1984

Intersectional Feminist Activism", *Souls: A Critical Journal of Black Politics, Culture, and Society*, Vol. 19, Issue 3 (2017).

[166] V. Mottier. "Reproductive rights", in: *The Oxford Handbook of Gender and Politics*, G. Waylen, K. Celis, J. Kantola, S. Laurel Weldon (eds.) (2013), p. 216.

[167] M. Unnithan, S. Leigh Pigg, "Sexual and reproductive health rights and justice – tracking the relationship" *Culture, Health & Sexuality*, Vol. 16, Issue 10 (2014), p. 1181.

[168] M. Unnithan, S. Leigh Pigg, "Sexual and reproductive health rights and justice – tracking the relationship" *Culture, Health & Sexuality*, Vol. 16, Issue 10 (2014), p. 1183.

[169] R. Pollack Petchesky, "The Body as Property: A Feminist Re-vision" in: *Conceiving the New World Order: The Global Politics of Reproduction*, F.D. Ginsburg, R. Rapp (eds.) (1995), pp. 403-404.

[170] R. Pollack Petchesky, "The Body as Property: A Feminist Re-vision" in: *Conceiving the New World Order: The Global Politics of Reproduction*, F.D. Ginsburg, R. Rapp (eds.) (1995) p. 403

[171] M. Unnithan, S. Leigh Pigg, "Sexual and reproductive health rights and justice – tracking the relationship" *Culture, Health & Sexuality*, Vol. 16, Issue 10 (2014), p. 1182.

where the participating women reached an agreement that this terminology was adequate to the political goals of the feminist movement – the advancement of women's reproductive lives across the world.[172] The second and more important stage came in the 1990-s when the language of reproductive rights in the context of human rights protection was adopted on the United Nations level. Reproductive rights had first been recognised as a subset of basic human rights in the non-binding Proclamation of Tehran of the UN International Conference on Human Rights in 1968 where it was stated in paragraph 16 that parents should have the right to determine freely and responsibly the number and spacing of their children. This statement was reinforced with the non-binding Cairo Programme of Action adopted at the UN International Conference on Population and Development in 1994 – also called the international conceptual anchor of reproductive rights". [173]

The latter contained the first UN definition of reproductive health, including individuals' right to have a satisfying and safe sex life and the capability to reproduce and the freedom to decide if, when and how often to do so.[174] This was further expanded at the UN 4th World Conference on Women in Beijing in 1995.[175]

2.4.2 The ICPD and the Programme of Action

The abovementioned Report of the UN International Conference on Population and Development (ICPD) describes the concept of reproductive rights as follows:

> *Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly*

[172] S. Corrêa, "From Reproductive Health to Sexual Rights: Achievements and Future Challenges*",* *Reproductive Health Matters*, Vol. 5, No. 10, *The International Women's Health Movement* (1997), p. 108.
[173] *Programme of Action of the International Conference on Population and development*. Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, 1995, A/CONF.171/13/Rev.1. A. M. Miller, M. J. Roseman. "Sexual and reproductive rights at the United Nations: frustration or fulfilment?", *Reproductive Health Matters,* Vol. 19, Issue 38 (2011), p. 104.
[174] "Reproductive health is 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. Consequently, reproductive health implies that people are able to have a satisfying and safe sex life, that they are able to reproduce and that they have the freedom to decide if, when and how often to do so. Implicit in this is 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, and the right of access to health-care services that will enable women to go safely through pregnancy and childbirth." UN Population Fund (UNFPA), Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, 1995, A/CONF.171/13/Rev.1.
[175] UN Doc. A/CONF. 177/20 (1995) and A/CONF. 177/20/Add. 1 (1995) http://www.un.org/womenwatch/daw/beijing/beijingdeclaration.html.

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 attainable standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents.[176]

Commenting on this development, Alicia Ely Yamin explains how prior to the ICPD, elements of reproductive health (including family planning, maternal health, and sexually transmitted diseases) were treated as fragmented aspects of women's health, whereas population policy revolved largely around utilitarian goals based on demographic imperatives and control of women's fertility leaving women and their needs and rights invisible, but the ICPD declaration united these disparate aspects under a comprehensive definition.[177] Mindy Jane Roseman and Laura Reichenbach similarly praise the ICPD Programme of Action for taking "a radically different approach to the population 'problem'", and showing that population concerns could not be separated from economic and social development agendas – especially the need for women's empowerment.[178] Thus, the ICPD "transformed population and development into reproductive health" by defining it as:

Reproductive health is 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. Consequently, reproductive health implies that people are able to have a satisfying and safe sex life, that they are able to reproduce and that they have the freedom to decide if, when and how often to do so.[179]

However, Roseman and Reichenbach add that the concept of "reproductive health" was not newly minted at ICPD, as the term had first been introduced by Dr. Mahmoud

[176] United Nations Population Division, Report of the International Conference on Population and Development, UN Doc A/CONF. 171/13, 18 October 1994, Programme of Action of the International Conference on Population and Development, para. 7.3.
[177] A. E. Yamin, *Power, Suffering, and the Struggle for Dignity Human Rights Frameworks for Health and Why They Matter* (2016), p. 92.
[178] M. J. Roseman, L. Reichenbach, "Global Reproductive Health and Rights: Reflecting on ICPD", in: *Reproductive Health and Human Rights. The Way Forward*, M. J. Roseman (ed.) (2009), p. 4.
[179] United Nations Population Division, Report of the International Conference on Population and Development, UN Doc A/CONF. 171/13, 18 October 1994, Programme of Action of the International Conference on Population and Development.

Fathalla from the World Health Organisation and was based on the WHO's definition for "health": Fathalla's view was that the reproductive health definition should definitely entail the following core elements: people's ability to have children and control their fertility, guarantee of safe pregnancy and childbirth and people's ability to enjoy and have safe sex.[180] Roseman and Reichenbach explain that the ICPD contained what has been called the "Cairo Paradigm" which shifted population policy away from fertility regulation and toward the notion of reproductive health, predicated on the exercise of reproductive rights and women's empowerment, and underscore that the ICPD was "an innovative model for understanding the connections between health, human rights, population, and development", but also a product of a compromise among different groups – feminists, public health professionals, development economists, demographers, environmentalists, faith communities, donors and governments.[181]

Roseman and Reichenbach note how this innovation of linking health outcomes to rights promotion and protection was twofold: first, human rights meant concrete legal obligations for governments and second, the rights-language enable addressing power imbalances hidden behind reproduction issues – it built on the idea of applying human rights to women's experiences related to reproduction:

> *Human rights, therefore, provided a tangible, legitimate methodology as well as an agenda for social transformation, through which international and national health policies and programs could be revised in ways that would improve health and its underlying social determinants*.[182]

Lance Gable praises the ICPD for having been "a clear articulation of reproductive health as a human right and remains the most compelling international statement of a rights-based conception of reproductive health", and notes that the legacy of ICPD "goes beyond its explicit recognition of the link between reproductive health and human rights" as the rights-based approach - despite persistent shortcomings – has "revolutionized global health practice and inspired the application of rights-based strategies in subsequent international policy

[180] M. J. Roseman, L. Reichenbach, "Global Reproductive Health and Rights: Reflecting on ICPD", in: *Reproductive Health and Human Rights. The Way Forward*, M. J. Roseman (ed.) (2009), p. 7.
[181] M. J. Roseman, L. Reichenbach, "Global Reproductive Health and Rights: Reflecting on ICPD", in: *Reproductive Health and Human Rights. The Way Forward*, M. J. Roseman (ed.) (2009), pp. 4-5.
[182] M. J. Roseman, L. Reichenbach, "Global Reproductive Health and Rights: Reflecting on ICPD", in: *Reproductive Health and Human Rights. The Way Forward*, M. J. Roseman (ed.) (2009), p. 9.

agreements and initiatives".[183] Marge Berer has also described the Programme of Action of the ICPD as an extraordinary document, but in opposition to other scholars points out that there was an "exception to its brilliance", a let-down: the way it addressed induced abortion. Namely, paragraph 8.25 of the Programme stated: "in circumstances where abortion is not against the law, such abortion should be safe".[184] Berer explains that such moral judgment on abortion constantly trumped the public health imperative to save women's health/lives, and allowed safe abortion be seen as an issue (obligation) for the governments only insofar as "Governments should take appropriate steps to help women avoid abortion", but did not address what the state's duty is when a woman has indeed an unwanted pregnancy, and seeks an abortion.[185]

Thus, Berer has written that the Programme of Action took an ambiguous (she called it "a masterpiece of equivocation") tone to abortion: not treating it as a means of fertility regulation or as a legitimate reproductive health service, but rather as something that should just be prevented.[186] However, Berer noted the long-term outcome despite its ambiguity: the ICPD put the problem of unsafe abortion on the global agenda in a way it had never been done before: "As powerful as the alliance against abortion was in 1994, the momentum generated by ICPD and the overwhelming acceptance at country level of the need to protect and promote sexual and reproductive health rights has been far stronger" - Berer asks whether women would have been worse off in terms of access to abortion if the Cairo compromise had not taken place, and answers herself that yes, women would have been

[183] L. Gable, "Reproductive Health as a Human Right", *Case Western Reserve Law Review*, Vol. 10, Issue 4 (2009-2010), pp. 988-989. Gable also notes that ICPD acted as a predecessor, and influential model for the above-mentioned General Comment 14 to the ICESCR

[184] M. Berer, "The Cairo 'Compromises' on Abortion and Its Consequences for Making Abortion Safe and Legal", in: *Reproductive Health and Human Rights. The Way Forward*, M. J. Roseman (ed.) (2009), p. 152.

[185] M. Berer, "The Cairo 'Compromises' on Abortion and Its Consequences for Making Abortion Safe and Legal", in: *Reproductive Health and Human Rights. The Way Forward*, M. J. Roseman (ed.) (2009), pp. 153-154.

[186] M. Berer, "The Cairo 'Compromises' on Abortion and Its Consequences for Making Abortion Safe and Legal", in: *Reproductive Health and Human Rights. The Way Forward*, M. J. Roseman (ed.) (2009), pp. 153-155. For example, Programme of Action, paragraph nr 7.24 stipulated that; "*Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counselling of women who have had recourse to abortion*". Berer comments, how such framing meant that women seeking abortions in countries where it is legally restricted and/or not provided safely were left with the "option" of having an unsafe abortion - in other words, the Programme of Action also did not recognise that requiring women to travel to other jurisdictions for a safe abortion affected women living in poverty and young women most severely and that abortion may be necessary as a consequence of sexual coercion (pp. 154-155).

worse off.[187] Sonia Corrêa also comments at ICPD+10 roundtable that the Programme of Action reflects "what the political conditions allowed us to achieve at that point".[188]

And just like Berer, Roseman and Reichenbach also conclude by stating that there is little doubt that ICPD has been "a major, if not proximate, factor in promoting the use of law, policy, and international human rights mechanisms in the service of reproductive health".[189] In other words, ICPD has been the framework that "joined together underlying social determinants, health systems, policies, laws, and human rights related to reproductive health", and as Roseman and Reichenbach write: "whether reproductive health today resembles the way ICPD articulated it may be less important than ensuring that the connections between gender, rights, health, and development are maintained and strengthened".[190]

2.4.3 Defining reproductive rights

I introduced in the previous section the ICPD's definitions for reproductive rights and reproductive health. Shortly put, reproductive health is 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, and the protection of reproductive health happens through reproductive rights which embrace "already recognised human rights". Many scholars working in the field of reproduction and human rights have built their own framings of these definitions and emphasised different aspects.

For example, Lynn P. Freedman defined reproductive and sexual rights in 1995 as "constellations of legal and ethical principles that relate to an individual woman's ability to control what happens to her body and her person by protecting and respecting her ability to make and implement decisions about her reproduction and sexuality".[191] Freedman explains that this definition purposely opts not to focus on the exact content of women's choices, but instead concentrates on her ability to maintain full control of her body, and such control over

[187] M. Berer, "The Cairo 'Compromises' on Abortion and Its Consequences for Making Abortion Safe and Legal", in: *Reproductive Health and Human Rights. The Way Forward* , M. J. Roseman (ed.) (2009), pp. 156, 159, 162.
[188] S. Corrêa, A. Germain, R. P. Petchesky, "Roundtable: Thinking Beyond ICPD+10: Where Should Our Movement Be Going?",*Reproductive Health Matters*, Vol. 13, Issue 25 (2005),, p. 110.
[189] M. J. Roseman, L. Reichenbach, "Global Reproductive Health and Rights: Reflecting on ICPD", in: *Reproductive Health and Human Rights. The Way Forward* , M. J. Roseman (ed.) (2009), p. 9.
[190] M. J. Roseman, L. Reichenbach, "Global Reproductive Health and Rights: Reflecting on ICPD", in: *Reproductive Health and Human Rights. The Way Forward*, M. J. Roseman (ed.) (2009), p. 19.
[191] L. P. Freedman, "Censorship and manipulation of reproductive health information. An issue of human rights and women's health", in: *The Right to Know. Human rights and access to reproductive health information*, S. Coliver (ed.) (1995), p. 5.

one's reproduction and sexuality is an essential element of human dignity and protecting and respecting this full bodily autonomy guarantees that women are subjects, and never objects – or instruments of reproductive politics.[192]

Furthermore, Sara E. Davies sees that specific thresholds and indicators should be adopted in addition to declarations about reproductive rights – Davies argues for a "measurable change in reproductive health care" as despite the appalling number of women dying from lack of reproductive health care and seeming global commitment to improve women's health, the "persistent inequalities remain" due to a lack of political will at the domestic and international level, and thus the key solution would be to "enumerate the precise rights essential for advancing women's reproductive health through developing a framework of indicators and then link this framework to an incentive structure that encourages political will to change this situation".[193]

She postulates that although the ICESCR and the General Comment 14 from 2000 have been "essential for identifying the responsibility of the state with respect to human rights, moving from commitment to action remains the key obstacle to achieving health as a human right", and reproductive health is especially difficult since "it is often the states that are responsible for violating women's rights in general".[194] I think that Davies is definitely after something with this approach– she makes links between women's reproductive health and the general state of women's human rights. My argument supports that since I propose that the way women's reproduction and sexuality is constructed – whether the narratives are harmful or not – without a doubt influences women as human rights holders in general. However, when Davies seems to argue for specific indicators since responsibilities of the state need to be more defined, I see a need for a change in narratives. Naturally, what Davies is proposing (indicators) is not mutually exclusive with my focus (narratives).

Davies argues that there is also a debate within the reproductive health movement as it does not always agree on how the "provision versus access tension" in human rights can best deliver the advances that women need in order to control and improve their reproductive health: the *right to reproductive self-determination advocates* generally argue that women do not need just family planning services, they also need the autonomy to decide when they

[192] L. P. Freedman, "Censorship and manipulation of reproductive health information. An issue of human rights and women's health", in: *The Right to Know. Human rights and access to reproductive health information*, S. Coliver (ed.) (1995), p. 5.
[193] S. E. Davies, "Reproductive Health as a Human Right: A Matter of Access or Provision?", *Journal of Human Rights,* Vol. 9, Issue 4 (2010), p. 388.
[194] S. E. Davies, "Reproductive Health as a Human Right: A Matter of Access or Provision?", *Journal of Human Rights,* Vol. 9, Issue 4 (2010),, pp. 392-393. Davies refers to UNGA 2008.

should have sex and with whom, and a choice of reproductive health care options, and *the right to reproductive health care advocates* generally argue that women need to enjoy access to safe, high-quality reproductive and sexual health care, and the reproductive self-determination is an end product, a result of the fulfilment of essential health care rights.[195]

Lance Gable notes how the recognition of reproductive health as a human right under international human rights law has been "sporadic, piecemeal, and indirect", and the recognition of reproductive health as a human right remains "in flux, its development unfinished, its contours uncertain, and its widespread international acceptance tenuous".[196] Gable argues for a combination of a "reproductive health model", and a "reproductive rights model": as according to him reproductive health rights sit at the "junction of these two evolving models", and thus a combined model for reproductive health rights should "swing toward supporting the foundational aspects of reproductive health rights, while maintaining strong support for the decisional aspects of reproductive health rights".[197]

Lastly, Rebecca J. Cook has listed reproductive interests: reproductive security and sexuality, reproductive health, reproductive equality, reproductive decision-making.[198] As emphasised previously, such lists are not wrong or useless, but the "normative expression"[199] in the form of spelled out services and freedoms are in truth only one important part of the story – what is more important, is the change in the general lens.

The ICPD definition of reproductive rights went beyond a simple desire to list these "certain human rights", or to fix in black letter all "reproductive rights". Instead, a new of a way of thinking, a (transformative) way of seeing and legally understanding human reproduction and women's experiences with reproduction – this is far more important than listing and labelling rights. Namely, the ICPD does neither offer a list of the "certain human rights" nor a list of "reproductive rights". The ICPD Programme of Action does however explicitly recognises the ways in which culture and law are shaped by patriarchal assumptions about women and their capacity for roles other than motherhood, and calls for these underlying assumptions to be subverted in order to realise reproductive rights for

[195] S. E. Davies, "Reproductive Health as a Human Right: A Matter of Access or Provision?",*Journal of Human Rights,* Vol. 9, Issue 4 (2010), p. 393.
[196] L. Gable, "Reproductive Health as a Human Right", *Case Western Reserve Law Review*, Vol. 10, Issue 4 (2009-2010), p. 959.
[197] L. Gable, "Reproductive Health as a Human Right", *Case Western Reserve Law Review*, Vol. 10, Issue 4 (2009-2010), p. 985.
[198] R. J. Cook, *"Human Rights and Reproductive Self-Determination", American University Law Review*, Vol. 44, No. 4 (1994-1995), p. 979.
[199] This term is borrowed from J. Tobin.

women.[200] In short, reproductive rights are constructed by making visible the gender dimensions of human rights.[201] It is through this kind of conscious naming that women's reproductive interests can be advanced through human rights that are already enshrined in international law, which range from affirmative entitlements to services and care to freedoms from coercion.[202] Therefore I understand reproductive rights as human rights that are constructed through a gender-conscious reading of already recognised human rights – as I have previously defined together with Alicia Ely Yamin.[203]

2.5 CONCLUSION: "UNSCHOLARLY, DISRUPTIVE, OR MAD" REPRODUCTIVE RIGHTS-BASED APPROACH

In the next chapters of this thesis I introduce 35 cases from four different human rights law forums. These cases involve many aspects of reproduction – from abortion and surrogacy to maternal mortality and home birth restrictions. I show how, despite some commendable examples that could be labelled as "landmark cases", as a whole this part of transnational jurisprudence still sees women's lives through not their own lived experiences and life plans, but through harmful stereotypes (going beyond gender stereotypes) that act as short-cuts to systematic human rights breaches.

In order to see these shortcomings, however, one needs to ask more questions than what the body of transnational courts/committees is asking, stop believing the beautiful, but harmful myth of a world that is fair place where structural injustices disappear if law is objective and neutral. Thus, I constructed a reproductive rights-based approach, which is rooted in feminist approaches to human rights, in human rights-based approaches to health, and in the global reproductive rights discourse. I paid special attention to anti-stereotyping, and how human rights law (scholarship) engages with stereotypes. Mapping these discussions demonstrated clearly that there is a lot of resistance against these ideas – historically speaking, but also in 2018, and both in theory (academia & scholarship), and praxis. Therefore, a reproductive rights-based approach is an analytical framework that "questions

[200] E. Nelson, *Law, Policy and Reproductive Autonomy* (2013) p. 65.
[201] This approach has been supported by the majority of human rights law scholars. See e.g R. J. Cook, "Human Rights and Reproductive Self-Determination", *American University Law Review*, Vol. 44, No. 4 (1994-1995), M. Scheinin, "Sexual Rights as Human Rights – Protected under Existing Human Rights *Treaties?", Nordic Journal of International Law*, Vol. 67, Issue 1 (1998), E. Kismödi *et al*., "Advancing sexual health through human rights: The role of the law", *Global Public Health*, Vol. 10, Issue 2 (2015).
[202] R. J. Cook, "Human Rights and Reproductive Self-Determination", *American University Law Review*, Vol. 44, No. 4 (1994-1995).
[203] L. Oja, A. E. Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?", *Columbia Journal of Gender and Law* , Vol. 32, No. 1 (2016).

everything", considers power relations from all different angles – also within feminist thinking itself, and is as "unscholarly, disruptive, or mad" as possible and necessary.

all the women.

in me.

are tired.

(Nayyirah Waheed)

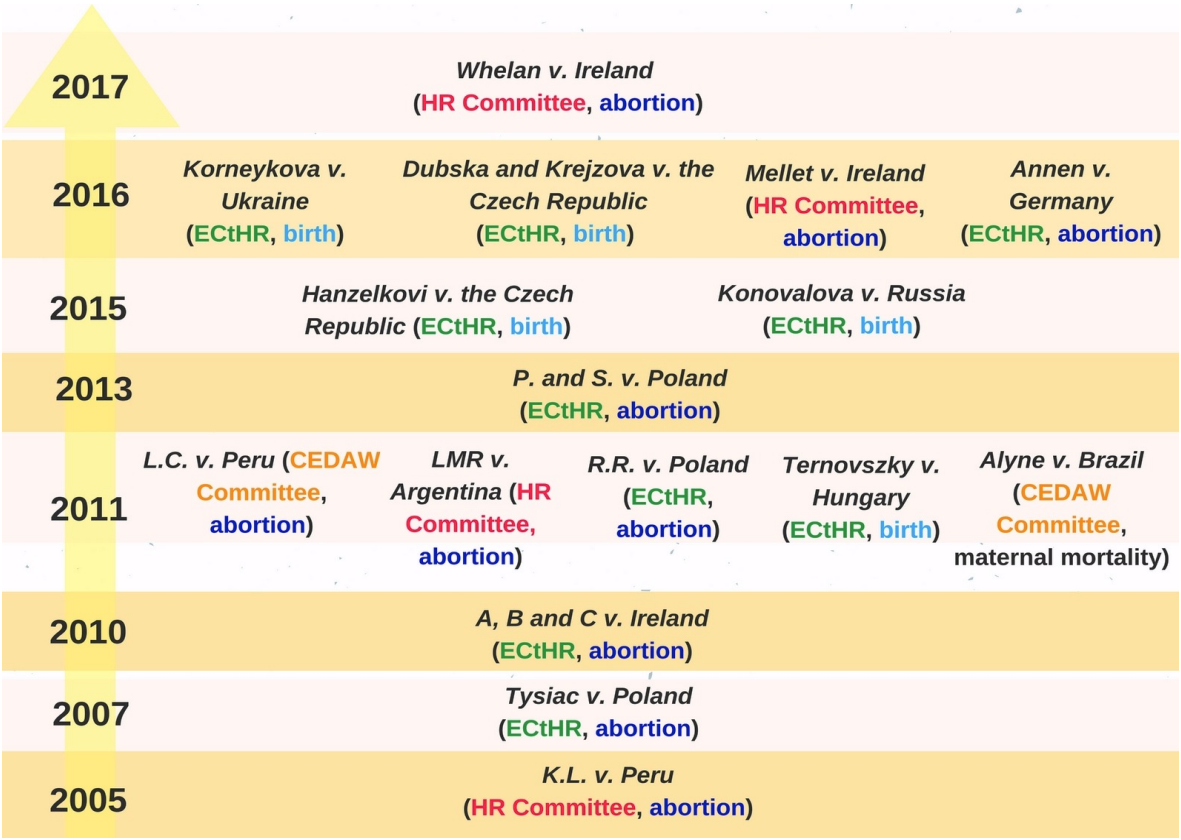
3. WOMEN, BIRTH AND PREGNANCY NARRATIVES

3.1 "DANGEROUS MOTHERS-TO-BE OR SUFFERING VICTIMS INCAPABLE OF AUTONOMOUS CHOICES"

As introduced above, I capture the answer to my question *"Who is the 'woman' in human rights law?*" by investigating harmful stereotypes that are cutting off women's voices, and disregarding their lived experiences in reproduction jurisprudence. I separate the results into three: pregnancy and birth narratives (Chapter 3), violence narratives (Chapter 4), and (in)fertility narratives (Chapter 5). These divisions here are rudimentary as in reality every category spills over its boundaries, and could be merged with another – e.g all of the included reproduction cases could be also discussed through *violence* narratives only. This interconnectedness is, however, not a flaw, but speaks instead to the purpose of this thesis; how I have set the thesis up to go beyond single issues to demonstrate links between different questions regarding women's reproductive lives, and how irrespective of the specific matter in each piece of jurisprudence (whether abortion or surrogacy) such cases are foremost and fundamentally about power that women have/do not have in a society. Thus, the three-part-structure serves the purpose of organising clearly how both – *process of silencing*, and *recognition of women's voices* – appear in my chosen transnational reproduction jurisprudence.

I begin by tracing pregnancy and birth narratives in jurisprudence concerning abortion, birth and maternal mortality: ten abortion stories from the period of 2005-2017: five

decisions from the European Court of Human Rights, four cases from the UN Human Rights Committee, and lastly one from the UN CEDAW Committee, and six stories about women and birth –five from the European Court of Human Rights (2011-2016), and one on maternal mortality from the UN CEDAW Committee (2011) (see the illustration below).



Looking at cases concerning access to abortion, birth regulations-practices, and maternal mortality together holds a strategic purpose. For one it allows me to underscore the World Health Organisation's statistics that connects these issues through empirical data, but which seems to be overlooked or ignored in legal analysis of abortion and birth: namely, the three biggest causes of *maternal mortality* are unsafe *abortion*, sepsis and haemorrhage at *childbirth*, which can all be avoided through proper (*i.e.* available and accessible) reproductive health care services (access to safe abortion and obstetric care included).

Second, moving further beyond the data, bringing these cases onto one spectrum and placing them next to each other helps to (re)conceptualise issues regarding abortion and childbirth. Drawing links between abortion, obstetric care, and maternal mortality reveals that similar patterns of harmful (gender) stereotyping are present in all three.

Judge Ganna Yudkivska of the European Court of Human Rights notes in her separate concurring opinion to the *de Sousa Morais* case, that although "there is a great temptation to believe that all of these millennia-old social stereotypes, persistent ideas and practices are nowadays just 'water under the bridge' at least in Europe" the unfortunate reality is that they are not.[204] Yudkivska's pessimism is unfortunately supported by my thesis, too, as the analysis below shows how narratives that would explicitly put women's lived experiences in the centre of human rights analysis are still absent or need to be "assumed and hoped for". Namely, in the case of the European Court of Human Rights, the court has so far never conceptualised abortion as a human right of all women irrespective of their reasons for termination of pregnancy or really considered the consequences of unsafe abortions, grasped the reproductive rights dimensions of childbirth adequately, or more generally speaking - understood fully how power dynamics, and stereotypes impact these matters. Although the CEDAW Committee and the UN Human Rights Committee show more commendable reproductive rights protection – especially in recent abortion cases regarding Ireland – the spill-over effect to the Strasbourg's Court's analysis has not taken place.

A reproductive rights-based approach allows me to tie narratives about birth to maternal mortality and abortion narratives to ask what happens to a woman's human rights and autonomy when she is in labour, and why are those women who do indeed have safe and legal access to facility-based birth nevertheless seeking alternatives such as home birth assisted by a midwife. Are the women who are challenging complete home birth bans

[204] *Carvalho Pinto de Sousa Morais v. Portugal,* Application no. 17484/15 (2017), Concurring Opinion of Judge Yudkisvka.

"irresponsible", and do not the newborn's best interests in mind, or are they reacting to human rights violations that take place in medical facilities, the hospitals and clinics that for most people seem unequivocally neutral, objective and safe.

Accordingly, in the context of this thesis that focuses on case-law it means that the human rights law forums must not just be very mindful about how they frame abortion, pregnancy and birth, but also understand the transformative potential their conceptualisations and interpretations could have. Namely, I argue that taking a reproductive rights-based approach challenges harmful and essentialising stereotypes that may act as shortcuts to human rights breaches. This rights-based approach that is concerned with how power is distributed also changes the dominant thinking about reproductive (health) services ("human rights of everyone", "privileges of a few" or "favours of the compassionate state"). Moreover, a reproductive rights-based approach challenges the standards for providing reproductive health services in countries that do not stand out with a high death toll, but should nonetheless not escape scrutiny: *just* providing these services is not enough – human rights must go far beyond *avoiding* maternal mortality and guaranteeing "survival". The idea of "receiving some services is better than no services" should under no circumstances be the guiding principle for human rights protection.[205]

3.2 ABORTION: ARE WE *STILL* PROTESTING THIS?[206]

Nayyirah Waheed's poem cited at the beginning is relevant for all parts of this thesis since as I have demonstrated, for decades and decades women (whether through scholarship or national/transnational advocacy for example) have been trying to convince societies and power structures that women are human beings, and women's rights are human rights.

[205] I have borrowed this thought from A. Solnes Miltenburg *et al*, "Maternity care and Human Rights: what do women think?", *BMC International Health and Human Rights*, Vol. 16, Article 17 (2016), p. 7.
[206] Different versions of this question have been appearing on posters at many recent women's rights marches to underscore that similar or almost identical struggles for women's rights are happening also after decades of human rights and feminist movements.

Nevertheless, her three short lines resonate especially well with the global fight for access to safe and legal abortion – it is exasperating that one of the fundamental elements of women's reproductive self-determination – access abortion in a safe and timely manner without any obstacles if they choose to terminate a pregnancy – continues to be a daily fight that costs millions of lives every year.[207] Namely, according to the World Health Organisation (WHO) the number of induced abortions decreased globally to 43.8 million in 2008 from 45.6 million in 1995.[208] However, the proportion of *unsafe abortion* to the total worldwide induced abortions has unfortunately *increased* from 44% in 1995 to 49% in 2008.[209] The WHO notes that induced abortion exists in absolutely every region of the world, but the "configuration of safe and unsafe abortions differs distinctively".[210] One of the 17 UN Sustainable Development Goals sets out two relevant targets both by year 2030: first, reducing the global maternal mortality ratio to less than 70 per 100,000 live births, and second, that countries ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and integrate reproductive health into national strategies and programmes".[211]

Access to contraception would help women worldwide avoid unwanted pregnancies, and also the need for abortion. However, as Gilda Sedgh *et al* explain: "even if all couples who wished to avoid pregnancy used contraception, unintended pregnancies and abortions would occur because no method is perfect and methods are sometimes used imperfectly", or "some women who want to have a child face circumstances that lead them to seek an abortion after

[207] L. Oja, A. E. Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?" *Columbia Journal of Gender and Law*, Vol. 32, No. 1 (2016).
[208] "WHO Information Sheet – Safe and unsafe induced abortion" (2012), available at: http://apps.who.int/iris/bitstream/10665/75174/1/WHO_RHR_12.02_eng.pdf (accessed 8 February 2018), p. 3.
[209] "WHO Information Sheet – Safe and unsafe induced abortion" (2012), available at: http://apps.who.int/iris/bitstream/10665/75174/1/WHO_RHR_12.02_eng.pdf (accessed 8 February 2018), p. 3.
[210] "WHO Information Sheet – Safe and unsafe induced abortion" (2012), available at: http://apps.who.int/iris/bitstream/10665/75174/1/WHO_RHR_12.02_eng.pdf (accessed 8 February 2018), p. 3.
[211] United Nations Sustainable Development Goals, available at: http://www.un.org/sustainabledevelopment/sustainable-development-goals/ (accessed 8 February 2018).

they become pregnant".[212] Additionally, there are some women who for different reasons cannot or do not wish to use any of the contraception methods available. Thus, women's access to safe, legal and timely abortion must be guaranteed as otherwise women are forced to seek recourse to unsafe procedures.

Induced abortion (generally called simply "abortion"), *i.e.* termination of pregnancy is to date without a doubt the most discussed – both in scholarship and in politics – reproductive rights issue (although, indeed, in majority of these discussions it is not presented as a reproductive rights question). There are countless books, articles, films and more generally stories about abortion – new ones appearing all the time.[213] Furthermore, even all but three of the transnational abortion cases I present in this thesis have been already widely analysed, discussed, deconstructed, criticised, contextualised.[214] However, the distinction I want to emphasise here is that my thesis is not a thesis about abortion *per se*, and I have intentionally excluded a detailed analysis of the beginning of life, different limitations to abortion, or critical accounts of country specific domestic abortion regulations.[215] Instead, to reiterate, I am interested in looking at abortion stories as *part* of the broader narratives about women,

[212] G. Sedgh *et al*, *Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends*, *Lance*t (2016), Vol. 388, p. 266.
[213] See for example: C. Sanger, *About Abortion: Terminating Pregnancy in Twenty-First-Century America* (2017); K. Greasley, *Arguments about abortion: personhood, morality, and law* (2017); S. De Zordo, J. Mishtal, L. Anton (eds.), *A fragmented landscape: abortion governance and protest logics in Europe* (2017); A. E. Yamin, P. Bergallo, M. Berer (eds.) *Health and Human Rights Journal,* Vol. 19, Issue 1, June 2017 *Special Section: Abortion and Human Rights;* M. Unnithan, S. De Zordo (eds.) *Global Public Health, (2017) Special Issue: "Re-situating Abortion: Bio-politics, Global Health and Rights in Neo-liberal Times"*.
[214] See for example: J. Erdman, "The Procedural Turn: Abortion at the European Court of Human Rights", in: *Abortion Law in Transnational Perspective: cases and controversies*, R.J. Cook, J. Erdman and B. Dickens (eds.) (2014); C. Cosentino, "Safe and Legal Abortion: An Emerging Human Right? The Long-lasting Dispute with State Sovereignty in ECHR Jurisprudence", *Human Rights Law Review,* Vol. 15, Issue 3 (2015); J. Westeson, "Reproductive Health Information and Abortion Services: Standards Developed by the European Court of Human Rights", *International Journal of Gynecology & Obstetrics,* Vol. 122, Issue 2 (2013); R. Rebouché, "Abortion Rights as Human Rights", *Social & Legal Studies*, Vol. 25, Issue 6 (2016).
[215] See for example: J. Erdman, "Theorizing Time in Abortion Law and Human Rights", *Health and Human Rights Journal*, Vol. 19, Issue 1 (2017); N. Sedacca, "Abortion in Latin America in International Perspective: Limitations and Potentials of the Use of Human Rights Law to Challenge Restrictions", *Berkeley Journal of Gender, Law & Justice*, Vol. 32 (2017); C. Ngwena, "Access to Safe Abortion as a Human Right in the African Region: Lessons from Emerging Jurisprudence of UN Treaty-monitoring Bodies", *South African Journal on Human Rights*, Vol. 29,Issue 2 (2013).

their bodies, sexuality, and reproduction constructed by the chosen human rights law forums, and in connection to other reproduction issues.

Rebecca J. Cook and Bernard M. Dickens trace the evolution of abortion laws worldwide, and propose that, by and large, usually three phases can be identified: first, abortion is regulated within criminal law, second, it moves from penal codes through decriminalisation to being a public health issue, and third, most recent and desirable for human rights scholars and abortion rights advocates, abortion is framed through constitutional law, or as a *human rights* matter.[216] In other words, the third phase links abortion to the *rights language*. If we consider the number of abortion cases in constitutional courts and human rights law forums, litigation efforts, and the judicialisation of sexual and reproductive rights more broadly then it is clear that the third phase is gaining momentum.[217]

Nonetheless, I have argued together with Alicia Ely Yamin elsewhere, how the rights phenomenon *alone* is not enough – it is not sufficient that several questions regarding access to abortion have reached transnational human rights forums (*i.e* deemed admissible), that these forums have applied legal provisions, and even established violations.[218] What I term as a reproductive rights-based approach goes beyond that and considers power relations, it questions how rights are framed and challenges these constructions more deeply. To illustrate, if we take a step back for a moment and really consider the phenomenon of *abortion* and *law*, then it is not difficult to realise that (paradoxically) even the a liberal/permissive regulation of pregnancy termination is still oppressive – women need a specific law to have been passed and enforced to protect and guarantee that they can make

[216] R. J. Cook, B. M. Dickens, "Human rights dynamics of abortion law reform," *Human Rights Quarterly*, Vol. 25, No.1 (2003), pp. 1–59.
[217] In addition to the transnational case-law I have included into this thesis consider also these projects funded by the Norwegian Research Council: "*Sexual and Reproductive Rights Lawfare: Global battles"* (https://www.cmi.no/projects/1836-sexual-and-reproductive-rights-lawfare; accessed November 2017*),* and *"Abortion Rights Lawfare in Latin America" (https://www.cmi.no/projects/1841-abortion-rights-lawfare-in-latin-america*, accessed November 2017*).*
[218] L. Oja, A. E. Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?" *Columbia Journal of Gender and Law*, Vol. 32, No. 1 (2016).

decisions about their reproductive lives. In other words, abortion cases are inherently about power dynamics that control women's lives and roles they take in a society.

Indeed, it is somewhat easy to overlook such power dynamics as anti-abortion and so-called pro-life movements (both religiously rooted and non-religious conservative actors) have achieved something very powerful that has affected legal framings and jurisprudence: visually abortion is more associated with the images of a foetus and a "dangerous selfish" woman, or alternatively, a foetus and a "troubled woman" who would become to *regret* the abortion.[219] These stereotypical constructions are also feeding into human rights jurisprudence as becomes apparent below where I introduce abortion cases from the European Court of Human Rights. This is happening despite the available global statistics on maternal mortality cited above – associating abortion with horrific images of the violent, bloody, or potentially deadly consequences of unsafe abortions is rare. Lynn P. Freedman describes this problem with a different example. Freedman notes how although censorship and manipulation of reproductive health information are human rights violations that might not have the "stomach-turning quality" of a report on the torture of prisoners or rape in war, this does not mean that there is no "fundamental assault" involved.[220] Rather, Freedman underscores how this just demonstrates that we have been "conditioned to think about health, about women's reproduction, and the concept of human rights itself".[221] In other words, how *little* we – both men and women themselves – are conditioned to think of women.

At the same time, in cases where the human rights law forums have agreed that a state restricting a woman's access to safe, legal and timely abortion had breached her human

[219] Consider for example the famous images of "a foetus sucking thumb" by the Swedish photojournalist Lennart Nilsson published in *Life* magazine "The Drama of Life Before Birth" (1965).
[220] L. P. Freedman, "Censorship and manipulation of reproductive health information. An issue of human rights and women's health", in: *The Right to Know. Human rights and access to reproductive health information*, S. Coliver (ed.) (1995).
[221] L. P. Freedman, "Censorship and manipulation of reproductive health information. An issue of human rights and women's health", in: *The Right to Know. Human rights and access to reproductive health information*, S. Coliver (ed.) (1995) p. 1.

rights, the most convincing argument seems to still stem from proving "enough" additional suffering (applicant is a minor, foetus not compatible with life, applicant was raped etc.) instead of highlighting the woman's simple wish to not be pregnant and give birth and her different life plan. Thus, in this I too look beyond the final conclusion of the courts and committees to rather ask, how these four human rights law forums are conditioned to "think about" women's reproductive functions, bodies, sexuality more broadly, and simultaneously abortion, birth, pregnancy more specifically.

3.2.1 Abortion jurisprudence of the European Court of Human Rights

I present here five cases from the European Court of Human Rights (ECtHR). In short, the Strasbourg Court found a human rights violation in all of them, but did not use a *reproductive rights-based approach* to contextualise abortion in relation to power dynamics in the society. Thus, despite confirming some specific standards for abortion services, it did not put women's lived experiences at the centre of its analysis to tackle stereotypes about women's bodies and sexuality that feed into restrictive abortion regulations-practices. Using again Barbara Havelkova's work on stereotyping and human rights, which considers also dissenting opinions, the abortion jurisprudence in this thesis similarly reveals a resistance – namely, a reluctance to confirm abortion as a human right of all women and girls.

For example, in *Tysiac v. Poland* concerning a woman who needed to terminate her pregnancy due to her health, but whose doctors disagreed on the certainty of this risk some ECtHR judges wrote, how that the Strasbourg Court was not concerned with "any abstract right to abortion" (Judge Bonello), and "if five experts did not think the woman's health would be threatened by the pregnancy and birth this should have been decisive" (Judge

Borrego Borrego).[222] In *A, B and C v. Ireland* the ECtHR, by referring that the two women – A and B – were not prevented from travelling *abroad* for abortion, failed to consider intersectionality and how women's socio-economic situations are different. Although in two other Polish abortion cases tried in the ECtHR (*R.R. v Poland*, and *P. and S. v. Poland*) the court did move beyond constructing abortion through "privacy" only, and established that the standard of "degrading treatment" was met, it did not arrive at such a conclusion because inflicting unwanted pregnancy or unsafe illegal abortion on someone in itself is already a degrading treatment, but rather because in these cases the applicants were able to show "extra suffering" – R.R. could not secure genetic tests for five months, and S. was a minor who had been raped and then bullied by the media, a Catholic priest, and was forced to get her abortion 500 km away from her home. The last abortion case I introduce from the ECtHR is not a "typical" abortion case: *Annen v. Germany* showcases how women's reproductive rights can also be potentially harmed through upholding someone's freedom of expression. This point was indeed put forward to some extent by Judges Yudkivska and Jäderblom's dissenting opinion in which they write how "derision of abortion doctors to which the applicant resorted, pushes more and more doctors to refuse to perform abortions, to the detriment of women in difficult situations", and the two doctors were "singled out as the victims of the applicant's struggle against women's procreative liberty". Thus, although not being a "typical" abortion case, *Annen*'s dissent adds more nuance to ECtHR's abortion jurisprudence.

In summary, the ECtHR mainly applied Article 8 (right to privacy) when analysing abortion cases, has established a violation of Article 3 (degrading treatment) by exception only (a 5-month delay in getting a necessary genetic screening or in case of a minor), and has

[222] *Tysiac v. Poland*, Application no. 5410/03 (2007), Separate Opinion of Judge Bonello, and Dissenting Opinion of Judge Borrego Borrego.

never referred to Article 14 (non-discrimination) and/or framed access to abortion as a gendered issue.

2016	***Annen v. Germany***	Art. 10 violation (not a "classic abortion case", but relevant as pointed out in a dissent)
2013	***P. and S. v. Poland***	Art. 8 + 3 violation (privacy + degrading treatment) reproductive rights/power/stereotypes not considered,
2011	***R.R. v. Poland***	Art. 8 + 3 violation (privacy + degrading treatment) reproductive rights/power/stereotypes not considered
2010	***A, B and C v. Ireland***	Art. 8 violation (only one applicant), reproductive rights/power/stereotypes not considered, court suggests women "are not banned from travelling"
2007	***Tysiac v. Poland***	Art. 8 violation (privacy), no violation of Art. 3 (degrading treatment), reproductive rights/power/stereotypes not considered

Tysiac v. Poland

In the first case, *Tysiac v. Poland* the applicant Alicja Tysiac was seeking an abortion as pregnancy and birth constituted a serious risk to her health, including to her eyesight.[223] However, since the consulting doctors disagreed about the certainty of this health risk she could not get an abortion, had to give birth and consequently suffered from severely deteriorated eyesight.[224] She submitted to the ECtHR that Articles 3, 8 and 14 of the European Convention on Human Rights (the Convention) had been violated by Poland. Article 3 prohibits torture, inhuman or degrading treatment,[225] Article 8 protects private and family life[226] and Article 14 prohibits discrimination, including on the basis of gender.[227]

[223] *Tysiac v. Poland,* Application no. 5410/03 (2007).
[224] Case, para. 14.
[225] Article 3 of the Convention states:
No one shall be subjected to torture or to inhuman or degrading treatment or punishment.
[226] Article 8 of the Convention states:

Regarding inhuman or degrading treatment the Court found that the facts of the case did not disclose a breach of Article 3.[228] The Court also established that it was not necessary to examine the complaint under Article 14 (prohibition of discrimination).[229] Rather, it found only the right to private life (Article 8) relevant as "legislation regulating the interruption of pregnancy touches upon the sphere of private life since whenever a woman is pregnant her private life becomes closely connected with the developing foetus".[230]

Importantly, the Court also explicitly established that the woman's right to private life is not of an absolute nature – "the woman's right to respect for her private life must be weighed against other competing rights and freedoms invoked including those of the unborn child".[231] The Court noted that "while the state regulations on abortion relate to the traditional balancing of privacy and the public interest, they must be in case of a therapeutic abortion be assessed against the positive obligations of the state to secure the physical integrity of mothers-to-be."[232] In considering how the availability of a therapeutic abortion in Polish law was applied to the applicant's case, the Court concluded that the procedures put in place to determine whether the applicant had met the conditions for obtaining a lawful abortion were inadequate.[233] Thus, the Court held that there had been a breach of the right to private life (Article 8) due to the lack of adequate information and procedural mechanisms.

1.Everyone has the right to respect for his private and family life, his home and his correspondence. 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

[227] Article 14 of the Convention states:

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

[228] *Tysiac v. Poland*, Application no. 5410/03 (2007), para. 66.

[229] Case, para. 144.

[230] Case, para. 106.

[231] Case, para. 106.

[232] Case, para. 107.

[233] The Court noted at para. 117 that in the context of access to abortion a relevant procedure should guarantee to a pregnant woman at least a possibility to be heard in person and to have her views considered. The competent body or person should also issue written grounds for its decision.

The decision also had a separate opinion by Judge Bonello. Namely, according to Judge Bonello, the Court was neither concerned with "any abstract right to abortion" nor "with any fundamental human right to abortion lying somewhere in the penumbral fringes of the Convention".[234] In addition to Judge Bonello, Judge Borrego Borrego provided a dissenting opinion in which he argued that "the Court is neither a charity institution nor the substitute for a national parliament", and if "five experts . . . did not think that the woman's health would be threatened by the pregnancy and the delivery", then this should have been decisive.[235] Borrego Borrego concluded that the violation was found "only on the sole basis of the applicant's fears".[236]

A, B and C v. Ireland

In the case of *A, B and C v. Ireland* three women needed to consider travelling to the United Kingdom to have abortions as the domestic laws of Ireland prevented them from getting legal abortions in their home country.[237] A, B and C were seeking abortions for different reasons: A felt that an unwanted pregnancy would harm her mental health and socioeconomic well-being, B did not want to be a mother without a partner, and C was advised against pregnancy due to her cancer. The Court dismissed applicants' allegations of degrading treatment (Article 3) and discrimination (Article 14), and again only considered Article 8 – right to respect for private life. The applicants accepted that the abortion restrictions were in accordance with Irish law and were aimed at protecting foetal life, but claimed that the law's restrictiveness no longer reflected the popular sentiment on abortion in Ireland –they therefore argued for a substantive violation.[238] In rejecting this claim, the Court

[234] *Tysiac v. Poland*, Application no. 5410/03 (2007), Separate Opinion of Judge Bonello, para. 1.
[235] *Tysiac v. Poland*, Application no. 5410/03 (2007), Dissenting Opinion of Judge Borrego Borrego, para. 10.
[236] *Tysiac v. Poland*, Application no. 5410/03 (2007), Dissenting Opinion of Judge Borrego Borrego, para. 14.
[237] *A, B and C v. Ireland*, Application no. 25579/05 (2010).
[238] Case, para. 170, see also: J. Erdman, "The Procedural Turn: Abortion at the European Court of Human Rights", in: *Abortion Law in Transnational Perspective: cases and controversies*, R. J. Cook, J. Erdman and B. Dickens (eds.) (2014), p. 121.

provided the Irish Government a wide margin of appreciation.[239] In *A, B and C v. Ireland* this margin could have been narrowed by the existence of relevant European consensus to which the Court referred.[240] Instead, the Court showed deference, finding no violation of the right to private life (Article 8) regarding applicants A and B, as they were able to travel abroad and secure access to abortion:

> *Accordingly, having regard to the right to travel abroad lawfully for an abortion with access to appropriate information and medical care in Ireland, the Court does not consider that the prohibition in Ireland of abortion for health and well-being reasons, based as it is on the profound moral views of the Irish people as to the nature of life (...) and as to the consequent protection to be accorded to the right to life of the unborn, exceeds the margin of appreciation accorded in that respect to the Irish State. In such circumstances, the Court finds that the impugned prohibition in Ireland struck a fair balance between the right of the first and second applicants to respect for their private lives and the rights invoked on behalf of the unborn*.[241]

The Court separated C's case from the rest as she was seeking an abortion due to her cancer and there was a risk to her life – which was an accepted exception in Irish abortion law. The Court held accordingly, as in the case of *Tysiac v. Poland*, that the state had failed

[239] Case, paras. 231-241.
[240] Case, para. 235: "In the present case, and contrary to the Government's submission, the Court considers that there is indeed a consensus amongst a substantial majority of the Contracting States of the Council of Europe towards allowing abortion on broader grounds than accorded under Irish law. In particular, the Court notes that the first and second applicants could have obtained an abortion on request (according to certain criteria including gestational limits) in some 30 such States. The first applicant could have obtained an abortion justified on health and well-being grounds in approximately 40 Contracting States and the second applicant could have obtained an abortion justified on well-being grounds in some 35 Contracting States. Only 3 States have more restrictive access to abortion services than Ireland namely, a prohibition on abortion regardless of the risk to the woman's life".
[241] Case, para. 241. This conclusion was criticised by Judges Rozakis, Tulkens, Hirvelä, Malinverni and Poalelungi in their joint partly dissenting opinion.

to comply with its positive obligation to put procedures in place for women to obtain therapeutic abortions, finding a violation of the right to private life (Article 8). [242]

R.R. v. Poland

In another case against Poland, *R.R. v. Poland* the applicant R.R. also gave birth after having been refused a therapeutic abortion even though several ultrasounds confirmed the likelihood of the foetus suffering from severe malformation. [243] For five months, the doctors delayed R.R. from getting a genetic test, which eventually did confirm a serious congenital disease, by forcing her to obtain continuous referrals to different hospitals.[244]

Noting there were no objective reasons for the delays in genetic tests, the Court found that as a result of "procrastination of the health professionals", she had to "endure weeks of painful uncertainty concerning the health of the foetus, her own and her family's future and the prospect of raising a child suffering from an incurable ailment".[245] The Court concluded that the applicant was treated "shabbily" and the required minimum threshold of severity for establishing a violation of the prohibition of degrading treatment (Article 3) had been reached.[246]

The Court distinguished this case from the case concerning Alicja Tysiac's case, by arguing that the issue was not access to abortion as such, but essentially timely access to a medical diagnostic service that would make it possible to determine whether conditions for a lawful abortion were obtained.[247] It confirmed with *R.R* that if the domestic laws allow for abortion in cases of foetal malformation, there must be an adequate legal and procedural

[242] Case, paras. 267-268.
[243] *R.R. v. Poland*, Application no. 27617/04 (2011).
[244] Turner syndrome is a chromosomal condition that affects development in females. The most common feature of Turner syndrome is short stature, which becomes evident by about age five. An early loss of ovarian function (ovarian hypo function or premature ovarian failure) is also very common.
[245] Case, para 159.
[246] Case. para. 160.
[247] Case, para. 196.

framework to guarantee that relevant, full and reliable information on the foetus' health is available to pregnant women.[248]

This construction of lack of information and procedural access to abortion as a form of degrading treatment was, however, questioned by Judge Bratza in his partial dissent, where he argued that the Court's analogy with cases of enforced disappearances was erroneous. He explained how in such cases authorities "systematically prevaricate or provide false information to applicants about the whereabouts and fate of their missing relatives", but he insisted that the actions of the doctors in the *R.R.* case "even if they were prompted to deter the applicant from pursuing the possibility of a termination of her pregnancy" were not comparable to institutional deception.[249]

P. and S. v. Poland

The last of the three infamous Polish abortion cases is *P. and S. v. Poland.*[250] On 9 April 2008, P. (the first applicant) went to the Public University Health Care Unit in Lublin. She said that she had been raped on 8 April 2008 by a boy of her own age. The medical staff told P. that they could neither examine her nor provide medical assistance because she was a minor and the consent of her legal guardian was necessary. The doctor also reported the case to the police and notified P's parents. Later that day, after reporting the rape, P. attended the hospital with her mother S. accompanied by a female police officer. S. gave her consent for the examination of her daughter, who was in a state of emotional shock. At the hospital, psychological help was offered and a family doctor confirmed bruises on her body. As a result of the rape P. became pregnant, and the applicants decided together that an abortion would be the best option, considering that P. was a very young minor, the pregnancy was the result of forced intercourse, and she wanted to pursue her education.

[248] Case, para. 201.
[249] Case, para. 5.
[250] *P. and S. v. Poland*, Application no. 57375/08 (2013).

On 20 May 2008, the District Prosecutor issued a certificate stating that P's pregnancy had resulted from unlawful sexual intercourse with a minor under 15 years of age. P's mother S. then went to different hospitals to ask for a termination of pregnancy, but was faced with doctors' suggestions to "meet with a Catholic priest" and to "get her daughter married" and how "under communism when abortion had been freely available no one had made her perform abortions, and that no doctor would have given permission for an abortion to be performed". S. was also asked to sign a statement: "*I am agreeing to the procedure of abortion and I understand that this procedure could lead to my daughter's death*". Moreover, P. was separated from her parents, locked up in a juvenile shelter, harassed by media, anti-abortion activists, a Catholic priest and finally forced to seek the abortion 500 km away from her home.

The Court found that "the events surrounding the determination of the first applicant's access to legal abortion were marred by procrastination and confusion" they were given "misleading and contradictory information", and they did not receive "appropriate and objective medical counseling".[251] Furthermore, regarding the relationship between P. and S., the Court underscored that "legal guardianship cannot be considered to automatically confer on the parents of a minor the right to take decisions concerning the minor's reproductive choices, because proper regard must be had to the minor's personal autonomy", but continued: "it cannot be overlooked that the interests and life prospects of the mother of a pregnant minor girl are also involved in the decision whether to carry the pregnancy to term or not".[252]

Accordingly, the Court established that the state must guarantee a "procedure for the determination of access to a lawful abortion whereby both parties can be heard and their views fully and objectively considered, including, if necessary, the provision of a mechanism

[251] Case, para. 108.
[252] Case, para. 109.

for counselling and reconciling conflicting views in favour of the best interest of the minor".[253]

The Court concluded that "the authorities failed to comply with their positive obligation to secure to the applicants effective respect for their private life", and thus there had been a breach of Article 8.[254] Furthermore, it established that the authorities treated P. in a "deplorable manner", and that "her suffering reached the minimum threshold of severity under Article 3 of the Convention" – thus, the Court found that Poland had breached Article 3.[255]

Annen v. Germany

The last abortion case from the European Court of Human Rights is *Annen v. Germany*, which is not a "typical" abortion case, but the views adopted by the ECtHR are nonetheless important for the purposes of my analysis.[256]

The applicant in this case was Mr Klaus Günter Annen. He campaigned against abortion and distributed leaflets in the immediate vicinity of the medical practices of anaesthetists Dr M. and Dr R, who were running a day clinic. Mr Annen also distributed the leaflets to all the letterboxes in the vicinity of the clinic. The front page of the leaflets stated: "*In the day clinic Dr M/Dr R [full name and address] unlawful abortions are performed*". This statement was followed by an explanation in smaller print: "*which are, however, allowed by the German legislator and are not subject to criminal liability. The attestation of counselling protects the "doctor" and the mother from criminal responsibility, but not from their responsibility before God*".

A box below contained the following text: "*According to international criminal law murder is the international "bringing-to-death" of an innocent human being*". Furthermore,

[253] Case, para. 109.
[254] Case, para. 112.
[255] Case, paras. 168-169.
[256] *Annen v. Germany*, Application no. 3690/10 (2016).

the other side of the leaflet Mr Annen had quoted the German Constitutional Court's leading judgment regarding abortion, made references to Auschwitz and to a webpage called *www.babycaust.de*. The latter was an online site operated which contained, *inter alia*, an address list of "abortion doctors" (Dr M and Dr R were also both mentioned).

Dr M and Dr R filed a civil injunction against Mr Annen and submitted that only legal abortions were performed at their clinic, but the leaflet created an impression that these abortions were illegal. The civil injunction was granted in the domestic legal system, and Mr Annen was ordered to not disseminate these leaflets in the immediate vicinity of the day clinic, and desist from mentioning Dr M and Dr R in the list of "abortion doctors" on the www.babycaust.de website.

The ECtHR analysed whether Mr Annen's right to freedom of expression (Article 10,) had been violated .[257] First, the Court investigated, whether there had been a breach of Article 10 in respect of the order to desist from further disseminating the leaflets. The Court established that Mr Annen's campaign "contributed to a highly controversial debate of public interest", and thus "there can be no doubt as to the acute sensitivity of the moral and ethical issues raised by the question of abortion".[258] The Court found that it is not clear, whether the applicant's activities actually caused the closure of the clinic.[259]

Furthermore, the Court said that it "cannot agree with the domestic courts' interpretation that the applicant had compared the doctors and their professional activities to

[257] Article 10:
1. Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This Article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.
2. The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary
[258] Case, para. 62.
[259] Case, para. 62.

the Nazi regime" as Mr Annen's reference to Auschwitz could also be understood as a "more general fact that law may diverge from morality".[260] The Court also noted that Mr Annen's statement about unlawful abortions was actually not incorrect from a judicial point of view.[261] Thus, the Court concluded that the domestic courts had failed to strike a fair balance between Mr Annen's right to freedom of expression and the doctors' personality rights, and found a violation of Article 10.[262]

The Court analysed further whether prohibiting Annen from having the doctors' names listed on the website under "abortion doctors" violated Article 10. In short, the Court considered that the doctors had not submitted the exact content, screenshots of or the general layout of the website at question to the domestic courts and accordingly the domestic court of appeal had "limited itself to finding that the same principles which had been elaborated with regard to the leaflet should also apply to the website".[263]

Consequently, the Court noted that the domestic courts did not draw a distinction between "the applicant's statement on the leaflet, which had a geographically limited impact, and (…) his statements on the Internet, which could be disseminated worldwide".[264] Thus, the Court found that by "failing to address specific elements related to the applicant's Internet site, the domestic courts cannot be said to have applied standards which were in conformity with the procedural principles embodied in Article 10", and found a violation of Article 10.[265]

This decision has a dissenting opinion that brings in themes the majority decision does not touch upon. Judges Yudkivska and Jäderblom summarise that the majority operated on a presumption that "the applicant's leaflets about two doctors, as well as mentioning their names and addresses on the website "contributed to a highly controversial debate of public

[260] Case, para. 63.
[261] Case, para. 60.
[262] Case, paras. 64-65.
[263] Case, para. 70.
[264] Case, para. 72.
[265] Case, para. 74.

interest". They continue to explain, how "it goes without saying that the very *issue of abortion* constitutes a matter of public interest, and society remains divided over abortion rights" and thus, "a similar campaign against those responsible for *government policy* in this respect would undoubtedly warrant strong protection under article 10".[266]

They write further that in the case of Mr Annen the public interest threshold had not been reached as the case involved "ordinary doctors, merely performing their professional duties in strict accordance with the relevant rules, like many other gynaecologists in Germany".[267] Thus, according to judges Yudkivska and Jäderblom, these two doctors were "singled out as the victims of the applicant's struggle against women's procreative liberty".

Moreover, the dissenting judges found it convincing that the activities of Mr Annan could have caused the closure of the clinic as "potential patients" would choose to not be treated by doctors whose practices were associated with the word "unlawful". They explain how Mr Annan was able to "demonise them by mixing their names with notions related to the most horrifying crime in the history of humankind – "Holocaust", "Auschwitz", "Nazi" and how this would be "tolerable as an artistic device to describe mass abortion as such in general", but not with respect to "individual doctors faultlessly performing their ordinary duties".

The dissent also sheds light to another aspect not voiced in the majority opinion: namely, the "broader consequences of the harassment actions against abortion doctors". Judges Yudkivska and Jäderblom explain how "derision of abortion doctors to which the applicant resorted, pushes more and more doctors to refuse to perform abortions, to the detriment of women in difficult situations". The judges conclude: "It could be perfectly legitimate to distribute leaflets and run a website criticising abortion as a phenomenon, which the applicant continues to do, but in the present case the actions prohibited by the domestic

[266] Joint Dissenting Opinion of Judges Yudkivska and Jäderblom.
[267] Joint Dissenting Opinion of Judges Yudkivska and Jäderblom.

judicial authorities were limited to the continued destruction of the professional reputation of two doctors".[268]

3.2.2 Abortion jurisprudence of the United Nations committees

Both of the United Nations committees have abortion jurisprudence that, in contrast with the European Court of Human Rights, at least to some extent uses a reproductive rights-based approach. The United Nations Human Rights Committee has decided four important abortion cases, and the CEDAW Committee one abortion case.

Rebecca J. Cook's and Simone Cusack's three-step methodology cited in Chapter 2 of this thesis explains the transformative power of naming (gender) stereotypes: how *naming* stereotypes reveals "otherwise hidden harm", and also, understands stereotypes as *human rights concern*.[269] The abortion jurisprudence of the European Court of Human Rights, for example, does not name stereotypes or understand abortion laws as reflections of women's lack of power in a society. Instead, as I elaborate below, the ECtHR jurisprudence enforces the normative motherhood stereotype.

The abortion jurisprudence of the United Nations two committees is indeed more progressive in its character even though this has not always been the case: in *K.L. v. Peru* and *L.M.R. v. Argentina* the Human Rights Committee did not explicitly acknowledge harmful stereotypes, but fortunately in its more recent cases brought against Ireland (*Whelan* and *Mellet*) the Human Rights Committee has sharpened its tools.

[268] Joint Dissenting Opinion of Judges Yudkivska and Jäderblom.
[269] R. J. Cook, S. Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (2010), p. 39.

2017	***Whelan v. Ireland*** **(HR Committee)**	Violation of Article 26 (non-discrimination), 7 (degrading treatment), 17 (privacy); analysis of reproductive rights/gender/stereotypes present
2016	***Mellet v. Ireland*** **(HR Committee)**	Violation of Article 26 (non-discrimination), 7 (degrading treatment), 17 (privacy); analysis of reproductive rights/gender/stereotypes present
2011	***L.C. v. Peru*** **(CEDAW Committee)**	Violation of Article 1, 2, 3, 5 (anti-stereotyping), 12 (non-discrimination in women's health) and 16 para. 1 (e); analysis of reproductive rights and stereotypes present
	LMR v. Argentina **(HR Committee)**	Violation of Article 2 (no access to effective remedy) in relation to Articles 3 (non-discrimination), 7 (degrading treatment), 17 (privacy); no analysis of reproductive rights/gender/stereotypes
2005	***K.L. v. Peru*** **(HR Committee)**	Violation of Article 2 (no access to effective remedy) in conjunction with Articles 7 (degrading treatment), 17 (privacy), 24 (rights of a child); no analysis of reproductive rights/gender/stereotypes

K.L. v. Peru

The author of this communication to the Human Rights Committee was K.L. [270] She became pregnant in March 2001 when she was 17 years old. On 27 June 2001 she went to a hospital in Lima and received a scan, which showed that she was carrying an anencephalic foetus, *i.e* a foetus that is missing a major portion of the brain, skull, and scalp. On 3 July a gynaecologist and obstetrician informed K.L. of the foetal abnormality and the risks to K.L.'s life if the pregnancy continued. The doctor told K.L. that she had two options: to continue the pregnancy or to terminate it. K.L. decided to terminate the pregnancy, and the necessary clinical studies were carried out again confirming the foetal abnormality.

On 19 July K.L. reported to the hospital together with her mother for admission to the preparatory phase of the operation. The doctor informed K.L. that she needed to obtain written authorization from the hospital director. Since K.L. was underage her mother submitted the request on her behalf. On 24 July the hospital director replied in writing that the termination of pregnancy could not be carried out since it would be unlawful as under the

[270] *K.L. v. Peru*, CCPR/C/85/D/1153/2003 (2005).

Peruvian Criminal Code abortion was punishable by a prison term also in cases when it was likely that at birth the child would suffer serious physical or mental defects. Therapeutic abortion was permitted only to save the life of the pregnant woman or avoid serious and permanent damage to her health.

On January 13 2002 K.L. gave birth to an anencephalic baby who survived for four days during which K.L. had to breastfeed the baby. After the birth K.L. was diagnosed with depression, and also suffered from an inflammation of the vulva, which required medical treatment.[271] K.L. submitted to the Human Rights Committee that Peru had violated Articles 2, 3, 6, 7, 17, 24, 26 of the International Covenant on Civil and Political Rights (the ICCPR).

The Committee found that Peru had violated Article 7 (the prohibition of torture and other cruel, inhuman or degrading treatment)[272] of the ICCPR as K.L. suffered from deep depression due to the hospital's refusal of abortion, and that could have been foreseen. The Committee thus established that "the omission on the part of the State in not enabling the author to benefit from a therapeutic abortion was (…) the cause of the suffering she experienced".[273]

The Human Rights Committee referred to the General Comment No. 20, which explains how "the right set out in article 7 of the Covenant relates not only to physical pain but also to mental suffering, and that the protection is particularly important in the case of minors".[274] Thus, the Committee also noted that in the light of this finding it was not necessary to consider Article 6 (the right to life).

[271] Case, paras. 2.1-2.6.
[272] Article 7.
No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.
[273] Case, para. 6.3.
[274] Case, para. 6.3.

Furthermore, the Committee also found that Peru had violated Article 17 (the right to privacy).[275] The Committee explained that the doctor at the hospital told K.L. that she had the option of terminating her pregnancy, thus "in the absence of any information from the State Party, due weight must be given to the author's claim that at the time of this information, the conditions for the lawful abortion as set out in the law were present".[276]

Moreover, the Committee noted "the special vulnerability of the author as a minor girl" and as K.L. did not receive any medical or psychological support necessary in her circumstances, Peru had violated article 24 (special mention of the rights of a child) of the ICCPR.[277] The Committee also established that there had been a violation of Article 2 (non-discrimination)[278] in conjunction with Articles 7, 17 and 24 as K.L. lacked an adequate legal remedy.[279]

The Committee did not comment on K.L.'s submission that there had been a breach of Article 3 (equal treatment of men and women) as well. K.L. had submitted that her "different and special needs were ignored because of her sex", and although she was entitled to a therapeutic abortion, she was denied because of "social attitudes and prejudices, thus preventing her from enjoying her right to life, to health, to privacy and to freedom from cruel, inhuman and degrading treatment on an equal footing with men".[280]

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[275] Article 17
1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.
2. Everyone has the right to the protection of the law against such interference or attacks.
[276] Case, para. 6.4.
[277] Case, para. 6.5.
[278] Article 2.
1. Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. (...)
[279] Case, para. 6.6.
[280] Case, para. 3.2.

L.M.R. v. Argentina

This case concerned L.M.R., a young woman with a permanent mental impairment living in Guernica, Buenos Aires province.[281] L.M.R. lived with her mother, attended a special school and received neurological care as she had been diagnosed with having a mental age of between 8 and 10 years. L.M.R. was represented in this case by her mother (V.D.A.).

In June 2006 V.D.A. took her daughter to Guernica Hospital because L.M.R. said that she was feeling unwell. At the hospital L.M.R. was found to be pregnant and her mother requested a termination of the pregnancy. The hospital staff, however, refused to perform the abortion and referred L.M.R. to San Martín Hospital in La Plata, a public hospital 100 kilometres from where L.M.R. and V.D.A. lived. The hospital staff also told V.D.A. that she needed to file a complaint with the police. On 24 June 2006 V.D.A. filed a complaint against L.M.R.'s uncle who was suspected of raping her. V.D.A. noted in her communication that Guernica Hospital had the resources necessary to perform the procedure, without needing to refer the case elsewhere, and that its refusal forced the family to travel 100 kilometres to the provincial capital and to incur the related costs and inconvenience.

L.M.R. was approximately 14 weeks pregnant on her arrival at San Martín Hospital. She was admitted on 4 July 2006 and the hospital authorities requested an urgent meeting with the Bioethics Committee to solicit its opinion. Since this was a case of non-punishable abortion, the hospital staff began the pre-surgical examinations necessary for the procedure.

The Argentinian domestic regulation provided that, in principle, female rape victims with a mental disability do have the right to terminate a pregnancy, but the law specified neither any deadlines nor the type of medical procedure to be used. In addition, it established no requirement for judicial authorisation of any form. The only requirements were that the

[281] *L.M.R. v. Argentina*, CCPR/C/101/D/1608/2007 (2011).

disability should be diagnosed, the victim's legal representative should give consent and a licensed physician should perform the abortion.

However, the hospital was issued with an injunction on all procedures and judicial proceedings were initiated to prevent the abortion. The juvenile court judge ruled that the termination of pregnancy should be prohibited because she did not find it acceptable to respond to a wrongful assault (sexual abuse) "with another wrongful assault against a new innocent victim, i.e. the unborn child". This decision was confirmed by the Civil Court, which instructed the juvenile court judge to perform regular checks on L.M.R's pregnancy to monitor the health of her and her unborn child directly.

V.D.A. contested this decision before the Supreme Court of Justice of Buenos Aires province, which overturned it on 31 July 2006, and ruled that the termination of pregnancy could proceed. Consequently, the Court informed San Martín Hospital that the abortion was legal and did not require judicial authorization. This ruling was issued almost a month and a half after V.D.A. had reported the rape, and requested the abortion.

Despite the ruling, San Martín Hospital and the family came under enormous pressure from various sources opposed to the termination, and the hospital refused to perform the procedure on the grounds that the pregnancy was too advanced (between 20 and 22 weeks). The press reports indicated that both the Rector of the Catholic University and the spokesperson of the Corporation of Catholic Lawyers contributed to the pressure exerted on the family and the doctors.[282]

The family contacted various health centres and hospitals, but none of them agreed to carry out a termination. However, the family managed to arrange an illegal termination on 26 August 2006.[283] V.D.A. submitted to the HR Committee that forcing L.M.R. to continue pregnancy, even though she should have enjoyed protection under domestic regulation

[282] Case, paras. 2.7-2.9.
[283] Case, paras. 2.1-2.9.

constituted cruel and inhuman treatment and therefore a violation of Article 7 (prohibition of torture and degrading treatment) of the ICCPR.

Argentinian Government argued that, while forcing L.M.R. "to endure a pregnancy resulting from rape and undergo an illegal abortion could have been a contributing factor to the mental injury that the victim suffered, it did not constitute torture".[284] The Committee, however, concluded that the State party's failure to guarantee L.M.R.'s right to a termination of pregnancy "caused L.M.R. physical and mental suffering constituting a violation of article 7 of the Covenant that was made especially serious by the victim's status as a young girl with a disability".[285] The Committee recalled its General Comment No. 20 in which it states that the right protected in Article 7 "relates not only to acts that cause physical pain but also to acts that cause mental suffering".[286]

Further, V.D.A. also submitted how the impossibility of obtaining a termination of pregnancy constituted a violation of the right to equality and non-discrimination (Article 3): "the State's failure to exercise due diligence in safeguarding a legal right to a procedure required solely by women, coupled with the arbitrary action of the medical staff, resulted in discriminatory conduct that violated L.M.R.'s rights. The victim's status as a poor, disabled woman adds to the seriousness of the violation since it heightened the State's obligation to protect her rights and eradicate the cultural and religious prejudices that were undermining her well-being".[287] V.D.A. further referred to the Committee's concluding observations in a periodic report regarding Argentina which stated that "traditional attitudes towards women continue to exercise a negative influence on their enjoyment of Covenant rights", and submitted that "since abortion is an issue that affects women only and is shrouded in all kinds of prejudices in the collective imagination, the attitude of the judicial officers and the medical

[284] Case, para. 9.2.
[285] Case, para. 9.2.
[286] Case, para. 9.2.
[287] Case, para. 3.5.

staff at San Martín Hospital, and the authorities' failure to enforce the law, were discriminatory, depriving L.M.R. of her right to a safe, lawful abortion".[288] The Committee considered this "allegation to be closely related to those made under other articles of the Covenant, and that they should therefore be considered together".[289]

The Committee also considered V.D.A.'s submission that there had been an arbitrary interference with L.M.R.'s private life –a violation of Article 17 of the ICCPR (right to privacy).[290] The Human Rights Committee noted how "the State's unlawful interference, through the judiciary, is an issue that should have been resolved between the patient and her physician" respecting L.M.R.'s right to privacy, and thus the facts reveal a violation of Article 17, paragraph 1 of the ICCPR.[291]

Lastly, the Committee found that Argentina was by omission responsible for the violation of article 2 of the ICCPR.[292] Namely, the Committee observed that although the judicial remedies sought at the domestic level to guarantee access to a termination of pregnancy were indeed resolved favourably for L.M.R. by the Supreme Court ruling, to achieve this result, V.D.A. had to "appear before three separate courts, during which period the pregnancy was prolonged by several weeks, with attendant consequences for L.M.R.'s health that ultimately led the author to resort to illegal abortion".[293]

For these reasons, the Committee concluded that the author did not have access to an effective remedy and the facts described constitute a violation of Article 2, paragraph 3 in relation to Articles 3, 7 and 17 of the ICCPR.[294]

[288] Case, para. 3.6.
[289] Case, para. 8.5.
[290] Case, para. 9.3.
[291] Case, para. 9.3.
[292] Case, para. 9.4.
[293] Case, para. 9.4.
[294] Case, para. 9.4.

L.C. v. Peru

This communication was submitted to the United Nations CEDAW Committee by T.P.F. on behalf of her daughter L.C.[295] When L.C. was 11 years old, an adult man named J.C.R. began to sexually abuse her. As a result of the abuse, L.C. became pregnant at the age of 13. In a state of depression she attempted suicide by jumping from a building on 31 March 2007. She was taken to a hospital where she was diagnosed with several traumas and with "a risk of permanent disability".

The damage to her spine in addition to other medical problems caused paraplegia of the lower and upper limbs requiring emergency surgery. The surgery was scheduled for 12 April 2007. On 4 April L.C. revealed during a psychological evaluation that her suicide attempt was caused by the sexual abuse and her fear of being pregnant. The following day a gynaecologist examined her and confirmed the pregnancy. Consequently the doctors told L.C. that the spinal surgery had to be postponed due to her pregnancy. L.C. was also diagnosed with moderate anxiety-depression syndrome for which she was, however, not given treatment as it was contraindicated during pregnancy. L.C.'s mother made several requests for a therapeutic abortion, which were denied. On June 16 2007 L.C. miscarried spontaneously and on 11 July she had the surgery for her spinal injuries – almost three and a half months after it had been decided that she needed the operation. After two weeks she was discharged and her medical records indicated that she needed intensive physical therapy and rehabilitation, but she was able to start the therapy only in December that year.

L.C. remained at the rehabilitation institute for two months, but had to abandon her treatment due to lack of means. Currently, she is paralysed from the neck down and has regained only partial movement in her hands. Thus, she depends on a wheelchair to get around and has a catheter, which must be changed five times a day under sterile conditions,

[295] *L.C. v. Peru*, CEDAW/C/50/D/22/2009 (2011).

which prevents her from attending school. L.C.'s mother is unable to work because she has to take care of L.C. full time and thus L.C.'s brothers had to leave school and start working.[296]

L.C.'s mother submitted to the CEDAW Committee that Peru has violated Articles 1, 2, 3, 5, 12 and 16 paragraph 1 (e) of the CEDAW. The Committee first established that despite Peru's objections there was indeed a direct relationship between the withdrawal of the emergency surgery and L.C.'s pregnancy. The Peruvian Government argued that L.C.'s surgery was postponed due to an infection, but the Committee refers that the surgery was scheduled for 12 April, but the first mention of the infection in L.C.'s medical records is only from 23 April.

The Committee established that L.C. did not have access to the emergency spinal surgery and the needed therapeutic abortion. The Committee also adds that "this is even more serious considering that she was a minor and a victim of sexual abuse".[297]Thus, the Committee establishes that Peru has violated Article 12 (non-discrimination in women's health).[298] Furthermore, the Committee also held that Article 5 (anti-stereotyping)[299] had been violated as "the decision to postpone the surgery due to the pregnancy was influenced by the stereotype that protection of the foetus should prevail over the health of the mother".[300] Lastly, the Committee found that Peru's failure to "protect women's reproductive rights and

[296] Case, paras. 2.1-3.2.
[297] Case, para. 8.15.
[298] Article 12
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.
2. Notwithstanding the provisions of paragraph I 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.
[299] Article 5
States Parties shall take all appropriate measures:
(a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;
[300] Case, para. 8.15.

establish legislation to recognize abortion on the grounds of sexual abuse and rape are facts that contributed to L.C.'s situation".[301]

Mellet v. Ireland

The author of this communication to the Human Rights Committee was Amanda Jane Mellet, an Irish citizen living in Ireland.[302] Mellet became pregnant in 2011, and on 11 and 14 November in 2011, *i.e* in her 21st week of pregnancy, she received scans at a hospital in Dublin which showed that her foetus had congenital heart defects. The doctor at the hospital also stated: "Terminations are not available in this jurisdiction. Some people in your situation may choose to travel". The doctor did not explain what "travel" involved, and did not recommend a suitable abortion provider in the United Kingdom. Mellet had another examination at the hospital and was informed that the foetus had trisomy 18 (Edwards syndrome), and would die in utero or shortly after birth.[303] Again, the midwife indicated to Mellet that she could either carry to term knowing that the foetus would most likely die inside of her, or she could "travel" – without explaining what "travelling" would entail.

Thus, Mellet was not referred by the hospital to a provider abroad that could terminate her pregnancy since health providers in Ireland are not permitted to make such appointments. Mellet used a family planning organisation to book an appointment in the United Kingdom. She flew to Liverpool with her husband where at the Women's Hospital she received medication to start the process of terminating the pregnancy and then once more to induce the labour. Mellet was in labour for 36 hours and delivered a stillborn baby. She had to return to Ireland already 12 hours after the labour, as she did not have funds to stay longer in Liverpool.

In Ireland Mellet did not receive any aftercare and counselling as she did not qualify for it since the "service does not extend to those who choose to terminate the pregnancy as a

[301] Case, para. 8.18.
[302] *Mellet v. Ireland*, CCPR/C/116/D/2324/2013 (2016).
[303] Case, paras. 2.1-2.2.

result of fatal foetal impairments".[304] Eventually, Mellet received post-abortion counselling at a family planning organisation, but not bereavement counselling specifically. Mellet submitted to the Human Rights Committee that Ireland had violated Article 7 (prohibition of cruel, inhuman or degrading treatment), Article 17 (right to privacy), Article 19 (freedom of information) and Articles 2(1), 3, 26 (non-discrimination) of the ICCPR.

The Human Rights Committee stated that the fact that a particular conduct or action is legal under domestic law does not mean that it cannot violate Article 7 – as claimed by Ireland.[305] The Committee found that Ireland had subjected Mellet to cruel, inhuman or degrading treatment as Mellet had her:

> *(…) physical and mental anguish exacerbated by: not being able to continue receiving medical care and health insurance coverage for her treatment from the Irish health care system; the need to choose between continuing her non-viable pregnancy or travelling to another country while carrying a dying foetus, at personal expense and separated from the support of her family, and to return while not fully recovered; the shame and stigma associated with the criminalization of abortion of a fatally ill foetus; the fact of having to leave the baby's remains behind and later having them unexpectedly delivered to her by courier; an the State's refusal to provide her with necessary and appropriate post-abortion and bereavement care*.[306]

The Committee noted how many of these experiences could have been avoided if Mellet had not been prohibited from terminating her pregnancy in Ireland. Furthermore, the Committee also found that Ireland had breached Mellet's right to privacy as "the options open to her were inevitably a source of intense suffering", and

[304] Case, para. 2.5.
[305] Case, para 7.4.
[306] Case, para 7.4.

the interference in her decision as to how best cope with her non-viable pregnancy was unreasonable and arbitrary.[307]

Lastly, the Committee found that Ireland had violated Article 26 of the ICCPR – the right to not be discriminated. The Committee considered how under the Irish legal regime women pregnant with a foetus with a fatal impairment, but who nevertheless decide to carry the foetus to term, continue to receive the full protection of the public health care system, and receive such protection even after a miscarriage or delivery of a stillborn child as they would qualify for post-natal medical attention and bereavement care.

By contrast, women who choose to terminate a non-viable pregnancy must rely on their own financial resources and are left entirely outside of the public health system: they must travel abroad at their own expense, and incur the financial, psychological and physical burdens that such travel imposes, and are denied much-needed post-termination care, and bereavement counselling. The Committee considered that such differential treatment of Mellet "in relation to other similarly situated women failed to adequately take into account her medical needs and socio-economic circumstances".[308]

Mellet referred in her complaint, how the Irish abortion regulation is inherently discriminatory as it reduces women to their reproductive capacity by prioritizing the protection of the "unborn" over the health needs of the woman and her decision to terminate the pregnancy. Thus, Mellet notes in the complaint how she "was subjected to a gender-based stereotype that women should continue their pregnancies regardless of the circumstances, their needs and wishes, because their primary role is to be

[307] Case, para 7.8.
[308] Case, para 7.11.

mothers and self-sacrificing caregivers".[309] The Committee took note of that, but found a violation of Article 26 based on the discriminatory different treatment compared to women deciding to not terminate a pregnancy. The Committee also decided that it would not examine Articles 2(1), 3 and 19 separately.

The decision comes with five separate opinions from which three criticise the Committee's view on Article 26 violation, and deem it too narrow or reductionist. For example, Committee member Yadh Ben Achour echoes Mellet's complaint and argues that the prohibition of abortion in Ireland which is "indirectly punitive and stigmatizing targets women *because they are women*" and that Mellet had indeed been a victim of the sexist stereotype.[310]

Further, Sarah Cleveland, another member of the Committee remained critical of the view according to which "differences in treatment that are based on biological differences unique to either men or women cannot be sex discrimination" as, according to Cleveland, "modern gender discrimination law is not so limited". Namely, she explains, non-discrimination means accommodating the fundamental biological differences between men and women in reproduction so that the unique needs of each sex are respected and there is no indirect or direct discrimination.[311]

Committee members Victor Rodriquez Rescia, Olivier de Frouville and Fabian Salvioli also added in their concurring opinion that the violation of Article 26 "should have been broader in scope, inasmuch as it also entailed structural discrimination against the author vis-à-vis men on the basis of sex and gender".[312]

[309] Case, paras. 3.15 and 3.19.
[310] Case, Appendix I, Individual opinion of Committee member Yadh Ben Achour, para. 4.
[311] Case, Appendix II, Individual opinion of Committee member Sarah Cleveland, para. 7.
[312] Case, Appendix IV, Individual opinion of Committee members Victor Rodriquez Rescia, Olivier de Frouville and Fabian Salvioli (concurring), para. 11.

Whelan v. Ireland

The most recent case regarding abortion from the UN Human Rights Committee concerned the communication of Siobhan Whelan against Ireland (2017).[313] Whelan was in the 20th week of her pregnancy when on 4 January 2010 she underwent an ultrasound scan in an Irish hospital. The obstetrician believed that the foetus was affected by holoprosencephaly (brain malformation). The doctor told Whelan that the foetus would likely die in utero or if carried to term, the baby would die during labour or very soon after birth. Additionally, the doctors raised concerns about the formation of the heart, kidneys and other organs. The obstetrician mentioned how "in another jurisdiction [they] would be offered a termination but obviously not in this country due to Irish law".[314] Whelan was not given further information, was not referred to anyone to discuss the diagnosis, the care she would be offered in Ireland or the possibility of travelling abroad to terminate the pregnancy. Instead, the obstetrician stated that Whelan "would continue with the pregnancy, attend ante-natal appointments 'as normal' and wait for nature to take course".[315]

The brain malformation was confirmed with another scan five days later and the doctor gave Whelan a report of the scan "in case [they] wanted to travel". When Whelan asked where she could go if she did want to "travel", she was told that there had been good reports about Liverpool Women's Hospital. Whelan indicated that she did not discuss it further as she "felt it was illegal to even discuss this or ask too many questions for fear of having the door slammed in our faces or of not receiving any help whatsoever". She was later also informed over the phone that the foetus also had Patau syndrome and this condition was "incompatible with life".[316]

[313] *Whelan v. Ireland*, CCPR/C/119/D/2425/2014 (2017).
[314] Case, para. 2.1.
[315] Case, para. 2.1
[316] Case, para. 2.2.

Whelan decided to terminate the pregnancy so she contacted several crisis pregnancy agencies to seek information on travelling to the United Kingdom. After several hurdles Whelan feeling like "a criminal leaving [her] country", was able to travel to a hospital in Liverpool where she received an injection that stopped the heartbeat of the foetus. Whelan gave birth to a stillborn baby at 21 weeks and 5 days.[317] She submitted to the Committee that the Irish abortion law had subjected her to cruel, inhuman and degrading treatment (thus a breach of Article 7 of the ICCPR), and encroached on her dignity and physical and mental integrity by denying her the reproductive health care and information she needed and forcing her to continue carrying a dying foetus, by compelling her to terminate her pregnancy abroad and subjecting her to intense stigma for terminating her pregnancy.[318] Additionally, Whelan submitted that there had been a violation of Article 17 (right to privacy), Article 19 (right to information), and of articles 2(1), 3, 26 (rights to equality and non-discrimination).[319] She noted in her application that she had been subjected to gender-based discrimination as she was stereotyped as "a reproductive instrument whose needs were subordinate to those of her unborn, non-viable foetus", and since her health was not endangered by the pregnancy she was "expected to sacrifice her own mental health and well-being for her dying foetus".[320]

The Irish Government rejected all the claims and remained at the position that the Irish law that denied Whelan from terminating her pregnancy in Ireland was striking a fair balance between the right to life of a foetus and women's rights.[321] The Committee established that "a high level of mental anguish" was caused to Whelan by "a combination of acts and omissions attributable to the State party", and thus there had been a violation of Article 7 (prohibition of torture and degrading treatment).[322] The Committee also established

[317] Case, paras. 2.3-2.6.
[318] Case, para. 3.1.
[319] Case, paras. 3.1-3.11.
[320] Case, para. 3.11.
[321] Case, paras. 4.1-4.15.
[322] Case, paras. 7.3-7.7.

that preventing Whelan from terminating her pregnancy in Ireland caused her mental anguish, and constituted "an intrusive interference in her decision as to how best cope with her pregnancy", thus leading to an "unreasonable interference" with Whelan's decision. The latter constituted an "arbitrary interference" in Whelan's right to privacy and violated Article 17 of the ICCPR.[323]

Lastly, the Committee analysed whether Ireland had been in breach of Article 26 of the ICCPR (non-discrimination). The Committee noted Whelan's claim that she was denied on the basis of her sex access to medical services that she needed in order to preserve her autonomy, dignity and physical and psychological integrity, how, in contrast, male patients and other patients in other situations in Ireland were not expected to disregard their health needs and travel abroad in relation to their reproductive functions, and how criminalisation of abortion subjected Whelan to a gender based stereotype that defines women's primary roles through maternity and reproduction.[324] It also considered, how the differential treatment of Whelan 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 hermedical needs and socioeconomic circumstances and did not meet the requirements of reasonableness, objectivity and legitimacy purpose".[325]Thus, the Committee concluded that Ireland's failure provide Whelan with the services she required constituted discrimination and violated her rights under Article 26.[326]

Four Committee members wrote an individual opinion. Notably, Committee member Yadh Ben Achour's concurring opinion points out how the Committee seemed to have focussed on the unjustified differential treatment between women from different socioeconomic groups whereas to Achour's the heart of the issue is the "disproportionate,

[323] Case, paras. 7.8-7.9.
[324] Case, para. 7.12.
[325] Case, para. 7.12.
[326] Case, para. 7.12.

abnormal and unjust existential burden on women", *i.e* all women by "virtue of being women".[327]

3.3 "ALL WOMEN ARE MOTHERS(-TO-BE)" AND "WOMEN ARE SUFFERING VICTIMS"

I ask in this thesis who the "*woman*" in human rights law is. One of the stereotypes that emerges from abortion case-law is what has been termed as "normative motherhood": regardless of women's individual choices or capacities, society ascribes "motherhood" as an essential attribute of being a woman.[328] Normative motherhood in other words means that "all women, regardless of their actual intention of having children become defined in important ways by the mere possibility of them becoming mothers".[329] Katherine Franke suggests another term – "repronormativity".[330] This stereotype appears in the above case-law in both explicit and implicit ways. One of the explicit expressions is for example the European Court of Human Rights' language in its abortion jurisprudence – in many occasions instead of referring to "women" or even "pregnant women", the Court prefers using the terms "mothers-to-be", or just "mothers".[331] Thus, just as the normative motherhood stereotype prescribes, – the European Court of Human Rights describes all women through the *potential* of motherhood. The harmful impact of such stereotype is however much deeper than what may seem an erroneous use of language. An excessive focus on motherhood can undermine women's full citizenship because if the value of women is perceived to arise solely through

[327] Individual opinion of Committee member Yadh Ben Achour (concurring), paras. 5-6.
[328] J. E. Hanigsberg, "Homologizing pregnancy and motherhood: a consideration of abortion", *Michigan Law Review,* Vol. 94, No. 2 (1995-1996), referring to M. Fineman's work p. 374 in footnote 12.
[329] J. E. Hanigsberg, "Homologizing pregnancy and motherhood: a consideration of abortion", *Michigan Law Review,* Vol. 94, No. 2 (1995-1996), p. 375.
[330] K. M. Franke, "Theorizing Yes: An Essay On Feminism, Law, And Desire", *Columbia Law Review*, Vol. 101, No. 1 (2001).
[331] E.g. in *Tysiac v. Poland* (para. 107) the Court noted that "while the state regulations on abortion relate to the traditional balancing of privacy and the public interest, they must be in case of a therapeutic abortion be assessed against the positive obligations of the state to secure the physical integrity of *mothers-to-be*."

motherhood, women acquire status only through pregnancy and childbirth.[332] Thus, women's (biological) capacities are replacing "women" as full human beings and equal members of society and consequently, women who choose not to mother can come to be seen as representing anti-maternalism.[333] Somewhat paradoxically, however, normative motherhood does not mean automatically that motherhood is perceived as positive.[334]

Furthermore, normative motherhood means normativity on two levels: the first level is the expectation that all women want to become mothers under any circumstances. The second level is the normativity *within* the motherhood. As Claudia Malacrida explains: "Despite the normative belief that motherhood is a natural set of practices common to all 'proper' or 'real' women, motherhood, like other aspects of femininity, is a set of behaviors, attitudes and actions that is learned and reproduced by social actors".[335] Therefore, as she summarises, there exists another role for women to perform – the "ideal motherhood" which in short means that mothers are ideally expected to be "all things, at all times, to their dependent children", which, as Malacrida argues, no woman, however motivated, can achieve.[336] Thus, the normative motherhood stereotype sets women inevitably up for failures and can thus justify punitive reproductive policies: *i.e* if a society sees women as mothers(-to-be), then those women who attempt to deviate from that role will need to accept consequences (restrictive abortion regulations).

Namely, abortion jurisprudence of the European Court of Human Rights relies on privacy doctrine which allows balancing between women's human rights, and what a society

[332] R. J. Cook, "Human Rights and Reproductive Self-Determination", *American University Law Review*, Vol. 44, No. 4 (1994-1995), p. 984 referring to M- F. Fathalla's work.
[333] J. E. Hanigsberg, "Homologizing pregnancy and motherhood: a consideration of abortion", *Michigan Law Review*, Vol. 94, No. 2 (1995-1996), p. 375.
[334] For example, Julia Hanigsberg gives and example of how employers might act on a presumption that women are likely to leave their jobs in order to bear and raise children at some point in their work lives and discriminate them based on such assumption. J. E. Hanigsberg, "Homologizing pregnancy and motherhood: a consideration of abortion", *Michigan Law Review*, Vol. 94, No. 2 (1995-1996), p. 375.
[335] C. Malacrida, "Performing motherhood in a disablist world: dilemmas of motherhood, femininity and disability", *International Journal of Qualitative Studies in Education*, Vol. 22, No. 1 (2009), p. 102.
[336] C. Malacrida, "Performing motherhood in a disablist world: dilemmas of motherhood, femininity and disability", *International Journal of Qualitative Studies in Education*, Vol. 22, No. 1 (2009), p. 100.

has constructed as the interests of a foetus.[337] To date, the European Court of Human Rights has neither recognised nor tackled the normative motherhood stereotype in its abortion jurisprudence. Although showing better understanding of reproductive rights the UN Human Rights Committee too had shortcomings in anti-stereotyping until the most recent case *Whelan*. Unsurprisingly, the CEDAW Committee established in *L.C. v. Peru* that "the decision to postpone the surgery due to the pregnancy was influenced by the stereotype that protection of the foetus should prevail over the health of the mother".[338]

The analysed case-law also demonstrates what Lisa M. Kelly has termed in her work as "innocent suffering narrative" – cases that involve an adolescent girl who has been raped (emphasis on her sexual innocence), becomes pregnant and with the support of her parents seeks to terminate the pregnancy and that reinforce narrow conceptions of "reasonable" or "deserved" abortions.[339] In other words this often means that women can access reproductive health services not because they have human rights to those services, but because they are able to demonstrate (enough) suffering. For example, the European Court of Human Rights turned from its privacy doctrine to the prohibition of degrading treatment in two cases. First, in *R.R. v. Poland,* where the European Court of Human Rights established that the R.R.'s treatment by the doctors amounted to degrading treatment under Article 3, and second, in *P. and S. v. Poland*, where a minor, who was seeking an abortion after having been raped was

[337] Patricia Londoño has criticised the European Court of Human Right's reliance on Article 8 (right to privacy): "this exceptionally limited approach marginalises entirely the reproductive rights of women in terms of substantive human rights protections and is out of keeping with international and European moves in this regard". See: P. Londoño, "Redrafting abortion rights under the Convention: A, B and C v. Ireland", in: *Diversity and European Human Rights*. *Rewriting Judgments of the ECHR,* E. Brems (ed.) (2013).
[338] *L.C. v. Peru*, CEDAW/C/50/D/22/2009 (2011), para. 8.15.
[339] L. M. Kelly, "Reckoning with Narratives of Innocent Suffering in Transnational Abortion Litigation", in: *Abortion Law in Transnational Perspective: cases and controversies*, R. J. Cook, J.Erdman and B. Dickens (eds.) (2014), p. 304.

harassed, mistreated by the media and doctors and finally forced to have an abortion – that she had a legal right to – 500 km away from home.[340]

As Kelly notes, however, framing cases through the suffering narrative seeks to avoid "the contested terrains of wanted sex, non-procreative desire, and family discord".[341] This, in turn, is again also linked to the normative motherhood stereotype, which prescribes roles for women in both the public and private spheres.[342] The special "suffering narrative" is not exclusive to reproductive rights issues – scholarship on human trafficking has shown how stereotypes about what a trafficking victim should be (*i.e* act and look like) create a reality where only some victims are seem as deserving of rights protection.[343]

Rachel Camp argues that if cultures and laws link women's sexuality only to child-bearing and assume that consent for sex means consent for pregnancy then women are left with no room to autonomously construct their experiences with pregnancy, and unintended pregnancy is seen either as an appropriate consequence (punishment) of having sex, or alternatively the "positive constructions of motherhood and anticipated joys of a resulting child offset any 'harm' an unintended pregnancy may impose".[344] Therefore, Camp rightly notes that in order to challenge coerced pregnancies there must be a change in our view of *pregnancy* itself – meaning that we need to challenge the normatively positive constructions of pregnancy and motherhood that provide little flexibility.[345]

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[340] L. Oja, A. E. Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?" *Columbia Journal of Gender and Law*, Vol. 32, No. 1 (2016), p. 75.
[341] L. M. Kelly, "Reckoning with Narratives of Innocent Suffering in Transnational Abortion Litigation", in: *Abortion Law in Transnational Perspective: cases and controversies*, R. J. Cook, J. Erdman and B. Dickens (eds.) (2014), p. 305.
[342] L. Oja, A. E. Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?" *Columbia Journal of Gender and Law*, Vol. 32, No. 1 (2016), p. 75.
[343] See e.g.: N. Christie, "The Ideal Victim", in: *From Crime Policy to Victim Policy: Reorienting the Justice System*, E. Fattah (ed.) (1986); M. Lee, "Constructing and Denying Victimhood in Trafficking", in: *Trafficking and Global Crime Control* (2011); J. Srikantiah, "Perfect Victims and Real Survivors: The Iconic Victim in Domestic Human Trafficking Law", *Boston University Law Review*, Vol 87, No. 157 (2007).
[344] R. Camp, "Coercing pregnancy", *William and Mary Journal of Women and the Law*, Vol. 21 (2015), p. 278.
[345] R. Camp, "Coercing pregnancy", *William and Mary Journal of Women and the Law*, Vol. 21 (2015), p. 279.

Placing women's actual lived experiences in societies with unequal power distribution at the centre of all abortion jurisprudence would mean re-theorising abortion restrictions as tools of coercion, punishment (forcing a woman to be pregnant and give birth) irrespective of whether a woman was raped or the foetus is malformed is essential for women's reproductive rights protection. If needed, the human rights law forums could look for inspiration from the international criminal law: forced pregnancy is a war crime and a crime against humanity under international law – the Rome Statute defines forced pregnancy as "the unlawful confinement of a woman forcibly made pregnant, with the intent of affecting the ethnic composition of any population or carrying out other grave violations of international law".[346]

3.4 BIRTH: "*A 'good birth' goes beyond having a healthy baby*"[347]

It becomes apparent in the abortion jurisprudence that in discussions concerning termination of pregnancy the actual lived experiences and life plans of women with unwanted pregnancies are profusely overlooked. Instead – with some exceptions in very recent case-law – the centre stage is occupied by a (constructed) conflict between a woman and the foetus in her body that needs to be protected (from the woman) by a society. In other words, abortion

[346] *Rome Statute*, Article 7, para. 2 (f). In fact, in December 2016, the trial in the case of *Prosecutor v. Dominic Ongwen* started. Dominic Ongwen is an alleged senior commander in the Lord's Resistance Army who is charged with responsibility for war crimes and crimes against humanity committed in various locations in Northern Uganda between 2002-2005. Ongwen is the first person in front of the International Criminal Court to face charges of forced pregnancy (among other charges). The Prosecution's Pre-Trial Brief provided: "*The value protected by the criminalisation of forced pregnancy is primarily reproductive autonomy*". Thus, we see an explicit reference to reproductive rights. The Brief further explains that forced pregnancy includes both: "(*en)forced impregnation (pregnancy as a result of rape or of an illegal medical procedure) and (en)forced maternity (being forced to carry the pregnancy)*". Importantly, the Prosecutor further adds that the act causing the pregnancy "*need not have occurred during the period of woman's unlawful confinement, nor need be attributed to the perpetrator of the confinement*". Thus, my reading of this is that the violation in forced pregnancy is the confinement itself that is not allowing a woman to make decisions about the pregnancy, *i.e* about her body. And indeed, the Brief supports my understanding as it notes that in the Confirmation Decision, the Pre-Trial Chamber ruled: "*it is (...) the act of confinement which must be carried out with the required special intent. Indeed the crime of forced pregnancy does not depend on the perpetrator's involvement in the women's conception; it is only required that the perpetrator knows that the women is pregnant and that she has been made pregnant forcibly. It is apparent that the essence of the crime of forced pregnancy is in unlawfully placing the victim in a position in which she cannot choose whether to continue the pregnancy*". See: No.: ICC-02/04-01/15 Date: 6 September 2016, https://www.icc-cpi.int/CourtRecords/CR2016_06511.PDF.

[347] **N.** Simelela, "A 'good birth' goes beyond having a healthy baby", available at: http://www.who.int/mediacentre/commentaries/2018/having-a-healthy-baby/en/ (accessed 15 February, 2018).

jurisprudence is to a large extent silencing and excluding women's perspectives and voices, disregarding or belittling women's lived experiences.

I now move from case-law concerning access to safe, timely and legal abortion services to jurisprudence concerning birth and maternal mortality. As I set out at the beginning of the thesis, I argue that conversations about maternal mortality, birth and abortion belong together. The World Health Organisation defines maternal death as "death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes". It estimates that each year about 287 000 women and girls die of maternal causes, and an additional 10 to 15 million suffer debilitating complications. Research shows that as much as 98% of maternal mortality, however, is preventable.[348]

Alicia Ely Yamin's work is rooted in this evidence and she notes, how "maternal mortality is not principally a medical problem", but instead a social, and an issue of political will.[349] Yamin explains that the great majority of women who die as a result of pregnancy-related complications have lived lives "marked by poverty, deprivation and discrimination".[350] It is what Yamin calls a "funnel of narrowing choices" which means that women cannot exercise their agency in a meaningful way whereas a rights-based approach to women's health would open "spaces for women to exercise choices and subverting the social- and power-relations that deny them their full humanity".[351] Yamin summarises this well: the reason that hundreds of thousands of women and girls are still dying every year is not that

[348] *Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.*
[349] A. E. Yamin, "Towards transformative accountability: applying a rights-based approach to fulfill maternal health obligations", *SUR*, Vol. 7, No. 12 (2010), p. 112.
[350] A. E. Yamin, "Towards transformative accountability: applying a rights-based approach to fulfill maternal health obligations", *SUR*, Vol. 7, No. 12 (2010), p. 95.
[351] A. E. Yamin, "Will we take suffering seriously; reflections on what applying a rights framework to health means and why we should care", *Health and Human Rights*, Vol. 10, No. 1, pp. 45-63.

"we do not know how to save them", but instead it is because "women's lives are not valued, because their voices are not listened to, because they are discriminated against and excluded in their homes and communities – and by health care systems that do not prioritize their needs".[352]

In short, I argue that broadening the focus from individual issues and instead analysing abortion, birth and maternal mortality cases together, next to one another, can help reveal stereotypes threading through the jurisprudence. Furthermore, measuring maternal mortality essentially means counting the number of deaths, which in its seriousness can help shape the way we understand the importance of guaranteeing safe and legal access to abortion, and obstetric-antenatal care. Maternal mortality is not a result of random, isolated unfortunate incidents, but echoing Yamin's words, it *starts* with how we treat women who wish to terminate an unwanted pregnancy, or who give birth. Just as the right to terminate an unwanted pregnancy and women's full and unwaivering control over the circumstances of delivering a wanted child are fundamental parts of reproductive rights.

However, although all of this might sound as a straightforward conviction, it is not mirrored by the practice and case-law regarding women's birth experiences. I argue elsewhere together with Yamin, how antenatal and obstetric care stand out as in no other area of medicine are the recipients of interventions (women) so often not the actual beneficiaries of that care or active agents in the design of the kind of care they wish to receive.[353] In other words, pregnancy (whether wanted or unwanted) has been socially constructed to instrumentalise women and strip them of some human rights, control and voice. Such instrumentalisation happens when women's identity is defined through childbearing, the result of the normative notion of motherhood. The idea that all women desire and are

[352] A. Yamin, "Towards transformative accountability: applying a rights-based approach to fulfill maternal health obligations", *SUR*, Vol. 7, No. 12 (2010), p. 112.
[353] L. Oja, A. E. Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?" *Columbia Journal of Gender and Law*, Vol. 32, No. 1 (2016).

destined for motherhood inevitably leads to disciplining women's bodies *during* pregnancy and birth-related care in a way that is deemed by the society both necessary and natural. Consequently, women who dare deviate from, and challenge these socially constructed ideas of motherhood – "that self-effacing, altruistic condition that requires 'mothers' or (…) pregnant women to do whatever is necessary" – are seen as villains for not fulfilling (or fulfilling them with gaps and errors) the roles for which they have been assigned.[354]

Thus, gender stereotypes play an important role in the over-medicalisation of women's bodies during pregnancy and childbirth.[355] Over-medicalisation is a possible side-effect and a tool for silencing and instrumentalisation as it can reduce women to objects without agency, causing a neglect of women's differential needs in pregnancy and delivery.[356]

To date, the European Court of Human Rights has discussed human rights regarding birth in five cases, all decided between 2011-2016. Additionally, there are two pending cases.[357] In this chapter I also analyse a landmark case on maternal mortality from the United Nations CEDAW Committee – the case of *Alyne da Silva Pimentel Teixeira v. Brazil* – to showcase anti-stereotyping as part of human rights analysis.

[354] S. Halliday, *Autonomy and Pregnancy. A Comparative Analysis of Compelled Obstetric Intervention* (2016), p. 212.
[355] K. Martin, "Giving Birth Like a Girl", *Gender & Society*, Vol. 17, Issue 1, p. 55 (2003). Legal scholarship has not given enough attention to childbirth, but this is compensated by an expansive sociological work. For example, see: C. Malacrida, T. Boulton, "The best laid plans? Women's choices, expectations and experiences in childbirth", *Health*, Vol 18, Issue 1 (2014), J. C. A. Shaw, "The Medicalization of Birth and Midwifery as Resistance", *Health Care for Women International* Vol. 34, Issue 6 (2013).
[356] J. Erdman, "Bioethics, Human Rights, and Childbirth", *Health and Human Rights Journal*, Vol. 17, No. 1 (2015), p. 47.
[357] In *Kosaitė-Čypienė and Others v. Lithuania* the applicants complain about their inability to obtain assistance of a health professional at childbirth at home, and the ECtHR gave notice of the application to the Lithuanian Government and put questions to the parties under Articles 34 (right of individual application) and 8 (right to respect for private and family life) of the ECHR. In the second pending case, *Pojatina v. Croatia* the applicant submits that Croatian law dissuaded health professional from assisting her when giving birth at home. The ECtHR gave notice of the application to the Croatian Government and put questions to the parties under Articles 8 (right to respect for private and family life) and 13 (right to an effective remedy) of the ECHR.

3.4.1 Birth jurisprudence of the European Court of Human Rights

The European Court of Human Rights jurisprudence concerning women and birth from the starts with *Ternovszky v. Hungary*, a case which concerned a woman who wished to give birth at home, but was unable to find a medical professional to assist her in that as the doctor or midwife would have faced the risk of being convicted for a regulatory offence. In that case the European Court of Human Rights again did not display a sufficiently advanced level of reproductive rights-based analysis, but nevertheless found a breach of right to privacy.

However, five years later, *Dubska and Krejzova v. the Czech Republic* changed its position, and found no violation of human rights in a situation where women had not been able to give birth at home. The Court disregarded Dubska's and Krejzova's negative previous experiences with facility-based birth, and the risk of obstetric violence. Interestingly, the dissenting judges did indeed underscore, how *patronising attitudes* among health personnel should not be taken lightly, and how the Court had ignored the international trends towards allowing assisted home births.

Although in the rest of the three cases the Court found a violation, it still lacked a deeper understanding of how power dynamics operate both in a society more broadly and in medical settings more specifically, and how stereotypes impact women's birth experiences. For example, the dissenting opinion of *Hanzelkovi v. Czech Republic* reveals disturbing under-currents as Judges Zupančič and Yudkivska write how in their opinion the majority "interferes with the expert medical considerations, which is something that the Court is not equipped to do", and how the applicant – a woman who has a *human right* to reproductive (obstetric) care - "was perfectly aware of Czech medical procedures and had agreed to abide

by the rules of the hospital on being admitted to it, could not reasonably expect that her escape would be tolerated in view of the above-mentioned risks".

Ternovszky v. Hungary

In *Ternovszky v. Hungary* the applicant Anna Ternovszky wished to give birth at home.[358] A decree issued by the Hungarian Government, however, provided that any health professional assisting a home birth would face the risk of being convicted for a regulatory offence. While there was no legislation banning home birth *per se* in Hungary, Ternovszky submitted that since this decree prevented her from getting professional assistance in case she did indeed opt for home birth, there was a discriminatory interference with her right to respect for private life – she relied on Article 8 (right to privacy) read in conjunction with Article 14 (non-discrimination).[359]

The Court analysed only Article 8, and affirmed that private life under Article 8 "incorporates the right to respect for both the decisions to become and not to become a

[358] *Ternovszky v. Hungary*, Application no. 67545/09 (2011).
[359] Case, para. 12.

parent", and "the notion of freedom implies some measure of choice as to its exercise".[360] The Court continued:

> *Therefore the right concerning the decision to become a parent includes the right of choosing the circumstances (emphasis added) of becoming a parent. The Court is satisfied that the circumstances of giving birth incontestably form part of one's private life*. [361]

When analysing whether there had been an interference with Anna Ternovszky's private life, the Court noted:

> For the Court, legislation which arguably dissuades such professionals who might otherwise be willing from providing the requisite assistance constitutes an interference with the exercise of the right to respect for private life by prospective mothers such as the applicant" and "the right to choice in matters of child delivery includes the legal certainty that the choice is lawful and not to subject sanctions, directly or indirectly.[362]

The Court commented on the states parties' deference:

> *It is true that, in this regard, the State has a wide margin of appreciation; however, the regulation should ensure a proper balance between societal interests and the right at stake. In the context of home birth, regarded as a matter of personal choice of the mother, this implies that the mother is entitled to a legal and institutional environment that enables her choice, except where other rights render necessary the restriction thereof. For the Court, the right to choice in matters of child*

[360] Case, para. 22.
[361] Case, para. 22.
[362] Case, paras. 22 and 24.

delivery includes the legal certainty that the choice is lawful and not subject to sanctions, directly or indirectly.[363]

However, the Strasbourg Court also noted how "it is debated in medical science whether, in statistical terms, homebirth as such carries significantly higher risks than giving birth in hospital".[364] The Court concluded that the "lack of legal certainty and the threat to health professionals limited the choices of the applicant considering home delivery", and therefore the right to respect for private life (Article 8).[365] The Court did not comment on Article 14, and concluded: "The foregoing considerations are sufficient to enable the Court to find that there has been a violation of Article 8 of the Convention".[366]

In their concurring opinion Judges Sajó and Tulkens add: "as the expectant mother has to interact during the period of pregnancy with authorities and regulated professionals who act as figures of some kind of public authority vis-à-vis the pregnant person, who is understandably very vulnerable because of her dependency" there is a need for "a positive regulatory environment, which will produce the legal certainty providing the right to choose with effectiveness", and how "without such legal certainty there is fear and secrecy, and in the present context this may result in fatal consequences for mother and child".[367] The concurring opinion also adds that "adequate legal security" cannot be "equated with liberalising home birth as such" as that is "obviously a matter of balancing in view of available (currently disputed) medical knowledge, the health of the mother and the child, the structure of health care services, etc".[368]

[363] Case, para. 24.
[364] Case, para. 24.
[365] Case, para. 26.
[366] Case, para. 27.
[367] Joint Concurring Opinion of Judges Sajó and Tulkens.
[368] Joint Concurring Opinion of Judges Sajó and Tulkens.

Konovalova v. Russia

The case of *Konovalova v. Russia* involved Yevgeniya Alekseyevna (the applicant) who submitted to the ECtHR that she had been compelled to give birth in front of medical students without her consent.[369] On the morning of 23 April 1999, Yevgeniya Alekseyevna was taken to the hospital after her contractions had started. After her admission, she was handed a booklet issued by the hospital, which entailed among other things a notice warning patients about the clinical teaching that takes place at the hospital.

The notice read: "We ask you to respect the fact that medical treatment in our hospital is combined with teaching for students studying obstetrics and gynaecology. Because of this, all patients are involved in the study process".[370] A doctor examined Alekseyevna and established that she was 40 weeks pregnant, but there were complications because she had excess amniotic fluid in the amniotic sac. The doctor noted that Alekseyevna's contractions were premature and that she was suffering from fatigue, so she was put in a drug-induced sleep for 2 hours.[371]

The the doctors then gave her anti-contraction medication to suppress premature labour and in the afternoon of the same day she was informed that her delivery was scheduled for the next day and that medical students would be present. She was again put in a drug-induced sleep. The next day the frequency and intensity of her contractions increased and the doctors found traces of meconium in her amniotic fluid, which indicated there was a risk that the foetus suffered from hypoxia.

The doctors examined Alekseyevna and the foetus and found their health satisfactory. The doctors decided to conduct a vaginal delivery. According to Alekseyevna, she objected to the presence of medical students in the delivery room.[372] However, there were still medical

[369] *Konovalova v. Russia*, Application no. 37873/04 (2015).
[370] Case, para. 7.
[371] Case, paras. 9-10.
[372] Case, paras. 10-15.

students present when she gave birth later that day. Alekseyevna submitted to the European Court of Human Rights that the unauthorised presence of medical students at her birth violated Article 8 of the Convention (right to privacy). She explained that she had not given written consent, and the notification about the presence of medical students had been belated, resulting in her inability to choose a different hospital. She explained that she had only learned of the presence of the students at 3pm on the day she was admitted to the hospital, but at that time she was nearly unconscious, had no access to phone to contact her relatives to arrange to give birth elsewhere, and given her physical condition was unable to leave the hospital on her own.[373]

The Russian Government submitted that there had been no interference with her rights as "the students' presence did not amount to "an interference" since she had implicitly given her consent in this respect and had never objected to her treatment at the hospital.[374] The Government further argued that the students were not involved in the medical procedure themselves, but they were only spectators, and even if there was an interference, it was lawful and pursued "the legitimate aim of providing for the needs of the educational process".[375]

The Court first established that Article 8 encompasses the physical integrity of a person and: "given the sensitive nature of the medical procedure which the applicant underwent (…), and the fact that the medical students witnessed it and thus had access to the confidential medical information concerning the applicant's condition (…), there is no doubt that such an arrangement amounted to "an interference".[376] The ECtHR further analysed whether the interference was in accordance with the law and found that although the

[373] Case, para. 37.
[374] Case, para. 36.
[375] Case, para. 36.
[376] Case, para. 41.

domestic Health Care Act allowed medical students to assist in medical treatment the law did not contain any safeguards protecting patients' private lives.[377]

The European Court of Human Rights concluded therefore: "the absence of any safeguards against arbitrary interference with patients' rights in the relevant domestic law at the time constituted a serious shortcoming".[378] Furthermore, the ECtHR argued how "the applicant learned of the presence of medical students during the birth the day before. Between two sessions of drug-induced sleep, when she had already been for some time in a state of extreme stress and fatigue (…)", and thus "it is unclear whether the applicant was given any choice regarding the participation of students on this occasion and whether, in the circumstances, she was at all capable of making an intelligible informed decision".[379]

The ECtHR further noted that "the domestic courts did not take into account other relevant circumstances of the case, such as the alleged insufficiency of the information contained in the hospital's notice, the applicant's vulnerable condition during notification (…), and the availability of any alternative arrangements in case the applicant decided to refuse the presence of the students during the birth".[380]

Thus, the Court concluded that Russia had not complied with the lawfulness requirement and accordingly there was a breach of Article 8 (right to privacy).[381] Alekseyevna also submitted that Article 3 of the convention (prohibition of torture and degrading treatment) had been breached as the management of the birth was deficient and her delivery had been intentionally delayed, but the ECtHR found this complaint unsubstantiated, and rejected it.[382]

[377] Case, para. 44.
[378] Case, para. 45.
[379] Case, para. 47.
[380] Case, para. 48.
[381] Case, paras. 49-50.
[382] Case, paras. 51-53.

Hanzelkovi v. the Czech Republic

This case concerned Eva Nolčová (the first applicant, born in 1977) and her son Miroslav Hanzelka (the second applicant, born in 2007).[383] Eva Nolčová had had regular medical check-ups during her pregnancy and attended ante-natal classes at the hospital. Prior to giving birth she had expressed, among other things, that she wishes to leave the maternity ward as soon as possible provided that there were no complications.[384] On 24 October 2007 she contacted a paediatrician, S., who agreed to take charge of her future child and visit both of them at their home after they will have been discharged from the maternity ward. S. also informed Nolčová that she would be away the following weekend. Nolčová told her that she intended to leave the hospital "earlier" without explaining this further. The paediatrician subsequently stated that it had not been her understanding that Nolčová wanted to leave the hospital a few hours after the birth.[385]

Nolčová gave birth to her son, the second applicant on 26 October 2007 at the hospital. It was a natural and spontaneous delivery with no complications. As the applicants did not have any health problems and the Apgar score of the second applicant was the highest possible, Nolčová decided to, despite meeting opposition from the medical team, leave the hospital the same day.[386]

After the applicants had left the hospital, the staff informed the police, this was standard practice in "situations where a patient left hospital prematurely without the doctor's consent and this could have repercussions on his or her health".[387]

The paediatrician S. then contacted the hospital, and the hospital staff "found it regrettable that the first applicant had not expressed her wish to leave the hospital only hours after the birth during the ante-natal classes" as, had she done so, "the staff would have

[383] *Hanzelkovi v. the Czech Republic*, Application no. 43643/10 (2015).
[384] Case, para. 6.
[385] Case, para. 7.
[386] Case, para. 8.
[387] Case, para. 9.

recommended that she obtain a personal care plan for the newborn baby and secure agreement from the paediatrician (…) whereupon her decision would have been accepted".[388] The social services were also informed of the situation at the request of the social welfare authority a doctor from the hospital drew up a note that said "*given the short period of time since the birth, the health and potentially the actual life of the child [would] be at risk if he [were] deprived of hospital care*".[389]

Based on this note a court granted the welfare authority the right to take the second applicant to the care of the hospital as an interim measure.[390] Thus, in the evening of October 26th 2007 a court bailiff and a social worker accompanied by police officers went to the applicants' house and explained to the child's father that the first applicant could go to the hospital with the second applicant. The child's father refused to take them there and consequently an emergency medical team was summoned. After examining the newborn baby, the doctor observed that he had no health problems, but "agreed with the others that for the purposes of implementing the interim measure the mother and child would be taken back to the hospital in the ambulance".[391] The baby was examined again art the hospital and he did not have any health problems, but the applicants were made to remain at the hospital for two days with no medical acts being carried out. Eva Nolčová refused neonatal screening and vaccination of the newborn and both applicants were released on 28 October 2007 after Nolčová had signed the form refusing further medical treatment.[392]

The applicants submitted to the ECtHR that ordering the second applicant's return to hospital a few hours after his birth had been neither lawful nor necessary and thus there had been a breach of the right to respect for private and family life (Article 8).[393] The applicants

[388] Case, para. 9.
[389] Case, para. 12.
[390] Case, paras. 13-14.
[391] Case, para. 15.
[392] Case, para. 16.
[393] Case, para. 42.

argued that their case illustrated a "general problem of obstetrical practice in the Czech Republic – which placed the emphasis on hospital care – and the prevalence of an authoritarian attitude on the part of doctors".[394]

The Court first established whether there had been an interference with the right. The Czech Government argued that there had not been interference under Article 8, since the applicants "had never been physically separated and had not been subjected to any medical intervention".[395] The Court found that the applicants' complaint fell within Article 8 since the "decision to admit the second applicant to hospital against the express will of his parents, resulting in the admission to hospital of the first applicant, who did not want to leave her baby alone" did concern the applicants' private and family life. The Court emphasised how "neither the brief length of the stay in hospital nor the fact that the applicants were not subjected to any medical intervention there should affect its finding that the situation of which they complain amounted to an interference with their right to respect for their private and family life".[396]

The Court then analysed whether the interference had been justified – in accordance with the law and necessary. It found that there was a legal basis for the situation and there was a legitimate aim – the protection of the health and rights of the second applicant.[397] As to the necessity, the Court found that "taking of a newborn baby into care at the moment of its birth is an extremely harsh measure" and thus: "there must be extraordinarily compelling reasons before a baby can be physically removed from its mother, against her will, immediately after birth as a consequence of a procedure in which neither she nor her partner has been involved".[398]

[394] Case, para. 56.
[395] Case, para. 66.
[396] Case, para. 67.
[397] Case, paras. 69-71.
[398] Case, para. 72.

The Court established that in such "delicate matters the imminent danger should be actually established".[399] Although the "conduct of the first applicant could have aroused concern among the hospital staff", the interim measure relied on "a general risk, without referring to concrete factors specific to the applicants' situation" and thus the domestic court "should have examined whether some less intrusive interference in the applicants' family life at such a critical point in their lives, was not possible".[400] Consequently, the Court found that the Czech Government had exceeded the national margin of appreciation. The interference had been disproportionate and there had been a violation of Article 8.[401]

The decision comes with a dissenting opinion that deserves attention. Judges Zupančič and Yudkivska open the dissent with: "We are sorry not to be able to agree with the majority judgment in this case. We feel that the substance of the judgment interferes with the expert medical considerations, which is something that the Court is not equipped to do".[402] The dissent continues: "The first applicant, who was perfectly aware of Czech medical procedures and had agreed to abide by the rules of the hospital on being admitted to it, could not reasonably expect that her escape would be tolerated in view of the above-mentioned risks".[403] Furthermore, the two dissenting judges argue:

> *The problem we perceive is that the mother's departure from the hospital, whatever her personal reasons for doing so, did not affect simply or even primarily her own well-being (...). However, the mother's unexpected departure after delivery affected the well-being of another person. We do not believe that a woman, simply by virtue of being the newborn's mother, has the*

[399] Case, para. 73.
[400] Case, paras. 75-78.
[401] Case, paras. 79-80.
[402] Dissenting Opinion of Judges Zupančič and Yudkivska.
[403] Dissenting Opinion of Judges Zupančič and Yudkivska.

automatic right – despite clear medical contraindications – to put at risk the well-being, and perhaps even the survival, of the newborn child".[404]

The judges add that the newborn child "cannot be captive to his or her mother's preferences". The dissent also underscores that the Court is not in a position to "assess potential medical problems and therefore in a position to decide whether the order to return the second applicant to the hospital to protect his well-being '[was] disproportionate in [its] effects on the applicants' potential for enjoying a family life as from the birth of the second applicant'".[405] The dissent asks "what the reaction of this Court would have been if the child had developed certain post-natal problems".

Lastly, the dissent notes that "premature departure from the obstetrics department" is not permissible just because home birth with the help of a midwife is permissible. Judges Zupančič and Yudkivska explain: "For obvious reasons, the two situations are incomparable. The role of the trained obstetrics nurse (the midwife) is not over with the delivery as such. She accompanies the mother and child for a few days after the delivery and is trained to recognise the immediate need for help of a neonatal paediatrician and the need for a transfer to hospital".[406]

Korneykova and Korneykov v. Ukraine

This case concerned Viktoriya Yuryevna Korneykova.[407] On 16 January the police detained her on suspicion of robbery. On the day of detention, Korneykova was five months pregnant. On May 22 2012 she was admitted to the hospital where she gave birth to a baby. Korneykova submitted to the Court that three female security officers guarded her in the hospital and stayed on the maternity ward during the delivery. Moreover, Korneykova also

[404] Dissenting Opinion of Judges Zupančič and Yudkivska.
[405] Dissenting Opinion of Judges Zupančič and Yudkivska.
[406] Dissenting Opinion of Judges Zupančič and Yudkivska.
[407] *Korneykova and Korneykov v. Ukraine*, Application no. 56660/12 (2016).

submitted that she had been continuously shackled to either her hospital bed or to a gynaecological examination chair – the shackles were only removed during the delivery.[408] She argued that the shackling breached Article 3 of the ECHR. The Ukrainian Government disputed this and provided that Korneykova had not been shackled to her bed while staying in the hospital, and she had failed to provide any evidence.

The Court found that based on the evidence it had at hand, it was sufficiently established that Korneykova had been subjected to continuous shackling in the maternity hospital. The Court added that there had been no risk of Korneykova "behaving violently or attempting to escape", and the police or the hospital staff never alleged that she had been aggressive.[409] The Court also noted, how Korneykova's "unjustified shackling continued after the delivery, when she was particularly sensitive".[410] Furthermore, the Court held that since Korneykova was guarded by three guards at all times this measure was already "severe enough to respond to any potential risks".[411] Thus, in conclusion the Court established: "in the circumstances of the present case, where the impugned measure was applied to a woman suffering labour pains and immediately after the delivery, it amounted to inhuman and degrading treatment".[412]

Dubska and Krejzova v. the Czech Republic

The next case to my analysis of birth-related jurisprudence is *Dubska and Krejzova v. the Czech Republic* in which the factual circumstances were similar, but the outcome opposite to *Ternovszky*.[413] In *Dubska and Krejzova*, the two applicants, Šárka Dubská and

[408] Case, paras. 13-14.
[409] Case, para. 112.
[410] Case, para. 113.
[411] Case, para. 114.
[412] Case, para. 115.
[413] *Dubska and Krejzova v. the Czech Republic*, Applications nos. 28859/11 and 28473/12 (2016).

Alexandra Krejzová, wished to give birth at home, but this wish was met with the state's denial to offer the midwife service in a private home.

Šárka Dubská gave birth to her first child at the hospital in 2007 without any complications. However, according to her, during the birth the medical personnel was urging her to agree to undergo various kinds of medical intervention even though she had expressly stated her wish not to be subjected to any unnecessary medical treatment. She was also forced to give birth in a position she did not find comfortable. She wanted to leave the hospital a few hours after the birth as both she and the baby were healthy, but the doctor ordered her to stay in the hospital.[414] In 2010 Dubská became pregnant for the second time. This pregnancy was free from complications and since she considered that giving birth in a hospital had been stressful for her, she decided to give birth at home and searched for a midwife to assist at the birth. However, she was unable to find a midwife willing to assist her with a home birth, so Dubská gave birth to her son alone at home.[415]

The second applicant, Alexandra Krejzová, had two children who had been born at home in 2008 and 2010 with the assistance of a midwife (without any authorisation from the state). Krejzová explained that before deciding to give birth at home, she had visited several hospitals which had all refused her requests to deliver the baby without any medical intervention that was not strictly necessary. They had also refused to agree to her wish for uninterrupted contact with the baby from the moment of birth, as the hospitals' regular practice was to take the child away from the mother immediately after the birth to be weighed and measured and for further medical observation for a period of two hours.

At the time of the application to the European Court of Human Rights Krejzová was pregnant again. The pregnancy was free from complications and she wished to give birth at home, but was unable to find a midwife willing to assist because of the risk of a heavy fine if

[414] Case, para. 9.
[415] Case, para. 10.

medical services were provided without authorisation.[416] Thus, Krejzová gave birth to a child in a maternity hospital where according to her, not all her wishes were respected: despite the fact that both she and the child were healthy and that no complications had occurred during the birth, they had to stay in the hospital for seventy-two hours, the newborn baby was separated from Krejzová after the birth, and before leaving the maternity hospital the remains of the child's umbilical cord had been cut off despite her wishes to the contrary.[417]

Accordingly, the applicants submitted that the right to respect for their private lives (Article 8) had been violated. The Court reiterated what it had said in *Ternovszky*: "the circumstances of giving birth incontestably form part of one's private life for the purposes of this provision".[418] Additionally the European Court of Human Rights expanded on this:

> *(...) while Article 8 cannot be interpreted as conferring a right to give birth at home as such, the fact that it is impossible in practice for women to be assisted when giving birth in their private home comes within the scope of their right to respect for their private life and accordingly of Article 8. Indeed, giving birth is a unique and delicate moment in a woman's life. It encompasses issues of physical and moral integrity, medical care, reproductive health and the protection of health-related information. These issues, including the choice of the place of birth, are therefore fundamentally linked to the woman's private life and fall within the scope of that concept for the purposes of Article 8 of the Convention.*[419]

When analysing the legitimate aim of the interference the Court found "that there are no grounds for doubting that the Czech State's policy of encouraging hospital births (…) was

[416] Case, paras. 17-19.
[417] Case, para. 23.
[418] Case, para. 162.
[419] Case, para. 163.

designed to protect the health and safety of the mother and the child during and after delivery".[420] Krejzová, however, maintained that the "monopolisation of hospital care did not represent any safety benefit for newborns but actually increased the risks for the mother, including the risk of obstetric violence, and that home births did not have any adverse impact on perinatal mortality".[421]

The Court constructed that, in this case, it had to decide whether the fact that it was impossible in practice to be assisted by a health professional during a home birth struck a fair balance between the applicants' right to respect for their private life (Article 8), and the interest of the State in protecting the health and safety of the child and of the mother, and whether introducing legislation that did not allow such assistance overstepped the margin of appreciation.[422] The Court found that "while the question of home birth does not as such raise acutely sensitive moral and ethical issues (…) it can be said to touch upon an important public interest in the area of public health".[423] It established that the margin of appreciation to be afforded to the national authorities must be a wide one.[424]

Thus, the Court supported the Government's argument that the risk for mothers and newborns is higher in cases of home births than in cases of births at maternity hospitals and that "even if a pregnancy proceeds without any complications and can therefore be considered a "low-risk" pregnancy, unexpected difficulties can arise during the delivery which would require immediate specialist medical intervention, such as a Caesarean section or special neonatal assistance".[425] In conclusion, the Court found that the interference with

[420] Case, para. 172.
[421] Case, para. 100.
[422] Case, para. 180.
[423] Case, para.181.
[424] Case, para. 184.
[425] Case, para. 186.

the applicants' right to respect for their private life was not disproportionate and, accordingly, there had been no violation of Article 8.[426]

The decision has a dissenting opinion written by Judges Sajó, Karakas, Nicolaou, Laffranque and Keller. The dissent criticized the blanket ban on home births as the Czech law *de facto* prevents home births and has a "chilling effect on mothers wishing to give birth at home".[427] Furthermore, the dissent referred to the "broader context" of obstetric services in Czech Republic that is characterized by "the widespread dissatisfaction with the failure to respect women's choices during childbirth in Czech hospitals and the economic dimension of the obstetric services provided", and to the previous case-law regarding Czech Republic that serve as "worrying signs".[428]

The dissenting judges underscored how "patronising attitudes among health personnel should not be taken lightly, as they may constitute a violation of an individual's right to self-determination".[429] Furthermore, the dissent noted that the Court "did not consider the international trends towards assisted home births and the efforts made to regulate midwifery".[430] In conclusion, the dissenting judges emphasised that providing for "only one option for giving birth, namely in hospital, cannot be viewed as proportionate and constitutes (…) an unnecessary interference with women's rights under Article 8".[431]

3.4.2 Maternal mortality case of the United Nations CEDAW Committee

Alyne da Silva Pimentel Teixeira v. Brazil

To this date, there has only been one case from a transnational human rights law forum that frames maternal mortality as a human rights violation. The author of the

[426] Case, paras. 190-191.
[427] Dissenting opinion, para. 11.
[428] Dissenting opinion, paras. 13-18.
[429] Dissenting opinion, para. 15.
[430] Dissenting opinion, para. 22.
[431] Dissenting opinion, para. 30.

communication to the CEDAW Committee is Maria de Lourdes da Silva Pimentel, mother of Alyne (deceased).[432] Alyne da Silva Pimentel Teixeira was a Brazilian woman of African descent, born in 1974.

In 2002 on November 11th da Silva Pimentel Teixeira went to a health centre suffering from severe nausea and abdominal pain. She was in her sixth month of pregnancy. The attending doctor prescribed some medicine against nausea, vitamins and a local medication for vaginal infection. The doctor additionally scheduled blood and urine tests to be conducted in 2-days-time, on 13 November 2002, and sent da Silva Pimentel Teixeira home. She started taking the prescribed medicine , but her condition worsened considerably.

On 13 November da Silva Pimentel Teixeira's accompanied by her mother, Maria de Lourdes da Silva Pimentel, went to the health centre in order to see if the obstetrician-gynaecologist could examine her before the scheduled urine and blood tests. She was examined and admitted to the health centre. The ultrasound confirmed that there was no foetal heartbeat, so she was given medication to induce the labour, and da Silva Pimentel Teixeira gave birth to a still-born foetus. She became disoriented immediately afterwards. About 14 hours after the delivery da Silva Pimentel Teixeira underwent a surgery to remove parts of the placenta and afterbirth after which her condition worsened (severe haemorrhaging, vomiting blood, low blood pressure).

She was given antibiotics and the doctors told her mother that Alyne da Silva Pimentel Teixeira's symptoms were consistent with those of a woman who had never received prenatal care and that she needed a blood transfusion. The health centre contacted hospitals and the only hospital that had room for her refused to use its only ambulance to transport her at that hour. Alyne da Silva Pimentel Teixeira's family was unable to secure a private ambulance and consequently she waited for 8 hours in a critical condition.

[432] *Alyne da Silva Pimentel Teixeira v. Brazil*, CEDAW/C/49/D/17/2008 (2011).

When she finally arrived at the hospital she was hypothermic, had acute respiratory distress, and presented a clinical picture compatible with disseminated intravascular coagulation. Her blood pressure dropped to zero and she had to be resuscitated. She was placed in a makeshift area in the emergency room hallway because there were no available beds. The medical attendants did not bring her medical records from the centre to the hospital, and when her mother went to bring them herself she was questioned and had to wait for them.

Alyne da Silva Pimentel Teixeira died in the evening of November 16. An autopsy found the official cause of death to have been digestive haemorrhage and according to the doctors this had resulted from the delivery of the stillborn foetus. The doctor at the health centre told da Silva Pimentel Teixeira's mother that the foetus had been dead for several days already and that this had caused Alyne's death.[433] Lourdes da Silva Pimentel submitted that Brazil violated da Silva Pimentel Teixeira's right to life and health under Articles 2 and 12 in conjunction with Article 1 of CEDAW as it did not ensure appropriate medical treatment in connection with pregnancy and did not provide timely emergency obstetric care – thus infringing the right to non-discrimination based on gender, race and socio-economic background.

The CEDAW Committee rejected Brazil's submission that Alyne da Silva Pimentel Teixeira's death cannot be framed as a "maternal death" as the cause was digestive haemorrhage. Instead, the Committee confirmed that the sequence of events indicates that da Silva Pimentel Teixeira's death "was indeed linked to obstetric complications related to pregnancy".[434]

The Committee also noted how access to quality medical care during delivery was a "systematic problem in Brazil" and how the lack of appropriate maternal health services that

[433] *Alyne da Silva Pimentel Teixeira v. Brazil*, CEDAW /C/49/D/17/2008, paras. 2.1-2.14.
[434] Case, para. 7.3.

"clearly fails to meet the specific distinctive health needs and interests of women not only constitutes a violation of article 12, paragraph 2 (…), but also discrimination against women under article 12, paragraph 1, and article 2 (…)."[435] The Committee established that Ms da Silva Pimentel Teixeira had been "discriminated against, not only on the basis of her sex, but also on the basis of her status as a woman of African descent and her socio-economic background".[436]

3.5 "WOMEN ARE DANGEROUS MOTHERS-TO-BE" AND "WOMEN ARE INCAPABLE OF MAKING AUTONOMOUS CHOICES"

Reading abortion jurisprudence together with birth jurisprudence in one analytical framework that asks about narrative construction and women's voices reveals a more specific dimension of the "normative motherhood" stereotype: "mothers-to-be are dangerous/subversive", and thus (potential) motherhood needs to be "measured" and "monitored" early on.

Constructing such false conflict between a "dangerous/subversive woman", and her newborn baby starts with *separating* a woman from her body, and forming a conflict between her and potential life (foetus).[437] For example, as seen above the European Court of Human Rights framed abortion as a conflict between the unborn and the woman in *Tysiac v. Poland* ("*the woman's right to respect for her private life must be weighed against other competing rights and freedoms invoked including those of the unborn child*"), and has since then not

[435] Case, para 7.6.
[436] Case, para 7.7.
[437] Linda Layne's work on pregnancy loss is also relevant for my argument. Layne writes about a woman-centered health care approach to pregnancy loss, and concludes: "Women who labor deserve to be treated with dignity regardless of whether their labor will result in a live birth". Layne argues that information pregnancy loss (how common it is, what are the physical/emotional implications) should be part of pre-natal/reproductive healt care. Although I have some reservations about to the extent of what Layne considers necessary ("pregnancy loss plans") her argument is useful for putting women's lived experiences with birth and pregnancy into focus to substitute mainstream narratives where women are defined through perfect motherhood and foetal stories. See: L. Layne, "Designing a Woman-Centered Health Care Approach to Pregnancy Loss: Lessons from Feminist Models of Childbirth", in: *Reproductive Disruptions: Gender, Technology, and Biopolitics in the New Millennium,* M. C. Inhorn (ed.) (2009), p. 94.

reconsidered it, opting instead to remain loyal to what Samantha Halliday terms as the "separate entities pregnancy model": the pregnant woman and the foetus are seen as distinct entities, this, as Halliday criticises, marginalises women and makes conflict between the foetus and the woman "almost inevitable".[438] This "automatic conflict" travels together with every woman to her obstetric care, and birth experiences– irrespective of whether their pregnancy is wanted or not. This can be seen above in the *Dubska and Krejzova* case concerning home birth where a woman's wish to give birth in an environment chosen by her is overridden by the "potential threat to the newborn", or in the *Hanzelkovi* case, where the dissent constructed the applicant through her "intolerable escape", and noted, how a newborn child "cannot be captive to his or her mother's preferences".

Camilla Pickles argues for a relational view of pregnancy that is neither the single-entity nor the separate-entities approach.[439] Pickles explains how the "not-one/not-two approach requires that pregnant women are viewed as more than one but do not constitute two, as a result of the connection between the pregnant woman and the unborn", and how such approach recognises women's interests in their unborn which therefore also includes the decision to *continue* with pregnancy, and the decisions *how* to progress through that pregnancy and birth.[440] Thus, she argues that a "focus on pregnancy as a relationship even though the pregnant woman and the unborn are not on an equal footing in law" articulates a view of pregnancy that is based on women's "lived realities" and is non-adversarial.[441] This relational view of pregnancy that goes beyond *termination* of pregnancy to include questions about the treatment and care women receive when they have decided to *continue* with a pregnancy is also relevant for the birth jurisprudence introduced above. Moreover, in Chapter

[438] S. Halliday, *Autonomy and Pregnancy. A Comparative Analysis of Compelled Obstetric Intervention* (2016), p. 178.
[439] C. Pickles, *Pregnancy Law in South Africa. Between Reproductive Autonomy and Foetal Interests* (2017).
[440] C. Pickles, *Pregnancy Law in South Africa. Between Reproductive Autonomy and Foetal Interests* (2017), pp. 303-304, 324.
[441] C. Pickles, *Pregnancy Law in South Africa. Between Reproductive Autonomy and Foetal Interests* (2017), pp. 335-336.

4 where I discuss women and violence narratives I show how some minority women experience reproductive violence (forced sterilisations) exactly because they have decided to continue with pregnancy.

In none of the cases concerning birth has the European Court of Human Rights considered stereotypes and power dynamics in the way we can see in the CEDAW Committee's *Alyne* case, where the Committee recognised the intersectional discrimination – that Ms da Silva Pimentel Teixeira was discriminated against, not only on the basis of her gender, but also on the basis of her status as a woman of *African descent* and her *socio-economic* background.

Negative framings of women mirror Rebecca Kukla's work on motherhood (similar to C. Malagrida's arguments above) where she argues that there is a tendency to "measure motherhood", not in "extended narratives" but rather by "a set of signal moments that we interpret as emblematic tests and summations of women's mothering abilities".[442] For example, she calls child birth "a maternal achievement test", and explains how the symbolic importance of birth has been elevated to the point where it appears to serve as a make-or-break test of a woman's mothering abilities – in order to "make it" the woman needs to manage her birth successfully by making "proper, risk-adverse, self-sacrificing choices, and maintaining both proper deference to doctors and control over her own body", and, accordingly, a woman fails the test, when she reveals herself as "selfish or undisciplined and risks deforming her baby's character, health, and emotional well-being".[443]

Thus, continuing the narrative of abortion jurisprudence: women are not only expected to take up a role (mother), but this very role has specifically been scripted for them. This means that women can fail on two levels: by refusing to take the assigned role and by

[442] R. Kukla, "Measuring mothering", *International Journal of Feminist Approaches to Bioethics*, Vol. 1, No. 1 (2008), p. 69.
[443] R. Kukla, "Measuring mothering", *International Journal of Feminist Approaches to Bioethics*, Vol. 1, No. 1 (2008), p. 74.

challenging the script of the role, *i.e* not behaving in a certain way. Kukla's conclusion echoes perfectly my findings as she summarises: "Our cultural insistence that women make 'proper' birth choices and maintain control over their birth narratives is not about minimizing real risks, rather, it supports our desire to measure mothering in terms of women's personal choices and of self-discipline exercised during signal moments".[444]

As I have argued previously together with Alicia Ely Yamin, conceptualising abortion or other women's reproductive health issues through a private life doctrine might create a space that might seem private, but not safe – where the woman is left alone. In this example, hospitals, medical settings, doctor's offices might be closed private systems just as family settings were traditionally a private sphere where abuse and violence was taking place out of the reach of the state's protection.[445] Namely, in the abortion and birth cases from the ECtHR, the Strasbourg Court shows a strong deference to medical professionals as representatives of science and thus assumes that the medical setting is free from power relations thus failing to engage in an inquiry about the systemic and institutional biases and personal incentives that may undermine "authoritative" opinions.[446] Samantha Halliday describes doctors as "gate-keepers" who control access to abortion and hold significant influence in determining what medical treatment women are required to accept during

[444] R. Kukla, "Measuring mothering", *International Journal of Feminist Approaches to Bioethics*, Vol. 1, No. 1 (2008), p. 78.
[445] L. Oja, A. E. Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?" *Columbia Journal of Gender and Law*, Vol. 32, No. 1 (2016), p. 74. As pointed out in our references, see further on how maintaining the divide between the public and the private sphere within the human rights framework hinders addressing intimate partner violence as traditionally human rights deals with acts taking place in the *public* sphere: C. Bunch, "Women's Rights as Human Rights: Towards a Re-envision of Human rights", *Human Rights Quarterly,* Vol. 12, No. 4 (1990).
[446] L. Oja, A. E. Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?" *Columbia Journal of Gender and Law*, Vol. 32, No. 1 (2016), p. 76.

pregnancy/birth – women, on the other hand, are portrayed as incapable of making a responsible decision on their own without a doctor's "guiding hand".[447]

Halliday shows in her work with case-law how "medical evidence is seen as scientific, rational and objective", and how, by contrast, women are portrayed as "incapable of making a responsible decision" and as "selfish hedonists willing to sacrifice the life of the foetus", "irresponsible individuals making decisions that are morally repugnant".[448] She explains that a woman must be permitted to determine for herself what constitutes an acceptable level of risk, conducting her own cost-benefit analysis in determining whether or not to allow treatment to take place" and very importantly – she must be allowed to make decisions that are "wrong".[449] Similarly, Rebecca Kukla *et al* emphasise, how any judgment about an option being "too risky" to be medically sound is already "encoding *someone's* valuation of different outcomes" as the size of different risks will vary greatly depending on the meaning of the various outcomes for the particular woman, her larger narrative, her needs, life projects, care responsibilities, cultural values, her sense of dignity and identity.[450] Rajat Khosla *et al* argue that identifying the human rights standards is the "first step towards addressing violations of human rights during facility-based childbirth".[451] Once we have acknowledged that childbirth is an issue of human rights, we can guarantee respectful treatment that does not violate a woman's dignity, and thus "improve the overall quality of maternal care".[452] The 2018 World Health Organisation's guidelines for intrapartum care also underscore that it is important to guarantee that women and their babies not only *survive*

[447] S. Halliday, *Autonomy and Pregnancy. A Comparative Analysis of Compelled Obstetric Intervention* (2016), p. 172.
[448] S. Halliday, *Autonomy and Pregnancy. A Comparative Analysis of Compelled Obstetric Intervention* (2016), p. 212.
[449] S. Halliday, *Autonomy and Pregnancy. A Comparative Analysis of Compelled Obstetric Intervention* (2016), p. 220.
[450] R. Kukla *et al*, "Finding autonomy in birth", *Bioethics*, Vol. 23, Issue 1, (2009), pp. 4-5.
[451] R. Khosla *et al*, "International Human Right and the Mistreatment of Women during Childbirth", *Health and Human Rights Journal*, Vol. 18, No. 2 (2016).
[452] R. Khosla *et al*, "International Human Right and the Mistreatment of Women during Childbirth", *Health and Human Rights Journal*, Vol. 18, No. 2 (2016).

labour complications if they occur, but also that they *thrive* and reach their full potential for health and life.[453]

Furthermore, the *Konovalova* case presents an interesting aspect of the suffering narrative mentioned above. Namely, the European Court of Human Rights found a violation of right to privacy, but did so by reasoning how Konovalova had been "some time in a state of extreme stress and thus it was unclear whether she was at all capable of making an intelligible informed decision", and how "the applicant's vulnerable condition during was not taken into account". Or similarly, in *Ternovszky* case concurring Judges Sajó and Tulkens construct an "expectant mother" as "very vulnerable" which in turn calls for a "a positive regulatory environment, which will produce the legal certainty providing the right to choose with effectiveness".

In a way, this shows that the Strasbourg Court accepts that pregnancy and birth are special experiences and impact women. However, I think that such framing can also raise questions, whether women can then actually make "intelligible and informed" decisions about their health and determine what they feel comfortable with and what they want during the labour – because determining that women in labour are in "vulnerable condition" can also open leeway for women's decreased autonomy and agency and, importantly, this approach does not speak of *rights* (*i.e* women have a right to make decisions about their birth experiences), but rather of again patronising vulnerability that would invoke compassion.

[453] "WHO recommendations: Intrapartum care for a positive childbirth experience", *World Health Organization* (2018). See also previous guidelines: "Companion of choice during labour and childbirth for improved quality of care", *World Health Organization* (2016); "The prevention and elimination of disrespect and abuse during facility-based childbirth", *World Health Organization* (2014).

3.6 CONCLUSION: WOMEN ARE MOTHERS – SOMETIMES DANGEROUS

I have mapped four stereotypes about women in abortion, birth and maternal mortality jurisprudence. The first stereotype is the widespread misbelief that all women want to become mothers – such normative motherhood constructs all women regardless of their individual desires and choices as mothers or mothers-to-be. The second stereotype derives from the first, but adds another layer that is especially apparent in cases concerning birth – it portrays women as *dangerous* mothers-to-be who would put their babies at risk if not monitored and disciplined by doctors and or even state officials during prenatal and obstetric care. The third stereotype depicts women as sufferers who need to prove enough suffering and a *certain type* and degree of suffering to be awarded human rights protection, and space for their choices, wishes, desires, needs.

The fourth, last stereotype constructs women as clueless, incapable of making autonomous choices about their reproductive lives, *i.e* family planning. I demonstrated how by *not* naming, describing and rejecting these stereotypes, which enforce narrow "single stories" of women's experiences, the reproduction jurisprudence is not transformative, but instead adds to the silencing processes. Overall the "woman" in these stories is someone who must throughout her existence endure the dangerous consequences of reproduction politics, is subjected to persistent gender stereotypes rooted *inter alia* in plain disbeliefs or moral judgments is obligated to fit into certain socially and legally constructed frames that assist her to seem more deserving of her *human rights*.

our bodies
tell stories
no books have
the spine to
carry

– *women of colour*
(rupi kaur)

4. WOMEN AND VIOLENCE NARRATIVES

4.1 "DIRTY MISBEHAVING WOMEN, UNWANTED MOTHERS, AND THE UNFORTUNATE VIOLENCE"

Who is the "*woman"* in human rights law if we consider the jurisprudence concerning forced sterilisations, "virginity" testing, and women's sexuality? I introduce a total of 12 cases from the European Court of Human Rights, the United Nations CEDAW Committee, and the Inter-American Court of Human Rights. Jurisprudence dealing with forced sterilisations has received relatively large amount of attention in human rights scholarship, whereas the issue of forced gynaecological examination has largely gone under the radar in the legal discipline.[454] The European Court of Human Rights has four forced sterilisation cases (all against Slovakia decided between 2009-2013 with almost identical factual circumstances), the United Nations CEDAW Committee one case concerning Hungary, and the most recent, and also progressive in how a reproductive rights-based approach is used is a case against Bolivia from the Inter-American Court of Human Rights.

In the introduction of this thesis I cited Barbara Havelkov*á's which maps how courts and governments use the "no intent" argument: how anti-discrimination law should target*

[454] An exception is M. Sjöholm's book (*Gender-Sensitive Norm Interpretation by Regional Human Rights Law Systems* (2017) I have cited in this thesis. For work on forced sterilisations see for example: E. Tilley *et al*., "'The Silence is roaring': sterilization, reproductive rights and women with intellectual disabilities", *Disability and Society*, Vol. 27, Issue 3 (2012), C. Zampas, A. Lamačková, "Ethical and legal issues in reproductive health: Forced and coerced sterilization of women in Europe", *International Journal of Gynecology and Obstetrics,* Vol. 114, Issue 2 (2011), R. Sifris, "The involuntary sterilisation of marginalised women: power, discrimination, and intersectionality", *Griffith Law Review*, Vol. 25, Issue 1 (2016), R. Sifris, "Involuntary Sterilization of HIV-Positive Women: An Example of Intersectional Discrimination", *Human Rights Quarterly*, Vol. 37, Issue 2 (2015), R. Sifris, "Conceptualising Involuntary Sterilisation as Severe Pain or Suffering for the Purposes of Torture Discourse", *Netherlands Quarterly of Human Rights*, Vol. 28, Issue 4 (2010).

only "hostile animus", and therefore not implicit bias.[455] *This pattern also reveals itself in the forced sterilisation jurisprudence of the European Court of Human Rights, where the court argues in different cases, how "sterilisation without consent calls for serious criticism", but does not find enough evidence to show that forced sterilisations of the Roma women in question were "organised policy or that the hospital staff's conduct was racially motivated", or that the "doctors involved acted in bad faith".*

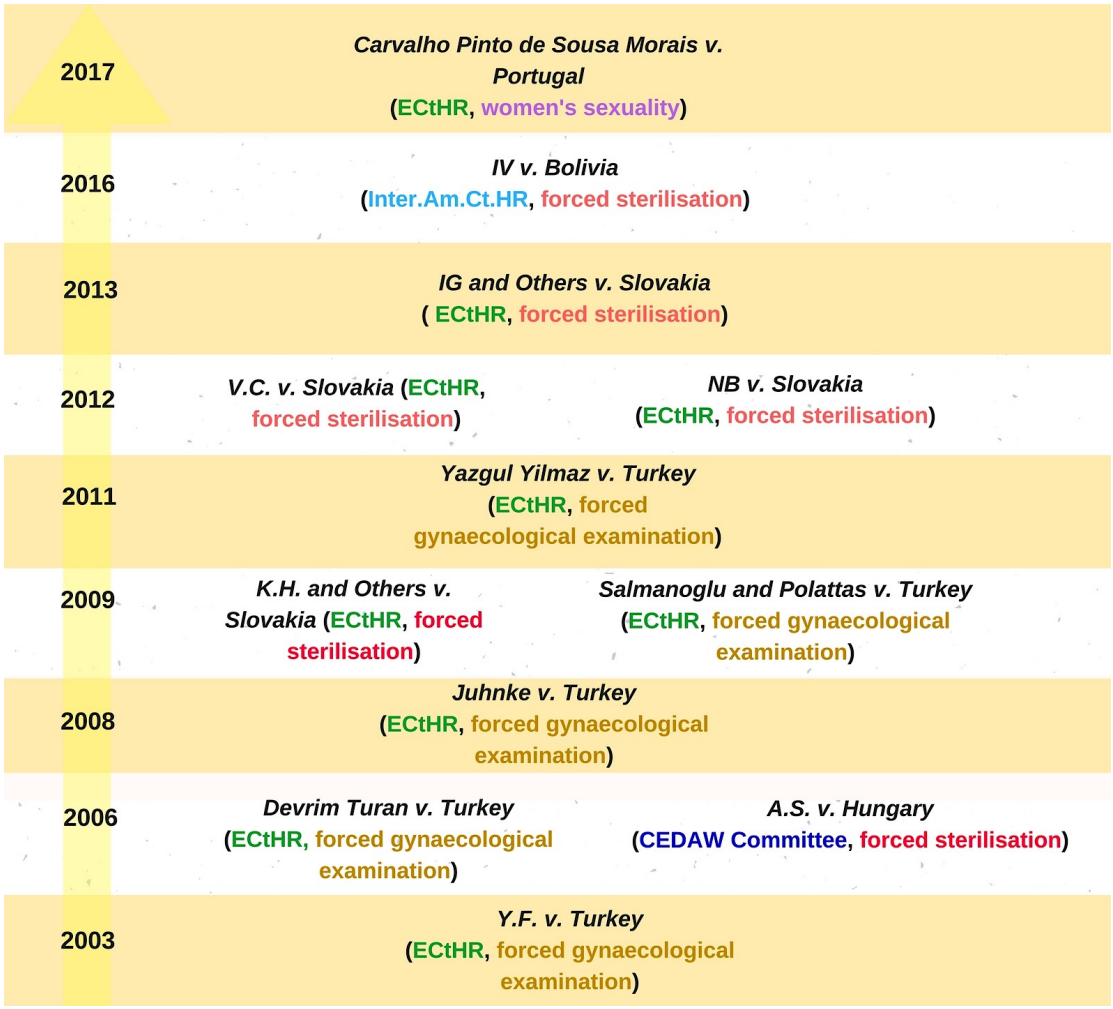
The European Court of Human Rights has heard five cases concerning forced gynaecological examinations between 2003-2011, all against Turkey and all with similar factual circumstances. The ECtHR did find a breach of human rights in most of these cases (either under prohibition of degrading treatment or right to privacy), but focused on the absence of consents and remaining silent on the practice of "virginity testing" itself and on the gender stereotypes justifying it. The last case is the already familiar case of *Carvalho Pinto de Sousa Morais* also from the European Court of Human Rights concerning a woman's sexuality in her 50s.

There is a strategic reason behind coupling forced sterilisations and "virginity testing" with the *de Sousa Morais* case which demonstrates a broader understanding of women's sexuality. Namely, I argue that more severe forms of reproductive violence such as forced sterilisations of certain women (e.g Black women, Roma women) and "virginity testing" as a form of punishment and control of women, is more likely to occur in an environment that accepts, allows and encourages general stereotypical framings of women's reproductive choices and sexuality more broadly. To put it simply, stereotypes serve as shortcuts to human rights breaches: just like maternal mortality, forced sterilisations do not happen "overnight" or unexpectedly, tolerating stereotypes lays the groundwork for these human rights violations.

Four harmful stereotypes emerge from these cases. The first stereotype involves women's sexuality – an expectation that women need to keep their "purity" through maintaining their "virginity", and consequently, a sexually active woman is shameful: women should not (openly) enjoy sex, govern their sexuality and/or determine their sex life. The second and third stereotype summarise how women's experiences of violence in medical settings are framed: mistreating women in clinics, health care centres and hospitals proves permissible as the context of reproduction justifies/requires said mistreatment. The fourth stereotype is a reversed version of the "normative motherhood" stereotype I discussed previously in Chapter

[455] B. Havelková, *"Judicial Scepticism of Discrimination at the ECtHR", in: H. Collins, T. Khaitan (eds.) Foundations of Indirect Discrimination Law* (2018), p. 88.

3: the jurisprudence here reveals that some women from specific marginalised groups (Roma women, Black women) are expected *not to* reproduce, not to become mothers. In other words, to *some* women the "normative motherhood" expectation does not apply.



4.2 WHERE ARE VIOLENCE AND GENDER IN HUMAN RIGHTS LAW?

4.2.1 Gender-based violence against women and girls: international law responds?

How to talk about gender-based violence against women and girls?[456] One approach is to speak through numbers: to showcase the available quantitative data that demonstrates the prevalence of physical/sexual violence as I first did with unsafe abortions and maternal mortality in the previous part of this thesis (Chapter 3). For example, a European Union-wide survey from 2014 concluded that one in three women (33%) has experienced physical and/or sexual violence since age 15.[457] The World Health Organisation's data from 2013 indicates a very similar global trend: overall, 35% of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence.[458]

Another way to frame the discussion about violence against women is to speak of violence as a violation of human rights. For example, the former *United Nations Special Rapporteur on Violence Against Women* Rashida Manjoo writes that violence against women impairs and nullifies women's realisation of human rights and prevents women from participating in their community as full, equal citizens.[459] The work of Alice Edwards summarises how international law and human rights frameworks more specifically have responded to gender-based violence and writes that prior to the 1990s violence against women was seen as an issue for national governments, as a question of criminal law, not of human rights law, even the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) adopted in 1979 did not have a provision outlawing violence against women – a failure that the CEDAW Committee tried to fix with its two general recommendations declaring violence against women sex discrimination.[460] Dubravka

[456] Some scholars prefer using the term "gender-based violence" instead of *violence against women* as the former seems to be more inclusive, and captures more precisely the idea how this form of violence is rooted in gender stereotypes. I use "violence against women" and "gender-based violence" interchange" is more precise term as it makes explicit the "gendered causes and impacts of the violence" and "further strengthens the understanding of this violence as a social - rather than an individual- problem, requiring comprehensive responses, beyond specific events, individual perpetrators and victims/survivors" (CEDAW/C/GC/35).

[457] EU Fundamental Rights Agency, "*Violence against women: an EU-wide survey"* (2014). See also: C. Bradbury-Jones *et al*., "A Profile of Gender-Based Violence Research in Europe: Findings From a Focused Mapping Review and Synthesis", *Trauma, Violence, & Abuse* (2017).

[458] "*Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence*", World Health Organisation, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council, (2013).

[459] R. Manjoo, "Special Guest Contribution: Violence against women as a barrier to the realisation of human rights and the effective exercise of citizenship", *Feminist Review,* Vol. 112, issue 1 (2016), p. 11.

[460] A. Edwards, *Violence Against Women under international Human Rights Law* (2011), p. 7. See further: A. Edwards, "Violence against Women as Sex Discrimination: Judging the Jurisprudence of the United Nations Human Rights Treaty Bodies", *Texas Journal of Women & the Law*, Vol. 18 (2008).

Šimonovic writes also how although CEDAW does not have a provision explicitly prohibiting violence against women, it "provides a gender specific framework on the elimination of all forms of discrimination against women that encompasses violence against women", and how the adoption of the CEDAW "introduced two fundamental innovations in human rights antidiscrimination law:

> *It acts as an asymmetric instrument for the protection of women against all forms of direct and indirect discrimination in various facets of life; and 2) it provides an obligation for state parties to adopt "all appropriate measures" to fully develop and advance women or to empower women.*[461]

It was not until the 1990s that the issue of violence against women started to feature more seriously on the agenda of the international community as the attention was brought to violence committed against women within the context of armed conflict, where women were "routinely raped, sexually assaulted, incarcerated, and forcibly impregnated as part of deliberate military and political strategies to debase and humiliate them".[462] Contemporary scholars working with gender and international criminal law reflect how "the last decade has seen unprecedented progress in the construction of an international legal framework for the criminalisation and prosecution of gender crimes perpetrated against women and girls during armed conflict or state repression".[463] Correspondingly, there is now a growing body of work that discusses violence against women in armed conflicts.[464] However, as Ruth Rubio-Marin and Dorothy Estrada-Tanck note, it has become "increasingly clear" that the ones most victimised in times of armed conflict are indeed women as they make up the majority of civilian deaths, the majority of refugees and are targets of rape and forced pregnancy, but it must not be overlooked that women's "basic well-being" is severely threatened in daily life

[461] D. Šimonovic, "Global and Regional Standards on Violence Against Women: The Evolution and Synergy of the CEDAW and Istanbul Conventions", *Human Rights Quarterly,* Vol. 36, No. 3 (2014), pp. 590, 592, 599.
[462] A. Edwards, *Violence Against Women under international Human Rights Law* (2011), p. 7.
[463] C. Duggan, R. Jacobson, "Reparation of Sexual and Reproductive Violence: Moving from Codification to Implementation", in: *The Gender of Reparations*, R. Rubio-Marin (ed.) (2009).
[464] R. Copelon, "Gender Crimes as War Crimes: Integrating Crimes against Women into International Criminal Law", *McGill Law Journal*, Vol. 46 (2000), K. Askin, "Treatment of Sexual Violence in Armed Conflicts: A Historical Perspective and the Way Forward", in: *Sexual violence as an international crime: interdisciplinary approaches*, A.-M. de Brouwer, C. Ku, R. Römkens, L. van den Herik (eds.) (2013), K. Engle, "Feminism and Its (Dis)Contents: Criminalising Wartime Rape in Bosnia and Herzegovina", *The American Journal of International Law*, Vol. 99, No. 4 (2005), D. E. Buss, "The curious Visibility of Wartime Rape: Gender and Ethnicity in International Criminal Law", *Windsor Yearbook of Access to Justice*, Vol. 25, No. 1 (2007).

by unequal access to resources, services, opportunities and by the violence women experience under "ordinary circumstances".[465]

Considering this, the mid-1990s saw a shift taking place within the United Nations human rights frameworks: for example, in 1993 the *UN Declaration of Violence against Women* (DEVAW) was adopted, and in 1994 the *UN Commission on Human Rights* (predecessor of UN Human Rights Council) appointed the first *Special Rapporteur on Violence against Women*.[466] In the 2000s the United Nations General Assembly adopted several resolutions calling for the intensification of efforts to eliminate all forms of violence against women and one of the targets of the 2030 UN Sustainable Development Goals agenda is elimination of all forms of violence against all women and girls in the public and private spheres. [467] There have also been regional developments.[468]

4.2.2 Human rights-based approaches against gender-based violence

Sally Engle Merry writes that in the area of violence against women, human rights ideas are powerful precisely because they can offer "a radical break from the view that violence is natural and inevitable", and defined as a human rights violation, gender violence becomes "a crime against the state that the state must punish".[469] Although I do agree with Engle Merry, I would add that in addition to the importance of accountability, challenging existing (gendered) power dynamics that cause, justify and validate violence against women and children also matters. I echo here Alicia Ely Yamin, who underscores that the power of human rights is the "capacity to challenge existing social relationships and power structures", and how human rights can provide a "radically different frame for thinking about the relations of power and inequality in society".[470] As Black feminist writers Dorothy Roberts

[465] R. Rubio-Marin, D. Estrada-Tanck, "Violence against Women, Human Security, and Human Rights of Women and Girls: Reinforced Obligations in the Context of Structural Vulnerability", in: *Gender, Violence, and Human Security: Critical Feminist Perspectives*, A. M. Tripp *et al* (eds.) (2013), p. 238.
[466] UN Commission on Human Rights, *Question of integrating the human rights of women into the human rights mechanisms of the United Nations*, 8 March 1995, E/CN.4/RES/1995/86, available at: http://www.refworld.org/docid/3b00f18d30.html [accessed 17 February 2018].
[467] See e.g. General Assembly resolution, *Intensification of efforts to eliminate all forms of violence against women* (A/RES/61/143, of 19 December 2006) and similar resolutions thereafter. For more on General Assembly's work on violence against women see: http://www.un.org/womenwatch/daw/vaw/v-work-ga.htm#in (accessed 17 February 2018).
[468] The *Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women* (Convention of Belém do Pará) entered into force in 1994, and in 2003 the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (Maputo Protocol) was adopted. Furthermore, the Council of Europe has adopted the *Convention on preventing and combating violence against women and domestic violence* (Istanbul Convention), which provides that violence against women is "a manifestation of historically unequal power relations between women and men".
[469] S. Engle Merry, *Human Rights and Gender Violence* (2009), p. 180.
[470] S. Engle Merry, *Human Rights and Gender Violence* (2009), p. 180.

and Patricia Williams emphasise, rights can "elevate one's status from human body to social being".[471] More specifically, Rashida Manjoo stresses the need to go beyond the public space.[472] Accordingly, Engle Merry explains how human rights can open up private domains: whereas Alicia Ely Yamin refers to medical settings, Merry talks about the family – "the penetration of rights into this patriarchal sphere represents a radical break".[473] Furthermore, the human rights-based approaches also need to be intersectional.[474]

The forms of violence that women can experience specifically in the context of reproduction vary in the degree of harm and impact: on the one end of this spectrum are for example giving women misinformation about reproductive health matters and micro-aggressions such as verbal abuse towards women in health care facilities or in public space through patronising social campaigns. On the other end of the spectrum lie reproductive penalties, obstetric violence, forced gynaecological examinations, forced sterilisations and maternal mortality. More important than listing all different expressions of violence is the understanding of the power dynamics that accept, permit or even encourage this violence.

Iris Marion Young argues that the oppression of violence is less about the particular acts themselves, though these are often utterly horrible", but rather the "social context surrounding them, which makes them possible and even acceptable". [475] Young's understanding here is in line with my conceptualisation of reproductive violence against women: it is possible and socially acceptable due to (gender) stereotypes that justify, pardon or sometimes even romanticise such expressions of violence. I also echo Young's call to turn the main focus from describing the acts of violence to highlighting how human rights-based responses can reject a social space where violence occurs and grows systematic indisputably. Namely, in some cases gender stereotypes are so strong, effective and silencing of women's voices that reproductive violence does not count as "actual violence" in the eyes of judges, policy-makers, doctors, but is instead framed as "a misfortune", or "inconvenience".

It is helpful to think about the "iceberg metaphor" that has been widely used for example the in research and scholarship of cultural studies and psychology, not to mention more general contexts. This metaphor has appeared as a useful tool for explaining gender-

[471] D. Roberts, *Killing the Black Body* (1997), p. 303, and P. Williams, *Alchemy of Race and Rights*, pp. 153-154.
[472] R. Manjoo, "Special Guest Contribution: Violence against women as a barrier to the realisation of human rights and the effective exercise of citizenship", *Feminist Review,* Vol. 112, Issue 1 (2016), p. 13.
[473] S. Engle Merry, *Human Rights and Gender Violence* (2009), pp. 181, 187.
[474] See further: L. Sosa, *Intersectionality in the human rights legal framework on violence against women: at the centre or the margins*? (2017).
[475] I. M. Young, *Justice and the Politics of Difference* (1990), pp. 61-62.

based violence research.[476] The iceberg metaphor essentially means that something has two parts - a visible part above, and an invisible part below the surface.

On the topic of women and violence, I propose picturing three different icebergs. In the first iceberg the violence women experience (*i.e* gender-based violence) would be under the surface in its entirety, and above the surface we would see the "real" violence (as defined from the masculine perspective) that happens in the public sphere and is committed by strangers. This iceberg characterises the phase where the concept of gender-based violence is not recognised at all. The second iceberg reflects the current reality of gender-based violence – above the surface we see rape, killing, sexual assaults, physical abuse women experience, and below the surface we find the cultures that set women up for the violence – verbal abuse, catcalling, harassment, micro-aggressions, "everyday sexism".[477] Lastly, the third iceberg could be titled "reproductive violence", the visible part showing forced sterilisations, maternal mortality, some elements of obstetric violence, and the invisible part under water would depict for example "virginity testing", misinformation, forced obstetric practices (see a sum of these three icebergs in *Appendix III*).

These icebergs illustrate Iris Marion Young's conceptualisation of how, due to its systemic character, its existence as a social practice, violence is a phenomenon of social injustice and not merely an "individual moral wrong".[478] In other words, this violence is structural.[479] The work of Suruchi Thapar-Björket *et al* helps further unpack this phenomenon of social practices as their research explains how social dynamics of everyday practices are often governed and shaped in many ways by gendered inequalities and "micro contexts of power" which in turn enable some forms of violence to continue without impunity – this is how violence becomes normalised and normative: practices that would usually be seen problematic gain social acceptance through particular discourses, practices and policies.[480]

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[476] See *Appendix II* (*El iceberg de la violencia de género. Infografía de Amnistía Internacional*).
[477] See e.g.: L. Bates, *Everyday Sexism* (2014).
[478] I. M. Young, *Justice and the Politics of Difference* (1990), pp. 61-62.
[479] The term "structural violence" was coined by Johan Galtung (see: J. Galtung, "Violence, Peace, and Peace Research", *Journal of Peace Research*, Vol. 6, No. 3 (1969)). Although Galtung offered tools to think about violence beyond single individual dimension and through social injustice and social structures his work did not specifically explore gender-based violence. For works that critically engage with Galtung's approaches see for example, K. A. Parsons, "Structural Violence and Power", *Peace Review*, Vol. 19, No. 2 (2007); A. Dilts, "Revisiting Johan Galtung's Concept of Structural Violence", *New Political Science*, Vol. 34, Issue 2 (2012); C. C. Confortini, "Galtung, Violence, and Gender: The Case for a Peace Studies/Feminism Alliance", *Peace Change*, Vol. 31, Issue 3 (2006); K. Hirschfeld, "Rethinking 'Structural Violence'", *Society*, Vol. 54, Issue 2 (2017).
[480] S. Thapar-Björket, L. Samelius, G. S. Sanghera, "Exploring symbolic violence in the everyday: misrecognition, condescension, consent and complicity", *Feminist Review*, Vol. 112, No. 1 (2016), pp. 145, 149.

Young's analysis of violence and oppression also discusses what happens to the *person* who is oppressed in the process. She comments on the effect of the oppression on the victim's identity and sense of wrong/right, and explains that violence is systemic because it directs a member of a group based simply on them belonging to said group: the "oppression of violence consists not only in direct victimization, but in the daily knowledge (…) that they are *liable* to violation, solely on account of their group identity".[481] Therefore, if reproductive violence against women is normalised, then women themselves are forced into positions of victims – using the words of Suruchi Thapar-Björket *et al*: "Domination that arises from symbolic violence is less a product of direct coercion, and more a product of when those who are dominated stop questioning existing power relations".[482]

This is why every case concerning reproductive violence that has reached a transnational human rights law forum is crucially important – it is an opportunity for human rights law to question and break down existing power relations. Accordingly, when constructing (transformative) narratives within reproduction jurisprudence, the human rights law forums must pay attention to language – explicitly refer to reproductive rights, and see the gendered power relations since "language includes and excludes, it frames discourses through which social reality is constructed, and consequently has implications of power" and by "deciding to misrecognise, particular silences are produced and reproduced and particular narratives about what is considered right and wrong are legitimised".[483] Therefore anti-stereotyping is essential in human rights analysis.

4.2.3 Women's experiences with violence, and prohibition of torture and degrading treatment

The *United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment* published in January 2016 a report in which he argues that the international framework on prohibition of torture and ill-treatment has failed to respond to the *unique experiences of women* since it does not adopt a gendered lens to adequately address patriarchal and discriminatory power structures and gender stereotypes.

[481] I. M. Young, *Justice and the Politics of Difference* (1990), p. 62.
[482] S. Thapar-Björket, L. Samelius, G. S. Sanghera, "Exploring symbolic violence in the everyday: misrecognition, condescension, consent and complicity", *Feminist Review*, Vol. 112, No. 1 (2016), p. 148.
[483] S. Thapar-Björket, L. Samelius, G. S. Sanghera, "Exploring symbolic violence in the everyday: misrecognition, condescension, consent and complicity", *Feminist Review*, Vol. 112, No. 1 (2016), pp. 148 and 152.

[484] The work of Alice Edwards and Ronli Sifris supports the Special Rapporteur's findings. Edwards argues that the torture prohibition reflects and responds to the experiences of men rather than women: "traditionally conceived as a prohibition on physical assault perpetrated by public officials against political dissidents or common criminals, it fits within the 'male' paradigm of international law", whereas as Edwards explains, women are more likely to suffer abuse at the hands of private citizens (thus, falling outside the scope of protection), or if women's experiences do get represented in the discourses then it is the experiences of women as wives, mothers or daughters of male victims, *i.e* "by virtue of their relationship with the victim rather than as autonomous actors".[485] Ronli Sifris writes about how preventing women from accessing abortion services or subjecting them to involuntary sterilisation procedures renders women powerless.[486]

How does the transnational jurisprudence beyond reproduction speak to this criticism? The Committee Against Torture (CAT) is the body monitoring implementation of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (UNCAT), and there are two cases to consider that give an insight into how CAT understands gender and violence within its torture and inhuman treatment framework.

The first case, *Bakatu-Bia*, concerned Sylvie Bakatu-Bia, born in the Democratic Republic of the Congo (DRC), who fled to Sweden as she had been tortured, beaten on her legs and her back, and repeatedly raped for her political views.[487] Her asylum application, however, was rejected as the "general situation in DRC did not constitute grounds for asylum", and as the authorities questioned her trustworthiness indicating that she "failed to adduce any documents proving her identity".[488] Sylvie Bakatu-Bia claimed that her forcible deportation would amount to a violation of Article 3 of the UNCAT (non-refoulement) as she would be arrested and tortured upon return to DRC due to her religious and political

[484] UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, 5 January 2016, A/HRC/31/57, available at: http://www.refworld.org/docid/56c435714.html (accessed 17 February 2018)
Prohibition of torture is regarded as one of the most important human rights provisions – called also as a *ius cogens* norm of customary law, an absolute/a non-derogable right. It can be found in the UDHR (Article 5), in the ICCPR (Article 7) in the ECHR (Article 3). There are also special treaties against torture – the *UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (UNCAT) adopted in 1984 and monitored by the Committee Against Torture (CAT), the *Inter-American Convention to Prevent and to Punish Torture* adopted in 1985, and the *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment* adopted in 1987.
[485] A. Edwards, *Violence Against Women under international Human Rights Law* (2011), p. 210.
[486] R. Sifris, *Reproductive Freedom, Torture and International Human Rights: Challenging the Masculinisation of Torture* (2014), p. 182.
[487] *Sylvie Bakatu-Bia v. Sweden*, CAT/C/46/D/379/2009, para. 2.2.
[488] Case, para. 2.5.

beliefs.[489] The Committee referred to United Nations expert report on the general dire human rights situation in DRC, but emphasised additionally how, according to the High Commissioner for Human Rights "sexual violence in DRC remains a matter of serious concern, particularly in conflict torn areas, and despite efforts by authorities to combat it, this phenomenon is still widespread and particularly affects thousand of women and children".[490] Thus, the Committee concluded that the removal of the complainant to DRC would violate Article 3 of UNCAT (non-refoulement).[491]

The second case, *F.B.*, concerned a Guinean woman whose asylum application was denied by the Netherlands.[492] F.B. was forced to undergo female genital mutilation (FGM), to leave school and marry against her will, and was also sexually abused by her step-mother's brother.[493] Consequently she argued that the Netherlands would violate Article 3 of UNCAT if forcibly removing her to Guinea. The Netherlands acknowledged the problems with human rights in Guinea, but F.B.'s "allegations that she was a victim of forced marriage to her stepmother's brother and her accounts about her family circumstances are not credible", and that "the fact alone that the complainant was a victim of FGM in the past, like 96,9% of girls and women in Guinea, does not mean that her return would be contrary to article 3 (…). She has provided no convincing arguments to support her claim that she would be subjected to genital mutilation again".[494] The Dutch Government also argued that since F.B. had already undergone FGM and there was no evidence to suggest that upon return she would be subjected to a medical examination that would reveal the reconstruction surgery and, although widespread, FGM is "usually instigated by parents or other female relatives", there is no threat of FGM for F.B.[495]

The Committee found that FGM is widespread in Guinea and that the pressure to undergo FGM is "not limited to direct relatives, but is a common feature of Guinean patriarchal society".[496] The Committee also explicitly acknowledged: "the practice of

[489] Case, para. 3. *Article 3: 1. No State Party shall expel, return ("refouler") or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture. 2. For the purpose of determining whether there are such grounds, the competent authorities shall take into account all relevant considerations including, where applicable, the existence in the State concerned of a consistent pattern of gross, flagrant or mass violations of human rights*
[490] Case, para. 10.6-10.7.
[491] Case, para. 11.
[492] *F.B. v. the Netherlands*, CAT/C/56/D/613/2014.
[493] Case, para. 2.1.
[494] Case, paras. 4.13-4.15.
[495] Case, para. 6.2.
[496] Case, para. 8.5.

subjecting a woman to FGM is contrary to the obligations enshrined in the Convention".[497] Furthermore, the Committee emphasised that the inconsistencies in the complainant's statements about her family are "not of nature as to undermine the reality of the prevalence of female genital mutilation".[498] The Committee concluded that the Netherlands "has failed to take into consideration the complainant's allegations regarding the events she experienced in Guinea, her condition as single woman within the Guinea society, the specific capacity of the authorities in Guinea to provide her with protection (…), and the severe anxiety that her return to Guinea may cause her (…)"[499], thus there were substantial grounds for believing that the complainant would be in danger of treatment contrary to UNCAT – in conclusion the Committee found a violation of Article 3 of UNCAT (non-refoulement).

The first time the European Court of Human Rights held that domestic violence constitutes a form of gender discrimination was in the *Opuz* case.[500] The case concerned an applicant who had been severely battered by her husband. The European Court of Human Rights coupled Articles 2 (right to life) and 3 (prohibition of torture and degrading treatment) with Article 14 (prohibition of discrimination) to demonstrate that domestic violence has a distinct gender dimension and that women suffer from it disproportionally more than men. [501]

The CEDAW Committee has also heard cases dealing with domestic violence. The *X and Y* case concerned Georgian nationals X (a mother) and Y (her daughter), who submitted that Georgia had violated their rights under articles 1, 2(b) – 2(f) and 5(a) of CEDAW.[502] In 1987 a man raped X. As according to X the Georgian society perceives virginity as a young woman's virtue that is a guarantee of a successful marriage, X thought that nobody else would marry her after she had been raped, and thus married the man who had raped her. They had five children. During the marriage the husband was violent, threatening and battering X and all of the children, and sexually abusing Y (one of the daughters).[503] Despite X's

[497] Case, para. 8.7.
[498] Case, para. 8.8.
[499] Case, para. 8.8.
[500] *Opuz v. Turkey*, Application no. 33401/02. *Opuz* was called a landmark case and a significant advance in the Strasbourg Court's approach to gender-based violence and it was hoped that it would have a spill-over effect. See e.g.: C. Danisi, "How Far Can the European Court of Human Rights Go in the Fight Against Discrimination? Defining New Standards in its Non-Discrimination Jurisprudence", *International Journal of Constitutional Law,* Vol. 9, No. 3-4 (2011); P. Londoño, "Developing Human Rights Principles in Cases of Gender-based Violence: Opuz v Turkey in the European Court of Human Rights", *Human Rights Law Review,* Vol. 9, Issue 4 (2009). To some extent this has indeed happened. In a 2016 case of *Halime Kılıç v. Turkey* the ECtHR found a violation of Article 2 (right to life) taken together with Article 14 (non-discrimination). But the jurisprudence from the European Court of Human Rights analysed in this thesis does not indicate a similar consistent trend.
[501] Case, paras. 198-202.
[502] *X and Y v. Georgia*, CEDAW/C/61/D/24/2009.
[503] Case, para. 2.1- 2.9.

statements and reports to the police the authorities repeatedly decided not to open a criminal case, asking the husband to simply submit a written document that he will not use violence, and referring to how the husband "had been positively assessed by his neighbours and business partners".[504]

Thus, X and Y submitted that these facts reveal a violation of articles 1, 2(b) – 2(f) and 5 (a) of the CEDAW because Georgia "has failed to comply with its duty to enact criminal law provisions to effectively protect women and young girls from physical and sexual abuse within the family, has failed to provide equal protection under the law to victims of domestic violence and sexual abuse and has subjected the authors to torture by failing to protect them from domestic violence".[505] The issue before the Committee was whether Georgia, through its public authorities and institutions had adequately addressed the complaints of X and provided her and Y with effective legal protection.[506]

The CEDAW Committee emphasised that provisions of CEDAW concerning fighting against violence against women include also include private acts in cases where the states have failed to act with due diligence to prevent violations of rights or to investigate and punish acts of violence.[507] The Committee criticised how "whenever a victim insisted on making an official complaint, the prosecutor's office would act as a mediator between the spouses rather than investigate the incident and prosecute the perpetrator".[508] The Committee concluded that the "unrefuted facts demonstrate that the State party's authorities have failed in their duty to adopt appropriate legislative and other measures", and to take "all appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices that are based on the idea of inferiority or the superiority of either sexes or on stereotyped roles for men or women".[509] The Committee thus found that Georgia had failed to fulfil its obligations and had thereby violated articles 2 (b)-2 (f), in conjunction with Articles 1 and 5 (a), of CEDAW, as well as the Committee's General Comment No. 19.[510]

In summary, these cases show a shift in human rights law, aimed at offering a better response to women's unique experiences with violence. However, as this thesis demonstrates, there is still a long way to go. In Chapter 3 of this thesis I raised my concern

[504] Case, para. 2.11.
[505] Case, para. 3.1.
[506] Case, para. 9.2.
[507] Case, para. 9.3.
[508] Case, para. 9.4.
[509] Case, para. 9.6.
[510] Case, para. 10.

with how some framings and interpretations in the abortion and birth-related case-law using the provisions of degrading treatment prohibition constructed the stories of women as the stories of "suffering victims". The trouble with this phenomenon becomes even more acute in this chapetr as the focus here is explicitly on women's experiences as targets of violence.

For example, Alice M. Miller argues that the feminist focus on violence elevates "women's victimhood", and emphasises sexual harm, which in turn minimises women's citizenship by reducing women to "suffering bodies" who are in need of protection by the law and the state, rather than as needing participation and equality in addition to protection.[511] I share Miller's view that overemphasising "suffering narrative" may be problematic. However, I think that the solution is not asking women to "reject" victimhood or downplay their suffering, and opt for the narrative of "survivors" *instead* as both such single-story constructions can be harmful if they are presented through good/bad, empowering/disempowering binaries. Instead, we should ask why is it that in human rights law women's victimhood is potentially stigmatising and "disempowering"; I argue that it is not women's responsibility to accommodate with the system and choose a role (a survivor or a victim) that protects them from (further) violence and harm, but instead it is the institutions, the society that need to change.

Treating gender-based violence against women as human rights violations offers a venue for a conversation, which could in turn lead to these changes. I argue that rights-based approaches to reproductive violence must work on two levels – firstly, we need to take this mostly unnoticed, "under water" violence seriously and not treat it lightly or differently as if women "were used to violence" or "were more accustomed to/deserving of pain" and secondly, we have to use a reproductive rights-based approach to understand women's experiences with reproduction means not only changing the way law defines the violations thresholds, but also explicitly challenging stereotypes that contribute to silencing of women. It means encouraging the courts and committees analysing reproductive rights issues to create with their case-law narratives which are truly empowering and that could be used by legislators, policy makers, litigators, other (domestic) courts and by women themselves as references and seeds of change. This is a holistic exercise that requires naming and unpacking

[511] A. M. Miller, "Sexuality, Violence against Women, and Human Rights: Women Make Demands and Ladies Get Protection", *Health and Human Rights*, Vol. 7, No. 2, *Sexuality, Human Rights, and Health* (2004). The "potential harm of victimhood" is one of the many questions feminist writers have discussed, and disagreed on. For a recent overview that summaries some of these discussions see: R. Stringer, *Knowing Victims: Feminism, agency and victim politics in neoliberal times* (2014).

the stereotypes, which is also an act of challenging the existing power dynamics. As Alicia Ely Yamin writes about power and human rights:

> *The power of hegemony lies in the acceptance of the inevitability of a given set of social structures and processes, to the point where they cease to be seen as mutable political arrangements and become the "way things are". Speaking truth to power requires that the human rights community stand outside the magical circle of belief about the neoliberal understanding of the progress in the world.*[512]

4.3 FROM DENIAL OF WOMEN'S SEXUALITY TO FORCED GYNAECOLOGICAL EXAMINATIONS

Many feminist writings explore questions about women's sexuality. I am more specifically interested in how ideas of "virginity" and purity lead to reproductive violence.[513] Sarah W. Rodriquez's historical analysis of female circumcision and clitoridectomy shows, how during the late 19th and early 20th centuries there was only *one kind of female orgasm* (clitoral), and there was also only *one kind of healthy sexual instinct for women* – "penetrative (hopefully procreative) sex with their husbands".[514] Thus, if women behaved outside of this norm – by for example masturbating or by not responding to their husband's embrace – their sexual instinct was seen as "impaired and disordered" because healthy women were not thought of as sexual beings – or rather, not as sexual beings on their own "without the promptings of their husbands".[515] Consequently, female circumcision and clitoridectomy were performed as women's bodies needed to "fit" better with their husbands bodies: "knowing the clitoris to be key to female sexual instinct, doctors removed the clitoral hood to promote stimulation from the penis to ensure that a woman's instinct was in keeping

[512] A. E. Yamin, "'Speaking truth to power:' a call for praxis in human rights", 18 April 2017, available at: https://www.opendemocracy.net/openglobalrights/alicia-ely-yamin/speaking-truth-to-power-call-for-praxis-in-human-rights (accessed 19 February 2018).

[513] Harmful ideas about women and girls being dirty or pure are present also in the context of menstrual cycle shame and stigma. See for example: I. Johnston-Robledo, J. C. Chrisler, "The Menstrual Mark: Menstruation as Social Stigma", *Sex Roles*, Vol. 68, No. 1-2 (2013), L. Mason *et al*, "We Keep It Secret So No One Should Know' – A Qualitative Study to Explore Young Schoolgirls Attitudes and Experiences with Menstruation in Rural Western Kenya", *PLoS ONE*, Vol. 8, Issue 11, (2013), A. Dahlqvist, *It's Only Blood* (2018).

[514] S. W. Rodriquez, "Rethinking the History of Female Circumcision and Clitoridectomy: American Medicine and Female Sexuality in the Late Nineteenth Century", *Journal of the History of Medicine and Allied Sciences,* Vol. 63, No. 3 (2007), p. 326 referring to T. Laquer's writings.

[515] S. W. Rodriquez, "Rethinking the History of Female Circumcision and Clitoridectomy: American Medicine and Female Sexuality in the Late Nineteenth Century", *Journal of the History of Medicine and Allied Sciences* Vol. 63, No. 3 (2007), p. 332.

with what was considered normal and healthy: heterosexual pleasure awakened by her husband".[516] This shows how gendered power relations become medicalised – which is also the case with "virginity testing".

Forced gynaecological examinations or as Nadera Shalhoub-Kevorkian terms, "imposed virginity testing", is a practice aimed at determining, whether a woman has been "sexually active" based on whether her hymen is intact or not.[517] Despite the existing transnational jurisprudence I introduce here human rights law scholarship has overlooked the issue of "virginity" testing, and how it is a form of gender-based violence; unfortunately, as Maria Sjöholm points out, feminist legal scholars have also largely been silent on this practice.[518] Shalhoub-Kevorkian explains how seeing women's sexuality as dangerous, harmful, uncontrollable and evil is universal to very diverse cultures and societies – controlling women's sexuality and bodies through laws, regulations, shaming-naming is a global phenomenon that transcends cultures, religions, income levels.[519] To briefly go back to previous chapters of this thesis–every abortion regulation or restrictive birth policy is also aimed at controlling women and their sexuality trying to force women to live certain lives, fulfil roles – and punish those who resist and reject such narrow paths.

[516] S. W. Rodriquez, "Rethinking the History of Female Circumcision and Clitoridectomy: American Medicine and Female Sexuality in the Late Nineteenth Century", *Journal of the History of Medicine and Allied Sciences* Vol. 63, No. 3 (2007), p. 346.
[517] N. Shalhoub-Kevorkian, "Imposition of virginity testing: a life-saver or a license to kill?", *Social Science & Medicine*, Vol. 60, Issue 6 (2005), p. 1188.
[518] M. Sjöholm, *Gender-Sensitive Norm Interpretation by Regional Human Rights Law Systems* (2017), p. 363.
[519] N. Shalhoub-Kevorkian, "Imposition of virginity testing: a life-saver or a license to kill?", *Social Science & Medicine*, Vol. 60, Issue 6 (2005), p. 1189.

2017	***Carvalho Pinto de Sousa Morais v. Portugal***	Art. 8 violation (privacy) + Art. 14 (non-discrimination), stereotypes considered
2011	***Yazgul Yilmaz v. Turkey***	Art. 3 violation (degrading treatment), power/stereotypes/reproductive rights not considered
2009	***Salmanoglu and Polattas v. Turkey***	Art. 3 violation (degrading treatment), power/stereotypes/reproductive rights not considered (some power analysis in dissent)
2008	***Juhnke v. Turkey***	Art. 8 violation (privacy), no Art. 3 violation, power/stereotypes/reproductive rights not considered
2006	***Devrim Turan v. Turkey***	No Art. 3 violation, power/stereotypes/reproductive rights not considered
2003	***Y.F. v. Turkey***	Art. 8 violation (privacy), power/stereotypes/reproductive rights not considered

4.3.1 "Virginity testing" jurisprudence of the European Court of Human Rights

Y.F. v. Turkey

In *Y.F. v. Turkey*, the applicant Y.F. and his wife Mrs. F. were taken to custody with a suspicion of aiding and abetting an illegal terrorist organization PKK (Workers' Party of Kurdistan).[520] After the police had detained Mrs. F. for three days they took her to a gynaecologist for an examination. The police requested that the report should indicate whether she had had vaginal or anal intercourse while in custody. Mrs. F. refused to undergo the examination, but was subjected to it nevertheless. The police officers remained on the premises while Mrs. F. was behind the curtain. The doctor reported that Mrs. F. had not had any sexual intercourse in the days preceding the examination.[521]

Mrs. F. submitted to the European Court of Human Rights that she had not consented to the gynaecological examination, but was still forced to undergo it and thus, her right to privacy (Article 8) had been breached. The Government submitted that it would not have been possible to perform such an examination without the consent of Mrs. F., thus she could have objected to it when she was taken to the doctor's consulting room.[522] The Court found that, "in the circumstances, the applicant's wife could not have been expected to resist

[520] *Y.F. v. Turkey*, Application no. 24209/94 (2003).
[521] Case, para. 12.
[522] Case, para. 34.

submitting to such an examination in view of her vulnerability at the hands of the authorities that exercised complete control over her".[523]

The Court further evaluated whether the gynaecological examination had been prescribed by law and whether such an examination was necessary in a democratic society. It concluded that the Turkish Government neither demonstrated the existence of a medical necessity or the circumstances defined by law nor did they suggest that the public prosecutor had made a request for a medical examination.[524] The Strasbourg Court added that although it "accepts the Government's submission that the medical examination of detainees by a forensic doctor can prove to be a significant safeguard against false accusations of sexual molestation or ill-treatment", it simultaneously considered that "any interference with a person's physical integrity must be prescribed by law and requires the consent of that person" as otherwise, a person in a vulnerable situation, such as a detainee, would be "deprived of legal guarantees against arbitrary acts". [525] Thus, as there was no domestic law prescribing the gynaecological examination at the time of Mrs. F's detention there had been a violation of Article 8 (right to privacy).[526]

Devrim Turan v. Turkey

In *Devrim Turan v. Turkey* the applicant was Devrim Turan.[527] In May 1999, she had been taken into police custody on suspicion of membership of an illegal organisation. Before her interrogation by the anti-terrorism branch of a regional security directorate, Turan was taken to a maternal hospital for a gynaecological examination. As she had not given her consent, she did not undergo a gynaecological examination. Turan was then taken to a hospital for a rectal examination, but this, too, was not performed since expressed her refusal. A week later, upon her release from the custody, she was again taken to the maternal hospital for a gynaecological examination and a rectal examination. As Turan did not consent, neither examination was performed. [528]

Turan submitted to the ECtHR that taking her to the hospital twice for a gynaecological examination constituted degrading treatment under Article 3. The Court noted that although "being taken to the hospital for a gynaecological examination might have caused distress to the applicant" the medical examinations of detainees by a forensic doctor

[523] Case, para. 34.
[524] Case, para. 43.
[525] Case, para. 43.
[526] Case, paras. 43-44.
[527] *Devrim Turan v. Turkey*, Application no. 879/02 (2006).
[528] Case, paras. 5-7.

"can prove to be a significant safeguard against false accusations of sexual molestations or ill-treatment".[529] Further, the Court argued how "when the applicant refused to undergo a gynaecological examination, no force was used against her and the doctors refrained from performing the said examination".[530] The ECtHR concluded that the "sole fact the applicant was taken to the hospital for a gynaecological examination on the first and last days of her arrest does not attain the minimum level of severity which amounts to degrading treatment".[531] Consequently, the Court found that "this part of the application must be rejected as being manifestly ill- founded".[532]

Judge Hedigan, joined by Judge David Thor Björgvinsson, has written a partly dissenting opinion to this decision. They first underscore how in its previous case-law the Court has repeatedly held that Article 3 "enshrines on of the most fundamental values of democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances and the victim's behaviour".[533]

They note how the Turkish Government argued that the purpose of the gynaecological examination of female detainees was to avoid false accusations of sexual violence being directed against the security forces, and how it additionally referred to the recommendations set out in the report of the European Committee for the prevention of torture and inhuman or degrading treatment or punishment following its visit to Turkey. Namely, the Turkish Government claimed that this report emphasised how forensic medical examination of detainees by a doctor was a significant safeguard against sexual violence, and thus it connected this to the practice of sending female detainees for gynaecological examination.[534] The dissent noted that the report deals with the medical examination of persons in custody and welcomes the provision that detainees should be medically examined at the beginning and end of police custody. But the dissenting judges maintained that the Turkish Government

[529] Case, para. 20.
[530] Case, para. 20.
[531] Case, para. 21.
[532] Case, para. 22. The Court also analysed other parts of Turan's submission. Namely, Turan submitted that during her detention she was *being stripped naked, threatened with rape, beaten, hosed with cold water, subjected to electric shocks and hung by her arms*. The Court provided that "a number of elements in the case raise doubts as to whether the applicant suffered treatment prohibited by Article 3 when she was detained in police custody" and found that "the medical report prepared at the Tokat State Hospital revealed no traces of ill-treatment on her body". Thus as "the applicant has adduced no material which could call into question the findings in that later report and add probative weight to her allegations" and the evidence before the Court "does not enable it to find beyond all reasonable doubt that the applicant was subjected to ill-treatment", the Court did not it proven that there has been a violation of the substantive aspect of Article 3 (paras. 36-42). What appears here is the Strasbourg Court's narrow idea of what is degrading treatment– as stated before in this thesis, degrading treatment can leave no physical marks – espacially gendered degrading treatment against women.
[533] Partly Dissenting Opinion of Judge Hedigan joined by Judge David Thor Björgvinsson, para. 6.
[534] Partly Dissenting Opinion of Judge Hedigan joined by Judge David Thor Björgvinsson, paras. 10-11.

had relied on the narrow ground that such medical examinations of detainees were for the purpose of avoiding false accusations of sexual harassment against the police ("*Nowhere in this report have I found any recommendation made concerning the gynaecological examination of female detainees*."). [535]

They dissenting judges further disagree with the majority's conclusion that merely taking Turan to the hospital where she was able to refuse from the examination does not amount to degrading treatment. Instead Judge Hedigan and Judge Björgvinsson underscore that it is important to "reflect upon the vulnerability of any female detainee in such situation" as "in custody, brought to a hospital, it is easy to imagine how even the strongest person's will might be overborne and consent formally given to that which is entirely repugnant to her".[536] They continue explaining how such examination "may also result in the revelation of a woman's sexual history or, at the very least, information about her sexual status which is a matter of the most intimate nature" and how "such information in the hands of detaining authorities seems entirely inappropriate".[537] They conclude that nothing supports the proposition that female detainees may be sent for a gynaecological examination as a "safeguard against false accusations of sexual molestation" as argued by the Government. Hedigan and Björgvinsson underscore:

> *It may well be that a useful purpose could be served by such examination but only where there are procedural safeguards in place to ensure that any consent given is given in circumstances that are demonstrably free of any coercion, intimidation or fear and where the results of such examination remain confidential to the detainee and the medical doctor involved.*[538]

In conclusion, they argue that there had been a violation of Article 3 as "such examination was subjected to treatment that was degrading because it was such as to arouse feelings of fear, anguish and inferiority capable of humiliating and debasing her".[539]

Juhnke v. Turkey

In *Juhnke v. Turkey*, the applicant was a German national Eva Tatjana Ursula Juhnke.[540] In 1997, she was arrested under the suspicion of having links to the PKK. An

[535] Partly Dissenting Opinion of Judge Hedigan joined by Judge David Thor Björgvinsson, para. 11.
[536] Partly Dissenting Opinion of Judge Hedigan joined by Judge David Thor Björgvinsson, para. 13.
[537] Case, para. 13.
[538] Dissenting opinion, para. 15.
[539] Dissenting opinion, para. 16.

obstetrician examined Juhnke and performed a gynaecological examination. The doctor's report described Juhnke as aggressive and presenting signs of depression. The report also dealt with whether or not she was a "virgin". She did not consent freely to the examination and submitted to the ECtHR that "the examination had been performed by a male doctor during which the gendarmes took her clothes off, made her lie down and touched every part of her body". Thus, Juhnke argued that there had been violations of Article 3 and Article 8.[541]

The Turkish Government communicated that the gynaecological examination was necessary to prevent accusations of rape.[542] The Court reiterated how "the mere fact of being taken to a hospital for a gynaecological examination does not attain the required minimum level of severity within the meaning of Article 3".[543] Further, when analysing Article 3 violation, the Court found "the applicant's allegations as regards the forced nature of the gynaecological examination unsubstantiated" and additionally there was no "prima facie evidence to support the applicant's version of facts regarding the manner in which she was examined".[544] The Court also noted that they did not find from the material presented to them that Juhnke's denial of the examination was overridden.[545] Thus the ECtHR concluded that "the facts of the case do not disclose a breach of Article 3".[546]

However, the Court did find that "the applicant had resisted a gynaecological examination until persuaded to agree to it", and emphasised that in certain circumstances "a person in detention cannot be expected to continue to resist submitting to a gynaecological examination, given her vulnerability at the hands of the authorities, who exercise complete control over her".[547] The Court did, however, find that as the gynaecological examination was imposed on the applicant without her free and informed consent and the Government did not show how the examination had been "in accordance with the law'" or "necessary in a democratic society" there had been a violation of the applicant's right to privacy (Article 8).[548]

The decision also had a dissent written by Judge David Thor Björgvinsson and Judge Garlicki.[549] The dissenting judges criticised that there had been no medical need for the

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[540] *Juhnke v. Turkey*, Application no. 52515/99 (2008).
[541] Case, para. 57.
[542] Case, para. 61.
[543] Case, para. 70.
[544] Case, para. 75.
[545] Case, para. 75.
[546] Case, para. 75.
[547] Case, para. 76.
[548] Case para. 82.
[549] Partly Dissenting Opinion of Judge David Thor Björgvinsson joined by Judge Garlicki.

examination, and "even assuming that there may be situations in which a gynaecological examination without free and informed consent may be justified, no such situation was present" in Juhnke's case.[550] Instead the Turkish Government had explained that submitting Juhnke to the examination was to protect the state from "possible allegations of rape or other sexual harassment or abuse".[551] The dissent argues that the level of severity required by Article 3 had been reached since: "a gynaecological examination in such situations gives rise to feelings of inferiority and degradation" and "the kind of treatment the applicant was subjected to (…) was degrading, and as such, aroused feelings of fear, aguish and inferiority capable of humiliating and debasing her".[552]

Yazgül Yilmaz v. Turkey

In *Yazgül Yilmaz v. Turkey*, the applicant was arrested and taken to a doctor without her consent for a gynaecological examination in order to check if her hymen was still intact.[553] In this case the Court found that the severity threshold of degrading treatment of Article 3 had indeed been met and thus the prohibition of degrading treatment under the Convention had been violated. It appears from the Court's analysis that the applicant's age, *i.e*. her being a minor, was relevant to the Court in qualifying this specific forced gynaecological examination as an Article 3 violation.[554]

Salmanoğlu and Polattas v. Turkey

This case concerned Nazime Ceren Salmanoğlu and Fatma Deniz Polattas.[555] Salmanoğlu had been taken into police custody on suspicion of membership of the Worker's Party of Kurdistan (PKK), which was deemed an illegal organisation in Turkey. On the same day as her arrest, she was taken to the hospital at the request of the anti-terrorist branch of the police headquarters to establish her "virginity status and determine whether she had had recent sexual relations".[556] The medical expert who conducted the examination concluded that Salmanoğlu "was still a virgin and had not had recent sexual relations".[557]

[550] Partly Dissenting Opinion of Judge David Thor Björgvinsson joined by Judge Garlicki.
[551] Partly Dissenting Opinion of Judge David Thor Björgvinsson joined by Judge Garlicki.
[552] Partly Dissenting Opinion of Judge David Thor Björgvinsson joined by Judge Garlicki.
[553] *Yazgül Yilmaz v. Turkey*, Application no. 36369/06 (2011).
[554] Case, paras. 47-48, 54.
[555] *Salmanoğlu and Polattas v. Turkey*, Application no. 15828/03 (2009).
[556] Case, paras. 5-7.
[557] Case, para. 7.

Fatma Deniz Polattas was also arrested in the context of a police operation conducted against the PKK. On the day of her arrest also she (similarly to Salmanoğlu) was taken to the hospital after the request of the anti-terrorist branch of the police headquarters to establish her "virginity status and determine whether she had had recent sexual relations". A doctor examined her and informed the police that Polattas "was a virgin and had not had recent sexual relations".[558] The applicants additionally argued that they had been subjected to ill-treatment and abuse during their detention, and thus submitted that there had been a violation of Article 3.

Among other things the Court also analysed the virginity tests to what Salmanoğlu and Polattas had been subjected to. The ECtHR first noted that the Government did not show that these examinations "were based on and were in compliance with any statutory or other legal requirement". Furthermore, no evidence of any written consents were submitted to the Court. The ECtHR continued:

> *Nevertheless, even assuming that the applicants' consent was valid, the Court considers that there could be no medical or legal necessity justifying such an intrusive examination on that occasion as the applicants had yet not complained of sexual assault when the tests were conducted. The tests in themselves may therefore have constituted discriminatory and degrading treatment.*[559]

In conclusion, the Court established that there had been a breach of Article 3. Salmanoğlu and Polattas also submitted that subjecting them to gynaecological examinations constituted discrimination on the basis of their sex – thus, a violation of Article 14. The Court, however, established that since it found a violation of Article 3, "there is no need to make a separate ruling under this head".[560]

The decision comes with a dissenting opinion by Judges Sajo, Tsotsoria and Karakas. They first held that they found the "application of the virginity test troubling, bordering on degrading treatment", but they also noted how "the medical examination of persons in police custody constitutes one of the essential safeguards against ill-treatment". Judges Sajo, Tsotsoria and Karakas continued to confirm that a female detainee "may not be compelled or subjected to pressure to undergo such an examination against her wishes". They also argue that in the case of Salmanoğlu and Polattas "it seems that the applicants had a genuine

[558] Case, para. 9.
[559] Case, para. 88.
[560] Case, paras. 104-105.

opportunity to refuse undergo the examination as, the second time they were asked, they were able to refuse it without difficulty", and there was no evidence of their refusal to the first examination. The dissenting judges conclude:

> *For reasons of legal certainty, we find the requirement of written consent indispensable, and we would welcome an exception to the general rule regarding medical examinations. At least, very young people should not have to undergo such tests as the humiliation is virtually inevitable while the protection against ill-treatment resulting from such tests is limited, given the possibility of alternative forms of sexual abuse.*[561]

4.3.2 A case concerning Women's sexuality and age from the European Court of Human Rights

Carvalho Pinto de Sousa Morais v. Portugal

This case, decided in 2017, concerned Ms Maria Ivone Carvalho Pinto de Sousa Morais.[562] She was born in 1945 and in 1993 she was diagnosed with a gynaecological disease that required a surgery. She had the surgery in 1995 and the glands on both sides of her vagina were removed. After the surgery, she started experiencing intense pain and loss of sensation in her vagina. De Sousa Morais found out that her pudendal nerve had been injured during the operation. She was awarded damages, but in 2014 the Supreme Administrative Court reduced the non-pecuniary damage and stated *inter alia*: "Additionally, it should not be forgotten that at the time of the operation the plaintiff was already 50 years old and had children, that is, an age when sex is not as important as in younger years, its significance diminishing with age".[563]

De Sousa Morais submitted to the European Court of Human Rights that this judgment had discriminated against her on the grounds of her sex and age and relied on Articles 8 and 14 of the Convention.[564] She emphasised that the Supreme Administrative Court had clearly discriminated against her based on an assumption and "by disregarding her right to a sex life [it] had breached one of the most basic principles of human dignity and had violated Articles 8 and 14 of the Convention".[565] The Government responded that "reading

[561] Partly Dissenting Opinion of Judges Sajo, Tsotsoria and Karakas.
[562] *Carvalho Pinto de Sousa Morais v. Portugal,* Application no. 17484/15 (2017).
[563] Case, para. 16.
[564] Case, para. 30.
[565] Case, para. 40.

the impugned passage in the Supreme Administrative Court's judgment out of context could indicate prejudice and a belittling of the applicant's suffering, in particular because of her age" and how there had been "an unfortunate use of terms".[566]

The Court first set out how "references to traditions, general assumptions or prevailing social attitudes in a particular country are insufficient justification for a difference in treatment on the grounds of sex".[567] The Court stated: "The question at issue here is not considerations of age or sex as such, but rather the assumption that sexuality is not as important for a fifty-year-old woman and mother of two children as for someone of a younger age" and argued how "That assumption reflects a traditional idea of female sexuality as being essentially linked to child-bearing purposes and ignores its physical and psychological relevance for the self-fulfillment of women as people".[568] The Court rejected the Government's claim that it was "an unfortunate turn of phrase", and highlighted how the applicant's "age and sex appear to have decisive factors in the final decision, introducing a difference of treatment based on those grounds".[569] The Court continued that in its view "those considerations show the prejudices prevailing in the judiciary in Portugal".[570] Thus, it concluded that Portugal had violated Article 14 taken in conjunction with Article 8.[571]

The judgment has two concurring opinions and one dissenting opinion. Judge Yudkivska explains that although "there is a great temptation to believe that all of these millennia-old social stereotypes, persistent ideas and practices are nowadays just 'water under the bridge' at least in Europe" the unfortunate reality is that they are not, and the Portuguese court had "in the best patriarchal traditions, connected the woman's sexual life with procreation".[572] Yudkivska also points out that although at first it could be argued that the decision "presents a somewhat novel approach to discrimination cases", a closer look suggests that "it merely addresses the reality – the more equality is provided for by law, the subtle gender discrimination becomes, precisely because stereotypes about the 'traditional' roles of men and women are so deeply rooted".[573] Yudkivska refers to S. Cusack's work cited throughout this thesis and criticises that the judiciary is failing at their role if they "facilitate the perpetuation of stereotypes by failing to challenge stereotyping".[574] Yudkivska also points

[566] Case, para. 42.
[567] Case, para. 46.
[568] Case, para. 52.
[569] Case, para. 53.
[570] Case, para. 53.
[571] Case, para. 55.
[572] Concurring Opinion of Judge Yudkisvka.
[573] Concurring Opinion of Judge Yudkisvka.
[574] Concurring Opinion of Judge Yudkisvka.

out how in this case "a long list of similar cases for comparison to find discrimination" was not needed as "the language of the judgment [of the Portuguese court was] discriminatory in and of itself".[575] Yudkivska concludes:

> "*The rejection of women's sexuality can take very subtle forms (...) but in the extreme it may transform into the most inhuman forms, such as a failure to condemn a rape or performing FGM. Prejudice, passed down through millennia, is a heavy burden that threatens both the present and the future. It must therefore be prevented in the strongest possible manner"*.[576]

Judge Yudkivska's line of reasoning is supported by the second concurring opinion, by Judge Motoc. Judge Motoc notes that "addressing stereotypes can be seen as a way of achieving transformative equality", and the ECtHR as "a human rights court can and should also address the deep roots of discrimination".[577] Judge Motoc explains how: "Stereotypes affect the autonomy of groups and individuals. For the disadvantage test it is enough to prove that the stereotypes are harmful to the group to which the applicant belongs and that the rule or practice applied by the State is based on such stereotypes".[578]

The dissent by Judges Ravarani and Bošnjak argues that "the comparative exercise is both delicate and potentially decisive" and "the choice of the comparator will often change the outcome of the case".[579] Judges Ravarani and Bošnjak explain their position: "It is important to note, in this context, that the applicant cannot dictate the scope of the comparability exercise; this is a legal issue that the judge has to deal with and he has to take 'into account the elements that characterise their circumstances in the particular context' and 'in the light of the subject-matter and purpose of the measure which makes the distinction in question". [580] The dissenting judges accept that he ECtHR has sometimes used the stereotypes-based analysis.[581]The dissent criticises the majority for not having used the comparator-based methodology and reject the stereotype-based analysis as the Portuguese Court also referred to the applicant's pre-surgery health complications and the dissenting judges felt that "it is impossible to second-guess to what extent the age factor concretely

[575] Concurring Opinion of Judge Yudkisvka.
[576] Concurring Opinion of Judge Yudkisvka.
[577] Concurring Opinion of Judge Motoc, paras. 4-5.
[578] Concurring Opinion of Judge Motoc, para. 18.
[579] Joint Dissenting Opinion of Judges Ravarani and Bošnjak, para. 9.
[580] Joint Dissenting Opinion of Judges Ravarani and Bošnjak, para. 10.
[581] Joint Dissenting Opinion of Judges Ravarani and Bošnjak, para. 12.

intervened in the assessment".[582] Furthermore, the dissenting judges contended that the case was not about gender at all, but only about age as the Portuguese court had not stated "women's sexual life is less important than that of men".[583] Consequently, the dissent concluded: "A judge who intends to deliver a message on a legal issue of general importance should wait for the right case to do so; otherwise he or she simply engages in politics". [584]

4.4 "WOMEN'S STATUS AND RIGHTS DEPEND ON THEIR VIRGINITY"

Nadera Shalhoub-Kevorkian explains how imposed "virginity tests" further harmful gender patterns through medical systems, and how such tests become "an almost easy mode of oppression".[585] In other words, many harmful practices can be cloaked under the seemingly neutral "science" and "medicine". Although "virginity testing" is a highly medicalised practice, there is no scientific foundation or what could be called "medical relevance" involved: even though "virginity tests" are based on the assumption that a doctor (a gynaecologist-obstetrician) can confirm after examining a woman's sex organs whether she has had sex, in reality this is blatantly false since it is impossible to determine that – even if we define "sexual activeness" through only penetrative vaginal intercourse. "Virginity testing" is rooted in the idea that all women have what is termed "hymen" – an embryological remnant that breaks during the first vaginal penetrative intercourse, and thus a virgin must bleed when she has sex for the first time. However, first of all, not all women have the "hymen" as the remnant might rupture during the later stage of embryo development, and thus does not exist after birth.[586] Secondly, even if there is such remnant, it might not be torn as a result of a penetrative vaginal intercourse as the vaginal orifice is elastic, which in turn means that even if a woman has not been sexually active she might not "bleed" after the first vaginal intercourse.[587]

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[582] Joint Dissenting Opinion of Judges Ravarani and Bošnjak, para. 35.
[583] Joint Dissenting Opinion of Judges Ravarani and Bošnjak, para. 37.
[584] Joint Dissenting Opinion of Judges Ravarani and Bošnjak, para. 38.
[585] N. Shalhoub-Kevorkian, "Imposition of virginity testing: a life-saver or a license to kill?", *Social Science & Medicine*, Vol. 60, Issue 6 (2005), p. 1995.
[586] Hanna Cinthio's research in contemporary Sweden demonstrates that the imagination of the "popping cherry" is widespread as many students are "flabbergasted when confronted with the rather undramatic truth of the matter" that there is no lid-like membrane covering the vaginal opening, but that the opening is encircled by elastic folds of mucous tissue, individually shaped in every female and that a majority of women do not bleed during their first vaginal intercourse. See: H. Cinthio, "'You go home and tell that to my dad!' Conflicting Claims and Understandings on Hymen and Virginity", *Sexuality and Culture,* Vol. 19, No. 1 (2015), pp. 173-174.
[587] See for example: R. J. Cook, B. M. Dickens, M. F. Fathalla, "Hymen Reconstruction", in: *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law* (2003), p. 298; R. J. Cook and B. M. Dickens, "Hymen reconstruction: Ethical and legal issues", *International Journal of Gynecology and Obstetrics*, Vol. 107, Issue 3 (2009); B. Essen *et al*, "The experience and responses of Swedish health professionals to

Nonetheless, a woman's "virginity" is framed as an issue of protection, and thus its protection expands from the family to the collective patriarchal system –as Nadera Shalhoub-Kevorkian explains how the "social anxiety over women's virginity as manifested through their hymen, accompanied by the unchanging needs of patriarchy to continually secure its power" results in the creation and ritualisation of many gender oppressive practices, and such "patriarchal practices relativize women's value by looking at her through the rubics of purity and contamination,".[588]

The hymen myth and the focus on "virginity" remains unchallenged and has paved the way for "virginity" certificates and hymen "reconstructions" – also termed as the hymen repair, hymenoplasty, hymen construction, hymen re-virgination, or hymenorraphy[589] Monica Christianson and Carola Eriksson call forced virginity examinations and hymen reconstructions gender-based violence that is abusive, cruel, and insulting.[590] Hanna Cinthio explains how doctors issuing the so-called virginity certificates that confirm a woman's virginity can protect women from the violent consequences of the myth, but simultaneously, such certificates "stamped and signed by gynaecologists" become a part of upholding the idea that there is in fact "a hymen which can be checked".[591] Some authors have also taken the position that such certificates can potentially lead to a gradual "devaluation of the entire concept of virginity", and thus decrease women's suffering and increase their agency and

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patients requesting virginity restoration (hymen repair)", *Reproductive Health Matters*, Vol. 18, No. 35 (2010); N. Juth, N. Lynöe, "Zero tolerance against patriarchal norms? A cross-sectional study of Swedish physicians' attitudes towards young females requesting virginity certificates or hymen restoration", *Journal of Medical Ethics*, Vol. 41, Issue 3 (2015).

[588] N. Shalhoub-Kevorkian, "Imposition of virginity testing: a life-saver or a license to kill?", *Social Science & Medicine,* Vol. 60, Issue 6 (2005), p. 1190.

[589] M. Christianson, C. Eriksson, "Promoting women's human rights: A qualitative analysis of midwives' perceptions about virginity control and hymen 'reconstruction'", *The European Journal of Contraception and Reproductive Health Care*, Vol. 20, Issue 3 (2015), p. 182. Hanna Cinthio writes, how there are different versions of these procedures. For example it can mean that a doctor just uses dissolvable stitches to "suture back the edges of the hymen", or if that is not possible, "a new hymen can be created either using a flap of the vaginal lining, complete with its blood supply, or through an incision in the vaginal membrane where both sides are pulled and stitched together". However, she refers to studies that show how the majority of women do not bleed during the first vaginal intercourse even after undergoing the reconstructive surgery. Nevertheless, the myth of hymen is so powerful that also women who have not been sexually active get such surgeries. (H. Cinthio, "'You go home and tell that to my dad!' Conflicting Claims and Understandings on Hymen and Virginity", *Sexuality and Culture,* Vol. 19, No. 1 (2015), pp. 173-174). See further: B. van Moorst *et al*., "Backgrounds of women applying for hymen reconstruction, the effect of counselling on myths and misunderstandings about virginity, and the results of hymen reconstruction", *The European Journal of Contraception and Reproductive Health Care*, Vol. 17, Issue 2, (2012).

[590] M. Christianson, C. Eriksson, "Acts of violence: Virginity control and hymen (re)construction", *British Journal of Midwifery,* Vol. 22, No. 5 (2014), p. 349.

[591] H. Cinthio, "'You go home and tell that to my dad!' Conflicting Claims and Understandings on Hymen and Virginity", *Sexuality and Culture,* Vol. 19, No.1 (2015), p. 174.

authorship.[592] Dilek Cindoglu remains critical of physicians rationalising the constructive surgeries as being supportive of women: she argues that such "pseudo-feminist attitude" is a clear manifestation of liberal gender ideology, which allows women to enjoy sexuality within the patriarchal expectations.[593] She argues that even if these surgeries can be seen as "survival strategies" for women who are living in patriarchal gender ideologies, medicine plays a significant role in controlling women's bodies and the "alliance between patriarchy and medicine exists as long as virginity tests and reconstructive surgery exist".[594] Nadera Shalhoub-Kevorkian emphasises how although the practices such as hymen constructions reinstate daily oppressions of women, they can also become "nothing short of a life or death matter" as they can save women from harsh punishments, thus, she calls for "more elastic feminism that takes into account the specificities of 'contexts', without incorporating that term into an orientalist, progressive/regressive, us/them binary".[595]

Sara Johnsdotter and Birgitta Essen discuss another crucial dimension– the politics of genital modifications that showcases the need for intersectional feminist approaches.[596] They draw links between attitudes toward, on the one hand, genital cosmetic surgeries (e.g they name: reduction of the inner labia, vaginal tightening, hymen reconstruction, clitoral "lifts", liposuction), and, on the other hand, "traditional" female genital cutting, and argue that although essentially these are very similar, Western societies respond differently – allowing one, but criminalising the other.[597]

From the five European Court of Human Rights cases against Turkey it is evident how stereotypes about women and their sexuality can influence women's treatment during criminal detention. More often than not, this was, however, unfortunately not pointed out by the Strasbourg Court. An exception to this pattern is the *Carvalho Pinto de Sousa Morais* case, where the European Court of Human Rights explicitly stated that the assumption that sexuality is not as important for a fifty-year-old woman reflects a traditional idea of female

[592] H. Cinthio, "'You go home and tell that to my dad!' Conflicting Claims and Understandings on Hymen and Virginity", *Sexuality and Culture*, Vol. 19, No. 1 (2015), p. 175. Referring to the works of N. Pekgul (in Swedish, 2008) and I. Goksel (2012).
[593] D. Cindoglu, "Virginity tests and artificial virginity in modern Turkish medicine", *Women's Studies International Forum*, Vol. 20, No. 2 (1997), p. 259.
[594] D. Cindoglu, "Virginity tests and artificial virginity in modern Turkish medicine", *Women's Studies International Forum*, Vol. 20, No. 2 (1997), p. 260.
[595] N. Shalhoub-Kevorkian, "Imposition of virginity testing: a life-saver or a license to kill?", *Social Science & Medicine,* Vol. 60, Issue 6 (2005), p. 1190.
[596] S. Johnsdotter, B. Essen, "Genitals and ethnicity: the politics of genital modifications", *Reproductive Health Matters*, Vol. 18, Issue 35 (2010). See also: A. Shahvisi, "Why UK doctors should be troubled by female genital mutilation legislation", *Clinical Ethics*, Vol. 12, Issue 2 (2017).
[597] S. Johnsdotter, B. Essen, "Genitals and ethnicity: the politics of genital modifications", *Reproductive Health Matters*, Vol. 18, Issue 35 (2010).

sexuality as being essentially linked to child-bearing purposes and ignores its physical and psychological relevance for the self-fulfillment of women as people".

Maria Sjöholm importantly notes that the exclusiveness of female victims in the "virginity testing" cases is less a result of physiological differences and more deeply rooted in a stereotype according to which women file false claims of rape.[598] I agree with Sjöholm when she points out that the Court does not find "virginity" tests without a legitimate aim, and how the Court's judgments are notably genderless: "By not highlighting the gender stereotypes upheld through the performance of such tests, the Court does little in dismantling them".[599] Sjöholm's work also showcases unfortunately that leaving harmful stereotypes about women's sexuality untouched is characteristic also to ECtHR's jurisprudence beyond cases concerning reproduction.[600] This unfortunate, but persistent resistance is also demonstrated in the otherwise applaudable *Carvalho Pinto de Sousa Morais* case where the dissenting judges concluded that the case was indeed *not* about gender and consequently criticised the majority: "A judge who intends to deliver a message on a legal issue of general importance should wait for the right case to do so; otherwise he or she simply engages in politics".

Similar unscientific myths about women's bodies (including their sexuality and reproductive systems) are apparent in other reproductive rights issues as I demonstrated previously in this thesis: the "virginity" ideal is connected to the "normative motherhood stereotype" discussed in Chapter 3. Namely, both of these speak of the failure to construct women as "sexual agents" – as human beings who could express themselves through sexual relations, who would want to enjoy sex outside of hetero-normative marriage or/and procreative sex. Instead, women are seen as "reproductive agents" – although using the word "agent" is actually misleading as it suggests *agency* (autonomy), which, however, women *also* lack in their reproduction decisions. As Hanna Cinthio's research demonstrates how female sexuality is treated as something women "give away" like gifts to other people – "something you do to please another, and not as something existing in its own right, and for

[598] M. Sjöholm, *Gender-Sensitive Norm Interpretation by Regional Human Rights Law Systems* (2017), p. 362. See also S. Cusack, A. S. H. Timmer, "Gender Stereotyping in Rape Cases: The CEDAW Committee's Decision in Vertido v The Philippines", *Human Rights Law Review*, Vol. 11, Issue 2 (2011), where the authors show how the stereotype "women are inherently untruthful and thus likely to fabricate allegations of rape" influences rape cases.
[599] M. Sjöholm, *Gender-Sensitive Norm Interpretation by Regional Human Rights Law Systems* (2017), pp. 375-376.
[600] See Chapter 6 on sexual violence in: M. Sjöholm, *Gender-Sensitive Norm Interpretation by Regional Human Rights Law Systems* (2017).

your own sake", and accordingly, Cinthio's interviewees described men as sexual subjects while for women "sex was thought to cause problems rather than pleasure".[601]

4.5 PUNISHING AND DISCIPLINING WOMEN WITH FORCED STERILISATIONS

In this part I introduce case-law concerning forced sterilisations of women. I look at forced sterilisation in the wider context of violence narratives impacting women's lives, as forced sterilisation is a form of reproductive violence, which in turn is part of gender-based violence against women and girls. The outrageous, but nevertheless persistent idea of how violence that happens in a "private" setting (for example at home, between partners/spouses, at a workplace between colleagues) does not concern (human rights) law is very familiar to feminist scholarship and women's rights advocates as I also showed above – it is only recently that courts, legislators and policy makers have recognised the imbalances of power in, and gendered nature of domestic violence for example. There is a parallel between domestic violence and different forms of reproductive violence that women can be subjected to in medical settings – just like domestic spaces (homes), hospitals, clinics and health centres are also *closed spaces* (guarded with the confidentiality requirement) with very clear power imbalances between the medical staff (also between doctors, nurses and staff members themselves), and patients. These power imbalances become even more significant when a woman is marginalised for, in addition to her gender, her race, disability, ethnicity, sexual orientation, age, religion, or passport status.

As I explained in Chapter 3 with maternal mortality and in subsection 4.2.2 above with the iceberg-analogy, forced sterilisations are an end-result of unchallenged negative stereotypes and systematic mistreatment of women in medical settings. In simple terms – the victims of forced sterilisations were set up for such degrading treatment through structural de-humanisation.

There is a lot of evidence of how structural injustices affect people negatively in medical settings. Diane E. Hoffmann and Anita J. Tarzian wrote in their ground-breaking article in 2001 about the bias against women in the treatment of pain, and how "female patients were more often perceived as anxious rather than in pain" (thus often receiving sedatives instead of painkillers), or how female patients "experience disbelief or other

[601] H. Cinthio, "'You go home and tell that to my dad!' Conflicting Claims and Understandings on Hymen and Virginity", *Sexuality and Culture,* Vol. 19, No. 1 (2015), p. 182.

obstacles at their initial encounters with health-care providers".[602] Consequently, women who seek help are less likely than men to be taken seriously when they report pain and are also less likely to have their pain adequately treated.[603] Hoffman and Tarzian refer to Gillian Bendelow who has suggested that women are often thought to be equipped with a natural capacity to endure pain because of their reproductive functioning.[604]

Hoffmann and Tarzian add that the Western medical model overemphasises objective, biological indicators of pain, and underacknowledges women's subjective, experiential reports, and Eva E. Johansson *et al* expand this by explaining how "although pain is the experience of the sufferer the voice of the subject is often lost".[605] In other words, there is no room for women's voices and lived experiences – just as in human rights law analysis that turns a blind eye to structural injustices and stereotypes. Thus, as Dayna Bowen Matthew suggests, structural injustices require adequate responses that tackle existing power systems: "only changes to the overarching environment and social system itself will interrupt the flow of messages that inform the stereotypes, class stratification, and unequal power distribution that distort the interaction between physicians and patients".[606]

It is important to note that gender is only one determinant causing the described biases, race and religion have the same effects.[607] For example, Vania Smith-Oka draws from the works of many scholars and writes about micro-aggressions that are "subtle insults and demeaning behavior typically aimed at people of color (or […] to "problematic others" […]) that reflect and enforce the perpetrators' perceptions of their superiority".[608] Furthermore,

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[602] D.E. Hoffmann, A.J. Tarzian, "The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain", *The Journal of Law, Medicine & Ethics*, Vol. 29 (2001), p. 17.

[603] D.E. Hoffmann and A.J. Tarzian, "The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain", *The Journal of Law, Medicine & Ethics*, Vol. 29 (2001), p. 19 referring to the research of C. Miaskowski in footnote 45.

[604] D.E. Hoffmann and A.J. Tarzian, "The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain", *The Journal of Law, Medicine & Ethics*, Vol. 29 (2001), p. 19 referring to G. Bendelow's work in footnote 32. Bendelow has explained that "the perceived superiority of capacities of endurance is double-edged for women – the assumption that they may be able to 'cope' better may lead to the expectation that they can put up with more pain, that their pain does not need to be taken so seriously".

[605] D.E. Hoffmann and A.J. Tarzian, "The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain", *The Journal of Law, Medicine &* Ethic, Vol. 29 (2001), p. 20; E. E. Johansson *et al*, "The meanings of pain: an exploration of women's descriptions of symptoms" *Social Science & Medicine*, Vol. 48, Issue 12 (1999), p. 1792.

[606] D. Bowen Matthew, "Toward a Structural Theory of Implicit Racial and Ethnic Bias in Health Care", *Health Matrix*, Vol. 25 (2015), p.76.

[607] See further e.g.: K. Lutfey Spencer & M. Grace, "Social Foundations of Health Care Inequality and Treatment Bias", *Annual Review of Sociology*, Vol. 42 (2016), E.N. Chapman *et al*, "Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities", *Journal of General Internal Medicine* Vol. 28, Issue 11 (2013), R. Tong, "Gender Justice in the Health Care System. An Elusive Goal", in: *Medicine and Social Justice: Essays on the Distribution of Health Care,* R. Rhodes, M. P. Battin, A. Silvers (eds.) (2012).

[608] V. Smith-Oka, "Microaggressions and the reproduction of social inequalities in medical encounters in Mexico", *Social Science & Medicine*, Vol. 143 (2015), p. 9. See further Smith-Oka's work regarding women's

Derald Wing Sue *et al* explain micro-aggressions in the context of race, and how there are three types of micro-aggressions: micro-assaults (overt verbal or nonverbal derogatory actions), microinsults (rude or insensitive interactions) and micro-invalidations (interactions that negate, dismiss, or nullify recipients' responses to micro-aggressions, such as calling them oversensitive).[609] Smith-Oka adds a fourth form: the corporeal micro-aggressions that emerge from "mainstream perceptions of moral superiority and are expressed as violent bodily treatment, such as sterilization efforts that target single mothers".[610] She explains that such violence can occur when unchallenged attitudes towards marginalised groups transform into actions in medical settings: hospitals and clinics can be seen as places where the state attempts to "shape motherhood", and where the constructions of "good" and "bad" mothers, supposed hypersexuality and hyperfertility of low-income women are woven into clinical encounters:

> *When a patient seemed to be ignoring clinicians' orders or she acted in unexpected ways, she was typically perceived as non-cooperative and non-compliance. This perception often seemed to justify not only verbal reprimands but rough physical treatment and interventions that may have had some medical justification but that to an outsider or patient appeared very much like punishment*.[611]

Such microaggressions can lead to what has been termed as obstetric violence (*violencia obstétrica*) in Latin America - the Venezuelan law defines obstetric violence as follows:

> *The appropriation of women's body and reproductive processes by health personnel, which is expressed by dehumanising treatment, abuse of medicalisation, and pathologisation of natural processes resulting in a loss of*

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rights in Mexico: V. Smith-Oka, "'They Don't Know Anything': How Medical Authority Constructs Perceptions of Reproductive Risk among Low-Income Mothers in Mexico", in: *Risk, Reproduction, and Narratives of Experience,* L. Fordyce and A. Maraesa (eds.) (2012).

[609] D. Wing Sue *et al*, "Racial microaggressions in everyday life: Implications for clinical practice", *American Psychologist*, Vol. 62, No. 4 (2007), pp. 271-286. See further on microaggressions and individual responsibility within structural oppression: C. Friedlaender, "On Microaggressions: Cumulative Harm and Individual Responsibility", *Hypatia*, Vol. 33, No. 1 (2018).

[610] V. Smith-Oka, "Microaggressions and the reproduction of social inequalities in medical encounters in Mexico", *Social Science & Medicine*, Vol. 143 (2015), p. 9. Smith-Oka explains that corporeal micro-aggressions connect to the "growing concern with obstetric violence", but says that whereas obstetric violence is rooted within "medical habitus where deep-seated notions of medical hierarchy, status, and gender collude to exert violence upon obstetric patients" the corporeal microaggressions are violent, but differing from obstetric violence, they emerge from "a substrate that moralizes motherhood".

[611] V. Smith-Oka, "Microaggressions and the reproduction of social inequalities in medical encounters in Mexico", *Social Science & Medicine*, Vol. 143 (2015), pp. 10, 14.

autonomy and ability to decide freely about their bodies and sexuality, negatively impacting women's life quality.[612]

The term has also been adopted in Mexico to describe hospital-based obstetric practices that are not just medicalising women's bodies, but are "structural modes of violence" that reflect the "deeper patterns of inequality" – obstetric violence is gendered violence.[613] Rachelle Chadwick notes how choosing the term "obstetric violence" over more neutral labels such as "mistreatment" is part of a "deliberate move to confront problematic practices, which have often been hidden, invisible and unacknowledged, as forms of violence".[614] There are many examples of different forms of obstetric violence: unnecessary episiotomies, performing episiotomies after delivery for the purpose of training, manual revision of women's uterine cavities without pain relief, tying women's legs to the delivery table, but also over-emphasising foetal risk and understating maternal risk or silencing women's dissent, lying to women about the progression of labour, neglecting women as a method of punishment for non-compliance.[615]

Camilla Pickles explains that the term "obstetric violence" is rooted in the notion that the "way birthing women are treated in health-care facilities correlates with their broader unequal social and economic standing and constitutes a form of gender-based violence", and it gives "expression to women's physical experiences of abusive, dehumanising or violent 'care' and to the wrongs suffered by women despite surviving birth and having a live born

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[612] "Ley Organica sobre el derecho de las mujeres a una vida libre de violencia" G. O. (38668 De 23 /4/2007) La Asamblea Nacional De La República Bolivariana De Venezuela
13. *Violencia obstétrica: Se entiende por violencia obstétrica la apropiación del cuerpo y procesos reproductivos de las mujeres por personal de salud, que se expresa en un trato deshumanizador, en un abuso de medicalización y patologización de los procesos naturales, trayendo consigo pérdida de autonomía y capacidad de decidir libremente sobre sus cuerpos y sexualidad, impactando negativamente en la calidad de vida de las mujeres.* See further: R. Pérez D'Gregorio, "Obstetric violence: a new legal term introduced in Venezuela", *International Journal of Gynaecology and* Obstetrics, Vol. 111, Issue 3, (2010).

[613] L. Zacher Dixon, "Obstetrics in a Time of Violence: Mexican Midwives Critique Routine Hospital Practices", *Medical Anthropology Quarterly*, Vol. 29, Issue 4 (2015), p. 438.

[614] R. Chadwick, "Obstetric violence in South Africa", *South African Medical Journal,* Vol. 106, No. 5 (2016), p. 423. Chadwick also suggests that often in the medical literature questions about mistreatment are predominantly framed in relation to "quality-of-care issues and the failure of evidence-based obstetric practice", which consequently leads to an assumption according to which "informing and training practitioners about evidence-based medicine is enough to change practices". She reiterates how abusive treating of women and girls in maternity services reflects the broader societal devaluation of women and girls and the normalisation of violence against them - accordingly she argues that we need to address both the individual – the perpetrator's – level and the structural forms of violence that create the conditions for individual abuse.

[615] See: C. Pickles, "Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa", *South African Crime Quarterly*, No. 54 (2015), p. 7 and endnotes.

child".[616] Michelle Sadler *et al* theorise how obstetric violence can be seen as a "reflection of how female bodies in labour are perceived as potentially opposing femininity – violence is therefore necessary to dominate them, restoring their 'inherent' feminine submission and passivity".[617] Thus, in this context violence is not only accepted, but also reinforced and reproduced.[618] Sara Cohen Shabot and Keshet Korem further stress how gendered shame is one of the most important *mechanisms* of obstetric violence: "Attempting to feminize women's bodies, obstetric violence makes continual use of gendered shame as a (violent) instrument with which to denigrate women for losing femininity or being too sexual or messy. It is performed and perpetuated by shaming women for being bad mothers-to-be and for acting against the myth of altruistic, self-sacrificing motherhood".[619] Cohen Shabot and Korem write that such gendered shame does not only "put women in their place", but it serves as a "resilient tool of oppression effectively promoting silence and depoliticizing experience" since women hide their oppressive experiences, believing themselves to be alone and consequently participating in a "vicious cycle of silence that precludes political struggle or social change".[620]

Pickles discusses responses to obstetric violence in South Africa and argues for a criminal law response, which however, as she adds, does not mean that applying other approaches (e.g human rights-based approach, changes in the health-care system) is mutually exclusive – Pickles recognises how "merely introducing a statutory crime in this context may not bring about a normative change and thus more is needed".[621] Indeed, human rights-based approaches do not support unaccountability, but their emphasis is nevertheless different: human rights-based approaches focus on the question of *why*. For example, *why* do nurses and doctors believe that abusive control and authority are necessary to achieve healthy births and maternal survival, or *why* does a hospital's medical staff feel it is acceptable to

[616] C. Pickles, "Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa", *South African Crime Quarterly*, No. 54 (2015), p. 7.
[617] M. Sadler *et al*, "Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence", *Reproductive Health Matters*, Vol. 24, No. 47 (2016), p. 51.
[618] M. Sadler *et al*, "Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence", *Reproductive Health Matters*, Vol. 24, No. 47 (2016), p. 52.
[619] S. Cohen Shabot, K. Korem, "Domesticating Bodies: The Role of Shame in Obstetric Violence"*, Hypatia*, Vol. 33, No. 3 (2018), p. 387.
[620] S. Cohen Shabot, K. Korem, "Domesticating Bodies: The Role of Shame in Obstetric Violence"*, Hypatia*, Vol. 33, No. 3 (2018), p. 394.
[621] C. Pickles, "Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa", *South African Crime Quarterly*, No. 54 (2015), p. 11.

circumvent a Roma woman's consent, and proceed with sterilisation.[622] To illustrate with the discussed "virginity testing" jurisprudence – these women with links to Kurdish liberation movement should never have been forced to have "virginity" tests not because there was no informed real consent, but because such punitive and disciplining practices are human rights violations *per se*. Thus, as Chadwick writes in her book for which she has recorded women's birth experiences in South Africa: "In order to improve maternity care for women and move beyond unproductive binaries, polarizations and idealizations, we need to begin by listening to what *matters* to women in relation to birth. The politics of birth can only be productively built on the bedrock of (diverse) women's perspectives".[623]

Therefore it is again essential that a human rights law forum analyses power dynamics, explicitly challenges harmful stereotypes and puts women's lived experiences and what they say as serious evidence in the focus of their analysis.

2016	***IV v. Bolivia*** **(Inter.Am.Ct.HR)**	Violations of several articles (e.g degrading treatment), thorough analysis of power/stereotypes/reproductive rights
2013	***IG and Others v. Slovakia*** **(ECtHR)**	Art. 3 violation (degrading treatment), Art. 8 violation (privacy), some analysis of power/stereotypes/reproductive rights, but "*not necessary to separately determine whether the facts of the case also gave rise to breach of Art. 14*"
2012	***V.C. v. Slovakia*** **(ECtHR)**	Art. 3 violation (degrading treatment), Art. 8 violation (privacy), some analysis of power/stereotypes/reproductive rights, but "*not necessary to separately determine whether the facts of the case also gave rise to breach of Art. 14*"
	NB v. Slovakia **(ECtHR)**	Art. 3 violation (degrading treatment), Art. 8 violation (privacy), some analysis of power/stereotypes/reproductive rights, but *"not necessary to separately determine whether the facts of the case also gave rise to breach of Art. 14*"
2009	***K.H. and Others v. Slovakia*** **(ECtHR)**	Art. 8 (privacy) violation, power/stereotypes/reproductive rights not considered
2006	***A.S. v. Hungary*** **(CEDAW Committee)**	Art. 10 (h), Art. 12, Art. 16 violations, power/stereotypes not considered

[622] "Stop making excuses: Accountability for Maternal Health Care in South Africa", *Human Rights Watch*, (2011), available at: https://www.hrw.org/report/2011/08/08/stop-making-excuses/accountability-maternal-health-care-south-africa. (accessed 28 February 2018).
[623] R. Chadwick, *Bodies That Birth: Vitalizing Birth Politics* (2018), p. 171.

4.5.1 Forced sterilisation jurisprudence of the European Court of Human Rights

K.H. and Others v. Slovakia

In the case of *K.H. and Others v. Slovakia* the applicants were eight Slovakian women of Roma ethnic origin.[624] They were treated at gynaecological and obstetrics departments in two hospitals in Slovakia during their pregnancies and deliveries. Despite continuing to attempt to conceive, none of the eight women had become pregnant since their last stay in the hospital when they delivered via Caesarean section. They suspected that the reason for their infertility was that the doctors had performed a sterilisation procedure on them during their delivery. Several applicants had been asked to sign documents prior to their delivery or on discharge from the hospital but they were not sure of the exact content of these documents.

The women submitted that they were unable to obtain photocopies of their medical records and that amounted to a breach of Article 8 of the European Convention on Human Rights. They argued that the "mere possibility of consulting the files and making handwritten excerpts thereof did not provide them with effective access to the relevant documents concerning their health".[625] The applicants explained that without the photocopies they are not able to establish a basis for civil litigation and also "demonstrate to their families and communities (…) that their infertility was not a result of any deliberate action on their part".[626]

The European Court of Human Rights established that the complaint concerned the applicants' "right of effective access to information concerning their health and reproductive status".[627] The Court denied Slovakia's arguments that the refusal to allow photocopies was within the margin of appreciation and rejected the idea of how the aim of the prohibition was information abuse: "the Court does not see how the applicants, who had in any event been given access to the entirety of their medical files, could abuse information concerning their own persons by making photocopies of the relevant documents".[628]

V.C. v. Slovakia

In *V.C. v. Slovakia*, V.C. was a Slovakian woman of Roma ethnic origin.[629] V.C.'s mother tongue was the Roma language, which she used together with a local dialect, as part of her daily communication. On 23 August 2000, V.C. was sterilised at the hospital where

[624] *K.H. and Others v. Slovakia,* Application no. 32881/04) (2009).
[625] Case, paras. 38-39.
[626] Case, para. 39.
[627] Case, para. 44.
[628] Case, para. 54.
[629] *V.C. v. Slovakia*, Application no. 18968/07 (2012).

she had gone to give birth. V.C. gave birth via Caesarean section and her sterilisation entailed tubal litigation by the Pomeroy method, which consists of severing and sealing the Fallopian tubes in order to prevent fertilisation. During her pregnancy V.C. did not have regular check-ups and visited her general practitioner only once. [630] V.C. submitted to the Court that after she had been in labour for several hours and was in pain, the medical staff approached her and asked if she wanted to have more children. V.C. responded "yes", but the medical personnel told her that if she had one more child, either she or the baby would die. V.C. started to cry, and as she was convinced that her next pregnancy would be fatal, she told the doctors "Do what you want to do". She was then asked to sign the delivery record under a note indicating that she is requesting a sterilisation. V.C. did not understand the term "sterilisation", but she signed the form out of her fear for fatal consequences.[631]

The words "Patient is of Roma origin" appeared on V.C.'s medical records folder.[632] During her stay at the hospital, V.C. was accommodated in a room occupied exclusively by women of Roma ethnic origin and she was prevented from using the same bathrooms and toilets as women who were not of Roma origin. V.C. has since been ostracised by the Roma community and her husband left her – V.C. maintained that her infertility was one of the reasons for their separation.[633]

V.C. submitted to the ECtHR that she had not given her free, full and informed consent to the sterilisation, and that the sterilisation had not been a life-saving procedure. The sterilisation had been carried out without considerations for alternative ways of protecting her from the alleged risks linked to a possible future pregnancy. She also maintained that the procedure was to be seen "in the context of the widespread practice of sterilising Roma women which had its origins in the communist regime and in the enduringly hostile attitudes towards persons of Roma ethnic origin".[634] Thus, V.C. submitted to the ECtHR that there had been a violation of Article 3 (prohibition of inhuman and degrading treatment).

The Government rejected this and explained how "the applicant's sterilisation was to be considered in the broader context, namely, with due regard to her health status and her failure to seek the appropriate pre-natal medical care", and how the decision for sterilisation

[630] Case, paras. 8-11.
[631] Case, para. 15.
[632] Case, para. 17.
[633] Case paras. 17, 18, 20.
[634] Case paras. 88-90.

was made after determining that a future pregnancy would present "a real threat to the applicant's life and/or that of her child".[635]

The Court underscored that Article 3 "enshrines one of the most fundamental values of democratic society", and prohibits "in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances and the victim's behaviour".[636] The Court noted: "Sterilisation constitutes a major interference with a person's reproductive health status. As it concerns one of the essential bodily functions of human beings, it bears on manifold aspects of the individual's personal integrity including his or her physical and mental well-being and emotional, spiritual and family life".[637] The Court established that although it is not the Court's role to "review the assessment by medical doctors of the state of health of the applicant's reproductive organs" sterilisation is not generally considered to be a life-saving surgery, and a free informed consent was a prerequisite even "assuming that sterilisation was a 'necessity' from a medical point of view".[638]

Furthermore, the Court argued that the way in which the medical personnel acted was "paternalistic" as V.C. was not "offered any option but to agree to the procedure which the doctors considered appropriate".[639] The Court concluded that since the sterilisation "grossly interfered with the applicant's physical integrity as she was thereby deprived of her reproductive capability", V.C. was only "at an early stage in her reproductive life", and although there was no indication that "the medical staff acted with the intention of ill-treating the applicant" there had been a violation of Article 3.

V.C. also submitted that there had been a violation of Article 8 (right to respect for private and family life). She argued that her infertility was irreversible as "a future *in vitro* fertilisation was not accessible to her for both religious and financial reasons" and that the sterilisation had resulted in the deterioration of her relationship with her husband and "impaired her standing in the Roma community".[640]

The Court found that the "absence (…) of safeguards giving special consideration to the reproductive health of the applicant as a Roma woman resulted in a failure (…) to comply with positive obligation", and thus established that there had been a violation of Article 8. The Government argued that the reference to V.C.'s Roma origin on her medical file "had been necessary as Roma patients frequently neglected social and health care and therefore

[635] Case para. 93.
[636] Case para. 100.
[637] Case para. 106.
[638] Case, para. 110.
[639] Case, para. 114.
[640] Case, para. 134.

requested special attention".[641] The Court rejected it, however, and explained: "Even assuming this to have been the reason for the entry, the reference in the record to the applicant's ethnic origin without further details being given indicates (…) a certain mindset on the part of the medical staff as to the manner in which the medical situation of a Roma woman should be managed".[642]

V.C. submitted that there had been a violation of Article 14 as she had been subjected to racial discrimination and sex discrimination as she had been subjected to a difference in treatment in connection with her pregnancy.[643] The Court, however, found that "the information available is not sufficient to demonstrate in a convincing manner that the doctors acted in bad faith with the intention of ill-treating the applicant" and "notwithstanding the fact that the applicant's sterilisation without her consent calls for serious criticism, the objective evidence is not sufficiently strong in itself to convince the Court that it was part of an organised policy or that the hospital staff's conduct was racially motivated".[644] Thus the Court held that it "was not necessary to separately determine whether the facts of the case also gave rise to breach of Article 14".[645]

The decision comes with a dissenting opinion by Judge Mijovic. She argues that the Government's argument regarding the "special attention" was "totally unacceptable" as according to her the "special attention" was in fact the sterilisation itself. Furthermore, Mijovic found: "Finding violations of Articles 3 and 8 alone (…) reduces this case to the individual level, whereas it is obvious that there was a general State policy of sterilisation of Roma women under the communist regime (…), the effects of which continued to be felt (…)."[646]Judge Mijovic concluded that the sterilisations were not "of an accidental nature", but V.C. was "marked out" because of her origin, and this represented "the strongest form of discrimination and should have led to a finding of a violation of article 14 in connection with the violations found of Articles 3 and 8".[647]

[641] Case, para. 151.
[642] Case, para. 151.
[643] Case, para. 171.
[644] Case, para. 177.
[645] Case, para. 180.
[646] Dissenting Opinion of Judge Mijovic.
[647] Dissenting Opinion of Judge Mijovic.

N.B. v. Slovakia

In the case of *N.B. v. Slovakia,* N.B. was a woman of Roma ethnic origin who was sterilised during the delivery of her second child by means of tubal ligation at the hospital. [648] At the time of her delivery, N.B. was underage and her legal guardian was not present. N.B. submitted that after she arrived at the hospital the doctors gave premedication in view of the envisaged Caesarean section. She was then approached by a member of the medical staff who was carrying papers, and who had taken the applicant's hand to sign the papers. N.B. was in labour and did not have the strength or the will to ask what the documents contained.

N.B. said that a doctor had told her that she would die unless she signed the papers. N.B.'s medical records also revealed that during the surgery the doctors discovered a rupture of her uterus and "since the applicant's uterus was severely damaged, it had been considered certain that a similar situation would occur in any future pregnancy and would pose a grave risk to the life of the applicant and her foetus". [649]

N.B. learned about her sterilisation in December 2002. She described that she had experienced inferior treatment during her stay at the hospital: in particular she indicated that patients in the gynaecological and obstetrics ward had been segregated according to their ethnic origin – N.B. had been accommodated in a "Gypsy room" –, separated from women who were not of Roma ethnic origin.[650]

N.B. submitted that she had been subjected to inhuman and degrading treatment – a violation of Article 3. The Slovakian Government submitted that the sterilisation had been carried out because there was a serious damage to N.B.'s uterus, she had given her consent and it was ex post approved by the committee. The Government maintained that N.B. had not been submitted to treatment contrary to Article 3 as "the doctors had acted with the intention of protecting her life and health, as well as the life of her child" and "had the doctors deliberately wished to deprive the applicant of her reproductive capacity, they would have carried out a hysterectomy which (…) would have been considered as a life-saving intervention given the state of the applicant's reproductive organs". [651]

The Court established that N.B.'s sterilisation had not been a life-saving medical intervention and that it had been carried out without her informed consent, i.e "the procedure was therefore incompatible with the requirement of respect for the applicant's human

[648] *N.B. v. Slovakia*, Application no. 29518/10 (2012).
[649] Case, para. 13.
[650] Case, para. 19.
[651] Case, para. 70.

freedom and dignity".[652] Furthermore, the Court argued how "the fact that the doctors had considered the procedure necessary because the applicant's life and health would be seriously threatened in the event of her further pregnancy cannot affect the position".[653]

The Court established:

> *(...) by removing on of the important capacities of the applicant and making her formally agree to such serious medical procedure while she was in labour, when her cognitive abilities were affected by medication, and then wrongfully indicating that the procedure was indispensable for preserving her life, violated the applicant's physical integrity and was grossly disrespectful of her human dignity".*[654]

Although the Court established that the doctors acted with "gross disregard for her human freedom", there is no proof that the medical staff had acted with the "intention of ill-treating the applicant".[655] The Court noted that N.B. was "still legally underage, and at an early stage of her reproductive life", and thus "the sterilisation grossly interfered with her physical integrity, as she was thereby deprived of her reproductive capacity".[656]

Furthermore, the Court underscored how, "given its serious nature and consequences, the sterilisation procedure, including the manner in which the applicant was asked to agree it, was liable to arouse in her feelings of fear, anguish and inferiority and to entail lasting suffering".[657] The Court also referred to N.B.'s ethnic background as a Roma woman: "the Court finds no reason to doubt that her inability to have children strongly diminished her position as a woman living within a Roma community and entailed mental suffering".[658] Thus, the Court established that there had been a violation of Article 3.

Additionally the Court established that Slovakia had also breached Article 8 of the Convention. Namely, the Court argued that N.B.'s sterilisation "affected her reproductive health status and had repercussions on various aspects of her private and family life" and since the Slovakian Government failed to fulfil its positive obligation by not "putting in place

[652] Case, para. 74.
[653] Case, para. 74.
[654] Case, para. 77.
[655] Case, para. 78.
[656] Case, para. 79.
[657] Case, para. 80.
[658] Case, para. 80.

effective legal safeguards to protect the reproductive health of, in particular, women of Roma origin", there had been also a violation of Article 8.[659]

Lastly, N.B. also submitted how "her race/ethnic origin played a determining role in her sterilisation and that she had also been discriminated against on the grounds of her sex in that respect".[660] The Court found that "it cannot be established that the doctors involved acted in bad faith, that the applicant's sterilisation was a part of an organised policy, or that the hospital staff's conduct was intentionally racially motivated".[661] Thus the Court concluded that it was not "necessary to separately determine whether the facts of the case also gave rise to a breach of Article 14 of the Convention".[662]

I.G. and Others v. Slovakia

The case of *I.G. and Others v. Slovakia* concerned three women of Roma ethnic origin: I.G., M.K. and R.H. They were all sterilised in the gynaecology and obstetrics department of a public hospital.[663] The first applicant I.G. was sterilised on 23 January 2000. After her admittance and preliminary checks, a gynaecologist ordered her to be transferred to theatre for a Caesarean section. During the operation I.G. was sterilised by tubal ligation. When she woke up from anaesthetic, she was told that she had given birth to a girl, but she was not informed about the tubal ligation. The next day a doctor approached I.G., and asked her to sign a document. I.G. was told that she had undergone a Caesarean section, and all women who had Caesarean sections had to sign this form.

On January 28 she was transferred to the hospital due to an inflammation as a post-surgery complication, where she underwent further surgery due to serious sepsis and infection. This operation was considered life-saving and during the operation the doctors performed a hysterectomy. I.G. found out about her sterilisation in 2003. I.G. submitted that she has been living "in constant fear that her partner will leave her because she is not able to bear him any more children".[664]

The second applicant M.K. gave birth on 10 January 1999. Shortly after having been admitted to the hospital, M.K. was approached by a nurse who told her that delivery would be by Caesarean section. During the surgery the doctors also performed a tubal ligation. At the time of the delivery, M.K. was a minor and neither she nor her legal guardian had given

[659] Case, paras. 96-98.
[660] Case, para. 118.
[661] Case, para. 121.
[662] Case, para. 123.
[663] *I.G. and Others v. Slovakia*, Application no. 15966/04 (2013).
[664] Case, paras. 8-17.

consent to the sterilisation. When M.K.'s partner learned that she would not be able to have another child due to the sterilisation, he left her.[665]

The third applicant R.H. gave birth to her fourth and fifth children (twins) by Caesarean section. She was hospitalised on 10 April 2002. After she had been taken to the theatre a nurse gave her a pre-medication injection as a precursor to the anaesthetic. R.H. felt that her head was spinning. The nurse then asked her to sign a paper, which R.H. was unable to read due to her dizziness. The nurse explained that she needed to sign this as she was going to have a Caesarean delivery. At her discharge, R.H. was asked to sign another document. A doctor explained to R.H. that this paper confirmed her sterilisation.[666]

All three women submitted that they had received inferior treatment at the hospital due to their Roma origin. In particular, the applicants stated that they had been accommodated separately from non-Roma women in what were called "Gypsy rooms", prevented from using the same bathrooms and toilets as non-Roma women, and could not enter the dining room.

The Court first decided that after R.H.'s death her children did not have standing to continue the proceedings.[667] With regard to I.G. and M.K. the Court analysed whether there had been a violation of Article 3. Similarly to V.C. and N.B., the Court established that the sterilisations were incompatible with "the requirement of respect for human freedom and dignity". The Court also found a violation of Article 8 as Slovakia failed to fulfil its positive obligations regarding the reproductive health of the applicants.[668]

Lastly, I.G. and M.K. complained that they had been discriminated on the grounds of sex, they argued that their sterilisation "performed without their full and informed consent was a form of violence against women" and there existed "no race-neutral explanation justifying their sterilisation during Caesarean delivery".[669] The Court reiterated that it could not be established that the sterilisation had been part of an "organised policy" or that the hospital staff's conduct had been "intentionally racially motivated", and thus the Court did not find it "necessary to determine separately whether the facts of the case also gave rise to a breach of Article 14".[670]

[665] Case, paras. 18-22.
[666] Case, paras. 23-29.
[667] Case, paras. 89-93.
[668] Case, para. 145.
[669] Case, paras. 160-161.
[670] Case, paras. 165-167.

4.5.2 The United Nations CEDAW Committee Case

A.S. v. Hungary

A.S. was a Hungarian Roma woman, a mother of three children, who discovered in May 2000 that she was pregnant. The delivery date was estimated to be in December 2000. A.S. followed antenatal treatment and attended all the scheduled appointments with the district nurse and gynaecologist. In January 2001 she went into labour and amniotic fluid broke which was accompanied by heavy bleeding. A.S. was taken to a hospital (an hour by an ambulance).

A doctor examined her upon her arrival and determined that the foetus had died in her uterus. The doctor therefore told her that a Caesarean section needed to be performed immediately in order to remove the dead foetus. While on the operating table, A.S. was asked to sign a form confirming her consent to the Caesarean section. She signed it together with a barely legible note that had been hand-written by the doctor, which said: "Having knowledge of the death of the embryo inside my womb I firmly request my sterilization [a Latin term unknown to the author was used]. I do not intend to give birth again; neither do I wish to become pregnant".[671]

The hospital records showed that, within 17 minutes of the ambulance arriving at the hospital, the Caesarean section was performed, the dead foetus and placenta were removed and the author's fallopian tubes were tied. Before leaving the hospital, A.S. asked the doctor information about her state of health and when she could try to have another baby. She then learned about the meaning of "sterilisation".

A.S. submitted to the CEDAW Committee that Hungary had violated Articles 10 (h), 12 and 16 paragraph 1 (e) of the CEDAW Convention. A.S. noted in her submission that sterilisation is never a life-saving intervention that needs to be performed on an emergency basis without the patient's full and informed consent. A.S. explained that she received no specific information about the sterilisation, the effects of the operation on her ability to reproduce, or advice on family planning and contraceptive measures – thus she was unable to make an informed decision about the procedure.[672]

Hungary submitted that since the sterilisation procedure is not irreversible, since A.S. already has three living children, she "must have been familiar with the nature of pregnancy and childbirth without further education", and she was given all the information "in a way that was appropriate in the given circumstances".

[671] Case, paras. 2.1-2.2.
[672] Case paras. 3.1-3.8.

The CEDAW Committee first analysed whether Hungary had violated Article 10 (h) of the CEDAW Convention by failing to provide information and advice on family planning.[673] The Committee established that A.S. had not been provided with "detailed information about the sterilisation, including the risks involved and consequences of the surgery, alternative procedures or contraceptive methods". The Committee also noted that any counselling A.S. received "must have been given under stressful and most inappropriate conditions". Thus, the Committee established that Hungary had violated Article 10 (h). Further, the CEDAW Committee analysed A.S.'s submission regarding Article 12.[674] The Committee emphasised, how A.S. during 17 minutes "was prepared for surgery, signed the statements of consent for the caesarean section, the sterilisation, a blood transfusion and anaesthesia and underwent two medical procedures, namely the caesarean section to remove the remains of the dead foetus and the sterilization".[675]

The Committee found that "it is not plausible that during that period of time hospital personnel provided the author with thorough enough counselling and information about sterilization, as well as alternatives, risks and benefits, to ensure that the author could make a well-considered and voluntary decision to be sterilized".[676] The Committee referred to its general recommendation No. 24 on women and health, which provides that states should not allow forms of coercion, such as non-consensual sterilisation that violate women's rights to informed consent and dignity. Thus, the Committee established that Hungary had also violated Article 12.

Lastly, the Committee also found that Hungary had violated Article 16, paragraph 1 (e) of the CEDAW Convention.[677] The Committee established that "the sterilization surgery

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[673] *Article 10*
States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women:
(h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

[674] *Article 12*
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.
2. Notwithstanding the provisions of paragraph I 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.

[675] Case para. 11.3.

[676] Case para. 11.3.

[677] *Article 16*
1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

was performed on the author without her full and informed consent and must be considered to have permanently deprived her of her natural reproductive capacity".[678]

4.5.3 The Inter-American Court of Human Rights Case

I.V. v. Bolivia

The Inter-American Court of Human Rights has also decided a case concerning forced sterilisation – *I.V. v. Bolivia*.[679] I.V. was a woman born in Peru who fled from persecution to Bolivia, where the authorities gave her and her family asylum in 1994. I.V. became pregnant with her third child in 2000. In July 2000 she went to the hospital after a spontaneous rupture of the membranes at week 38,5 of her pregnancy. At the hospital, the doctors decided that I.V. should deliver via a Caesarean section. A resident started the Caesarean section, but due to some complications an obstetrician-gynaecologist took over.[680] After the baby had been born the doctors performed another procedure – the tubal ligation. The doctors did not have I.V.'s consent – I.V.'s husband signed the consent form for the Caesarean section, but for the sterilisation the medical staff could not find him.[681] The Court considered Articles 5.1, 7.1, 11.1, 11.2, 17.2, 3 and 1.1 in conjunction with Article 7 of the Belem do Para convention.[682]

The Court recognised that there is a power relationship between a doctor and a patient, which can be worsened by the unequal power dynamics between men and women and by persistent gender stereotypes that reinforce the position of women as dependents and subordinates.[683] It continued with the power analysis and explained how harmful gender stereotypes can impact and affect women's access to information on sexual and reproductive health, as well as the process and manner in which consent is obtained – since a woman who is not aware of her rights may adopt a less assertive attitude towards her rights. This can lead to further paternalism and situations where health professionals make decisions without

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(e) 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;

[678] Case para. 11.4.

[679] *I.V. v. Bolivia*, Preliminary Objections, Merits, Reparations, and Costs, Judgment, IACtHR (ser. C) No. 329 (2016) (Only Spanish version available). See gender analysis of the awarded reparations: D. Alaattinoğlu, "Gender-Sensitive Reparations in the I.V. v. Bolivia Case: A Missed Opportunity?", March 24, 2017, available at: https://ilg2.org/2017/03/24/gender-sensitive-reparations-in-the-i-v-v-bolivia-case-a-missed-opportunity/.

[680] Case, paras. 63-64.

[681] Case, para. 65

[682] Inter-American Convention On The Prevention, Punishment And Eradication Of Violence Against Women "Convention Of Belem Do Para".

[683] Case, para. 186.

taking into account the patient's autonomy and wishes.[684] The Court gave examples of stereotypes frequently applied to women in the health sector: women are identified as vulnerable and unable to make reliable or consistent decisions, women are considered impulsive and fickle in need of guidance, women should bear the responsibility of sexual health of the couple.[685] Thus, the Court concluded it was integral to recognise and reject the stereotypes that might violate the rights established in the Convention.[686] It also underscored the importance of consent particularly in cases where the woman has scarce economic resources and/or low levels of education as harmful stereotypes might act as justification of population control.[687]

The Court concluded that the sterilisation in a public hospital, under stress and without informed consent causing I.V. serious physical and psychological damage that implied the permanent loss of her reproductive capacity, constituted an act of violence and discrimination against her – thus violating Articles 5.1, 7.1, 11.1, 11.2, 13.1 and 17.2 in relation to 1.1 of the American Convention and Article 7.a) of the Convention of Belém do Pará.[688]

The Court also analysed whether Bolivia had violated the prohibition of torture and other cruel, inhuman or degrading treatment (Article 5).[689] It first noted the context – how historically the framework for protection against torture and ill-treatment had developed in the context of deprivation of liberty, as an instrument of punishment or intimidation for interrogation, but how the international community has recognised that torture and other inhuman treatment can also occur in other contexts, e.g. in the field of health services and specifically of reproductive health.[690] Thus, the Court highlighted the need to adopt a gender lens to analyse women's experiences with violence, torture and ill-treatment.[691] In this regard, the Court quotes I.V.'s words and notes that the sterilisation "radically marked the life of I.V.".[692] In conclusion, it found that I.V. was subjected to cruel, inhuman and degrading

[684] Case, para. 187.
[685] Case, para. 187.
[686] Case, para. 187.
[687] Case, para. 188.
[688] Case, paras. 255-256.
[689] *Article 5. Right to Humane Treatment*
1. Every person has the right to have his physical, mental, and moral integrity respected.
2. No one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment. All persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person.
[690] Case, para. 263.
[691] Case, para. 263.
[692] Case, para. 269.

treatment, and Bolivia had breached Article 5.1 and 5.2 of the American Convention in relation to Article 1.1.[693]

4.6 "SOME WOMEN CAUSE PROBLEMS WHEN THEY HAVE BABIES"

As I explained in subsection 4.5 how micro-aggressions are silencing women's voices in medical settings, and can lead to reproductive violence. The forced sterilisation jurisprudence is an expression of this violence that can be conceptualised through a reversed version of the "normative motherhood" stereotype discussed in Chapter 3 (subsection 3.3). Namely, the "reversed normative motherhood" is an appalling belief according to which some women should not have children, or at least not *more* children than they already have, which can in turn lead to systematic policies of forced sterilisation of women from a specific ethnicity group, race, socioeconomic backgrounds, mental health problems and/or with disabilities. Barbara Gurr explains, how a state's interest in producing a collective national identity "assigns different values to different reproductive bodies, reflecting and producing different reproductive experiences", and in this context diversity and heterogeneity are perceived as a "challenge to security, to cultural normativity, and to the availability of resources", which means that women's reproductive bodies become "a site of both active and passive regulation" since the "other" must be eliminated, managed, or contained.[694] In other terms, regulations or practices regarding reproduction become punitive.[695] This stereotype is present in all the forced sterilisation cases of Roma women presented above.[696]

Priti Patel explains that although countries might argue that cases of forced sterilisations happen due to medical negligence or malfeasance on the part of individual providers, the root causes are structural stigmatisation and discrimination of certain women, which shows the importance of framing forced sterilisation of women as discrimination, and Patel therefore writes that the "failure of courts to acknowledge that the coerced or forced sterilization of marginalized women amounts to a violation of their right to be free from discrimination points to a misunderstanding of the nature of forced and coerced sterilization as targeting women specifically because they are from population groups deemed unworthy

[693] Case, para. 270.
[694] B. Gurr, *Reproductive Justice* : *The Politics of Health Care for Native American Women* (2015), pp. 27-29.
[695] *Open Society Foundations*, "Against Her Will: Forced and Coerced Sterilization of Women Worldwide" (2011) available at: https://www.opensocietyfoundations.org/publications/against-her-will-forced-and-coerced-sterilization-women-worldwide (accessed 26 February, 2018).
[696] See further specifically on Roma women: A. Oprea, "Toward the recognition of critical race theory in human rights law: Roma women's reproductive rights", in: *Realizing Roma rights*, J. Bhabha, A. Mirga, M. Matache (eds.) (2017), G. Albert, M. Szilvasi, "Intersectional Discrimination of Romani Women Forcibly Sterilized in the Former Czechoslovakia and Czech Republic", *Health and Human Rights Journal*, Vol. 19, No. 2 (2017).

of procreation".[697] As I have expressed above I agree with Patel that understanding forced sterilisation as "gender discrimination" is essential for recognising gendered power dynamics that enable and encourage such violence, but I would not describe the absence of gender and power dimension and feminist approaches in courts' rights analysis as a "misunderstanding". Instead, there is a deliberate resistance to leave it out as a holistic reading of different reproductive rights cases demonstrates – some judges showcase sexism in their dissenting opinions, and some might perceive such analysis as "political" or disruptive/unlawyerly.

Feminist writers have demonstrated, how racism leads to grave reproductive rights violations of Black women and indigenous women.[698] Dorothy Roberts terms the phenomenon as the "devaluation of Black motherhood", which traces back to slavery and defines Black women as "welfare queens", dangerously "superfertile", poor, drug addicts deviant and in summary unworthy of procreation.[699] Roberts gives examples of forced birth control in her book.[700] Furthermore, women with disabilities are in general not expected to become pregnant and give birth or be mothers, as women significant mobility disability may not have the "physical grace or ease" central to "male notions of attractiveness".[701] Women with disability are not expected to be sexual, and even further – depending on the nature of their disability, some women should be prohibited from being sexual beings, becoming pregnant, giving birth, and choosing parenthood for themselves.[702]

Alexandra Gartrell, Klaus Baesel and Cornelia Becker write how women with disabilities can be excluded from activities that promote access to sexual and reproductive rights information, screening, prevention and care services because disability is tied to

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[697] P. Patel, "Forced sterilization of women as discrimination", *Public Health Review*, Vol. 38, No. 15 (2017), pp. 2-3.

[698] See e.g: D. Roberts, *Killing the Black Body: Race, reproduction, and the meaning of liberty* (1997), A. Davis, *Women, Race, & Class* (1983), P. Williams, *Alchemy of Race and Rights* (1991), B. Gurr, *Reproductive Justice* : *The Politics of Health Care for Native American Women* (2015).

[699] D. Roberts, *Killing the Black Body: Race, reproduction, and the meaning of liberty* (1997).

[700] D. Roberts, *Killing the Black Body: Race, reproduction, and the meaning of liberty* (1997), pp. 104-149. Also, forced contraception has been very briefly mentioned (but largely understudied) in the context of post-conflict Timor-Leste. The Chega report: "Some attackers, moreover, had access to relatively sophisticated contraceptive technology, including medication that they injected into their victims prior to raping them" (p. 2667), *The Final Report of the Timor-Leste Commission for Reception, Truth and Reconciliation (CAVR).* Similarly, Rukmini Callimachi reports on forced birth control by fighters of Islamic State to prevent Yazidi women and girls held as sex slaves from becoming pregnant: https://www.nytimes.com/2016/03/13/world/middleeast/to-maintain-supply-of-sex-slaves-isis-pushes-birth-control.html.

[701] A. Asch, M. Fine, "Introduction: beyond pedestals", in: *Women With Disabilities, Essays in Psychology, Culture, and Politics,* A. Asch, M. Fine (eds.) (1988); V. Kallianes, P. Rubenfeld, "Disabled Women and Reproductive Rights", *Disability & Society*, Vol. 12, No. 2 (1997).

[702] See e.g. E. Tilley *et al*., "'The silence is roaring': sterilization, reproductive rights and women with intellectual disabilities", *Disability & Society*, Vol. 27, No. 3 (2012); L. I. Iezzoni *et al*, "'How did that happen?' Public responses to women with mobility disability during pregnancy", *Disability and Health Journal,* Vol. 8, Issue 3 (2015).

incorrect stereotypes of asexuality, and an inability/lack of desire to bear and parent children.[703] Women with mental health problems may often be perceived as "inadequate" or "dangerous".[704] If they have indeed become mothers then they are facing additional "monitoring" from the society.[705] Claudia Malacrida argues that while ideal motherhood is both unachievable and blaming for all women, it is *particularly challenging* construct to negotiate for women with disabilities: mothers with disabilities face many economic, social and environmental barriers such as poverty, limited access to public spaces, heightened vulnerability to abuse, unemployment, and violence.[706] Similarly, women with disabilities are vulnerable to mistreatment during their pregnancy (antenatal care), or birth (obstetric care).[707] Women with disability might be automatically qualified as "high-risk", and their right to remain autonomous throughout the birth experience might be interfered with.[708] Thus, an intersectional approach is needed to fully unpack the impact of "normative motherhood" stereotypes for different women with different identities, backgrounds, socio-economic status. Borrowing from the research of Alexandra Gartrell, Klaus Baesel and Cornelia Becker – women with disabilities should be treated as *experts* of their own experience.[709]

The forced sterilisation jurisprudence of the Strasbourg Court demonstrates the court's resistance to framing reproductive violence against Roma women as discrimination based on gender and ethnicity. Although the applicants' stories show how they were put in separate rooms for the "Gypsies", or the medical files indicated their ethnic background, and how they were treated in a degrading way, the majority opinions resisted this framing,

[703] A. Gartrell, K. Baesel, C. Becker, "'We do not dare to love": women with disabilities' sexual and reproductive health and rights in rural Cambodia", *Reproductive Health Matters*, Vol. 25, No. 50 (2017), p. 32. For example, they write how relevant information and services may be "physically inaccessible, communication modalities mayb be inappropriate, health care systems may lack disability awareness and be poorly prepared to cater for women with disabilities".

[704] C. Malacrida, "Performing motherhood in a disablist world: dilemmas of motherhood, femininity and disability", *International Journal of Qualitative Studies in Education*, Vol. 22, No. 1 (2009), p. 100.

[705] See e.g. L. Grue, K. Tafjord Laerum, "'Doing Motherhood': Some experiences of mothers with physical disabilities", *Disability & Society*, Vol. 17, No. 6 (2010).

[706] C. Malacrida, "Performing motherhood in a disablist world: dilemmas of motherhood, femininity and disability", *International Journal of Qualitative Studies in Education*, Vol. 22, No. 1 (2009), pp. 100, 102.

[707] See e.g. country specific studies: M. W. Gichane, "'They must understand we are people': Pregnancy and maternity service use among signing Deaf women in Cape Town", *Disability and Health Journal*, Vol. 10, Issue 3 (2017); B. Höglund, "Midwives' knowledge of, attitudes towards and experiences of caring for women with intellectual disability during pregnancy and childbirth: A cross-sectional study in Sweden", *Midwifery,* Vol. 29, Issue 8 (2013), in this study *e.g* more than one-third of midwives considered that women with intellectual disability "should not be pregnant and give birth at all".

[708] See e.g.: D. Walsh-Gallagher *et al*, "Normalising birth for women with a disability: The challenges facing practitioners", *Midwifery,* Vol. 29, Issue 4 (2013).

[709] A. Gartrell, K. Baesel, C. Becker, "'We do not dare to love": women with disabilities' sexual and reproductive health and rights in rural Cambodia", *Reproductive Health Matters*, Vol. 25, No. 50 (2017), p. 32. They write how women's access to reproductive and sexual rights should not depend on the hope that their spouse or another family member will pass on necessary information for example as "whilst a spouse can be a source of support, love and care, they can also be abusive and unsupportive" (p. 40).

concluding for example that "the information available is not sufficient to demonstrate in a convincing manner that the doctors acted in bad faith with the intention of ill-treating the applicant", "notwithstanding the fact that the applicant's sterilisation without her consent calls for serious criticism, the objective evidence is not sufficiently strong in itself to convince the Court that it was part of an organised policy or that the hospital staff's conduct was racially motivated", thus finding that it "was not necessary to separately determine whether the facts of the case also gave rise to breach of Article 14".

Indeed, Judge Mijovic's dissent in *V.C.* case criticised similarly: "Finding violations of Articles 3 and 8 alone (…) reduces this case to the individual level, whereas it is obvious that there was a general State policy of sterilisation of Roma women under the communist regime (…), the effects of which continued to be felt (…)". Judge Mijovic concluded that the sterilisations were not "of an accidental nature", but V.C. was "marked out" because of her origin, and this represented "the strongest form of discrimination and should have led to a finding of a violation of article 14 in connection with the violations found of Articles 3 and 8".

In contrast, as seen above in the *I.V.* case, the Inter-American Court of Human Rights recognised the power relationship between a doctor and a patient, which can be "worsened by the unequal power dynamics between men and women and by persistent gender stereotypes that reinforce the position of women as dependents and subordinates", and explained how harmful gender stereotypes can impact and affect women's access to information on sexual and reproductive health, which can in turn lead to more paternalism and situations where health professionals make decisions without taking into account the patient's autonomy and wishes.

never
trust anyone
who says
they do not see color.
this means
to them
you are invisible
– is

(Nayyirah Waheed)

5. WOMEN AND (IN)FERTILITY NARRATIVES

Chapter 5 analyses women and (in)fertility narratives by considering assisted reproduction jurisprudence. Legal scholarship usually looks at assisted reproduction through familiar legal categories such as *access*, *consent* or *accountability* attempting to define clearly and exhaustively *which* assisted reproduction services should be available for *which* people under *wha*t circumstances – what should be legal, illegal. The legal discipline also attempts to create and then reinforce a perception according to which questions about assisted reproduction are layered and nuanced matters of "lived experiences" *only* for sociologists and anthropologists whereas law (the legal discipline) can with its normative and legalistic approach clear out controversies and set up a neutral system. However, a legal analysis that does not consider the social context in which assisted reproduction fails to recognise that neither assisted reproduction nor the science behind it are neutral, but impacted by race, gender, class, religion, ethnicity and other identity elements.

Therefore, the transnational human rights law forums – courts and committees – should explicitly acknowledge that with their high level legal interpretation they are creating and reinforcing (if not challenging) power systems through human rights law by defining sex, reproduction, families, framing and compartmentalising people: determining who is in, who is out when it comes to the "game of reproduction". The approach the European Court of

Human rights has adopted for example may seem balanced, objective and neutral as it awards the member states the margin of appreciation. However, by holding on to what Barbara Havelková called the *"belief in the existence of a fair world based on a confidence that existing institutional set-ups are fair and neutral"* (cited in Chapter 2), the Strasbourg Court may actually fall short in understanding the rights framework as an expression of power relationships.

The total number of cases in Chapter 5 is lower than in previous chapters, but I am following a similar structure in demonstrating the narratives. I begin with explaining the social dimensions of infertility and the power dynamics behind assisted reproduction regulations and follow by introducing seven cases: two decisions concerning surrogacy from the European Court of Human Rights and five judgments regarding access to assisted reproductive technologies: four from the European Court of Human Rights and one from the Inter-American Court of Human Rights.

5.1 SOCIAL DIMENSIONS OF INFERTILITY

What is infertility? The World Health Organisation offers a clinical definition that sees infertility as a "disease, defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected intercourse".[710] The time limit of 12 months is arbitrary, but corresponds with the fact that the majority of couples who achieve pregnancy without medical interference will do so within 12 months – the main purpose of this time limit as explained by Liberty Walther Barnes is to alert patients to seek medical help in the "race against the woman's biological clock".[711]

The World Health Organisation's definition does not currently capture the social dimensions of infertility.[712] Arthur Greil, Julia McQuillan and Kathleen Slauson-Blevins on the contrary explain how the social construction of health and illness is "even more striking in the case of infertility than for other health conditions".[713] They highlight for example that irrespective of how medicine defines infertility, couples do not define themselves infertile or turn to treatment unless they "embrace parenthood as a desired social role", thus infertility is signalled by the "absence of desired state", and how there exist other possibilities than pursuing cure – e.g. voluntary childlessness, adoption, changing partners.[714] Furthermore, Walther Barnes notes how some infertility treatments are designed to resolve the *social* issues that infertility presents rather than to fix biological problems: this means that *in vitro* fertilisation for example does not treat the cause of a couple's inability to achieve pregnancy, but it simply "circumvents whatever is impeding conception to make pregnancy possible" – or in other words: the ultimate goal is not "necessarily to repair or replace broken parts; it is to make a baby and turn people into parents".[715]

Infertility is a global problem.[716] However, despite the proved worldwide prevalence, Margaret E. Greene and Ann E. Biddlecom demonstrate in their work how demographic

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[710] See: http://www.who.int/reproductivehealth/topics/infertility/definitions/en/ (also for other definitions of infertility). See beyond the WHO definition in a recent collection: *The Palgrave Handbook of Infertility in History: Approaches, Contexts and Perspectives*, G. Davis, T. Loughran (eds.) (2017).
[711] L. W. Barnes, *Conceiving Masculinity: male infertility, medicine, and identity* (2014), p. 10.
[712] See a discussion about changing the definition: G. Nargund, "Involuntary childlessness: extending fertility treatment to single people and same-sex couples", *Bionews*, 14 November 2016, available at: https://www.bionews.org.uk/page_95783 (accessed 28 February 2018).
[713] A. Greil, J. McQuillan, K. Slauson-Blevins, "The Social Construction of Infertility", *Sociology Compass*, Vol. 5, Issue 8 (2011), p. 737.
[714] A. Greil, J. McQuillan, K. Slauson-Blevins, "The Social Construction of Infertility", *Sociology Compass*, Vol. 5, Issue 8 (2011), p. 737
[715] L. W. Barnes, *Conceiving Masculinity: male infertility, medicine, and identity* (2014), pp. 10-11.
[716] M. N. Mascarenhas *et al*, "National, Regional, and Global Trends in Infertility Prevalence Since 1990: A Systematic Analysis of 277 Health Surveys", *PLOS Medicine* (2012). Research estimating infertility prevalence between 1990-2010 demonstrates that it was the highest in South Asia, Sub-Saharan Africa, North Africa/Middle East, and Central/Eastern Europe and Central Asia.

studies on reproduction have been strongly influenced by Western ideas of kinship, family, gender roles.[717] Furthermore, an edited collection on ethnicity and fertility by Lorraine Culley, Nicky Hudson, and Floor van Rooij explains how infertility treatment in less developed countries "evokes feelings of disbelief and discomfort, since the dominant image of such societies is that of 'over-population'".[718] Moreover, the collection reveals how similar fixed ideas impact public perceptions of marginalised communities *within* "Western societies", resulting in "a desire to limit the reproductive capacity of such groups" instead of making any efforts to assist people's procreative choices, which means that infertility and new reproductive technologies are differentially experienced "according to an individual's or couple's location in a social space, and their agency in negotiating and navigating that location".[719]

Mindy Jane Roseman comments how the World Health Organisation's framing is a "heterosexual biomedical model of infertility" in which women bear more of the "conceptual and actual burden":

> *Fertility and sterility are demographic measures recorded as the number of children born to women, in the case of the former and women's inability to conceive a pregnancy in the latter. Men do not figure as participants in reproduction or infertility.*[720]

Accordingly, Roseman suggests that de-medicalising infertility would allow the focus to shift to social and structural factors: "Reconceptualising infertility as a disabling status having bio-medical and social/structural causes, coupled with more inclusive norms surrounding family formation, has the potential to recast state's human rights".[721] Furthermore, in a similar vein Jasmine Fledderjohann and Liberty Walther Barnes argue that "reproductive imaginaries" – prevailing social beliefs about who can and should re-produce – shape the design and conclusions of infertility research and consequently, some social groups

[717] M. E. Greene, A. E. Biddlecom, "Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles", *Population and Development Review*, Vol. 26, No. 1 (2000).
[718] L. Culley, N. Hudson, F. van Rooij, "Introduction: Ethnicity, Infertility and Assisted Reproductive Technologies", in: *Marginalized Reproduction: Ethnicity, Infertility and Reproductive Technologies*, L. Culley, N. Hudson, F. van Rooij (eds.) (2013).
[719] L. Culley, N. Hudson, F. van Rooij, "Introduction: Ethnicity, Infertility and Assisted Reproductive Technologies", in: *Marginalized Reproduction: Ethnicity, Infertility and Reproductive Technologies*, L. Culley, N. Hudson, F. van Rooij (eds.) (2013).
[720] M. J. Roseman, "The fruits of someone else's labor: gestational surrogacy and the promise of human rights in the 21st Century", in: *New Human Rights in the 21st Century* (forthcoming in 2018).
[721] M. J. Roseman, "The fruits of someone else's labor: gestational surrogacy and the promise of human rights in the 21st Century", in: *New Human Rights in the 21st Century* (forthcoming in 2018). However, Roseman also considers that people may not want to frame their family desires as illness or disability.

or populations "fall under the radar of infertility tracking practices, rendering their infertility and reproductive health needs invisible".[722] They identify these people as the "invisible infertile", and refer to their omission from infertility data and statistics—whether intentional or unintentional—as the "process of invisibilization".[723]

Furthermore, the World Health Organisation's disease-based framing of infertility does not capture the *gender* dimensions of infertility. Infertility is a women's reproductive health issue as secondary infertility is commonly a consequence of unsafe abortion or insufficient obstetric care.[724] Unsafe abortion and insufficient obstetric care are not purely biomedical problems as I showed in Chapters 3 and 4, but have a strong social dimension as they are caused by societal power dynamics that do not value women, and do not see women's decisions about reproduction as human rights issues.

Liberty Walther Barnes writes how despite the fact that infertility is equally common in men and in women it is very often considered as "a women's issue, the "wife's problem, a female disorder", and thus women are more likely to bear the social stigma of childlessness, and are more likely to undergo medical treatments even in the cases of male infertility as a result of a strong cultural belief (that influences medicine and the sociological constructions of infertility) according to which healthy testicles and potent sperm are the symbols of power, strength and thus also manliness and masculinity: "a real man can get the sex he wants and impregnate a woman when he so desires".[725] Thus, Walther Barnes notes how women are portrayed as responsible for all aspects of reproduction from "contraception to conception, from fetal health to breastfeeding".[726]

Maya Unnithan adds how the fear of infertility is especially widespread in poorer parts of the world: "The gendered burden of infertility in these contexts falls heavier on the woman, for whom childbearing and motherhood remain the key determinants of what it means to be

[722] J. Fledderjohann, L. Walther Barnes, "Reimagining infertility: a critical examination of fertility norms, geopolitics and survey bias", *Health Policy and Planning*, Vol. 33, Issue 1 (2018), p. 35.
[723] J. Fledderjohann, L. Walther Barnes, "Reimagining infertility: a critical examination of fertility norms, geopolitics and survey bias", *Health Policy and Planning*, Vol. 33, Issue 1 (2018), p. 35.
[724] Secondary infertility: "*When a woman is unable to bear a child, either due to the inability to become pregnant or the inability to carry a pregnancy to a live birth following either a previous pregnancy or a previous ability to carry a pregnancy to a live birth, she would be classified as having secondary infertility. Thus those who repeatedly spontaneously miscarry or whose pregnancy results in a stillbirth, or following a previous pregnancy or a previous ability to do so, are then not unable to carry a pregnancy to a live birth would present with secondarily infertile*". (http://www.who.int/reproductivehealth/topics/infertility/definitions/en/).
[725] L. W. Barnes, *Conceiving Masculinity: male infertility, medicine, and identity* (2014), pp. 3, 5.
[726] L. W. Barnes, *Conceiving Masculinity: male infertility, medicine, and identity* (2014), p.14. See further: L. Ying Ying *et al*, "Gender differences in experiences with and adjustments to infertility: A literature review", *International Journal of Nursing Studies*, Vol. 52 (2015).

an adult woman".[727] Additionally, scholars have explored whether infertility can make women more vulnerable to domestic/interpersonal gender-based violence.[728] The evidence showing how women experience the social stigma of infertility more violently and aggressively is linked to the "normative motherhood" narrative explained in Chapter 3.

5.2 MANAGING PEOPLE & DISTRIBUTING ROLES AND POWER WITH ASSISTED REPRODUCTIVE TECHNOLOGIES

Assisted reproduction becomes relevant when there is an obstacle to a person's wish to reproduce. This obstacle does not need to be necessarily a purely biomedical one however as explained above – infertility is not a purely biomedical phenomenon. Mindy Jane Roseman explains that assisted reproductive technologies have opened novel possibilities for family formation and thus it is "not surprising that politics, not biology, guard the gates of reproduction in the 21st century".[729] Accordingly, as Roseman contends, laws regulating surrogacy and *in vitro* fertilisation attempt to "stabilise, reproduce and protect" or "diverse" a state's vision of the family – heterosexual, nuclear, genetically-related.[730].

Infertility treatment was changed forever when the first "test-tube-baby", Louise Brown, was born in 1978 in the United Kingdom after a successful *in vitro* fertilisation.[731] Since that time the field of assisted reproductive technologies has evolved extensively, but *in vitro* fertilisation itself is only *one* of the technologies. Sarah Franklin explains, how "artificial insemination, surrogacy, surgery, and hormonal enhancement of fertility, as well as contraception and abortion can all be counted as forms of technological assistance to reproduction, or what are known as reproductive technologies".[732] However, despite assisted reproduction seemingly creating more opportunities, one must not forget that they are

[727] M. Unnithan, "Learning from infertility: gender, health inequities and faith healers in women's experiences of disrupted reproduction in Rajasthan", *South Asian History and Culture*, Vol. 1, No. 2 (2010), p. 320. See further on how infertility/childlessness impacts women's status and position: e.g. S. De Vos, "Biologically childless women 60+ often live in extended family households in Latin America", *Journal of Cross-Cultural Gerontology*, Vol. 29, Issue 4 (2014), J. J. Fledderjohann, "'Zero is not good for me': implications of infertility in Ghana", *Human Reproduction*, Vol. 27, No. 5, L. Remennick, "Childless in the Land of Imperative Motherhood: Stigma and Coping Among Infertile Israeli Women", *Sex Roles*, Vol. 43, Nos. 11/12 (2000).
[728] See e.g: M. Shah *et al.,* "Infertility and gender based violence in Kampala, Uganda", *Fertility and Sterility*, vol.100 (3) (2013); R. Ozturk *et al*., "Another face of violence against women: Infertility", *Pakistan journal of medical sciences*, Vol. 33, No. 4 (2017); F. Akpina *et al*., "Intimate partner violence in Turkey among women with female infertility", *Sexual and Relationship Therapy* (2017).
[729] M. J. Roseman, "The fruits of someone else's labor: gestational surrogacy and the promise of human rights in the 21st Century", in: *New Human Rights in the 21st Century* (forthcoming in 2018).
[730] M. J. Roseman, "The fruits of someone else's labor: gestational surrogacy and the promise of human rights in the 21st Century", in: *New Human Rights in the 21st Century* (forthcoming in 2018).
[731] See also further: K. Dow, "Now She's Just an Ordinary Baby": The Birth of IVF in the British Press", *Sociology* (2018).
[732] S. Franklin, *Biological Relatives. IVF, Stem Cells, and the Future of Kinship* (2013), p. 189.

situated in specific power dynamics and are thus (as noted above) experienced differently by different social groups.

Feminist literature on assisted reproduction is quite expansive, but what is more remarkable (although not surprising in the context of feminisms as explained in the beginning of this thesis) how contradictive views different feminist writers have. In 1985 Gena Corea published the first major feminist monograph addressing assisted reproductive technologies where she argued that assisted reproductive technologies are tools of patriarchal oppression as these technologies facilitate and expand the male technological control over women's bodies.[733] A year later, in 1986 Barbara Katz Rothman published her book in which she defends the opposite: to her reproductive technology is not inherently patriarchal, but merely an *opportunity*: she underscores how these new technologies can push the society to rethink the definitions of parenthood, motherhood, and fatherhood.[734] Maria Sjöholm's work too discusses whether assisted reproductive technologies can provide women with more autonomy and freedom and challenge gender roles and relations, or actually reinforce them, expose women bodies to over-medicalisation, and create the expectation that women should do everything they can to become mothers, and accept all pain (violence), financial costs.[735]Letizia Palumbo argues that the question whether assisted reproductive technologies are potentially liberating or restrictive does not have a universal linear answer, but instead it is determined by the "interplay of economic, social, cultural, and normative factors within different countries".[736]

Liberty Walther Barnes also highlights how infertility is not life-threatening, but it is "life-defining": meaning that having biological children is seen as an important part of a person's (especially women's) identity and thus there is a social expectation according to which people who want a baby, but cannot conceive "should take advantage of the medical opportunities".[737] In other words, there is an expectation to *try*, *i.e* take advantage of assisted reproductive technologies at whatever cost – as Maya Unnithan asks whether access to assisted reproductive technologies creates an expectation (a pressure) to make use of the

[733] G. Corea, *The Mother Machine: From Artificial Insemination to Artificial Wombs* (1985).
[734] B. Rothman, *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood* (1986).
[735] M. Sjöholm, *Gender-Sensitive Norm Interpretation by Regional Human Rights Law Systems* (2017), pp. 582-584.
[736] L. Palumbo, "The Borders of Legal Motherhood", in: *Reassembling motherhood: procreation and care in a globalized world*, Y. Ergas, J. Jenson, S. Michel (eds.) (2017), p. 77.
[737] L. W. Barnes, *Conceiving Masculinity: male infertility, medicine, and identity* (2014), p. 9.

available technology, are women (and men) expected to at least to be seen to "strive" for parenthood, to be at least "trying".[738]

Furthermore, Yasmine Ergas, Jane Jenson, and Sonya Michel write how in one way we could see the *expanding of choices* for women without viable oocytes, women approaching or in menopause, women without wombs as they can also become pregnant and achieve parenthood that is rooted in shared genetics/biology.[739] Thus they argue that although assisted reproductive technologies are potentially "redefining who may procreate, whether by direct gestation or through surrogacy, and with what or whose genetic material", the possibility to choose how to mother is not equally available to everyone within one country or globally as "compulsion and coercion, exclusion and privilege persist".[740] Similarly, Merete Lie and Nina Lykke note that although assisted reproductive technologies are positioned as "means to achieve the 'democratization' of childbirth and queer family-building, including same-sex and single parent families", which might be accurate to some extent, this "democratization" is happening in the context of "gendered and geopolitical inequalities and power differentials".[741]

Sarah Franklin underscores that over 30 years of ethnographic research demonstrates two contrasting global trends: the enormous variation in the governance and regulation of assisted reproductive technologies, and the "equally striking consistency of people's reasons for choosing to pursue technologies like IVF or PGD, and their descriptions of their experiences of doing so, which remarkably constant and predictable patterns across the globe and over time".[742] She also confirms the power patterns and identity politics within assisted reproduction when she writes how assisted reproductive technologies have a highly symbolic role "as markers of modernity, tests of religious conviction, or proofs national scientific

[738] M. Unnithan, "Learning from infertility: gender, health inequities and faith healers in women's experiences of disrupted reproduction in Rajasthan", *South Asian History and Culture*, Vol. 1, No. 2 (2010), p. 318. Also Sarah Franklin asks, why despite the less-than-50%-success-rate the use of IVF has expanded rapidly, and proposes that maybe it is because the pursuit of IVF itself offers something and/or at least "being seen to try to procreate is preferable to doing nothing", see in: S. Franklin, *Biological Relatives. IVF, Stem Cells, and the Future of Kinship* (2013), p. 153.

[739] Y. Ergas, J. Jenson, S. Michel, "Introduction: Negotiating "Mother" in the Twenty-First Century", in: *Reassembling motherhood: procreation and care in a globalized world*, Y. Ergas, J. Jenson, S. Michel (eds.) (2017), pp. 2-3.

[740] Y. Ergas, J. Jenson, S. Michel, "Introduction: Negotiating "Mother" in the Twenty-First Century", in: *Reassembling motherhood: procreation and care in a globalized world*, Y. Ergas, J. Jenson, S. Michel (eds.) (2017), p. 2.

[741] M. Lie, N. Lykke, "Editorial Introduction" in: *Assisted Reproduction Across Borders: Feminist Perspectives on Normalizations, Disruptions and Transmissions*, M. Lie, N. Lykke (eds.) (2017).

[742] S. Franklin, "Changing Global Fertilities: a third demographic transition?" (2016) available at: http://www.reprosoc.sociology.cam.ac.uk/blog-and-podcasts/blog/changing-global-fertilities-a-third-demographic-transition.

achievement", thus assuring that legislation in this area is never "simply (or even primarily) practical or administrative".[743] Instead, as Franklin theorises, *in vitro* fertilisation is not only about "managing or improving reproduction, but is itself a means of producing other things, other relationships, other values, or other identities".[744]

Maria Sjöholm also considers assisted reproductive technologies in her work on reproductive rights and writes: "Whether access to IVF should be considered to be a human rights norm is appoint of contention, as is the question regarding the appropriate scope of state obligations if it were to be included within the human rights framework".[745] With this Sjöholm frames one way to consider assisted reproduction within human rights law (scholarship). However, determining "appropriate scope of state obligations" is mainly focusing on framing human rights through specific goods or services, but as I laid out in Chapter 2 I am interested in this thesis how human rights and power(lessness) intersect. I adopted Alicia Ely Yamin's definition of rights as "bundles of relationships", which allows a different reading of assisted reproduction cases, and connects them to other narratives regarding women's lives, their bodies, experiences with violence and their silencing.

The narrative analysis in Chapter 5 is somewhat distinct from the previous chapters on women and pregnancy/birth/violence narratives as the cases regarding assisted reproduction I have included concern couples and there is no explicit focus on *women* alone. Also the jurisprudence occasionally demonstrates a tendency that Merete Lie *et al* describe as "stories of egg and sperm": the focus in the story of human reproduction has shifted from human beings to the level of the cells so that gametes have become the central agents.[746]

I argue that the central agents need to be human beings and their lived experiences. Therefore, the deconstruction work to find the stories about women is different, but it does not mean that just because the courts do not explicitly talk about women, they are not nevertheless constructing women's identities. As Cicely Martson, Alicia Renedo and

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[743] S. Franklin, "Changing Global Fertilities: a third demographic transition?" (2016) available at: http://www.reprosoc.sociology.cam.ac.uk/blog-and-podcasts/blog/changing-global-fertilities-a-third-demographic-transition. Franklin proposes a term "repronationalism" to describe, how each country uses reproductive policy to shape its national identity, while also similarly expressing its national identity through its reproductive policy, and how the turn to technology is changing how people understand fertility, parenthood, reproduction and family. Also Marcia C. Inhorn talks about repronationalism in the context of the United Arab Emirates and describes, how "emiratization appears to be consolidating the privileges of an already privileged citizen-minority, leading to reproductive discrimination and disenchantment among infertile 'outsiders' living in, or travelling to, this global reprohub", in: M. C. Inhorn, "Cosmopolitan conceptions in global Dubai? The emiratization of IVF and its consequences", *Reproductive BioMedicine and Society Online* (2016).

[744] S. Franklin, *Biological Relatives. IVF, Stem Cells, and the Future of Kinship* (2013), p. 153

[745] M. Sjöholm, *Gender-Sensitive Norm Interpretation by Regional Human Rights Law Systems* (2017), p. 581.

[746] M. Lie, M. Ravn, K. Spilker, "Reproductive Imaginations: Stories of Egg and Sperm", *Nordic Journal of Feminist and Gender Research*, Vol. 19, Issue 4 (2011), p. 243.

Gertrude Nsorma Nyaaba confirm, analysing fertility regulations must take into account women's "subject positions (i.e positions made available to women in society via particular practices, cultural discourses and social relationships) and the social identities that develop through women's experiences and negotiations of such subject positions".[747] Also Maya Unnithan writes how "infertility is a relational condition" that therefore entails "a contextually defined biology caught within webs of social obligation and expectation", and thus, infertility is an "especially appropriate means through which to understand how reproductive identity is gendered and how power is exercised by the family as well as by the state, medical institutions and health-service personnel".[748]

In Chapter 2 I referred to Maya Unnithan and Stacy Leigh Pigg's idea how applying rights analysis on the "messiness of everyday life" requires a closer (re)-examination of how rights are framed, not just operationalised.[749] Infertility and assisted reproduction can make the "everyday life" even messier, but not in a light-hearted way. Namely, Merete Lie and Nina Lykke write that even though assisted reproductive technologies today are "solidly founded in standardized and routinized biomedical procedures and practices, their performative effects, their entanglement in global and local power relations, and their way of reinforcing or deconstructing intersecting power differentials are by no means clear or given".[750]

Thus, understanding the social dimensions of infertility is vital as Maya Unnithan notes: "Focusing on the social meanings of infertility and its connection with construction of identity provides important insights into not only how infertile individuals and couples feel about their condition, but, linked to this, also how they seek to act in response to their infertility", and suggests that the conviction that infertility requires only or primarily a

[747] C. Marston, A. Renedo, G. Nsorma Nyaaba, "Fertility regulation as identity maintenance: Understanding the social aspects of birth control", *Journal of Health Psychology*, Vol. 23, Issue 2 (2018), p. 240. Consequently they add: "Family planning programmes that fail to take social dimensions into account risk maintaining the reproductive status quo of the women they aim to help, reproducing social spaces where women still struggle both to claim their reproductive rights and to constitute themselves as subjects of those rights", p. 249.
[748] M. Unnithan, "Learning from infertility: gender, health inequities and faith healers in women's experiences of disrupted reproduction in Rajasthan", *South Asian History and Culture*, Vol. 1, No. 2 (2010), pp. 316, 323.
[749] M. Unnithan, S. Leigh Pigg, "Sexual and reproductive health rights and justice – tracking the relationship" *Culture, Health & Sexuality,* Vol. 16 (2014), p. 1183.
[750] M. Lie, N. Lykke, "Editorial Introduction", in: *Assisted Reproduction Across Borders: Feminist Perspectives on Normalizations, Disruptions and Transmissions*, M. Lie, N. Lykke (eds.) (2017), p.7.

biomedical intervention needs to be challenged by scholars.[751] This means that law needs to turn to other disciplines to reflect people's lived experiences and realities.[752]

5.3 SURROGACY: "MORAL AND ETHICAL DEGRADATION OF THE SOCIETY"

Surrogacy is a practice whereby a woman becomes pregnant with the intention of giving the child away upon birth. While surrogacy is not a new reproductive practice, it is an increasingly prevalent phenomenon.[753] Generally two types of surrogacy are talked about: first, traditional surrogacy (also called low-technology or partial surrogacy) describes an arrangement whereby the surrogate's eggs are used and she would be the genetic mother and second, gestational surrogacy is a form of surrogacy in which the surrogate provides the uterus whereas the egg comes from another woman. Another division is based on whether the woman who is a surrogate gets paid: commercial surrogacy and altruistic surrogacy.

Surrogacy is criminalised or just simply legally impossible in most of the world.[754] Some countries have opened a discussion for moving from criminalisation to legalisation – for example Estonia has considered allowing altruistic surrogacy if there is a medical indication.[755] Others have, however, moved from permissive regulations to restrictions as a result of becoming a popular global destination for surrogacy arrangements.[756] Such

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[751] M. Unnithan, "Learning from infertility: gender, health inequities and faith healers in women's experiences of disrupted reproduction in Rajasthan", *South Asian History and Culture*, Vol. 1, No. 2 (2010), p. 321.

[752] Anthropologists whose work should inform also legal scholarship record people's experiences with infertility and assisted reproductive technologies in different parts of the world. See e.g: A. Whittaker, *Thai In Vitro: Gender, Culture and Assisted Reproduction* (2015), M. Inhorn, *Cosmopolitan Conceptions: IVF Sojourns in Global Dubai* (2015) & *The New Arab Man: Emergent Masculinities, Technologies, and Islam in the Middle East* (2012), A. Greil, *Not yet pregnant: Infertile Couples in Contemporary America* (1991); K. Ram, *Fertile Disorder: spirit possession and its provocation of the modern* (2013); G. Becker, *The Elusive Embryo: How Women and Men approach the New reproductive technologies* (2000).

[753] *A Comparative study on the regime of surrogacy in EU Member States*. European Parliament, Directorate General for Internal Policies, Policy Department C: Citizen's rights and constitutional affairs (May 2013), p. 9.

[754] Meaning that the civil law usually defines motherhood through birth: the woman who gives birth is the mother. For example, the Estonian Family Act: § 83. Mother: The woman who gives birth to a child is the mother of the child (https://www.riigiteataja.ee/en/eli/527012015010/consolide); the German Civil Code: Section 1591: Maternity: The mother of a child is the woman who gave birth to it (http://www.gesetze-im-internet.de/englisch_bgb/). See further: *International surrogacy arrangements: legal regulation at the international level*, K. Trimmings, P. Beaumont (eds.) (2013).

[755] To date surrogacy is still criminalised in Estonia. The Penal Code: *§ 132. Illegal surrogate motherhood*
(1) Transfer of a foreign ovum, or an embryo or foetus created therefrom to a woman whose intention to give away the child after birth is known is punishable by a pecuniary punishment.
(2) The same act, if committed by a legal person, is punishable by a pecuniary punishment.

[756] See on India for example: D. Deomampo, *Transnational reproduction: race, kinship, and commercial surrogacy in India* (2016); S. Rudrappa, *Discounted life: the price of global surrogacy in India* (2015); F. Nahavandi, *Commodification of Body Parts in the Global South: Transnational Inequalities and Development Challenges* (2016); A. Pande, "Transnational Commercial Surrogacy in India: Gifts for Global Sisters?", *Reproductive Biomedicine Online,* Vol. 23, Issue 5 (2011); M. Unnithan, "Thinking through Surrogacy

acumination, however, has also raised questions about global inequality, poverty, racism and colonialism.[757] Anthropologists have researched surrogacy arrangements in different countries to show people's lived experiences with this reproduction practice.[758] Also human rights law scholars have increasingly discussed surrogacy.[759]

Furthermore, growingly more research is available that looks at how surrogacy connects with other reproduction (reproductive rights) issues.[760] This is important because firstly, surrogacy issues cannot be separated from assisted reproductive technologies as gestational surrogacy is impossible without *in vitro* fertilisation - in other words, legalising surrogacy requires a permissive *in vitro* fertilisation regulation. Secondly, surrogacy is also connected to questions about abortion and birth (*i.e* the decision of termination of her pregnancy and autonomy over birth experience remains with the surrogate and does not transfer to the intended parent(s)). And thirdly, questions about women's roles, narratives of their bodies and sexuality and harmful gender stereotypes naturally travel between different reproduction issues. Surrogacy cases offer an additional dimension for understanding dominant pregnancy and motherhood narratives. Namely, if the prevailing narrative is that all women wish/choose to be mothers and pregnancy is as necessary precondition for *full* motherhood then gestational surrogacy entails a deep conflict as motherhood and pregnancy/birth are split between women.

Andrea Mulligan analyses the two surrogacy cases from the Strasbourg Court and notes that since across Europe there are varied approaches to surrogacy (from permissive laws to criminalisation) the European Court of Human Rights "faces a difficult task in seeking to define and apply Convention rights in the surrogacy context" as it is "essential to understand what, precisely, the Convention requires from domestic surrogacy regimes".[761] The European Court of Human Rights itself also seems to frame issues as "difficult tasks" using the language of "sensitive moral and ethical issues" – in abortion jurisprudence as seen

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Legislation in India: Reflections on Relational Consent and the Rights of Infertile Women", *Journal of Legal Anthropology*, Vol. 1, No.3 (2013).

[757] F. Winddance Twine, *Outsourcing the Womb: Race, Class and Gestational Surrogacy in a Global Market* (2011).

[758] E. Teman, *Birthing a Mother: the Surrogate Body and the Pregnant Self* (2010); H. Ragone, *Surrogate Motherhood: Conception in the Heart* (1994).

[759] See e.g: Y. Ergas, "Babies without Borders: Human Rights, Human Dignity, and the Regulation of International Commercial Surrogacy", *Emory International Law Review*, Vol. 27, Issue 1 (2013); *Surrogacy, law and human rights*, P. Gerber, K. O'Byrne (eds.) (2015).

[760] *Reassembling motherhood: procreation and care in a globalized world*, Y. Ergas, J. Jenson, S. Michel (eds.) (2017).

[761] A. Mulligan, "Identity Rights and Sensitive Ethical Questions: The European Convention on Human Rights and the Regulation of surrogacy Arrangements", *Medical Law Review*, Vol. 0, No. 0 (2018).

in Chapter 3 and also in assisted reproduction jurisprudence as I show below in subsection 5.3.1.

Although I agree that human rights protection and guaranteeing dignified life for all are complicated matters with no easy and quick solutions, I challenge such "difficult task" and "sensitive moral and ethical issue" framings as in my view they hinder human rights-based analysis that engages with how power is divided in the society, and shifts the responsibility of creating transformative narratives away from the European Court of Human Rights. Mulligan maintains that the European Court of Human Rights is "reluctant to enforce on the Member States an orthodoxy which does not exist, or perhaps more accurately, an orthodoxy which does not *yet* exist", and shows "a marked reluctance to involve itself in sensitive ethical and moral questions".[762]

My reading of the Strasbourg Court's surrogacy decisions is different and what Mulligan describes as "reluctance" I perceive as resistance – especially when surrogacy cases are read together with other cases concerning reproduction. I argue that the European Court of Human Rights is engaging in what Mindy Jane Roseman describes as "stabilising, reproducing and protecting" of a certain vision of the family – heterosexual, nuclear, genetically-related.[763] And maintaining such a strict normative vision is connected to silencing. Jill Allison's work on infertility in Ireland argues that silence around infertility in Ireland "sustains the myth of fertility as a universal experience, suppressing contrary experiences in an ideology of *motherhood* and *symbolic ideal of family*", and thus silence becomes the "mechanism through which people maintain contingent identities as both *moral citizens* and prospective parents".[764] To illustrate, in Judge Dedov's separate opinion to the *Paradiso and Campanelli case* he suggests that "surrogacy is carried out by poor people or in poor countries", the "recipients are usually rich and glamorous" and the European Court of Human Rights needs to "prevent the moral and ethical degradation of the society". As Mindy Jane Roseman argues – behind "morality concerns" is often a concern for the heteronormative nuclear family.[765]

[762] A. Mulligan, "Identity Rights and Sensitive Ethical Questions: The European Convention on Human Rights and the Regulation of surrogacy Arrangements", *Medical Law Review*, Vol. 0, No. 0 (2018), p. 8.
[763] M. J. Roseman, "The fruits of someone else's labor: gestational surrogacy and the promise of human rights in the 21st Century", in: *New Human Rights in the 21st Century* (forthcoming in 2018).
[764] J. Allison, "Conceiving Silence: Infertility as Discursive Contradiction in Ireland", *Medical Anthropology Quarterly*, Vol. 25, Issue 1 (2011), p. 17 (Emphasis added by L. Oja).
[765] M. J. Roseman, "The fruits of someone else's labor: gestational surrogacy and the promise of human rights in the 21st Century", in: *New Human Rights in the 21st Century* (forthcoming in 2018).

5.3.1 Jurisprudence from the European Court of Human Rights

Mennesson v. France

Mennesson v. France involved a husband and wife holding French citizenship (first and second applicants) and their two children who were born through a surrogacy arrangement in the USA (third and fourth applicants).[766] The used embryo was created with the husband's sperm and a donor's egg (the wife was infertile) and implanted into a surrogate's uterus in California. A Californian court ruled that the applicants were the parents, but the French authorities refused to register the children's birth certificates. The European Court of Human Rights first observed how "there is no consensus in Europe on the lawfulness of surrogacy arrangements or the legal recognition of the relationship between intended parents and children thus conceived abroad," and argued consequently how "this lack of consensus reflects the fact that recourse to a surrogacy arrangement raises sensitive ethical questions".[767]

Characterising the issue as "ethical" led the Court to grant France a margin of appreciation in this matter—but since "an essential aspect of the identity of individuals is at stake where the legal parent-child relationship is concerned," that margin was reduced.[768] This distinction enabled the Court to differentiate between the first and second "applicants' right to respect for their family on the one hand and the right of the third and fourth applicants to respect for their private life on the other".[769] The Strasbourg Court held that there was no violation of the first and second applicants' (the parents) right to respect for their family life (Article 8), since France's denial to register the birth certificates did not prevent the applicants from living in France with their children, and thus France had struck a fair balance "between the interest of the community in ensuring that its members conform to the choice made democratically within that community and the interest of the applicants".[770]

Regarding the children (the third and fourth applicants), however, the Court found that although "the children have been identified in another country as the children of the first and second applicants, France nonetheless denies them that status under French law" and that "a

[766] *Mennesson v. France*, Application no. 65192/11 (2014).
[767] Case, paras. 78-79.
[768] Case, para. 80.
[769] Case, para. 86.
[770] Case, paras. 84-85.

contradiction of that nature undermines the children's identity within French society".[771] According to the ECtHR, France had violated Article 8 when it overstepped the permissible margin of appreciation by not recognising the importance of biological parentage as a component of each individual's identity and the child's legal relationship with their biological father.[772]

Paradiso and Campanelli v. Italy

The case *Paradiso and Campanelli v. Italy* concerned two Italian nationals, Donatino Paradiso and Giovanni Campanelli – a married couple.[773] Paradiso and Campanelli tried to have a child and had also resorted to medically assisted reproduction technologies, but were unsuccessful. They then put themselves forward as adoptive parents. Paradiso and Campanelli subsequently decided to a make a surrogacy arrangement and contacted a clinic based in Moscow. The clinic certified in February 2011 that Campanelli's sperm had been used for the embryos that were implanted into a surrogate's uterus. The child was born in Moscow on February 26th 2011, and on the same day the surrogate gave her written consent to the child being registered as Campanelli's and Paradiso's child. In the following days Paradiso moved with the baby into a flat in Moscow that she had rented in advance and Campanelli who had remained in Italy was communicating with them regularly.

On March 10 2011 the Registry Office in Moscow registered Campanelli and Paradiso as the newborn's parents. The birth certificate was certified in accordance with the provisions of the Hague Convention. On 29 April 2011 Paradiso went to the Italian consulate in Moscow with the birth certificate to obtain the documents that would enable her to return to Italy with the child. The Italian Consulate issued the necessary documents. When already in Italy, the Italian authorities started the proceedings to suspend Campanelli's and Paradiso's parental responsibility as they had brought the child to Italy in breach of the procedure provided for international adoption. It was also established that the child did not have any genetic link to Campanelli although the applicants had assumed that his sperm was used to create the embryos – the clinic in Moscow had made an error.

It was also established that the child was in good health, Campanelli and Paradiso took very good care of him and they asked for the child to be placed with them – with a view to adopting him if necessary. The Italian domestic court, however, ordered that the child must

[771] Case, para. 96.
[772] Case, para. 100.
[773] *Paradiso and Campanelli v. Italy*, Application no. 25358/12 (2017).

be removed from Campanelli and Paradiso, taken into the care of the social services and placed in a children's home. The child was placed in a children's home for about 15 months in a location that was unknown to the applicants and all contact between the applicants and the child was prohibited. In January 2013 the child was placed in a new family with a view to his adoption. During the European Court of Human Rights proceedings the Italian Government confirmed that the child had been given a new identity and had been adopted.[774]

Paradiso and Campanelli submitted to the Strasbourg Court that permanently removing the child had breached their right to respect for private and family life guaranteed by Article 8. The Court first established, whether Paradiso's and Campanelli's relationship with the child could have been regarded as family life under Article 8, and regarded:

> " (…) *the absence of any biological tie between the child and the intended parents, the short duration of the relationship with the child and the uncertainty of the ties from the legal perspective, and in spite of the existence of a parental project and the quality of the emotional bonds, the Court considers that the conditions enabling it to conclude that there existed a de facto family life have not been met."*[775]

Thus, the Court concluded that no family life existed in the case of Paradiso and Campanelli.[776] The Court moved on to analyse whether the facts of the case fell within the scope of "private life" instead. It established that since Paradiso and Campanelli had "a genuine intention to become parents" and "a major part of their lives was focused on realising their plan to become parents, in order to love and bring up the child" then what was at issue was the "right to respect for the applicants' decision to become parents and the applicants' personal development through the role of parents".[777] Thus, the ECtHR concluded that the facts of the case did fall within the scope of the applicants' private life.[778] The Court established that the interference – giving the baby a status of "an abandoned child" and removing him from Paradiso and Campanelli – was "in accordance with the law". This interference pursued a legitimate aim of "preventing disorder", and the Court also regarded legitimate the Italian authorities' wish to "reaffirm the State's exclusive competence to recognise a legal parent-child relationship – and this solely in the case of biological tie or

[774] Case, paras. 8-56.
[775] Case, para. 157.
[776] Case, para. 158.
[777] Case, para. 163.
[778] Case, para. 164.

lawful adoption – with a view to protecting children".[779] The ECtHR also argued that in this case Italy enjoyed a wide margin of appreciation and analysed whether a fair balance had been struck. It found that:

> *(...) public interests at stake weigh heavily in the balance, while comparatively less weight is to be attached to the applicants' interest in their personal development by continuing their relationship with the child. Agreeing to let the child stay with the applicants (...) would have been tantamount to legalising the situation created by them in breach of important rules of Italian law. The Court accepts that the Italian courts, having assessed that the child would not suffer grave or irreparable harm from the separation, struck a fair balance between the different interests at stake, while remaining within the wide margin of appreciation (...).*[780]

Thus, the Strasbourg Court found that there had been no violation of Article 8.[781] The judgment has three concurring opinions and one dissenting opinion. In the Joint Concurring Opinion of Judges De Gaetano, Pinto de Albuquerque, Wojtyczek and Dedov the judges agree that there had been no violation, but they "regret that the Court did not take a clear stance against such practices" as gestational surrogacy. The concurring judges commented on surrogacy:

> *More generally, we consider that gestational surrogacy, whether remunerated or not, is incompatible with human dignity. It constitutes degrading treatment, not only for the child but also for the surrogate mother. Modern medicine provides increasing evidence of the determinative impact of the prenatal period of human life for that human being's subsequent development. Pregnancy, with its worries, constraints and joys, as well as the trials and stress of childbirth, create a unique link between the biological mother and the child. From the outset, surrogacy is focused on drastically severing this link. The surrogate mother must renounce developing a lifelong relationship of love and care. The unborn child is not only forcibly placed in an alien biological environment, but is also deprived of what should have been the mother's limitless love in the prenatal stage. Gestational surrogacy also*

[779] Case, para. 177.
[780] Case, para. 215.
[781] Case, para. 216.

> *prevents development of the particularly strong bond which forms between the child and a father who accompanies the mother and child throughout a pregnancy. Both the child and the surrogate mother are treated not as ends in themselves, but as means to satisfy the desires of other persons. Such a practice is not compatible with the values underlying the Convention.*[782]

Judge Dedov also presented a separate opinion. He noted, how "the phenomenon of surrogacy is itself quite dangerous for the wellbeing of society". Judge Dedov explains: "In a successfully developing society all of its members contribute by means of their talents, energy and intellect. (…) Yet even if the only valid resource available to an individual is a beautiful or healthy body, this is not enough to justify earning money via prostitution, pornography or surrogacy". Dedov argues how since "not everyone is capable of using intellect" it is "much easier to earn money using the body", but he sees that it would "compromise with human rights and fundamental values". Moreover, Judge Dedov suggested how "surrogacy is carried out by poor people or in poor countries", and the "recipients are usually rich and glamorous". He concluded that in order to "prevent the moral and ethical degradation of the society" the Court must support value-based actions and not "hide behind the margin of appreciation".

The dissent by Judges Lazarova, Trajkovska, Bianku, Laffranque, Lemmens and Grozev disagreed with the majority and suggested that there had been an interference with Paradiso's and Campanelli's right to respect for their family life. The dissenting judges explained: "For us it is important that the cohabitation started from the very day the child was born, lasted until the child was removed from the applicants, and would have continued indefinitely if the authorities had not intervened to bring it to an end".[783] Moreover, the dissenting judges explained that they "fear that the majority thus make a distinction between a "legitimate" and an "illegitimate" family".[784] The dissenting judges further added:

> We do not intend to express any opinion on the prohibition of surrogacy arrangements under Italian law. It is for the Italian legislature to state the Italian policy on this matter. However, Italian law does not have extraterritorial effects. Where a couple managed to enter into surrogacy agreement abroad and to obtain from a mother living abroad a baby, which

[782] Joint Concurring Opinion of Judges De Gaetano, Pinto de Albuquerque, Wojtyczek and Dedov.
[783] Dissent, para. 4.
[784] Dissent, para. 4.

> subsequently is brought legally into Italy, it is the factual situation in Italy stemming from these earlier events in another country that should guide the relevant authorities in their reaction to that situation.[785]
>
> The dissent concluded that the Italian authorities did not strike a fair balance.[786]

5.4 ACCESS TO ASSISTED REPRODUCTIVE TECHNOLOGIES

There are five cases that address assisted reproductive technologies – one case concerning access to *in vitro* fertilisation from the Inter-American Court of Human Rights and four cases from the European Court of Human Rights that touch several issues – embryo preservation, access to *in vitro* fertilisation, gamete donation and pre-implantation genetic diagnosis.

5.4.1 Jurisprudence from the European Court of Human Rights

Evans v. the United Kingdom

In *Evans v. the United Kingdom* the applicant was Natalie Evans.[787] Evans and her partner J. were informed during an appointment at an assisted conception clinic that Evans had serious pre-cancerous tumours in both ovaries and that her ovaries would have to be removed. The doctors also told Evans and J. that since the tumours were growing slowly it would be possible first to extract eggs for *in vitro* fertilisation. Thus, they created six embryos before her ovaries were removed due to cancer. Natalie Evans and J. both consented to the procedure and signed a document stating that these embryos would be implanted into the applicant's uterus. They were also informed that it would be possible for either to withdraw his or her consent at any time before the embryos have been implanted in the uterus. Evans also inquired about the possibility of freezing her unfertilised eggs, but the doctor informed her that this procedure "had a much lower chance of success" and was not performed at that clinic. At that point J. reassured Evans that they would not split up, she did not need to consider freezing her own eggs and that "she should not be negative and that he wanted to be the father of her child".

However, after their relationship ended in May 2002, J. requested the clinic to destroy the embryos and the clinic informed Evans that they have the legal obligation to do so.[788] Evans submitted to the European Court of Human Rights that the domestic provisions which permitted J. to withdraw his consent after the fertilisation of her eggs with his sperm, violated

[785] Dissent, para 11.
[786] Dissent, para. 12.
[787] *Evans v. the United Kingdom*, Application no. 6339/05 (2007).
[788] Case, paras. 13-19.

her right to respect for her private and family life under Article 8.[789] She explained that "in the case of a woman with the applicant's medical history, she would never again have the opportunity to attempt to create a child using her gametes", how the "female's role in IVF treatment was much more extensive and emotionally involving" as the woman donates eggs from a finite limited number available her after series sometimes painful medical interventions designed to maximise the potential for harvesting eggs.[790] Evans submitted to the ECtHR that the domestic regulation operated so that her "rights and freedoms in respect of creating a baby were dependent on J.'s whim".[791]

The Court noted that Evans "does not complain that she is in any way prevented from becoming a mother in a social, legal or even physical sense, since there is no rule of domestic law or practice to stop her from adopting a child or even giving birth to a child originally created *in vitro* from donated gametes", but rather the consent provisions prevented her from using the embryos she and J. had created together and thus "from ever having a child to whom she is genetically related".[792] The ECtHR that in this case "each person's interest is entirely irreconcilable with the other's" since if Evans is permitted to use the embryos, J. will be forced to become a father, whereas if J.'s refusal is upheld, Evans is denied the opportunity to become a genetic parent.[793]

The Strasbourg Court established that "since the use of IVF treatment gives rise to sensitive moral and ethical issues against a background of fast-moving medical and scientific developments, and since the questions raised by the case touch on areas where there is no clear common ground amongst the member States (…) the margin of appreciation to be afforded to the respondent State must be a wide one".[794] Thus, the Court noted that it needed to evaluate whether the "application of a law which permitted J. effectively to withdraw or withhold his consent to the implantation in the applicant's uterus of the embryos created jointly by them struck a fair balance between the competing interests".[795] Although it acknowledged that both interests were protected under Article 8, and it had "great sympathy for the applicant, who clearly desires a genetically related child above all else," it did not consider that "the applicant's right to respect for the decision to become a parent in the

[789] Case, para. 57.
[790] Case, para. 62.
[791] Case, para. 62.
[792] Case, para. 72.
[793] Case, para. 73.
[794] Case, para. 81.
[795] Case, para. 83.

genetic sense should be accorded greater weight than J.'s right to respect for his decision not to have a genetically related child with her."[796]

Thus, the Court considered that "given the lack of European consensus on this point, the fact that the domestic rules were clear and brought to the attention of the applicant and that they struck a fair balance between the competing interests, there has been no violation of Article 8 of the Convention".[797]

The decision also had a dissent written by Judges Türmen, Tsatsa-Nikolovska, Spielmann and Ziemele. The dissenting judges found that "the applicant's right to decide to become a genetically related parent weighs heavier than that of J.'s decision not to become a parent".[798] The dissent criticises the majority for suggesting that the UK Government had struck a balance when "no balance is possible in the circumstances of the present case since the decision upholding J.'s choice not to become a parent involves an absolute and final elimination of the applicant's decision. Rendering empty or meaningless a decision of one of the two parties cannot be considered as balancing the interests".[799] Furthermore, the dissenting judges add that J. gave Evans "an assurance that he wanted to be the father of her child", but the majority gives no weight to this assurance.[800] The dissent explains that the decisive date was "the date when the eggs were fertilised and six embryos created" as "from that moment on, J. was no longer in control of his sperm" and "an embryo is a joint product of two people, which, when implanted into the uterus, will turn into a baby".[801]

Thus, the dissent suggested that the "applicant's interests weigh more heavily than J.'s interests and that the United Kingdom authorities' failure to take this into account constitutes a violation of Article 8".[802] Lastly, the dissent also added that the Court should have found a violation of Article 14 in conjunction with Article 8 as "a woman is in different situation as concerns the birth of a child, including where the legislation allows for artificial fertilisation methods" and due to the "excessive physical and emotional burden and effects" caused by the condition of Evans.[803]

[796] Case, para. 90.
[797] Case, para. 92.
[798] Dissent, para. 6.
[799] Dissent, para. 7.
[800] Dissent para. 8.
[801] Dissent, para. 8.
[802] Dissent, para. 9.
[803] Dissent, para. 15.

Dickson v. the United Kingdom

The case of *Dickson v. the United Kingdom* concerned two applicants, Kirk and Lorraine Dickson.[804] Kirk Dickson was convicted of murder in 1994 and was in prison during the time of the case. Kirk and Lorraine Dickson met in 1999 through a pen-pal network while Lorraine was imprisoned. They got married in 2001 and Lorraine Dickson was released. The Dicksons wished to have a child together and in October 2001 Kirk Dickson applied for the facilities for artificial insemination. They relied on the length of their relationship and the fact that, given Kirk's earliest release date and Lorraine's age (born in 1958) it was unlikely that they would be able to have a child together without the use of artificial insemination facilities.[805]

The application was refused for the following reasons: first, the Dicksons had established their relationship while in prison, and had thus not "tested it in the normal environment of daily life", which in turn meant that "a reasoned and objective assessment of whether the relationship would subsist" could not have carried out. Secondly, the child would remain without the presence of a father "for an important part of his or her childhood years", and thirdly, the Secretary of the State argued that there would be "legitimate public concern" that the punitive and deterrent elements of the imprisonment were being "circumvented" if Kirk Dickson was allowed to "father a child by artificial insemination while in prison".[806]

The Dicksons submitted to the European Court of Human Rights that the refusal to give access to the artificial insemination facilities breached their right to respect for their private and family life guaranteed by Article 8.[807] The Court considered that Article 8 was applicable to the applicants as "the refusal of artificial insemination facilities concerned their private and family lives, which notions incorporate the right to respect for their decision to become genetic parents".[808] It also reiterated its previous argument, how a person "retains his or her Convention rights on imprisonment, so that any restriction on those rights must be justified in each individual case", and how it "cannot be based solely on what would offend public opinion".[809] The Court considered that since artificial insemination remained "the only realistic hope" of having a child together given Lorraine Dickson's age and Kirk Dickson's

[804] *Dickson v. the United Kingdom*, Application no. 44362/04 (2007).
[805] Case, paras. 9-12.
[806] Case, para. 13.
[807] Case, para. 37.
[808] Case, para. 66.
[809] Case, para. 68.

release date the matter was "of vital importance to the applicants".[810] The UK Government cited throughout the proceedings in the ECtHR three justifications for the policy.

Firstly, before the Grand Chamber they relied on the suggestion that "losing the opportunity to beget children was an inevitable and necessary consequence of imprisonment".[811] Secondly, the Court refers how "the Government appeared to maintain, although did not emphasise (..) that public confidence in the prison system would be undermined if the punitive and deterrent elements of a sentence would be circumvented by allowing prisoners guilty of certain serious offences to conceive children".[812] The ECtHR commented "(…) while accepting that punishment remains one of the aims of imprisonment, the Court would also underline the evolution in European penal policy towards the increasing relative importance of the rehabilitative aim of imprisonment".[813] Thirdly, the Government argued how "the absence of a parent for a long period would have a negative impact on any child conceived and, consequently, on society as a whole".[814] The Court found that it is "prepared to accept" that the authorities "should concern themselves as a matter of principle with the welfare of any child", but "that cannot go so far as to prevent parents who so wish from attempting to conceive a child in circumstances like those of the present case, especially as the second applicant was at liberty and could have taken care of any child conceived until such time as her husband was released".[815]

The ECtHR argued that although in this case the UK enjoyed a wide margin of appreciation the policy did not permit "a required proportionality assessment in an individual case".[816] Thus, it concluded: "the absence of such an assessment as regards a matter of significant importance for the applicants (…) must be seen as falling outside of any acceptable margin of appreciation so that a fair balance was struck between the competing public and private interests involved", and accordingly it found that UK had violated Article 8.[817]

Judges Wildhaber, Zupancic, Jungwiert, Gyuluman and Myjer wrote a joint dissenting opinion. The dissenting judges criticised the majority for not awarding the UK the margin of appreciation it should have enjoyed in this matter. The dissent furthermore commented how

[810] Case, para. 72.
[811] Case, paras. 73-74.
[812] Case, para. 75.
[813] Case, para. 75.
[814] Case, para. 76.
[815] Case, para. 76.
[816] Case, para. 84.
[817] Case, para. 85.

"the majority did not weigh several interests that ought to have deserved consideration", and suggested that "the Court might have wished to discuss the very low chances of a positive outcome of *in vitro fertilisation* of women aged 45", and how the Court also "fails to address the question whether all sorts of couples (for example, a man in prison and a woman outside, a woman in prison and a man outside, a homosexual couple with one of the partners in prison and the other outside) may request artificial insemination facilities for prisoners".[818] Lastly the dissent found:

> *In conclusion, in the specific circumstances of the case (the couple established a pen-pal relationship while both were serving prison sentences; the couple had never lived together; there was a 14-year age difference between them; the man had a violent background; the woman was at an age where natural or artificial procreation was hardly possible and in any case risky; and any child which might be conceived would be without the presence of a father for an important part of his or her childhood years), it could not be said that the British authorities had acted arbitrarily or had neglected the welfare of the child which would be born*".[819]

S.H. and Others v. Austria

The case of *S.H. and Others v. Austria* concerned two married couples in Austria who needed to resort to either egg or sperm donation in order to take advantage of *in vitr*o fertilisation.[820] The first and the second applicants were Ms S.H. and Mr D.H. (married). The third and fourth applicants were Ms H.E.-G. and Mr M.G. (married). Ms S.H. suffered from fallopian-tube-related infertility that did not allow her ova to pass to the uterus, which meant that natural fertilisation was impossible for her. However, although she was able to produce ova, Mr D.H. was infertile. Thus, they needed to access *in vitr*o fertilisation with the option of using sperm from a donor.

Ms H.E.-G. and Mr M.G. had a different problem – Mr M.G. was fertile, but Ms H.E.-G. did not produce ova. Thus, they needed to access *in vitr*o fertilisation with the option of using the ova from a donor. However, the Austrian domestic law allowed homologous methods (such as using ova and sperm from the spouses or from cohabitating couple itself) and methods which did not involve a particularly sophisticated technique and were not too far

[818] Dissent.
[819] Dissent.
[820] *S.H. and Others v. Austria,* Application no. 57813/00 (2011).

removed from natural means of conception. Accordingly, in fact donor sperm was allowed in the case of *in vivo*, but *in vitro* fertilisation and ovum donation was always prohibited.

The applicants submitted that the prohibition of heterologous artificial procreation techniques for *in vitro* fertilisation laid down by the Austrian domestic law violated their rights under Article 8 (right to respect for private and family life).[821] The Court established that the right of a couple to conceive a child and to make use of medically assisted procreation for that purpose is protected by Article 8 as "such a choice is an expression of private and family life".[822] The Court then moved on to analyse, whether Austria had exceeded the margin of appreciation. When determining whether there was a European consensus on the matter the Court said:

> *The Court would conclude that there is now a clear trend in the legislation of the Contracting States towards allowing gamete donation for the purpose of in vitro fertilisation, which reflects an emerging European consensus. That emerging consensus is not, however, based on settled and long-standing principles established in the law of the member States but rather reflects a stage of development within a particularly dynamic field of law and does not decisively narrow the margin of appreciation of the State.*[823]

It added however:

> *Since the use of in vitro fertilisation treatment gave rise then and continues to give rise today to sensitive moral and ethical issues against a background of fast-moving medical and scientific developments, and since the questions raised by the present case touch on areas where there is not yet clear common ground among the member States, the Court considers that the margin of appreciation to be afforded to the respondent State must be a wide one*.[824]

The Court considered the justifications presented by the Austrian Government. The Government argued how "medically advanced techniques of artificial procreation (…) carried the inherent risk that they would not be employed for therapeutic purposes only, but also for other objectives such as the 'selection' of children".[825] Furthermore, it explained that

[821] Case, para. 49.
[822] Case, para. 82.
[823] Case, para. 96.
[824] Case, para. 97.
[825] Case, para. 101.

"there was a risk that ovum donation might lead to the exploitation and humiliation of women, in particular those from economically disadvantaged backgrounds", and how "pressure might be put on a woman who would otherwise not be in a position to afford *in vitro* fertilisation to produce more ova than necessary".[826] The Court noted that the Austrian legal framework for assisted reproduction "was guided by the idea that medically assisted reproduction should take place similarly to natural procreation", and thus the Court "cannot overlook the fact that the splitting of motherhood between a genetic mother and the one carrying the child differs significantly from adoptive parent-child relations and has added a new aspect to this issue".[827]

When commenting the different approaches to using donor sperm in the case of *in vitro* (prohibited) and *in vivo* (allowed) fertilisation the Court accepted that some of the arguments raised by the Government in defence of the prohibition of gamete donation were not applicable (*i.e.* reference to exploitation of women donating ovum). However, the Court underlined how "the intervention of third persons in a highly technical medical process was a controversial issue in Austrian society raising complex questions of a social and ethical nature on which there was not yet a consensus in society and which had to take into account human dignity, the well-being of children thus conceived and the prevention of negative repercussions or potential misuse", and thus, "the prohibitions must be seen in this wider context".[828]

The Court added, how "there is no prohibition under Austrian law on going abroad to seek treatment of infertility that uses artificial procreation techniques not allowed in Austria".[829] Thus, in conclusion the Court found that Austria had not exceeded the margin of appreciation afforded to it and accordingly, did not find a violation of Article 8.[830]

Judge de Gaetano wrote a separate opinion for the judgment. He commented how Article 8 cannot be "construed as granting a right to conceive a child *at any cost*" and accordingly, how the "desire" for a child cannot "become an absolute goal which overrides the dignity of every human life". Judge de Gaetano referred to the *Dickson* case and criticised how in this case the Court held that "procreation detached from the conjugal act fell within the ambit of Article 8", and how "that decision did not advance human dignity but merely played second fiddle to advances in medical science". Thus, the Judge underlined how

[826] Case, para. 101.
[827] Case, paras. 104-105.
[828] Case, para. 113.
[829] Case, para. 114.
[830] Case, paras. 115-116.

"human procreation, instead of being personal act between a man and a woman, was reduced to a medical or laboratory technique".[831]

Judges Tulkens, Hirvelä, Lazarova Trajkovska and Tsotsoria submitted a joint dissenting opinion in which they criticise the majority for taking "the unprecedented step of conferring a new dimension on the European consensus and applies a particularly low threshold to it, thus potentially extending the States' margin of appreciation beyond limits".[832] The dissent noted, how already in 2001 it was established that more than 80 million people worldwide are affected by infertility and how the International Covenant on Economic, Social and Cultural Rights recognised the right to enjoy the benefits of scientific progress and its applications, and the right to health. Accordingly it put forward: "Ultimately, what is at stake here is not a question of choice between different techniques but, more fundamentally, a restriction on access to heterologous *in vitro* fertilisation constituting denial of access to available treatment".[833]

The dissenting judges found particularly problematic that the majority accepted the argument of how couples could go abroad to access the necessary services:

> *In our view, the argument that couples can go abroad (without taking into account the potential practical difficulties or the costs that may be involved) does not address the real question, which is that of interference with the applicants' private life as a result of the absolute prohibition in Austria (...). Furthermore, by endorsing the Government's reasoning according to which, in the event that treatment abroad is successful, the paternity and maternity of the child will be governed by the Civil Code in accordance with the parents' wishes, the Grand Chamber considerably weakens the strength of the arguments based on "the unease existing among large sections of society as to the role and possibilities of modern reproductive medicine", particularly concerning the creation of atypical family relations (...). Lastly, if the concerns for the child's best interests – allegedly endangered by recourse to prohibited means of reproduction – disappear as a result of crossing the border, the same is true of the concerns relating to the mother's health*

[831] Separate opinion, paras. 2-3.
[832] Dissent, para. 8.
[833] Dissent, para. 9.

referred to several times by the respondent Government to justify the prohibition.[834]

Costa and Pavan v. Italy

In *Costa and Pavan v. Italy* the applicants Ms Rosetta Costa and Mr Walter Pavan were healthy carriers of cystic fibrosis—a hereditary disease that manifests itself in breathing difficulties and generally culminates in severe respiratory failure.[835] Rosetta Costa became pregnant in 2010 and had a prenatal test carried out. After the results showed that the foetus was affected by cystic fibrosis Costa decided to terminate the pregnancy. The applicants then wanted to take advantage of assisted reproductive technologies and pre-implantation genetic diagnosis (PGD), as it would have allowed identifying genetic abnormalities in embryos conceived by *in vitro* fertilisation before the implantation. The Italian law, however, had a blanket ban on pre-implantation genetic diagnosis. At the same time couples in which the man suffered from sexually transmissible viral disease (for example HI virus, or hepatitis B and C) were allowed to use sperm washing before the *in vitro* fertilisation in order to avoid the risk of contamination of the woman and/or the foetus. Costa and Pavan submitted to the ECtHR that the ban on pre-implantation genetic diagnosis meant for them that the only way to make sure the foetus was not affected by the disease, was to commence the pregnancy, then have a prenatal test, and terminate the pregnancy if needed. They argued that forcing them into such situation violated Article 8.[836]

The Court considered that the applicants' desire to conceive a child unaffected by cystic fibrosis and to use assisted reproductive technologies and pre-implantation genetic diagnosis was protected under the right to respect for privacy and family life (Article 8).[837] Although the Italian Government justified the interference by referring to the "concern to protect the health of 'the child' and the woman, the dignity and freedom of conscience of the medical professions and the interest in precluding a risk of eugenic selection", the Court was not convinced.[838] The Government suggested that the woman's health would be "susceptible to depression on account of ovarian stimulation and oocyte retrieval".[839] The Court, however, stressed that "the concept of 'child' cannot be put in the same category as that of 'embryo'", and found that the Italian legislation lacked consistency in that area—allowing therapeutic

[834] Dissent, para. 13.
[835] *Costa and Pavan v. Italy*, Application no. 54270/10 (2013).
[836] Case, para. 36.
[837] Case, para. 50
[838] Case, para. 54.
[839] Case, para. 39.

abortion in cases of foetal malformation, but banning pre-implantation genetic diagnosis.[840] That is, it would have been possible for the applicants to start the pregnancy by natural means and then terminate it if a prenatal genetic test showed that the foetus was unhealthy. In finding that that the applicant should not be faced with such a scenario, the Court very importantly noted in this case that although "access to PGD raises sensitive moral and ethical questions (…) the solutions reached by the legislature are not beyond the scrutiny of the Court".[841] Thus, the Court established that there had been a violation of Article 8.[842]

5.4.2 Case from the Inter-American Court of Human Rights

Artavia Murillo et al v. Costa Rica

The case of *Artavia Murillo et al. ("in vitro fertilization") v. Costa Rica* concerned nine Costa Rican married couples who were not able to legally access *in vitro* fertilisation in Costa Rica.[843] The Costa Rican Ministry of Health issued an Executive Decree in 1995 that authorised *in vitro* fertilisation for married couples and regulated its practice. So accordingly *in vitro* fertilisation was practiced in Costa Rica from 1995-2000 by a private entity (*Instituto Costarricense de Infertilidad*) before the Constitutional Chamber declared the Executive Decree unconstitutional in March 2000. The Constitutional Chamber determined that *in vitro* fertilisation "clearly jeopardizes the life and dignity of the human being" as "once conceived, a person is a person".[844] The Constitutional Chamber reasoned: "The human embryo is a person from the time of conception; hence it cannot be treated as an object for investigation purposes, be submitted to selection processes, kept frozen and, the most essential point for the Chamber, it is not constitutionally legitimate to expose it to a disproportionate risk of death".[845] The stories of the nine couples are all similar in how the decision of the Constitutional Chamber affected them. Grettel Artavia Murillo and Miguel Mejias Carballo got married in 1993. Mejias Carballo had a work-related accident when he was 19 years old and as a result he was permanently paraplegic.

Their doctor diagnosed that the couple would be unable to procreate naturally and accordingly they underwent eight artificial insemination treatments that were all unsuccessful. In February 2000 their doctor informed them that their last alternative was to undergo *in vitro* fertilisation. But a month later, in March 2000 the Constitutional Chamber

[840] Case, paras. 55-57.
[841] Case, para. 61.
[842] Case, para. 64.
[843] Preliminary Objections, Merits, Reparations, and Costs, Judgment, IACtHR. (ser. C) No.257 (2012).
[844] Case, para. 71-74.
[845] Case, para. 76.

banned the IVF practice in Costa Rica. Artavia Murillo and Meijas Carballo however did not have the financial resources to go abroad to undergo the treatment. The couple divorced in March 2001 and one of the reasons was the impossibility of having biological children.[846]

First the Court (IAmCtHR) analysed the scope and applicability of Article 11 of the American Convention.[847] It emphasised that the American Convention contains an additional provision protecting family life–Article 17 of the American Convention recognises the "central role of the family and family life in a person's existence and in society in general, and consequently the family's right to protection entails, among other obligations, facilitating, in the broadest possible terms, the development and strength of the family unit".[848] Further, the Court linked the right to private life to reproductive autonomy, and access to reproductive health services, which as provided by the Court "includes the right to have access to the medical technology necessary to exercise this right" and "respect for the decisions both to become a mother or a father, and a couple's decision to become genetic parents".[849]

Lastly, the Court referred to CEDAW, the ICPD and the WHO's definitions of the right to health and reproductive health (all discussed in Chapter 2) and concluded that "the right to private life and reproductive freedom is related to the right to have access to the medical technology necessary to exercise that right" and thus the scope of the rights to private life, reproductive autonomy and to found a family extends to the right of everyone to benefit from scientific progress and its applications.[850] The Court also substantiated this by explaining how "the right to have access to scientific progress in order to exercise reproductive autonomy and the possibility to found a family gives rise to the right to have access to the best health care services in assisted reproduction techniques, and, consequently, the prohibition of disproportionate and unnecessary restrictions, *de iure* or *de facto*, to exercise the reproductive decisions that correspond to each individual".[851]

The Court discussed the meaning of Article 4 (1) of the American Convention in relation to embryos and "beginning of life". After using different methods of interpretation it

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[846] Case, paras. 85-88.
[847] Article 11. *Right to Privacy*
1. Everyone has the right to have his honor respected and his dignity recognized.
2. No one may be the object of arbitrary or abusive interference with his private life, his family, his home, or his correspondence, or of unlawful attacks on his honor or reputation.
3. Everyone has the right to the protection of the law against such interference or attacks.
[848] Case, para. 145.
[849] Case, para. 146.
[850] Case, para. 150.
[851] Case, para. 150.

concluded that an embryo cannot be understood to be a person for the purposes of Article 4 (1), and that "conception" in the sense of Article 4(1) occurs at the moment when the embryo becomes implanted in the uterus, which explains why, before this event, Article 4 of the Convention would not be applicable.[852] The Court analysed the Costa Rican ban on *in vitro* fertilisation in relation to disability, gender, and socio-economic situation.[853] It analysed the degree of harm to the right to private life and to found a family, and to the right to personal integrity, taking into account the impact of the prohibition of *in vitro* fertilisation on the intimacy, autonomy, mental health and reproductive rights of the applicants.[854]

The Court cited the lived experiences of some of the applicants and noted how couples suffered a severe interference in relation to their decision-making concerning the methods or practices they wished to attempt in order to procreate a biological child – *e.g* were forced to travel abroad.[855] Regarding gender the Court considered, how "the ban on IVF can affect both men and women and may have differentiated disproportionate impacts owing to the existence of stereotypes and prejudices in society", and referred to an example of how in some societies the blame for infertility is attributed mainly and disproportionately to women.[856] The Court emphasised that such gender stereotypes are "incompatible with international human rights law and measures must be taken to eliminate them", *i.e* the Court was not "validating these stereotypes", but only "recognizes them and defines them in order to describe the disproportionate impact of the interference caused".[857] Lastly, it noted how the ban on *in vitro* fertilisation had a disproportionate impact on the infertile couples that did not have the financial resources to undergo *in vitro* fertilisation abroad.[858] In conclusion, the Court found that with its total ban on *in vitro* fertilisation Costa Rica had violated Articles 5 (1), 11 (2) and 17 (2) of the American Convention.

[852] Case, para. 264.
[853] Case, para 276; regarding disability the Court found in para. 293: "Based on these considerations and taking into account the definition developed by the WHO according to which infertility is a disease of the reproductive system (…), the Court considers that infertility is a functional limitation recognized as a disease and that persons with infertility in Costa Rica, faced with the barriers created by the Constitutional Chamber's decision, should consider that they are protected by the rights of persons with disabilities, which include the right to have access to the necessary techniques to resolve reproductive health problems".
[854] Case, para. 278.
[855] Case, para. 279.
[856] Case, paras. 294-295.
[857] Case, para. 302.
[858] Case, para. 303.

5.5 (IN)FERTILITY NARRATIVES: WOMEN IN "HETEROSEXUAL, NUCLEAR, GENETICALLY-RELATED" FAMILIES

Compared to assisted reproduction case-law, finding harmful stereotypes in cases concerning abortion, maternal mortality, forced sterilisations, obstetric care and "virginity testing" seems easier as in those cases the human rights law forums usually reveal their understandings of women's sexuality, gender roles and expectations for women's reproductive bodies. Accordingly, using the anti-stereotyping methodology proposed by Rebecca J. Cook and Simone Cusack (introduced in Chapter 2) becomes a more straightforward task. Namely I highlighted both: positive examples of human rights analysis that considers power dynamics and creates transformative narratives, and negative ones, where women's stories and life experiences are disregarded by human rights law forums and the transnational human rights jurisprudence is consequently contributing to the processes of silencing of women.

However, although the step-by-step methodology Cook and Cusack propose is easy-to-follow and comprehensible, my thesis demonstrates that the problem with the reproductive rights jurisprudence is not technical, *i.e* the transnational human rights law forums do not know how to *recognise* and *challenge* stereotypes. Instead, as argued also by Barbara Havelkov*á* and showcased also in this thesis, there is a resistance to the very idea that stereotypes marginalise people and impact their human rights. Therefore, although the anti-stereotyping methodology is a useful tool, it is not enough if, simply put, a court or a committee does not *see* stereotypes and unequal power distributions in a society. A fundamental change in thinking is required: willingness from the human rights law courts or committees to *listen* and do the *labour* (using the words of Carrillo Rowe and Malhotra from Chapter 1). Accordingly, in the context of assisted reproduction a reproductive rights-based thinking would require courts and committees to explicitly consider all the different social dimensions of infertility and the ambitions to enforce certain power dynamics behind assisted reproductive technologies or surrogacy regulations, as explained at the beginning of this chapter.

By and large, in the introduced assisted reproduction cases the Strasbourg Court has neither acknowledged the social dimensions of infertility nor asked how power dynamics and stereotypes intersect with assisted reproduction. Instead, from the analysed jurisprudence it is possible to find examples for "stabilisation, reproduction and protection" of the "heterosexual, nuclear, genetically-related" family as framed above by Mindy Jane Roseman.

Maria Sjöholm notes regarding the *Evans* case how the European Court of Human Rights took a consent-based approach, which, as Sjöholm argues, is limiting the focus of autonomy without fully examining the potentially different impact based on gender.[859] For example, Ilana Löwy explains that even in the process of *in vitro* fertilisation, egg retrieval is not only medically much more complicated, but also culturally and socially more loaded than sperm retrieval.[860] Maura Ryan has likewise shown how a conventional bioethical analysis would ignore the interplays of gender, status and health, revealing why discussions around assisted reproduction should go beyond questions of choice and access.[861] In the *Evans* case the dissenting judges, indeed, added that the European Court of Human Rights should have found a violation of Article 14 (non-discrimination) in conjunction with Article 8, as "a woman is in different situation as concerns the birth of a child, including where the legislation allows for artificial fertilisation methods".

At first sight, this could serve as a sign of the dissent considering gender dimensions of assisted reproduction. However, the dissenting judges are not saying that the applicant would suffer stigmatisation due to a "normative motherhood" stereotype in the British society and/or due to a perverse higher value given to genetic links between children and their parents – both of which are *harmful* and should be therefore *challenged*. Instead, my reading of the case is that the dissenting judges indeed perceived "giving birth to a genetically related child" as integral to a woman's identity. The *Paradiso* case too connects to the "normative motherhood" narrative discussed in Chapter 3 – the majority opinion does not voice these thoughts, but the concurring judges spell out their understanding of motherhood, pregnancy and women's roles in these: "pregnancy, with its worries, constraints and joys, as well as the trials and stress of childbirth, creates a unique link between the biological mother and the child" and surrogacy is focused on "drastically severing this link".

In addition to the "unique link developed through pregnancy" the assisted reproduction jurisprudence also gives insight into how much value the European Court of Human Rights gives to genetic links. Andrea Mulligan explains how in the *Paradiso* case the "absence of a genetic link was decisive in the Court's finding that the right to respect for family life was not

[859] M. Sjöholm, *Gender-Sensitive Norm Interpretation by Regional Human Rights Law Systems* (2017), p. 592. See further: M. Ford, "Evans v United Kingdom: What Implications for the Jurisprudence of Pregnancy?", *Human Rights Law Review*, Vol. 8(1) (2008). Another piece criticising a "gender-neutral approach": A. Donchin, "Toward a gender-sensitive assisted reproduction policy", *Bioethics*, Vol. 23, Issue 1 (2009).
[860] K. Parizer-Krief, "*Gender Equality in Legislation on Medically Asssited Procreation in France"*, 29 *International Journal of Law, Policy and the Family* (2015), p. 208 (referring to Ilana Löwy's work).
[861] M. A. Ryan, "The Introduction of Assisted Reproductive Technologies in the "Developing World": A Test Case for Evolving Methodologies in Feminist Bioethics", *Signs*, Vol. 34. No. 4 (2009), p. 805.

engaged" as without that the applicants had no entitlement to assert the child's interests, and as a result, the "whole orientation of the case differed fundamentally from that in Mennesson where the child took centre stage".[862]

Letizia Palumbo comments on the gender perspective in the *S.H. and Others* case and writes that the European Court of Human Rights was "privileging a questionable moral/ethical approach that does not take into account the issue of the health and well being of couples and, especially, of women".[863] Namely, Palumbo argues that the Austrian Government together with the European Court of Human Rights were unconcerned with "the unusual family forms resulting from a split between the biological and the legal *father*" – as opposed to "splitting" up motherhood by allowing egg donation.[864] Merete Lie explains how assisted reproductive technologies involve conception outside of the body and "whereas sperm has always left the body, it is more controversial to retrieve egg cells and use them outside of a woman's body".[865] Therefore, in contrast to egg donation, sperm donation does not create a situation different from natural reproduction.[866] Mike Sanderson similarly argues that there is an assumption that male reproduction is "simple and easily controlled" whereas female reproduction is "complex and easily confused" and how consequently unlike the "male biological market (in sperm)" the "female biological market (in ova)" requires control.[867] Such need for control also gets translated into paternalism – by only expressing concern for women's exploitation and humiliation the Austrian Government "implicitly reinforced gender-biased stereotypes, in particular with regard to women's particular

[862] A. Mulligan, "Identity Rights and Sensitive Ethical Questions: The European Convention on Human Rights and the Regulation of surrogacy Arrangements", *Medical Law Review*, Vol. 0, No. 0 (2018), pp. 19-20. Linda Hart analyses adoption cases of the European Court of Human Rights and suggests that in addition to biological, legal, and social relations in the order of family life there is also the symbolic order, made up of gendered, structural relations that set out the rules of genealogy and the normative complementarity of the sexes in procreation and child rearing. And accordingly, if extra-familial adoption or other forms of family formations comply with the symbolic order then they show resemblance to "natural facts" and are more likely to be accepted by the Court. See: L. Hart, "Individual Adoption by Non-Heterosexuals and the Order of Family Life in the European Court of Human Rights", *Journal of Law and Society,* Vol. 36 (2009).

[863] L. Palumbo, "The Borders of Legal Motherhood", in: *Reassembling motherhood: procreation and care in a globalized world*, Y. Ergas, J. Jenson, S. Michel (eds.) (2017), p. 80

[864] The emphasis here is mine as they *were* concerned with "split motherhood" - L. Palumbo, "The Borders of Legal Motherhood", in: *Reassembling motherhood: procreation and care in a globalized world*, Y. Ergas, J. Jenson, S. Michel (eds.) (2017), p. 82.

[865] M. Lie, "Reproduction inside/outside: Medical imaging and the domestication of assisted reproductive technologies", *European Journal of Women's Studies*, Vol. 22 (1) (2015), p. 63.

[866] M. Lie, "Reproduction inside/outside: Medical imaging and the domestication of assisted reproductive technologies", *European Journal of Women's Studies*, Vol. 22 (1) (2015), p. 64.

[867] M. Sanderson, "A new approach to sex-based classifications in the context of procreative rights: S.H. & Others V. Austria in context", *European Journal of Health Law,* Vol. 20, Issue 1 (2013), p. 38.

vulnerability in the context of gamete donation", *i.e* women needing protection – a stereotype that the European Court of Human Rights did not challenge.[868]

In the *Dickson* case the dissenting judges criticised the majority for failing to address the question whether "all sorts of couples (for example, a man in prison and a woman outside, a woman in prison and a man outside, a homosexual couple with one of the partners in prison and the other outside) may request artificial insemination facilities for prisoners". More specifically, the dissent provided its idea of who should *not* become parents: they found the Dicksons *problematic* as potential parents, as they were *inter alia* a couple that had a "14-year age difference", had "established a pen-pal relationship while both were serving prison sentences", had "never lived together, and therefore, "any child which might be conceived would be without the presence of a father for an important part of his or her childhood years".

Similarly to other reproduction issues also in assisted reproduction we find the narrative of deserving/undeserving people (as the example of Roma women in Chapter 4). Maili Malin's work on infertility physicians' perceptions of women patients in Finland describes this well in the context of assisted reproductive technologies.[869] Her research shows that women need to demonstrate that they are "deserving" – this means, for example that "mentally ill, alcoholic and asocial persons are not supposed to be intellectual, purposeful or patient enough for IVF".[870] The question of who *should* preserve their fertility and have access assisted reproductive technologies needs a more nuanced analysis than what stems from the women/men binary – just like with other reproduction issues people's gender identities, race, religion, socio-economic status are all impacting how much power they have in their reproductive choices.[871]

Furthermore, Judge de Gaetano's separate opinion in the *S.H. and Others* case gives a sense of what according to him human procreation should look like: he underlined how "human procreation, instead of being personal act between a man and a woman, was reduced to a medical or laboratory technique" (de Gaetano was referring to the *Dickson* case). Similarly, the *Paradiso* case speaks not only of regulations and restrictions that are shaping a

[868] L. Palumbo, "The Borders of Legal Motherhood", in: *Reassembling motherhood: procreation and care in a globalized world*, Y. Ergas, J. Jenson, S. Michel (eds.) (2017), p. 84.
[869] M. Malin, "Good, Bad and Troublesome: Infertility Physicians' Perceptions of Women Patients", *The European Journal of Women's Studies*, Vol. 10, Issue 3 (2003).
[870] M. Malin, "Good, Bad and Troublesome: Infertility Physicians' Perceptions of Women Patients", *The European Journal of Women's Studies*, Vol. 10, Issue 3 (2003), p. 308.
[871] See for example: K. Mitu,"Transgender Reproductive Choice and Fertility Preservation", *AMA Journal of Ethics*, Vol. 18, Issue 11 (2016); E. F.S. Roberts, "Resources and race: assisted reproduction in Ecuador", *Reproductive Biomedicine & Society Online* (June 2016).

nation, but of a *punitive* system that punishes those who "circumvent" prohibitions: Judge Dedov suggested how "surrogacy is carried out by poor people or in poor countries", and the "recipients are usually rich and glamorous". He concluded that in order to "prevent the moral and ethical degradation of the society" the European Court of Human Rights must support value-based actions and not "hide behind the margin of appreciation".

However, there are also moments in the discussed jurisprudence that seem to represent different views less concerned with guarding the "traditional nuclear heterosexual genetically related families", but focusing on people's *lived realities*. For example, in *Artavia Murillo* case the Inter-American Court of Human Rights referred to the applicants' own lived experiences with infertility to substantiate its analysis. Furthermore, in the *S.H. and Others* case the dissent noted the global prevalence of infertility and how "what is at stake is not a question of choice between different techniques but, more fundamentally, a restriction on access to heterologous *in vitro* fertilisation constituting denial of access to available treatment". Moreover, in *Costa and Pavan* case, the European Court of Human Rights noted that although access to pre-implantation genetic diagnosis does raise "sensitive moral and ethical questions" the solutions reached by the legislature are *not* beyond the scrutiny of the European Court of Human Rights.

"We believe the one who has the power. He is the one who gets to write the story. So when you study history, you must always ask yourself, Whose story am I missing? Whose voice was suppressed so that this voice could come forth? Once you have figured that out, you must find that story too. From there, you begin to get a clearer, yet still imperfect, picture".

(Y. Gyasi, *Homegoing)*

6. CONCLUSION: WHO IS THE "WOMAN" IN HUMAN RIGHTS LAW?

6.1 SILENCING AS A LACK OF MEANINGFUL "LISTENING"

To answer the question of this thesis – "*Who is the 'woman' in human rights law*?" – I explored women's voices and silencing in transnational human rights jurisprudence. Specifically, I analysed a total of 35 cases regarding reproduction between 2003-2017 from four transnational human rights law forums (the European Court of Human Rights, the Inter-American Court of Human Rights, the United Nations CEDAW Committee and the United Nations Human Rights Committee). These cases concern a range of issues: access to safe and legal abortion, forced gynaecological examinations, forced sterilisations, women's sexuality, surrogacy, birth experience and obstetric care, maternal mortality, assisted reproductive technologies.

The writings of two contemporary feminist thinkers, Chimamanda Ngozi Adichie and Rebecca Solnit, highlighted the general frame and context for my inquiry. Firstly, from Adichie I borrowed the idea how stereotypes are dangerous because they enforce *one single story* about people. Secondly, from Solnit's work I picked her conceptualisation of human rights, voices and silencing. Namely, Solnit underscores how oppression happens when people's voices are silenced and thus a person's power over their life experience is either reduced or completely taken away. I connected these two ideas and, accordingly, in this thesis I considered stories, voices and power in the context of human rights to analyse how harmful stereotypes in the context of reproduction and sexuality are either challenged or reinforced by the four different human rights law forums.

Very importantly, I geared my thesis towards showing the gaps in the work of the transnational human rights forums. In other words, I operated from the premise that it is not the silenced individual or group who must "activate" and "find their voice" in order to resist and transform the conditions of *their* oppression, but instead, the *burden of social change* must be placed on the institutions that are part of the oppressive systems – as Aimee Carrillo

Rowe and Sheena Malhotra argue in their work. In the context of my thesis this implies that the human rights law forums need to *listen* and do the *labour*. Another contemporary feminist writer, Mary Beard notes similarly how women are still perceived as belonging "outside power" since women's access to power is described as "women knocking on the door", "storming the citadel", "smashing the glass ceiling".[872]

This means, as Beard explains, that women are seen as breaking down barriers and taking something to which "they are not quite entitled" and thus, if women are not perceived to be fully *within* the structures of power, it is power that needs to be redefined rather than women.[873] Accordingly, when analysing jurisprudence I focused on how the human rights law forums are *silencing* women when they disregard societal power dynamics, fail to put women's lived experiences in the centre of their analysis and instead rely on stereotypes, *i.e* on what they believe to be true about women's life plans.

My thesis does not focus only on the jurisprudence but, in fact, I explored how the silencing of women's voices is happening in three interconnected spaces: in the legal discipline in general, in human rights law and finally, in the analysed transnational human rights case-law. Thus, the silencing of women is a result of systematic, intentional and structural processes as opposed to the idea how women have been omitted through "forgetfulness" (G. Pollock).

6.2 SILENCING IN SCHOLARSHIP, LEGAL DISCIPLINE AND TRANSNATIONAL JURISPRUDENCE

Firstly, in Chapters 1-2 I positioned this thesis as a feminist work to underscore the still persistent resistance against feminist approaches in scholarship and in legal discipline more specifically. I explained how feminist methods stem from the "very radical act of taking women seriously" (C. Littleton), how they celebrate a "permanent partiality" (S. G. Harding), emphasise conversations and dialogues rather than the production of "a single triumphant truth" (H. Charlesworth), "question everything" (H. R. Wishik) and strategically use styles of writing to conceptualise *certain* types of harm or wrong, or to reveal *certain* kinds of interest or subject position" that would otherwise be left to the margins (N. Lacey). Therefore, feminist methodologies challenge many accepted scholarly traditions and are regularly seen as "unscholarly, disruptive, or mad" (H. Charlesworth). Thus, by combining feminist works from many different disciplines and asking questions beyond "traditional" legal analysis this

[872] M. Beard, *Women & Power. A Manifesto* (2017), pp. 56-57.
[873] M. Beard, *Women & Power. A Manifesto* (2017), p. 83.

thesis serves as an attempt to penetrate a space – scholarship – where it is still considered if not completely unwanted, then troublesome and unruly.

Secondly, in Chapters 1-2 I also demonstrated how women's voices are silenced *specifically* in the legal discipline and human rights law. I showed how the feminist approaches to law challenge the central feature of many Western theories: law being "distinct from the society" and consequently capable of achieving "neutrality and objectivity" (H. Charlesworth, C. Chinkin, S. Wright). And such challenges are, as highlighted in Chapter 2, still met with a lot of resistance in international human rights law and also in global health. Flaws and shortcomings of human rights law have been illuminated at the level of "law, procedure and policy", but these flaws have been made to seem like "simple misunderstandings or oversights, deficiencies of leadership or accountability, or quirks of local history or culture" not "man-made" and consequential to "some wider systemic context" (S. Marks). However, a human rights law framework that does *not* accept that powerlessness and marginalisation of women is *not* accidental or incidental, but actually institutionalised only reinforces powerlessness of already marginalised people (H. Charlesworth).

I dedicated Chapter 2 to explaining my tailored analytical framework – a reproductive rights-based approach – to read the selected 35 cases in a way that allowed me to extract narratives about women and their experiences with reproduction. Namely, this thesis is not an in-depth analysis of each case or a specific reproductive rights issue (e.g abortion or surrogacy). Instead, it showed conversations between the cases by considering the jurisprudence in an analytical frame that asked about power distribution and silencing processes within spaces of power.

I referred to R. Cook's and S. Cusack's anti-stereotyping methodology that includes *naming*, *describing* and *challenging* stereotypes as a useful and clear toolbox but I also argued that the problem of stereotyping is not something that can always be fixed with technical step-by-step guidelines. Because as the systematic reading of reproductive rights jurisprudence showed, the problem is not a lack of knowledge or misunderstandings in expert bodies or judiciaries, but a resistance to the idea that inequalities are structural. This is in line with what B. Havelkov*á's work demonstrates: there is a "belief in the existence of a fair world based on a confidence that existing institutional set-ups are fair and neutral" in the European Court of Human Rights.*

Thus, what is needed is a fundamental change in thinking. Consequently, I argued for a *different* human rights thinking that understands rights as "bundles of relationships that are

supported by the state's monopoly on force" (A. E. Yamin), not just "simply discrete legal instruments but concepts whose meaning is interpretive, relationally constituted, experientially based, and historically shaped" (M. Unnithan) and that moves beyond binaries of local/global, protection/empowerment, and insiders/outsiders by "introducing new voices, new rights, and new pathways to fulfillment" (A. Brysk).

This means that methodology and analytical frames matter since, as Allison Corkery writes, the methods "determine what injustices we see and prioritize, making methodology far more than just a technical choice".[874] It is vital to deny that in order to protect law's objectivity and fairness law needs to resist any engagement with gender, race, religion, and "messiness of life" (M. Unnithan, S. L. Pigg). Human rights analysis that considers power dynamics and people's lived realities does *not* equal with "biased" and "unscientific". As I spelled out in the very beginning of this thesis and showcased throughout all the chapters – the strength of feminist approaches is the constant "questioning" also *within* the women's movements and between feminist scholars. Suspicious or hostile responses to feminist approaches are rooted in the need to keep *certain* voices out of the discourse in order to maintain power structures. Thus, it is important to welcome criticisms and concerns from other disciplines into the legal discipline (and vice versa) instead of bluntly rejecting such cross-overs by saying "this is not law" or creating either competing polarising binaries such as rights/justice, law/non-law or separate spaces for "women's issues".

In conclusion I proposed in Chapter 2 an analytical frame that captures all of the above: a reproductive rights-based approach which rooted in feminist legal theory, social dimension of health, human rights-based thinking and the reproductive rights discourse. Thus, it is an analytical framework that "questions everything", considers power relations from all different angles – also within feminist thinking itself – and is as "unscholarly, disruptive, or mad" as possible and necessary.

The third and space in which I explored *silencing* is the chosen reproductive rights jurisprudence: 35 cases from four different transnational human rights law forums. I divided the emerging narratives into three: women and pregnancy/birth narratives (Chapter 3), women and violence narratives (Chapter 4), and women and (in)fertility narratives (Chapter 5).

[874] A. Corkery, "Methodological choices in human rights research are political, not just technical", 21 December 2017, available at: https://www.openglobalrights.org/methodological-choices-in-human-rights-research-are-political-not-just-technical/?lang=English (accessed 8 February, 2018).

In Chapter 3 I considered case-law regarding abortion, maternal mortality and birth – a total of 16 cases between 2005-2017 from the European Court of Human Rights and the two United Nations Committees: the Human Rights Committee and the CEDAW Committee. Analysing jurisprudence concerning birth regulations-practices, maternal mortality and abortion together was strategic as it allowed me to draw links between access to safe abortion, obstetric care and the global maternal mortality emergency and reveal that similar patterns of harmful (gender) stereotyping are present in all three. Namely, the main narratives emerging from stories about pregnancy and birth have given all women the role of mothers – irrespective of their own life-plans.

Furthermore, I showed in Chapter 3 how this harmful "normative motherhood" (or "repronormativity" as K. Franke terms) stereotype has also travelled from abortion jurisprudence to case-law regarding birth and obstetric care, where the conflict between the woman and the foetus grew into a conflict between the woman and her new-born. This "automatic conflict" travels together with every woman to her obstetric care, and birth experiences– irrespective of whether their pregnancy is wanted or not as seen in the *Dubska and Krejzova* case concerning home birth where a woman's wish to give birth in an environment chosen by her is overridden by the "potential threat to the newborn", or in the *Hanzelkovi* case, where the dissent constructed the applicant through her "intolerable escape", and noted, how a newborn child "cannot be captive to his or her mother's preferences".

To date, the European Court of Human Rights has neither recognised abortion as a human right of all women and girls nor considered abortion restrictions as possible gender discrimination. Instead, the Strasbourg Court has opted for a gender-neutral analysis that treats abortion as any other health service and instead contributed to the "innocent suffering" narrative (L. M. Kelly). This "innocent suffering" narrative leaves women the role of victims, but tailors it in a very specific way – women need to seem *deserving* (ideal victims) and show enough specific kind of suffering (e.g. an underage rape victim needs to terminate the pregnancy). Indeed, as a contrast, the recent abortion cases from the United Nations Human Rights Committee (*Wheland* and *Mellet* case) show a positive development towards framing abortion as a human rights issue with a gender dimension, but against the backdrop of what is happening to women's reproductive rights globally the Committee's analysis still comes across as somewhat hesitant and cautious.

The birth jurisprudence of the European Court of Human Rights reads similarly to its abortion jurisprudence. Admittedly, in all but one (*Dubska and Krejzova*) the Strasbourg

Court found a violation of women's human rights. However, as explained, in this thesis I am interested in the analysis before the final resolution as this is where narratives about women, their sexuality and reproductive bodies are created. And in that respect *Korneykova*, *Hanzelkovi, Konovalova* and *Ternovszky* all fall short since the European Court of Human Rights does not consider how gendered power dynamics and paternalistic medical settings can harm the human rights of women seeking obstetric care.

Namely, I argued in Chapter 3 that placing women's actual lived experiences in societies with unequal power distribution at the centre of abortion jurisprudence would mean re-theorising all abortion restrictions as tools of coercion, punishment (forcing a woman to be pregnant and give birth) irrespective of whether a woman was raped or the foetus malformed. This would, however, also call for a different thinking about pregnancy – a non-adversarial relational view of pregnancy that is based on women's "lived realities" (as argued by C. Pickles). A relational view of pregnancy goes beyond *termination* of pregnancy to include questions about the treatment and care women have a *right* to receive when they have decided to *continue* with a pregnancy regardless of whether their labour will result in a live birth (L. Layne). Women's lived realities of birth and pregnancy should substitute current debilitating narratives of perfect motherhood, hostile/dangerous women and defenseless foetuses that can in most serious cases lead to not only silencing, but to death as global maternal mortality rates demonstrate.

Chapter 4 on women and violence narratives explored who are women in reproductive violence jurisprudence. I introduced five forced gynaecological examination (i.e "virginity testing") cases from the European Court of Human Rights and altogether six forced sterilisation cases: four from the Strasbourg Court, one from the United Nations CEDAW Committee and one from the Inter-American Court of Human Rights. Additionally, I also included the full case of *Carvalho Pinto de Sousa Morais* from the European Court of Human Rights concerning a woman's sexuality in her 50s. I used this case throughout the thesis as in this 2017 decision the European Court of Human Rights explicitly used anti-stereotyping to demonstrate the prejudices within the Portuguese judiciary and explained how the assumption that for a woman in her 50s sexuality is less important reflected a "traditional idea of female sexuality as being essentially linked to child-bearing purposes" and "ignored its physical and psychological relevance for the self-fulfillment of women as people".

Similarly to Chapter 3 I had a strategic reason behind coupling cases concerning forced sterilisations and "virginity testing" with the *de Sousa Morais* decision that demonstrated a broader understanding of women's sexuality. Namely, I argued in Chapter 4

that severe forms of reproductive violence such as forced sterilisations of certain women and "virginity testing" as a form of punishment or control of women are more likely to occur in an environment that accepts, allows and encourages general stereotypical framings of women's reproductive choices and sexuality. I other words I argued that stereotypes serve as shortcuts to human rights breaches: like maternal mortality, forced sterilisations do not happen "overnight" or unexpectedly, but leaving stereotypes unchallenged is what lays the groundwork for these human rights violations.

I showed how with the "virginity testing" jurisprudence of the European Court of Human Rights in which the Strasbourg Court does *not* challenge such practice *per se* women are given the roles of passive objects of male sexual pleasure which denies them of any sexual autonomy as they are not seen as "sexual beings on their own" (S. W. Rodriquez). Again, although the European Court of Human Rights sees harm in unconsented medical procedures its gender-neutral focus on consent does little for actually dismantling such a degrading practice (M. Sjöholm).

Furthermore, a reversed version of the "normative motherhood" stereotype discussed in Chapter 3 reveals itself in Chapter 4. Namely, women from marginalised groups (Roma women, Black women, disabled women) are presumed to be either asexual or hypersexual (hyper-fertile) and expected to *not* reproduce, *not* become mothers, as their procreation is undesirable and disruptive for a society. Such ideas of women as potentially "dangerous, misbehaving and with poor judgment" were also present in Chapter 3 where I discussed obstetric care. Portraying women in such roles makes medical paternalism acceptable, forced treatments or invasive procedures (sterilisations) excusable if not justifiable and constructs for example the question of home birth as a matter of convenience or preference rather than a human right – therefore consequently ignoring the reasons (obstetric violence) *why* women would decline a hospital birth. Furthermore, stereotypes about women making no reliable/consistent decisions in medical settings leads to circumventing them – if they cannot make decisions in an acceptable way their involvement in decision making is not needed. This creates cultures where violence against *some* bodies is either not actual *violence* as it is permissible, justified or even if unfortunate still inevitable, but not a breach of human rights. Although the European Court of Human Rights does recognise Roma women as a marginalised group, it refuses to accept that the forced sterilisation of these women were expressions of power relations present in the Slovakian society and thus intentional and racially motivated. In contrast, the Inter-American Court of Human Rights in its *I.V.* case explicitly explained and challenged gendered power relations that caused the human rights

violations (forced sterilisation) of I.V. Thus it highlighted the *need* to adopt a gender lens to analyse women's experiences with violence, torture and ill-treatment.

Lastly, in Chapter 5 I analysed the (in)fertility narratives emerging from the cases concerning assisted reproductive technologies and surrogacy. I considered two surrogacy cases from the European Court of Human Rights and five judgments regarding access to assisted reproductive technologies: four from the European Court of Human Rights and one from the Inter-American Court of Human Rights. This chapter explored women's roles within larger systems of kinship and family formations.

I again explained the importance of considering societal power relations since ideas about *which* people should/should not reproduce and form families ("reproductive imaginaries") characterise also assisted reproduction laws and regulations (J. Fledderjohann, L. Walther Barnes) and as although assisted reproductive technologies appear as "standardised and routinised biomedical procedures and practices", they have deep "performative effects" as they impact global and local power relations (M. Lie, N. Lykke).

Nevertheless, the jurisprudence of the European Court of Human Rights demonstrated how, by and large, the Strasbourg Court is using its power to attempt to "stabilise, reproduce and protect" a *specific* vision of the family – heterosexual, nuclear, genetically-related (M. J. Roseman). By and large, in the introduced assisted reproduction cases the Strasbourg Court has neither acknowledged the social dimensions of infertility nor asked how power dynamics and stereotypes intersect with assisted reproduction. Instead, from the analysed jurisprudence it is possible to find examples for "stabilisation, reproduction and protection" of the "heterosexual, nuclear, genetically-related" family as framed above by Mindy Jane Roseman.

For example the *Paradiso* case connects to the "normative motherhood" narrative discussed in Chapter 3 when the concurring judges describe their understanding of motherhood, pregnancy and women's roles in these: "pregnancy, with its worries, constraints and joys, as well as the trials and stress of childbirth, creates a unique link between the biological mother and the child" and surrogacy is focused on "drastically severing this link". In the *Dickson* case the dissenting judges criticised the majority for missing the important question whether "all sorts of couples may request artificial insemination facilities", in the *S.H. and Others* case a separate opinion gives a sense of what human procreation *should* look like ("a personal act between a man and a woman and not and act reduced to a medical or laboratory technique") and one separate opinion of the *Paradiso* case argues for prohibition of surrogacy as a "prevention of the moral and ethical degradation of the society". Indeed, there are also moments in the discussed jurisprudence that represent different views less

concerned with guarding the "traditional nuclear heterosexual genetically related families", but focusing on people's *lived realities* (for example, *Artavia Murillo* case, *Costa and Pavan* case or the dissent in *S.H. and Others*). However, in larger narratives about women their gendered roles and the state of women's reproductive rights, such occasional exceptions do not speak volumes.

In summary, the *woman* in transnational jurisprudence regarding reproduction is still unfortunately given very limiting roles that are not rooted in women's own life plans and do not take women seriously, but instead assume and stereotype violently. Rebecca Solnit writes how "a free person tells her own story" and "a valued person lives in a society in which her story has a place".[875] Accordingly, the transnational human rights law forums must accept explicitly the very reality that human rights violations are *structural* thus needing corresponding structural intersectional responses. Therefore, it is the power structures and institutions (courts and committees) that need to assume responsibility and do the *labour of listening*.

What could be the further implications of this work, *i.e* how to move forward? My thesis put into one conversation different forms of resistance against the critical thinking of feminist approaches that trouble and challenge many taken-for-granted concepts, definitions, binaries and practices. I showed how this resistance can be found in the legal discipline that calls feminist approaches "unscholarly, disruptive, or mad" (H. Charlesworth), in international human rights law that desires remaining "gender-blind" instead of recognising how structural inequalities create shortcuts to human rights violations and most importantly, within transnational human rights jurisprudence regarding women's sexual and reproductive rights that disregards women's lived experiences and centuries-old harmful stereotypes about women's roles, bodies and sexuality.

I demonstrated how in reproductive rights protection single harmful narratives such as denying women from having home births as if this put "a woman's convenience ahead of the baby's safety" are eventually becoming the very building blocks of a whole culture of not taking women – and what they say about their bodies, pain, and experiences – seriously. In contrast, acknowledging that obstetric violence or maternal mortality for example are not individual failures or isolated cases but structural issues impacted by societal power dynamics creates a space where women can share their experiences without fearing victim blaming, penalisation or dismissal. Accordingly, if the transnational human rights law forums

[875] R. Solnit, *The Mother of All Questions* (2017), p. 19.

do not explicitly challenge harmful narratives, they are complicit in further enforcing silencing cultures. Therefore, to move forward, the human rights law forums must commit to not just "allowing" evidence that has investigated women's lived experiences, but seeking after it and taking it seriously, thus doing the active labour of listening. Connecting women's lived experiences to human rights language can really shift the conversations: having the appropriate and suitable language can be transformative – we can start pinpointing, unpacking, challenging and unlearning harmful stereotypes: the transnational human rights law forums need to interpret human rights law provisions so that they create and free up space for experiences that go beyond of the experiences of white male able cis bodies.

Furthermore, I would like to come back to the *Carvalho Pinto de Sousa Morais v. Portugal* cited throughout this thesis. The European Court of Human Rights found that Portugal had discriminated against the applicant as the domestic court decision "reflects a traditional idea of female sexuality as being essentially linked to child-bearing purposes and ignores its physical and psychological relevance for the self-fulfillment of women as people".[876] Although the wording is both clumsy and rather unfortunate the thought is important for conceptual reasons as I highlighted already before: conversations about women's reproductive rights need to also discuss how is women's sexuality perceived in a society – are women sexual agents who have an equal say in their sexuality and what is sexual pleasure for them, or is women's sexuality only serving male pleasure and/or reproductive purposes. In this thesis I looked at violence and suffering narratives to a great extent, but there are strong arguments for the empowering benefits of a *positive approach to sexuality*, which do not necessarily replace, but instead complement the focus on reproduction, violence and diseases by adding conversations about desire and pleasure.[877] Focusing on pleasure can open a space for a better understanding of women's experiences of violence and violation without defining survivors by their negative experiences and restricting them to move beyond these to enjoy sexual relationships again.[878] Consequently, the *Carvalho Pinto de Sousa Morais* can illustrate a dimension that should be included much more into reproductive and sexual rights analysis.

Lastly, the implications of my work are not solely contained in how reproductive and sexual rights are understood by transnational human rights law forums, or how my work could serve as a blueprint for lobbying, litigation, advocacy efforts in sexual and reproductive

[876] *Carvalho Pinto de Sousa Morais v. Portugal,* Application no. 17484/15 (2017), para. 52.
[877] See: S. Jolly, A. Cornwall, K. Hawkins (eds.), *Women, Sexuality and the Political Power of Pleasure* (2013).
[878] S. Jolly, A. Cornwall, K. Hawkins (eds.), *Women, Sexuality and the Political Power of Pleasure* (2013), p. 8.

rights. Instead, as I showed how the resistance against taking women's lived experiences seriously is happening on many levels there also needs to be a push for better science, better research, teaching, and training strategies more broadly.[879] Handing out anti-stereotyping methodologies to judges or committee members is not a solution. Indeed, transnational human rights jurisprudence should be unpacked in different ways that reveal new dimensions as I have done in this thesis but in order to bring about change the criticism needs to travel further. It is crucial to ask what is being researched: whose experiences are being traced, recorded, theorised, translated into policies? Feminist approaches can advocate for more inclusive and better research agendas. For example, Anna Dahlqvist writes how menstrual pain, menstrual protection and menstruation poverty have been considered "low-priority" and thus remained "underexplored".[880] Or similarly with endometriosis: how it is as common as diabetes but has been historically overlooked by researchers and science as women's pain is considered "natural" or "inevitable" resulting in slow diagnosis and limited treatment options.[881] Consequently, if there is no research that has asked about women's experiences, the fight against stereotypes will remain rather weak and superficial.

At the same time it is significant that even when the research does exist it is often ignored. This again requires questions about knowledge production and academia: who is being hired, promoted, whose work is cited? Who are the people teaching law and what are they teaching? Is "gender and law" an elective course for some or a natural part of every law student's curriculum? Furthermore, it is not an accident that there are many (predominantly male) human rights scholars who do neither consider nor engage with feminist works as if the decades' long conversations have not been happening.[882] Or how many scholars from the Global North whose scholarship – even when it discusses countries and case-studies outside of Europe or North America – ignores scholarly work from the Global South. These gaps in research directly affect policy-making, laws, education and what gets considered/accepted as "evidence" in courts and tribunals.

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[879] See: A. Saini, *Inferior: How Science Got Women Wrong - and the New Research That's Rewriting the Story* (2017).

[880] A. Dahlqvist, *It's Only Blood* (2018), p. 100. Furthermore, Dahlqvist writes on p. 107: "No one knows. No one listens. Ignorace and Indifference are common denominators for the entire family of menstruation-related ill health: menstrual pains, endomentriosis, PMS, PMDD. There is no doubt that it is an exceptionally underexplored are in relation to the very large group who are affected – like the infections connected with menstrual management. Not to say alarmingly low priority. It is as if it does not even belong in the medical sphere".

[881] H. Massy-Beresford, "Non-invasive tests to provide quicker diagnosis of endometriosis", 19 July 2018, available at: https://horizon-magazine.eu/article/non-invasive-tests-provide-quicker-diagnosis-endometriosis_en.html?utm_source=twitter&utm_medium=s (accessed 16 August 2018).

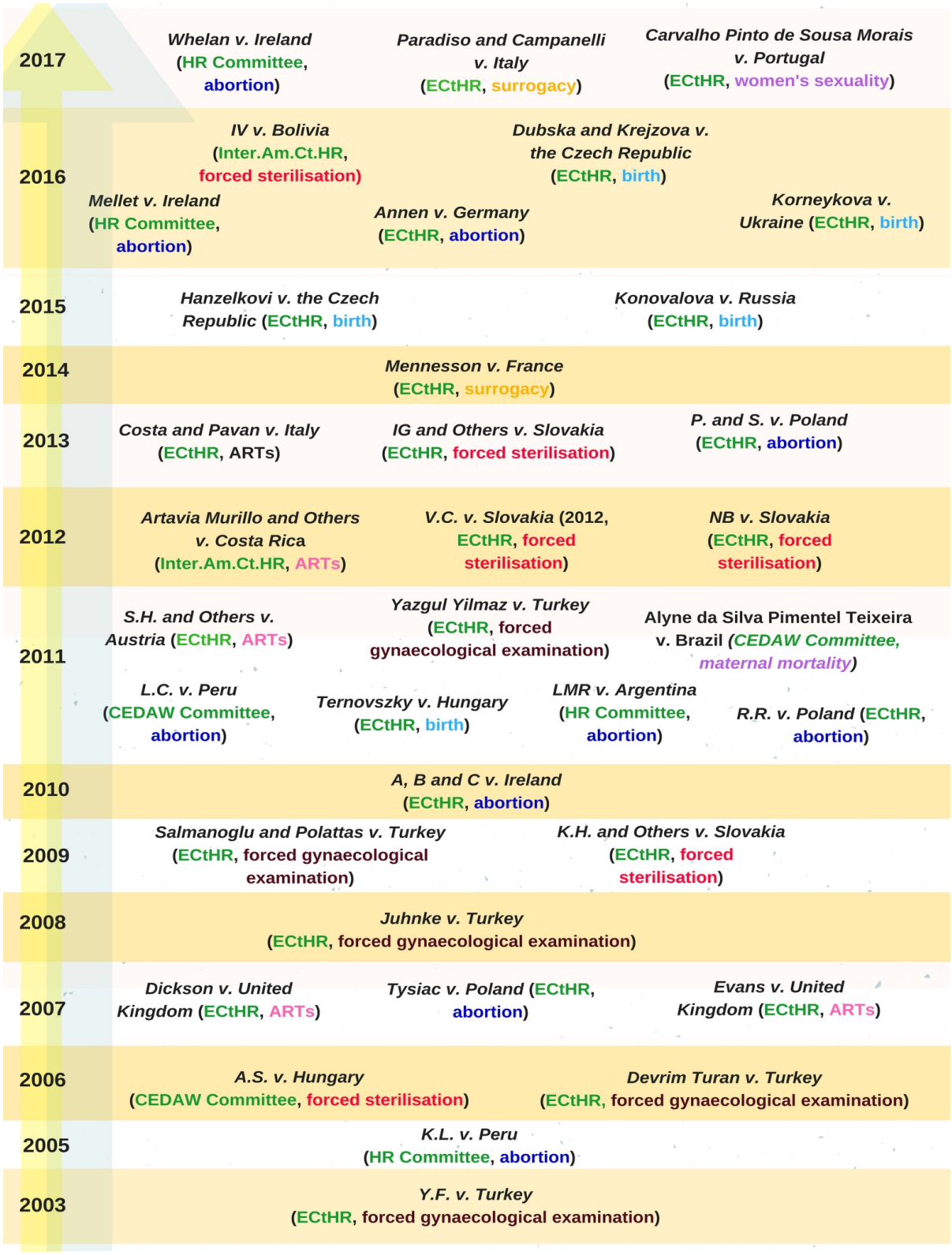
[882] See for example: M. L. Dion, J. L. Sumner, S. M. Mitchell, "Gendered Citation Patterns across Political Science and Social Science Methodology Fields", *Political Analysis*, Vol. 26, Issue 3 (2018).

Another important further conclusion is that the understanding of human rights-based approaches to health (reproductive and sexual health included) cannot remain within the legal discipline only – be something that "lawyers do, understand and define". Instead, in order to design health care systems that put their focus on human rights, the conversations about rights need to transcend the legal community. Health care professionals need to be asked how they define and understand autonomy, violence, consent, sexuality, and sexual and reproductive rights should also feature in every medical school curriculum – again, not as an occasional elective course but as something fundamental.

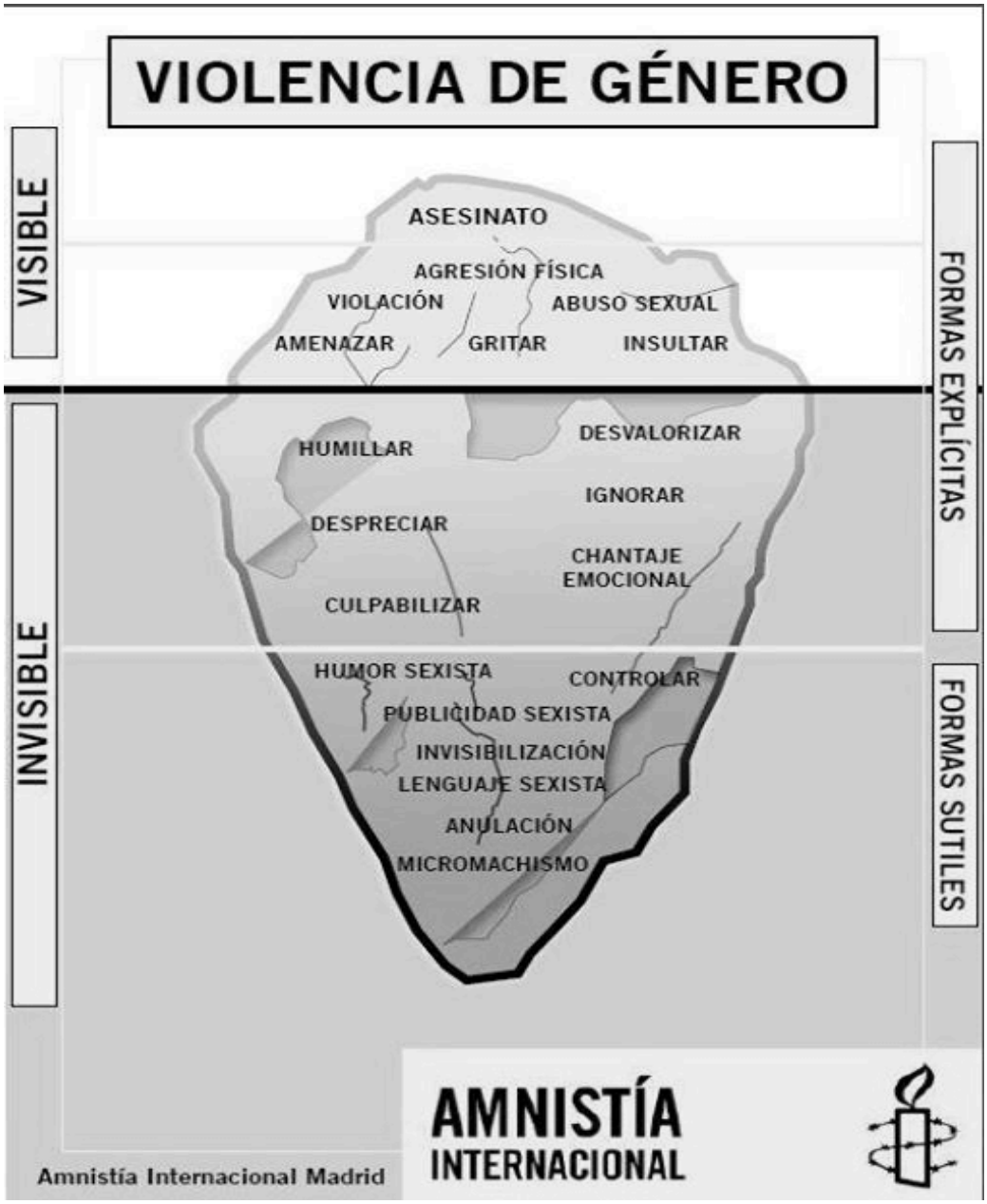
Thus, my work can be read in several ways and it can inspire an push for multiple conversations by problematising the ways in which transnational reproduction jurisprudence narrates women's roles, sexuality and bodies and more broadly how such harmful depictions are part of a larger resistance against feminist approaches in the legal discipline. Therefore, as Yaa Gyasi in the motto of this concluding chapter suggests, one must always ask: "*Whose story am I missing? Whose voice was suppressed so that this voice could come forth*?" and once we have looked for that missing story, we begin to get *"a clearer, yet still imperfect, picture"*.

APPENDICES

Appendix I



Appendix II


VIOLENCIA DE GÉNERO
VISIBLE
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FORMAS EXPLÍCITAS
FORMAS SUTILES
ASESINATO
AGRESIÓN FÍSICA
VIOLACIÓN
ABUSO SEXUAL
AMENAZAR
GRITAR
INSULTAR
HUMILLAR
DESVALORIZAR
IGNORAR
DESPRECIAR
CHANTAJE EMOCIONAL
CULPABILIZAR
HUMOR SEXISTA
CONTROLAR
PUBLICIDAD SEXISTA
INVISIBILIZACIÓN
LENGUAJE SEXISTA
ANULACIÓN
MICROMACHISMO
AMNISTÍA INTERNACIONAL
Amnistía Internacional Madrid

Appendix III

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