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Sexual and Reproductive Health and Rights during the COVID-19 pandemic in Poland, the UK, and the Netherlands

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Abstract

The COVID-19 pandemic has brought unforeseen challenges to human rights as states attempt to curb the spread of the virus. In light of the disproportionate consequences of the pandemic on women, this thesis examines the impact of COVID-19 on sexual and reproductive health and rights (SRHR) in Poland, the United Kingdom, and the Netherlands. Through an analysis of human rights obligations, this thesis questions the extent to which states may use restrictions and derogations to respond to the crisis. By comparing legal and regulatory changes affecting SRHR during the pandemic in three case studies, positive and negative developments are identified and commented upon from a human rights perspective. Through the case studies, this thesis highlights that COVID-19 represented a window of opportunity for both welcome progress and unlawful regress in the area of SRHR. Finally, it argues that a fair and just answer to the difficult balancing question between public health and human rights can only be found if human rights are placed at the center of response efforts. Thus, this thesis suggests and explores the application of a feminist human rights-based approach to public health emergencies.

Key words: COVID-19, sexual and reproductive rights, public health, derogations, abortion, telemedicine.

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Abbreviations

CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CEDAW	International Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CoE	Council of Europe
CRC	Convention on the Rights of the Child
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
ESC	European Social Charter (Revised)
ESR	Economic and social rights
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICJ	International Court of Justice
IHR	International Health Regulations
NIHRC	Northern Ireland Human Rights Commission
OHCHR	Office of the United Nations High Commissioner for Human Rights
PACE	Parliamentary Assembly of the Council of Europe
PPE	Personal protective equipment
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
UK	United Kingdom
UN	United Nations
UDHR	Universal Declaration of Human Rights
UNFPA	United Nations Population Fund
UNTS	United Nations Treaty Series
WHO	World Health Organization

1 Introduction

Currently, the world is facing a highly demanding crisis. As I start writing this thesis in late March 2021, we have seen the COVID-19 pandemic play out for more than a year in Europe, and the virus continues to dictate many aspects of everyday life. Over the past year, states have implemented an array of measures to protect their population from the virus, ranging from the prohibition of public events, introducing the obligation to wear a mask in public, to implementing lockdowns and curfews. While these measures aim to protect public health by avoiding the further spread of the virus, they have far-reaching consequences for the fulfillment of other international human rights. Nevertheless, in exceptional situations such as a global pandemic, lockdown measures might be justified and could be within the legal range of actions a state can take. For this reason, the question arises in how far states can restrict human rights to protect the public from the further spread of COVID-19.

1.1 Background

When assessing states' responses to the pandemic, it is apparent that states are confronted with a tricky balancing act. In particular, in their fight against the COVID-19 virus, states face the challenge of the pandemic's unequal impact on women[1] and men.[2] In nearly every aspect of life, the pandemic results in different consequences for women and men: from carrying a heavier burden in the workspace, struggling with higher rates of gender-based violence,[3] and, what this thesis will focus on, limited access to sexual and reproductive health services.[4] According to UN Women, 2020 has been the year of the so-called *"Shadow Pandemic"*.[5] With lockdowns and stay-at-home orders in place, women and girls increasingly find themselves in precarious situations as they are confined with their abusers, leading to a stark increase in

[1] In this thesis, the term "women" is used as this is also the language used in international law. However, it is important to note that access to SRHR is also highly relevant for other people, such as non-binary, trans- or birth people who can get pregnant.
[2] UNFPA, 'COVID-19: A Gender Lens - Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality' (2020) 5 <https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_A_Gender_Lens_Guidance_Note.pdf> accessed 7 April 2021.
[3] United Nations, 'Put Women and Girls at Centre of COVID-19 Recovery: UN Secretary-General' (*UN Website*, 9 April 2020) <https://news.un.org/en/story/2020/04/1061452> accessed 6 April 2021.
[4] Clare Wenham and others, 'Women Are Most Affected by Pandemics - Lessons from Past Outbreaks' (2020) 583 Nature 194, 194; UNFPA, 'COVID-19: A Gender Lens - Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality' (n 2) 4.
[5] UN Women, 'COVID-19 and Ending Violence Against Women and Girls' (2020) <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006> accessed 30 March 2021.

violence against women, particularly domestic violence.[6] For example, during the first lockdown in March 2020, France noted an increase of 30 % in reported domestic violence.[7] A Ukrainian organization providing support to victims of domestic violence even reported 40 % more complaints than before the pandemic.[8]

In light of this, the provision of sexual and reproductive health services is now more critical than ever. However, in reality, women's real-life experiences show a very mixed picture, with some countries taking proactive measures to ensure women's rights and others using the pandemic as an opportunity to introduce restrictions on reproductive health services.[9] During the past year, providers and women seeking care faced a multitude of challenges. As the fight against COVID-19 already strained the states' health systems, many clinics lacked personnel and protective equipment, making access to sexual and reproductive health services increasingly difficult.[10] At times, the disruption of global supply chains called the availability of contraceptives into question.[11] This already precarious situation was exacerbated by states' lockdown measures to avoid a further spread of the pandemic, as they posed additional hurdles for women to access care. Some countries, such as Slovakia[12] and certain US states[13], classified abortion as a non-essential service in order to support the struggling health sector. In the US, this prohibition and postponement of abortions was explicitly introduced to save personal protective equipment (PPE).[14]

Even if some countries did not explicitly restrict access to SRHR, lockdown measures posed new, nearly insurmountable hurdles for women. With stay-at-home orders and travel restrictions in place, many women chose not to seek care due to the fear of being exposed to

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[6] ibid.

[7] 'Domestic Violence Cases Jump 30% during Lockdown in France' (*Euronews*, 27 March 2020) <https://www.euronews.com/2020/03/28/domestic-violence-cases-jump-30-during-lockdown-in-france> accessed 7 April 2021.

[8] Jashodhara Dasgupta and others, 'Axes of Alienation: Applying an Intersectional Lens on the Social Contract during the Pandemic Response to Protect Sexual and Reproductive Rights and Health' (2020) 19 International Journal for Equity in Health 1, 3.

[9] Caroline Moreau and others, 'Abortion Regulation in Europe in the Era of COVID-19: A Spectrum of Policy Responses' (2020) 0 BMJ Sexual & Reproductive Health 1, 1; Deborah J Bateson and others, 'The Impact of COVID-19 on Contraception and Abortion Care Policy and Practice: Experiences from Selected Countries' (2020) 46 BMJ Sexual & Reproductive Health 241, 242.

[10] Jaime Todd-Gher and Payal K Shah, 'Abortion in the Context of COVID-19: A Human Rights Imperative' (2020) 28 Sexual and Reproductive Health Matters 1, 28.

[11] UNFPA, 'Impact of COVID-19 on Family Planning: What We Know One Year into the Pandemic' (2021) <https://www.unfpa.org/sites/default/files/resource-pdf/COVID_Impact_FP_V5.pdf> accessed 16 March 2021.

[12] Olga Pietruchova, 'Access to Abortion Services for Women in the EU - Slovakia' (*European Parliament* 2020) 13 <https://www.europarl.europa.eu/RegData/etudes/IDAN/2020/659922/IPOL_IDA(2020)659922_EN.pdf> accessed 28 March 2021; Todd-Gher and Shah (n 10) 28.

[13] Rachel K Jones, Laura Lindberg and Elizabeth Witwer, 'COVID-19 Abortion Bans and Their Implications for Public Health' (2020) 52 Perspectives on Sexual and Reproductive Health 65, 65.

[14] Jones, Lindberg and Witwer (n 13).

the virus.[15] It is conceivable that access to health care when living with a controlling partner is made more difficult during a lockdown.[16] Additionally, travel restrictions made it effectively impossible for some women to access treatment. This was particularly common in countries where abortion remains illegal or limited to a few exceptions, for example, in Malta. Maltese women who previously relied on international travel to access abortion in neighboring countries could no longer do so when international flights were suspended and were thus left to resort to illegal or unsafe methods.[17]

It is necessary to consider these consequences of COVID-19 lockdown measures on women's ability to access care within the broad picture of pre-existing hurdles. Even before the pandemic hit, geographical factors, such as a person's socioeconomic status, or even stigma and discrimination, posed obstacles to access to reproductive care.[18] Recent developments have not improved women's abilities - many women were (and will be) disproportionately affected by the economic downturn caused by the pandemic while taking up the increased amount of unpaid care work at home.[19] Combined with school closures in various countries, women need to be able to afford child care and travel expenses when seeking reproductive health care.[20] Therefore, especially economic hurdles could have a significant impact on the access to SRHR during the pandemic.[21] In a survey conducted by the Guttmacher Institute, almost 30% of women reported worry concerning their financial means to access sexual and reproductive health services, for example, contraceptives, during the pandemic.[22] A higher number of Hispanic, queer, and low-income women reported increased worry, which could indicate the pandemic reaffirming previously existing inequalities in

[15] Daniel Schensul and Purba Tyagi, 'My Body, My Life, My World Through a COVID-19 Lens' (2020) 19 <https://www.unfpa.org/sites/default/files/pub-pdf/COVID19_My_Body_My_Life_My_World_.pdf> accessed 13 July 2021.
[16] Abigail RA Aiken and others, 'Demand for Self-Managed Online Telemedicine Abortion in Eight European Countries during the COVID-19 Pandemic: A Regression Discontinuity Analysis' (2021) 0 BMJ Sexual & Reproductive Health 1.
[17] Liza Caruana-Finkel, 'Abortion in the Time of COVID-19: Perspectives from Malta' (2020) 28 Sexual and Reproductive Health Matters 54, 55.
[18] Elizabeth Chloe Romanis, Jordan A Parsons and Nathan Hodson, 'COVID-19 and Reproductive Justice in Great Britain and the United States: Ensuring Access to Abortion Care during a Global Pandemic' (2020) 7 Journal of Law and the Biosciences 1, 2; Clare Wenham, 'The Gendered Impact of the COVID-19 Crisis and Post-Crisis Period' (*European Parliament* 2020) 44–45 <https://www.europarl.europa.eu/RegData/etudes/STUD/2020/658227/IPOL_STU(2020)658227_EN.pdf> accessed 19 March 2021.
[19] United Nations, 'Put Women and Girls at Centre of COVID-19 Recovery: UN Secretary-General' (n 3).
[20] Jones, Lindberg and Witwer (n 13) 66.
[21] Laura D Lindberg and others, 'Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences' (2020) 6 <https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health>.
[22] ibid 5.

society.[23] Thus, particular attention should be paid to the pandemic's consequences for vulnerable or marginalized groups and their SRHR.

These developments illustrate that lockdown measures, even if they do not always address women specifically, can have a far-reaching and long-lasting impact on women's sexual and reproductive health and rights (SRHR). These significant consequences for SRHR are not a new phenomenon: similar experiences were made during other public health emergencies, such as the Zika or Ebola epidemics.[24] During these epidemics, it quickly became clear that the lack of access to SRHR services during public health emergencies has dire consequences and can result in a higher number of unintended pregnancies, unsafe abortions, and complications for pregnant women.[25]

While the concrete impact of COVID-19 on SRHR is not clear yet, early UNFPA estimates indicate that the disruption of sexual and reproductive health services could result in up to 7 million additional unintended pregnancies.[26] Moreover, the pandemic could lead to an increased number of women resorting to unsafe abortion methods.[27] The World Health Organization (WHO) warns that a mere 10 % reduction in SRHR services could result in more than 3 million additional unsafe abortions worldwide in the next year.[28]

Although these numbers represent a worrisome development, it is crucial to highlight that the pandemic also comes with a moment of opportunity. Previous experiences during health emergencies in Brazil and West Africa showed that the inclusion of a gender-sensitive approach to health emergencies improves health interventions' success, promoting gender equality and health equity.[29] Therefore, it is crucial to examine and evaluate the pandemic's consequences for women's sexual and reproductive rights, as the gendered impact of COVID-19 will be felt long after the pandemic itself is overcome – whether it is negative or positive.

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[23] ibid.
[24] Wenham (n 18) 9.
[25] Kelli Stidham Hall and others, 'Centring Sexual and Reproductive Health and Justice in the Global COVID-19 Response' (2020) 395 The Lancet 1175, 1176.
[26] UNFPA, 'Coronavirus Disease (COVID-19) Pandemic UNFPA Global Response Plan' (2020) <https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA_Global_Response_Plan_Revised_June_2020_.pdf> accessed 10 June 2021.
[27] Wenham (n 18) 47.
[28] World Health Organization, 'Maintaining Essential Health Services: Operational Guidance for the COVID-19 Context' (2020) 29 <https://apps.who.int/iris/handle/10665/332240> accessed 16 March 2021.
[29] UNFPA, 'COVID-19: A Gender Lens - Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality' (n 2) 6.

1.2 Aim and research questions

This thesis aims to contribute a perspective on how measures in response to COVID-19 affect the protection of sexual and reproductive rights. Thus, the research question is: *"How have women's sexual and reproductive health rights been affected in Europe during the COVID-19 pandemic?"*. Since this research question is quite broad, the thesis focuses on specific aspects of sexual and reproductive health and rights, such as access to reproductive health care. Therefore, some aspects of SRHR cannot be addressed in detail, as will be explained later in the delimitations section. Accordingly, this thesis aims to fulfill the following objectives:

- Identify state obligations regarding the protection of SRHR during COVID-19.
- Analyze how states have considered SRHR during the implementation of COVID-19 lockdown measures.
- Consider the role and relationship between public health and human rights during the implementation of COVID-19 lockdown measures in Europe.
- Explore a feminist human rights-based approach to the COVID-19 response and, based on this approach, identify good practices in states' responses concerning SRHR, particularly when it comes to the needs of vulnerable groups.
- Based upon the results of the case studies, make recommendations on the protection of SRHR during public health emergencies by applying a feminist human rights-based approach.

1.3 Methodological, theoretical, and material aspects

1.3.1 Establishing the theoretical background

The theoretical background of this thesis is established through a legal analysis of international law sources, which are enumerated in art. 38(I) of the ICJ Statute[30]. By analyzing jus cogens, international customary law, general principles of international law and international treaty law, state obligations concerning sexual and reproductive health and rights during normal times and COVID-19 are identified. Thus, the primary sources analyzed are international and regional human rights instruments, such as the Universal Declaration of Human Rights[31], the International Covenant on Economic, Social and Cultural Rights

[30] Statute of the International Court of Justice (signed on 26 June 1945, entered into force 24 October 1945) 993 TS 3 (ICJ Statute).
[31] Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 2017 A(III) (UDHR).

(ICESCR)[32], the International Covenant on Civil and Political Rights (ICCPR)[33], the International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[34], the European Convention on Human Rights (ECHR)[35], and the Revised European Social Charter (ESC)[36]. Other human rights treaties and conventions such as the Convention on the Rights of the Child (CRC)[37], the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)[38], the Convention against Torture (CAT)[39] and the Istanbul Convention[40], are mentioned briefly if they are of particular relevance. Additionally, the Vienna Convention on the Law of Treaties (VCLT)[41] is referred to for guidance in interpretation. Further, a selection of the most relevant general comments and concluding observations of United Nations (UN) treaty bodies, such as the Human Rights Committee or the Committee on Economic, Social and Cultural Rights, will be considered.

1.3.2 Why comparative law is applied

In the three case studies, comparative law is applied. Depending on the chosen comparative law method, it can address multiple aims, from gathering knowledge about model solutions to a specific problem, informing on legislator's decisions, contributing to the unification of law, to the development of law.[42] In this thesis, the comparison of three states serves to highlight different approaches in respecting, protecting, and fulfilling SRHR in Europe during COVID-19. According to Baxter & Jack, case studies provide an array of data that allows the

[32] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR)
[33] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR).
[34] Convention on the Elimination of All Forms of Discrimination Against Women (opened for signature, ratification and accession on 18 December 1979, entered into force on 3 September 1981) 1249 UNTS 13 (CEDAW).
[35] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR).
[36] European Social Charter (revised) (opened for signature on 3 May 1996, entered into force on 1 July 1999) ETS 163 (ESC).
[37] Convention on the Rights of the Child (opened for signature, ratification and accession on 20 November 1989, entered into force on 2 September 1990) 1577 UNTS 3 (CRC).
[38] International Convention on the Elimination of All Forms of Racial Discrimination (adopted and opened for signature and ratification on 21 December 1965, entered into force on 4 January 1969) 660 UNTS 195 (ICERD).
[39] Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted and opened for signature, ratification and accession on 10 December 1984, entered into force 26 June 1987) 1465 UNTS 85 (CAT).
[40] Council of Europe Convention on preventing and combating violence against women and domestic violence (opened for signature and accession on 11 May 2011, entered into force on 1 August 2014) CETS no. 210 (Istanbul Convention).
[41] Vienna Convention on the Law of Treaties (opened for signature 23 May 1969, entered into force 27 January 1980) 1155 UNTS 331 (Vienna Convention).
[42] Konrad Zweigert and Hein Kötz, *Introduction to Comparative Law* (3rd rev. ed, Clarendon Press 2011) 15-16.

researcher to develop a more comprehensive understanding of a current issue.[43] By providing insight from several perspectives, a researcher can develop a more solid understanding of the issue at hand and draw more credible conclusions.[44] Thus, an analysis of the situation in three countries, Poland, the UK, and the Netherlands, provides samples to understand the real-life situation in Europe regarding sexual and reproductive health and rights during the COVID-19 pandemic. As for the UK, a focus will solely lie on its two constituent parts Northern Ireland and England. These specific countries were chosen for several reasons. While they are all part of the CoE and thus part of the regional European human rights system, they had diverse responses to the COVID-19 pandemic and chose different approaches regarding SRHR.[45] Additionally, an analysis of three CoE-member states allows for a more general conclusion on the situation within the CoE. On this basis, it will be possible to compare different approaches to the COVID-19 response and SRHR and draw conclusions on human rights-based practices.

1.3.3 The comparative law method chosen for this thesis

All too often, legal practitioners show the tendency to see the rules and regulations of their own system as the basis for their comparisons.[46] However, the fact that another legal system includes or does not include the same particular rule is not sufficient to draw any meaningful conclusions.[47] Therefore, the comparative law method chosen for this thesis comprises a *functional* approach.[48] Instead of comparing the existence of a legal rule, it is analyzed *how* the legal system addresses a specific problem in practice.[49] By focusing on the concrete question, which is the protection of SRHR during COVID-19, conclusions can be drawn on the positive or negative impacts of different approaches to the same challenge at hand. Thus, the comparative law method is applied in this thesis to identify and evaluate the different approaches states have chosen to protect sexual and reproductive health during the pandemic while considering their differing legal systems, history, and culture.

[43] Pamela Baxter and Susan Jack, 'Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers' (2008) 13 The Qualitative Report 544, 544.
[44] ibid 554.
[45] Moreau and others (n 9) 9.
[46] Zweigert and Kötz (n 42) 35.
[47] ibid.
[48] ibid 34.
[49] ibid 35.

1.4 Delimitations

Due to the broad scope of the research questions and the broad concept of sexual and reproductive health, this thesis will focus on *access* to reproductive services during public health emergencies. I will not go into SRHR-related issues such as assisted reproduction, surrogacy, gender-based violence, harmful practices such as female genital mutilation, and the right to abortion. Particularly, it is not the aim of the research to determine or comment upon whether states have or should have an obligation to legalize abortion on request, including for economic or social reasons. This question has been subject to previous discussion and research and will only be mentioned briefly; a comprehensive discussion would exceed the scope of this thesis.[50] While certain developments towards a right to abortion could be observed during the last years, a true right to abortion international level does not seem to exist yet.[51] Only if the life or health of the women is significantly at risk, or if the pregnancy was caused by rape or incest, international human rights seem to extend a partial right to abortion to women.[52] Therefore, no extensive comment on the legal, moral and ethical issue of whether abortion should be allowed on demand for any reason will be made, as this would move the focus from the topic at hand. This has been a choice to handle the chosen research questions in some depth.

1.5 Outline of the thesis

This thesis consists of six parts. The current chapter (1) introduces the issue of sexual and reproductive health and rights (SRHR) during COVID-19, highlighting the potential negative consequences on women's rights that could occur as states are responding to the crisis. Additionally, the chapter outlines the chosen comparative law method for this thesis and explains the delimitations and general outline of the research.

Subsequently, chapter 2 establishes the theoretical background. To begin with, the chapter explores the development and definition of the concepts of sexual health and reproductive health. It defines sexual and reproductive health and rights (SRHR) for the context of this thesis. Then, the relationship between SRHR and public health is considered,

[50] Federico Fabbrini, 'The Right to Abortion', *Fundamental Rights in Europe* (Oxford University Press 2014) 246–247; Christina Zampas and Jaime M Gher, 'Abortion as a Human Right - International and Regional Standards' (2008) 8 Human Rights Law Review 249, 292; Audrey Lebret, 'The European Court of Human Rights and the Framing of Reproductive Rights' (2020) 18 Droits fondamentaux 40.
[51] Zampas and Gher (n 50) 255; Rebecca J Cook, 'Gender, Health and Human Rights' in Michael A Grodin and others (eds), *Health and Human Rights in a Changing World* (Routledge 2013) 344; Maja Kirilova Eriksson, *Reproductive Freedom: In the Context of International Human Rights and Humanitarian Law* (Kluwer Law International 2000) 317.
[52] Zampas and Gher (n 50) 255.

focusing on the relationship between human rights and public health during health emergencies. In this context, the concept of a feminist human rights-based approach to public health emergencies is introduced, forming the basis of analysis for the case studies and recommendations in the subsequent chapters.

Chapter (3) examines how international human rights law incorporates the concept of SRHR. It analyses human rights obligations regarding SRHR, taking into account the delimitations mentioned above. For this purpose, the chapter examines jus cogens, international customary law, and international and regional human rights treaties, as well as general comments and concluding observations from UN treaty bodies if relevant.

Following this, chapter (4) considers the international and regional human rights treaties mentioned above regarding the possibility of human rights limitations and derogations in times of emergencies. It will be analyzed under which conditions states may introduce human rights restrictions or limitations during COVID-19 and tries to shed light on minimum standards concerning SRHR that have to be upheld at all times.

In chapter (5), concrete measures and their impact on sexual and reproductive rights will be analyzed by applying a feminist human rights-based approach to three case studies. In particular, it will be considered whether the UK, Poland, and the Netherlands implemented legal or regulatory changes with consequences for SRHR during COVID-19, and how these can be evaluated from a human rights perspective.

Lastly, in chapter (6), the case study analysis will be concluded, which includes a comparison of positive and negative practices regarding SRHR during COVID-19, followed by recommendations on the protection of SRHR during COVID-19 and future pandemics.

2 Theoretical background

2.1 Sexual and reproductive health and rights: concepts and definition

First, the definition and concept of sexual and reproductive health and rights (SRHR) has to be considered. The concept refers to the two terms "sexual health" and "reproductive health". While these terms often used in combination or interchangeably, should be distinguished.[53]

2.1.1 The concept and definition of reproductive health

On the international level, the formalization of the concept of reproductive health can be traced back to the end of the 20th century, where it played a significant role during the 1994 UN Conference on Population and Development (ICPD) in Cairo and the 1995 UN Conference on Women in Beijing.[54] As a result of the 1994 Conference in Cairo, the so-called Programme of Action, which defines reproductive health, and in part, sexual health, was adopted by more than 179 countries. Until today, these definitions remain current.

As elaborated in the Programme of Action and restated in the Beijing declaration, reproductive health is defined as *"*[…] *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes* […]*"*.[55] The definition goes on to highlight several major aspects of the concept of reproductive health, namely the individual's freedom to decide if and when to reproduce, supported by having access to *"*[…] *safe, effective, affordable and acceptable methods of family planning* […]*"*.[56] Additionally, the importance of access to safe and appropriate maternal health services is underlined.[57]

Ultimately, what makes the definition of reproductive health so unique is that it goes much further than merely ensuring the absence of reproductive health issues, as it additionally incorporates sexual health.[58] Even though the Programme of Action does not define sexual health explicitly,[59] some of its aspects are enumerated within the definition of reproductive

[53] Thérèse Murphy, *Health and Human Rights* (Colin Harvey ed, Hart Publishing 2013) 162.
[54] Rebecca J Cook, Bernard M Dickens and Mahmoud F Fathalla, *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law* (Oxford University Press 2003) 11–12; Sonia Corrêa and Rebecca Lynn Reichmann, *Population and Reproductive Rights: Feminist Perspectives from the South* (Zed Books 1994) 61.
[55] United Nations, 'Platform for Action and Beijing Declaration' (Department of Public Information 1995) para 94 <https://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf> accessed 26 April 2021
[56] ibid.
[57] ibid.
[58] Cook, Dickens and Fathalla (n 54) 12.
[59] World Health Organization, 'Defining Sexual Health: Report of a Technical Consultation on Sexual Health 28-31 January 2002, Geneva' (2006) 4

health. According to the Programme of Action, sexual health includes "[…] *the ability to enjoy mutually fulfilling sexual relationships, freedom from sexual abuse, coercion, or harassment, safety from sexually transmitted diseases, and success in achieving and preventing pregnancy.*".[60] As a result, the focus of reproductive health care is no longer only on sex as a means for reproduction but also as a means to ensure a person's well-being through "[…] *the enhancement of life and personal relations*".[61]

2.1.2 The concept and definition of sexual health

A more detailed definition of sexual health is provided by the WHO, which argues that the current concept of sexual health is broader than the concept of reproductive health and should also be considered independently.[62] Though it does not reflect the official WHO position, in 2006, the organization published a working definition of sexual health as "[…] *a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.*".[63] In that respect, sexuality is understood as "[…] *a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, roles and relationships.* […] *Sexuality is the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.*".[64]

<https://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf> accessed 10 April 2021.

[60] Cook, Dickens and Fathalla (n 54) 8.

[61] United Nations, 'Platform for Action and Beijing Declaration' (n 55) para 94; Cook, Dickens and Fathalla (n 54).

[62] World Health Organization, 'Developing Sexual Health Programmes: A Framework for Action' (2010) IV WHO/RHR/HRP/10.22 <http://apps.who.int/iris/bitstream/handle/10665/70501/WHO_RHR_HRP_10.22_eng.pdf?sequence=1> accessed 17 March 2021 .

[63] World Health Organization, 'Defining Sexual Health: Report of a Technical Consultation on Sexual Health 28-31 January 2002, Geneva' (n 59) 5.

[64] ibid.

2.1.3 Contentious aspects of reproductive health

It is important to note that during the ICPD, states could not form a consensus on the issue of abortion.[65] While some authors argue that the drafters of the Programme of Action intended to legalize abortion, many governments and the Holy Sea explained that their understanding of reproductive health does not include access to abortion.[66]

Looking at the provisions in the text itself, one cannot deduct a clear intent to work towards the legalization of abortion. Para. 8.25 of the Programme of Action emphasizes that abortion should "[…] *in no case be promoted as a method of family planning*".[67] The same paragraph only mentions that in countries where abortion is already legalized, it should be safe.[68] Thus, this provision recognizes safe and legal abortion as a means of fertility control as part of reproductive health.[69] However, as the Programme of Action does not go further than this, whether the concept of reproductive health calls for the general legalization of abortion remains one of the concept's most controversial aspects.

2.1.4 The concept of reproductive justice

As a short but critical side note, it must be mentioned that many feminist and reproductive health activists do not find the previously discussed sexual and reproductive health and rights discourse adequate to address the real-life issues faced by women, particularly those who are part of marginalized groups.[70] Instead, calls for reproductive justice are increasing. This concept originated as a consequence of the struggles experienced by women of color and indigenous women in the United States.[71] While highlighting the importance of reproductive freedoms of the individual, the concept of reproductive justice additionally emphasizes how invisible structures, such as economic, political, or social circumstances, negatively impact women's ability to exercise these rights.[72]

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[65] Mindy Roseman and Laura Reichenbach, 'Global Reproductive Health and Rights: Reflecting on ICPD' in Laura Reichenbach and Mindy Jane Roseman (eds), *Reproductive Health and Human Rights: The Way Forward* (University of Pennsylvania Press 2011).
[66] Eriksson (n 51) 172.
[67] United Nations, 'Report of the International Conference on Population on Development, Cairo, 5-13 September 1994 - Programme of Action' (United Nations Secretariat 1994) UN Doc A/CONF.171/13/Rev.1 para 8.25.
[68] ibid.
[69] Eriksson (n 51) 177.
[70] Kalpana Wilson, 'In the Name of Reproductive Rights: Race, Neoliberalism and the Embodied Violence of Population Policies' (2017) 91 New Formations 50, 66–67.
[71] ibid 72.
[72] ibid.

2.1.5 Definition of SRHR in this thesis

In this thesis, the aforementioned definitions of sexual health and reproductive health are applied. Following a rights-based approach, sexual and reproductive rights are understood as all human rights guaranteeing sexual and reproductive health. These include the right to freely decide the number and spacing of one's children, to have the information, education, and the means to exercise this right,[73] as well as all rights that serve to protect the fulfillment and expression of one's sexuality and the enjoyment of sexual health.[74]

2.2 The relationship between public health and human rights

The next question concerns the relationship between human rights (particularly SRHR) and public health, especially during public health emergencies.

2.2.1 The definition of public health and its connection to SRHR

Public health and human rights, and SRHR in particular, are closely intertwined. There are various broader and narrower definitions of public health,[75] depending on the context, for example, in international law or domestic law. For this thesis, following the WHO's approach, public health is defined as *"the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society"*.[76] Public health focuses on creating an environment that ensures the health of the population as a whole, rather than solely the individual's health.[77] Nevertheless, public health also requires measures to ensure the health of individuals, as they are the foundation of the community as such. Only if predominantly healthy individuals make up the community, the community can be healthy too.[78] Furthermore, certain conditions affecting individuals, such as sexually transmitted infections, can affect the health of the general population.[79]

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[73] Paola A Guzman Alejandro, 'Reproductive Rights' (2020) 89 Revista Juridica Universidad de Puerto Rico 249, 266; Lynn P Freedman and Stephen L Isaacs, 'Human Rights and Reproductive Choice' (1993) 24 Studies in Family Planning 18, 19.
[74] World Health Organization, 'Developing Sexual Health Programmes: A Framework for Action' (n 62) 4.
[75] Lawrence O Gostin (ed), *Public Health Law and Ethics: A Reader* (2010) 2.
[76] 'Public Health Services' (*World Health Organization | Europe*) <https://www.euro.who.int/en/health-topics/Health-systems/public-health-services/public-health-services> accessed 5 May 2021.
[77] Lawrence O Gostin, 'A Theory and Definition of Public Health Law' (2007) 10 Journal of Health Care Law & Policy 1, 7.
[78] ibid.
[79] ibid.

Examples of public health issues closely related to SRHR are maternal mortality and morbidity due to unsafe abortions.[80] By addressing these public health issues, for example, by improving the availability of family planning services, states may simultaneously fulfill crucial SRHR, which will be explained in further detail in chapter 3.

However, this strong correlation between public health and human rights is not always a mutually beneficial relationship. The implementation of public health policies can also adversely affect human rights. For example, targeting one specific disease may lead to a prioritization of health issues that does not consider the experience of marginalized groups and the human rights principle of non-discrimination.[81] Similarly, the assessment of public health through studies like phone surveys may raise human rights concerns in terms of data protection and privacy.[82] In the past, there have been tensions between ensuring public health and respecting human rights, with public health being invoked to restrict the rights of individuals for the presumed common good.[83]

To conclude, public health and human rights are inseparable, as the individual's right to health is unlikely to be fulfilled in a system that does not equally protect the population's health as a whole. However, certain problems come from excessively focusing on one of the two concepts. An over-emphasis on sustaining and fulfilling public health, especially during public health emergencies, runs the risk of disregarding critical human rights principles. Therefore, it can be held that, although both concepts are conditional upon each other, simultaneously ensuring public health and human rights does not come without significant challenges.

2.2.2 Public health in times of emergency

In a globalized world, it is especially challenging for states to protect their population from public health risks such as new infectious diseases like COVID-19. When it comes to the prevention and reaction to public health crises, multiple terms have been developed to describe different versions of emergency preparedness.[84] Namely, the WHO has issued guidance on three important terms – public health security, being *"*[…] *the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of national populations"*, its international counterpart global

[80] Zampas and Gher (n 50) paras 255–256.
[81] JM Mann and others, 'Health and Human Rights' (1994) 1 Health & Human Rights 6, 13.
[82] ibid 14.
[83] ibid 15.
[84] Murphy (n 53) 58–59.

public health security, which *"widens this definition to include acute public health events that endanger the collective health of populations living across geographical regions and international boundaries"*,[85] and finally, public health emergency legal preparedness, which describes having a sufficient legal framework in place and implementing it accordingly during a public health emergency[86].

Given that during the COVID-19 pandemic, international organizations and non-governmental organizations issued numerous statements on the importance of upholding international human rights law in emergency responses, one starts to wonder: How are international human rights integrated into the response to public health emergencies? What role does or could a human rights-based approach play? Would a rights-based approach be able to mitigate better the disproportionate impact of health emergencies on women than the public health preparedness concepts by themselves?

2.2.3 The relationship between public health and human rights in times of emergency

In order to answer the question of the relationship between public health and human rights in times of emergency, it is first necessary to have a closer look at how global health law already incorporates human rights. An integral part of the legal framework for public health emergency preparedness are the 2005 International Health Regulations (IHR), adopted by the WHO to ensure international public health security.[87] These regulations are a legally binding attempt to harmonize state parties' approaches to preventing and mitigating public health crises.[88] One focus of the IHR is to strengthen the member states' national capacity to prevent, monitor, and respond to health emergencies through the development of national action plans in accordance with the IHR.[89] Although very brief and broadly formulated, the treaty creates a link between states' emergency responses and human rights in art. 3, setting out that the implementation of the IHR *"*[…] *shall be with full respect for the dignity, human rights, and fundamental freedoms of persons."*.[90] In theory, this leaves enough room for international human rights law in emergency responses: the WHO has to develop recommendations for

[85] World Health Organization, 'The World Health Report 2007: A Safer Future - Global Public Health Security in the 21st Century' (2007) 1, Box 1.1 <https://www.who.int/whr/2007/whr07_en.pdf> accessed 3 April 2021.
[86] Murphy (n 53) 59.
[87] World Health Organization, 'International Health Regulations (2005): Areas of Work for Implementation' (2007) WHO/CDS/EPR/IHR/2007.1 5.
[88] ibid.
[89] ibid 6.
[90] World Health Organization, 'International Health Regulations' (2005) 10 <https://www.paho.org/en/documents/international-health-regulations-2005-third-edition> accessed 5 April 2021.

health measures in compliance with human rights standards. Beyond this, states' national implementation of health measures also has to adhere to human rights standards.

Nevertheless, some argue that these brief references do not comprehensively include human rights principles in public health emergency preparedness.[91] The relatively few and vague references to human rights tend to portray human rights as a system external to the IHR (that may aid in taking effective health measures) instead of fully integrating human rights protection as a foundation to emergency responses.[92] As a result, although human rights are theoretically given a critical place in emergency responses, states and their governments can easily downplay this significance in light of an "exceptional situation" requiring "exceptional measures".

2.2.4 A feminist human rights-based approach to public health emergencies

Therefore, this thesis proposes a feminist human rights-based approach to public health emergencies, exploring whether a close focus on the international human rights system can bring a better balance into the synergy between public health and human rights, leaving no one behind. In general, the human rights-based approach is a framework that promotes and protects international human rights by addressing inequality and discrimination, building on five principles: universality, indivisibility, equality, non-discrimination, participation, and accountability.[93] This approach emphasizes holding states as duty-bearers accountable to their human rights obligations and empowering rights-holders to claim their rights.[94]

Furthermore, a gender lens will be used to enhance this approach. A *feminist* rights-based approach pays special attention to the gender impact of a law or measure and may help understand its purpose.[95] This approach was chosen in light of the undeniable disproportionate effects of the pandemic on women, which were highlighted in the introduction. Especially when asking how COVID-19-measures have impacted women's sexual and reproductive health and rights, it is, therefore, essential to focus closely on the lived experiences of women. By analyzing public health measures during COVID-19 through a feminist lens, the larger societal implications of laws and measures, for example, on gender stereotypes and gender

[91] Clare Wenham, *Feminist Global Health Security* (Oxford University Press 2021) 38; Andraž Zidar, 'WHO International Health Regulations and Human Rights: From Allusions to Inclusion' (2015) 19 International Journal of Human Rights 505, 506.
[92] Zidar (n 91) 506.
[93] UN Sustainable Development Group, 'Human Rights-Based Approach' (2021) <https://unsdg.un.org/2030-agenda/universal-values/human-rights-based-approach> accessed 4 July 2021.
[94] ibid.
[95] Duke Global Health Institute, 'Human Rights, Feminism, and Abortion Law Reform' (*YouTube*, 19 January 2018) min 45:46-45:56 <https://www.youtube.com/watch?v=FWRzx9Qe7bQ> accessed 6 July 2021.

equality, can be illuminated. It is precisely the view of the big picture and the long-term impact on women that is needed in order to make practical recommendations for future pandemics as a final step of this thesis.

2.2.5 Conclusion: Public health and human rights

To conclude, it can be held that (global) public health and human rights are inseparably linked but not always mutually beneficial. Although treaties such as the International Health Regulations recognize this connection and emphasize that international human rights law should be adhered to at all times, these references may not be sufficient to remind states of their human rights obligations. Especially during public health emergencies such as COVID-19, there is a risk that states set aside their human rights obligations in an attempt to protect public health. To explore the challenging question of striking an appropriate balance between public health and human rights, this thesis will now continue to analyze international human rights obligations concerning SRHR during normal times and public health emergencies, followed by case studies analyzed using a feminist human rights-based approach.

3 SRHR in international human rights law

This section addresses how the concept of SRHR is reflected in the human rights framework. Today, the concept of sexual and reproductive health and rights is enshrined in several international and regional human rights treaties as a human right, either explicitly or implicitly through other human rights.[96] As such, sexual and reproductive rights are protected through a framework of various interrelated human rights.[97] In this regard, *Cook et al.* identifies several categories of human rights which are of significance in relation to sexual and reproductive health:

[…]

- *life, survival, security, and sexuality;*
- *reproductive self-determination and free choice of maternity;*
- *health and the benefits of scientific progress;*
- *non-discrimination and due respect for difference; and*
- *information, education, and decision-making.*[98]

It is important to keep in mind that even if these various human rights are enumerated separately, they cannot truly be seen as separate.[99] The fulfillment of one right is most likely going to impact the fulfillment of another.

3.1 SRHR at the international level

First, a closer look is taken at the incorporation of SRHR in the international human rights framework. For this purpose, the most relevant human rights sources are analyzed to establish the scope of protection of sexual and reproductive rights. However, due to the broad scope of the concept, it is impossible to enumerate all rights and possible scenarios in which human rights provisions can be applied to protect sexual and reproductive health in this thesis; thus, it should not be seen as an exhaustive list. The analysis intends to illustrate the development of SRHR in international human rights law and consider the various approaches to address these rights.

[96] Cook, Dickens and Fathalla (n 54) 158.
[97] ibid 437-442; Martin Scheinin, 'Sexual Rights as Human Rights - Protected under Existing Human Rights Treaties?' (1998) 67 Nordic Journal of International Law 17, 17.
[98] Cook, Dickens and Fathalla (n 54) 158.
[99] ibid 159.

3.1.1 SRHR as part of jus cogens, customary international law, and general principles of international law

As articulated in art. 38(1) of the ICJ Statute, the main sources of international law are international conventions, international customary law, and general principles of law.[100] As in the article itself, there is no hierarchy between these sources. However, an exception to this are jus cogens norms, reflecting preemptory norms of international law, which are placed at a higher rank[101] and cannot be derogated from.[102] It is contested which norms are part of jus cogens, however, consensus that certain norms, such as the prohibition of slavery, the prohibition of torture or the prohibition of racial discrimination, exists.[103] Although violations of these norms will only occur in especially severe cases and therefore extremely rarely, jus cogens norms are of relevance for SRHR especially with regard to the prohibition of torture. For example, depending on the specific circumstances, forced abortions or sterilizations may amount to torture.[104]

Moreover, customary international law and the general principles of international law incorporate human rights that are relevant to SRHR. The initially non-binding Universal Declaration of Human Rights (UDHR) has since become part of customary international law, at least most of its norms.[105] For example, the principles of gender equality and non-discrimination have to be mentioned in this regard. Additionally, customary international law includes the prohibition of female genital mutilation as a harmful traditional practice.[106]

Thus, there is a range of norms relevant for SRHR within jus cogens, customary law and general principles of international law. However, international treaty law has the advantage of being more precise when it comes to deducting concrete state obligations and clarifying under which circumstances restrictions and derogations from SRHR are permissible. For this reason, this thesis will rely on treaties and conventions to provide more details on SRHR in the international human rights framework.

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[100] Statute of the International Court of Justice (signed on 26 June 1945, entered into force 24 October 1945) 993 TS 3 (ICJ Statute) art 38.
[101] Olivier De Schutter, *International Human Rights Law* (3rd edn, Cambridge University Press 2019) 85.
[102] Vienna Convention on the Law of Treaties (opened for signature 23 May 1969, entered into force 27 January 1980) 1155 UNTS 331 (Vienna Convention) art 53.
[103] De Schutter (n 101) 85.
[104] UN Human Rights Council, 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak' (2008) UN Doc A/HRC/7/3 para 38.
[105] De Schutter (n 101) para 59.
[106] Romy Klimke, 'Kapitel 7: Das Verbot von Schädlichen Traditionellen Und Kulturellen Praktiken Als Völkergewohnheitsrecht', *Schädliche traditionelle und kulturelle Praktiken im internationalen und regionalen Menschenrechtsschutz. Beiträge zum ausländischen öffentlichen Recht und Völkerrecht* (Heidelberg 2019) 486.

3.1.2 SRHR in the UDHR

The 1948 Universal Declaration of Human Rights (UDHR)[107] does not explicitly refer to reproductive rights. The only provision which slightly approaches the topic is article 25(2), stating that *"motherhood and childhood are entitled to special care and assistance.* […]".[108] However, most importantly, the UDHR provided the foundation for many other human rights relevant to the protection of sexual and reproductive rights today, for example, the right to privacy (art. 12), the right to marry and found a family (art. 16), the prohibition of discrimination (art. 7), and the prohibition of torture, cruel, inhuman, or degrading treatment or punishment (art. 5).[109] Although at the time of its making, the UDHR represented a non-binding declaration,[110] it provided an essential basis for the further development of provisions in the ICCPR[111] and ICESCR[112], which are being applied to protect aspects of SRHR today. Moreover, as mentioned before, it is conceived that the UDHR has at least in part become customary international law.[113]

3.1.3 SRHR in the ICESCR

In 1966, the UDHR was followed by the adoption of two legally binding Covenants, the ICESCR[114] and the ICCPR[115]. As in the UDHR, there is no explicit reference to sexual and reproductive rights in the ICESCR. Generally, there are only a few explicit references to sexual and reproductive health in international treaties, one of them being art. 25(a) CRPD[116]. However, even in this article, the right to sexual and reproductive health is not seen as a self-standing right but mentioned in the context of equal access to health care for people with disabilities. Thus, one quickly realizes that sexual and reproductive rights are given particular

[107] Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 2017 A(III) (UDHR).
[108] Lance Gable, 'Reproductive Health as a Human Right' (2010) 60 Case Western Reserve Law Review 957, 978.
[109] ibid 974.
[110] Eriksson (n 51) 140.
[111] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR).
[112] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR).
[113] Eriksson (n 51) 140.
[114] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR).
[115] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR).
[116] Convention on the Rights of Persons with Disabilities (adopted on 24 January 2007) A/RES/61/106 (CRPD) art 25(a): "[…] *In particular, States Parties shall: a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care* […] *including in the area of sexual and reproductive health and population-based public health programmes;* […]".

importance in the context of the right to health, enshrined in multiple human rights provisions, such as art. 25 UDHR[117], art. 12 ICESCR[118], art. 24 CRC[119] or art. 12 CEDAW[120].

The perhaps most comprehensive framework for the protection of the right to health, set out in art. 12 ICESCR[121], does not mention sexual and reproductive rights.[122] However, the Committee on Economic, Social, and Cultural Rights (CESCR) interprets this right to the highest attainable standard of health to include sexual and reproductive freedom.[123] This is in line with the interpretations of the Committee on the Elimination of Discrimination against Women and the Committee on the Rights of the Child, who have also proclaimed that the scope of the right to health includes sexual and reproductive health.[124]

The right to sexual and reproductive health under the ICESCR guarantees a broad range of freedoms to the individual, including the right to freely decide on all matters concerning one's body and sexual and reproductive health, free of violence, coercion, and discrimination.[125] States have the responsibility to *respect* the right to health by refraining from denying or limiting access to care, including access to contraceptives or other reproductive health services.[126] Under the obligation to *protect*, states must take measures to prevent others from interfering with the right to health.[127] Lastly, the obligation to *fulfill* defines the obligation to take active measures towards realizing the right to health, for example, through new legislation.[128]

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[117] Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 2017 A(III) (UDHR) art 25.
[118] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) art 12.
[119] Convention on the Rights of the Child (opened for signature, ratification and accession on 20 November 1989, entered into force on 2 September 1990) 1577 UNTS 3 (CRC) art 24.
[120] Convention on the Elimination of All Forms of Discrimination Against Women (opened for signature, ratification and accession on 18 December 1979, entered into force on 3 September 1981) 1249 UNTS 13 (CEDAW) art 12.
[121] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) art 12.
[122] Murphy (n 53) 161.
[123] ibid.
[124] UN Committee on the Elimination of Discrimination Against Women, 'General Recommendation No. 24: Article 12 of the Convention (Women and Health)' (1999) UN Doc A754/38/Rev.1 para 1; UN Committee on the Rights of the Child, 'General Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Art. 24)' (2013) UN Doc CRC/C/GC/15 para 24.
[125] UN Committee on Economic Social and Cultural Rights, 'General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)' (2016) UN Doc E/C.12/GC/22 para 5.
[126] Office of the United Nations High Commissioner for Human Rights (OHCHR), 'The Right to Health: Fact Sheet No. 31' (2008) 25-26 <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf> accesssed 11 April 2021.
[127] ibid 26.
[128] ibid 27.

In light of these three forms of obligations, art. 12 ICESCR encompasses four main areas that are significant for the protection of the right to health: ensuring (1) Availability, (2) Accessibility, (3) Acceptability and lastly (4) Quality. Thus, states have an obligation to ensure the availability of an adequate number of healthcare facilities, services, goods, and programs, as well as trained and professional personnel.[129] This obligation includes ensuring the availability of essential medicines, such as (emergency) contraceptives.[130] Accessibility describes the obligation to make all matters related to sexual and reproductive health care accessible without discrimination.[131] It requires states to ensure that health facilities and providers are within physical and geographical reach, ensuring that the lack of financial means does not pose a barrier to seeking care and ensuring the accessibility of information regarding sexual and reproductive health issues.[132] This includes the state obligation to ensure all individuals can access affordable, safe, and effective contraceptives.[133] Acceptability describes the obligation to ensure that all facilities, goods, information, and services are provided in a manner that respects the individual's background, gender, disability, and age.[134] Lastly, the state obligation to ensure quality requires current, evidence-based, and medically appropriate facilities, goods, information, and services.[135]

Moreover, states have an obligation to address underlying factors which could hinder the fulfillment of sexual and reproductive rights, such as providing access to safe and potable water, adequate sanitation, safe and healthy working conditions, health-related information, and effective protection from all forms of violence and discrimination.[136] Most importantly, in light of the previously mentioned reproductive justice concept, social dynamics that might impact the right to health have to be addressed. The CESCR has acknowledged that inequalities in society, which are affected by gender, ethnicity, age, disability, or other factors, can negatively impact the fulfillment of sexual and reproductive rights and thus need to be addressed by state parties.[137]

Additionally, the CESCR has highlighted the state obligation to eliminate any law which could undermine the right of individuals or certain groups to access sexual and reproductive

[129] Committee on Economic Social and Cultural Rights, 'General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)' (n 125) paras 12-13.
[130] ibid 13.
[131] ibid 15.
[132] ibid 16-18.
[133] ibid 28.
[134] ibid 20.
[135] ibid 21.
[136] ibid 7.
[137] ibid 8.

health care, goods, and information.[138] Gender-based violence and harmful practices, such as female genital mutilation, forced marriage, as well as domestic and sexual violence, must be prohibited and should be awarded effective protection.[139]

As part of the right to health, the right to sexual and reproductive health is subject to the principle of progressive realization. According to art. 2(1) ICESCR, states must take progressive steps towards the full realization of the rights enshrined in the Covenant, taking into account the available resources of a state.[140] However, certain core obligations, such as the principle of non-discrimination, are of immediate effect, regardless of a state's resources.[141] Additionally, the CESCR has recognized ensuring reproductive and maternal health care as a state obligation of comparable importance to core obligations.[142] However, in light of the COVID-19 pandemic, one should note that the CESCR also qualifies the obligation under the right to health to prevent, treat and control epidemic and endemic diseases as equally important.[143]

3.1.4 SRHR in the ICCPR

The second international covenant is the 1966 ICCPR,[144] which also does not explicitly mention sexual and reproductive health and rights. Although, based on the name, one would not immediately associate civil and political rights with the concept of sexual and reproductive health, they play a significant role in its protection, for example when it comes to a states' obligation to reduce and prevent maternal mortality. A multitude of civil and political rights addresses this issue by obliging states to guarantee access to legal abortion, for example as part of the right to life (art. 6 ICCPR) and the right to be free from torture, cruel, inhuman, or degrading treatment or punishment (art. 7 ICCPR), or the right to privacy (art. 17 ICCPR).[145] Possible violations of these rights are restrictive laws that require a

[138] ibid 49(a).
[139] ibid 49(d).
[140] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) art 2(1).
[141] UN Committee on Economic Social and Cultural Rights, 'General Comment No. 14: The Right to the Hightest Attainable Standard of Health (Art. 12)' (2000) UN Doc E/C.12/2000/4 para 30.
[142] ibid 44(a).
[143] ibid 44(c).
[144] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR).
[145] UN Human Rights Committee, 'General Comment No. 36 (2018) on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life' (2018) UN Doc CCPR/C/GC/36 para 8.

husband's authorization for sterilization, or laws that make it obligatory for providers to report women who have had an abortion.[146]

Unique to the ICCPR is art. 26, a non-discrimination provision which is, unlike other provisions securing equality, not accessory.[147] An interesting case in this regard is the communication received by the Human Rights Committee, *Mellet v. Ireland.*[148] In this communication, the Committee found a violation of art. 7 (prohibition of torture, cruel, inhuman or degrading treatment or punishment), art. 17 (right to protection of privacy, family, home and correspondence), and art. 26 (right to equal treatment) of the ICCPR.[149] It concerned the case of an Irish woman who could, due to the almost full abortion ban which was in place at that time, not access abortion in Ireland despite knowing that her child would die in her womb or just shortly after its birth, and was thus forced to travel abroad to seek care.[150] The fact that the applicant had to travel abroad was deemed to exacerbate the violations, as the woman's intense physical and mental suffering could have been alleviated if care was available in Ireland, with providers that she knew and with whom she felt comfortable.[151] The Human Rights Committee found a violation of *Mellet's* right to equal treatment (art. 26 ICCPR), as being forced to travel abroad to seek an abortion has a disproportionately negative effect on women with low socioeconomic status and discriminated against the applicant due to her gender.[152] Particularly noteworthy is the further explanation concerning the application of art. 26 by *Cleveland,* a member of the Committee who issued a concurring opinion. She stated that severely restrictive abortion laws could support gender-based stereotypes portraying women merely as caregivers and mothers and thus infringe her right to gender equality.[153] Having to carry a (non-viable!) fetus to term, no matter the consequences for the psychological and physical health of the women, creates the stereotype of women as selfless mothers, whose task is to fully sacrifice themselves for bearing children.[154]

However, it is noteworthy that the ICCPR does not establish a self-standing right to abortion. According to the Human Rights Committee, states only have to ensure access to safe

[146] UN Human Rights Committee, 'CCPR General Comment No. 28: Article 3 (The Equality of Rights Between Men and Women)' (2000) UN Doc CCPR/C/21/Add.10 para 20.
[147] Carla Edelenbos, 'The Human Rights Committee's Jurisprudence under Article 26 of the ICCPR: The Hidden Revolution' in Gudmundur Alfredsson and others (eds), *International Human Rights Monitoring Mechanisms: Essays in Honour of Jakob Th. Möller* (2nd Revise, Martinius Nijhoff Publishers 2009) 77.
[148] *Mellet v. Ireland* (2013) comm no 2324/2013 UN Doc CCPR/C/116/D/2013.
[149] ibid para 8.
[150] ibid paras 2.1-2.2.
[151] ibid. para 7.2
[152] ibid Annex II, para 2.
[153] ibid Annex II, para 4.
[154] ibid Annex II, para 4.

abortion when a woman's life is at risk, or if continuing the pregnancy would cause severe physical or mental pain or suffering, for example, if it was caused by rape or incest, or if it is not a viable pregnancy.[155] In line with this, states have a duty to prevent unsafe abortions under art. 6 (right to life) and art. 7 ICCPR (right to be free from torture, inhuman or degrading treatment or punishment).[156] The reason for this is that, when faced with a very restrictive abortion law, there is an increased risk that women will resort to unsafe, illegal abortions,[157] which could ultimately threaten the life of a woman.[158] Thus, to comply with their human rights obligations, states might have to revise particularly restrictive abortion regulations[159] and refrain from introducing new barriers for women to access services.[160] Nevertheless, the Human Rights Committee frequently emphasizes that abortion should always be seen as the last resort.[161] A larger importance is given to the provision of legal access to services and contraceptives,[162] as well as the provision of quality-based information and education about sexual and reproductive health.[163]

3.1.5 SRHR in the CEDAW

The CEDAW[164] was adopted in 1979 and sets out the most extensive protection framework for women's rights on the international level.[165] It focuses on creating substantive equality for women by establishing positive state obligations to guarantee that women's human rights do not only exist on paper but in practice.[166] Compared to the two international Covenants, the CEDAW is much more explicit in protecting reproductive rights, particularly regarding the right to health.[167] Throughout the Convention, its provisions frequently draw reference to the impact of reproductive rights on a woman's life, including in the area of health, education, and

[155] UN Human Rights Committee (n 145) para 8.
[156] ibid.
[157] ibid.
[158] Zampas and Gher (n 50) para 255.
[159] Fleur van Leeuwen, *Women's Rights Are Human Righs: The Practice of the United Nations Human Rights Committee and the Committee on Economic, Social and Cultural Rights* (Intersentia 2010) 48.
[160] UN Human Rights Committee (n 145) para 8.
[161] Concluding Observations on Moldova (2009), UN doc CCPR/C/MDA/CO/2 para 17.
[162] UN Human Rights Committee (n 145) para 8.
[163] ibid.
[164] Convention on the Elimination of All Forms of Discrimination Against Women (opened for signature, ratification and accession on 18 December 1979, entered into force on 3 September 1981) 1249 UNTS 13 (CEDAW).
[165] María Isabel Plata, 'Reproductive Rights as Human Rights: The Colombian Case' in Rebecca J Cook (ed), *Human Rights of Women: National and International Perspectives* (University of Pennsylvania Press 1994) 515.
[166] Anne; Hellum and Henriette Sinding (eds), *Women's Human Rights: CEDAW in International, Regional and National Law* (Cambridge University Press 2013) para 236.
[167] Gable (n 108) 979.

work.[168] They aim to ensure women's access to fertility regulation and reproductive health services to empower women rather than serving as a means of population control.[169] In this regard, specific provisions come to attention.

Art. 12(1) of the Convention defines the state obligation to eliminate all discrimination against women in the field of health care, including access to health care services related to family planning.[170] This provision is truly unique as it is the only explicit reference to family planning in international human rights treaties.[171] In light of this, the Committee on the Elimination of Discrimination Against Women has called on states to ensure universal access to sexual and reproductive health services.[172] According to art. 12(2), every woman has the right to safe motherhood and emergency obestric services.[173] States are required to allocate the maximum extent of available resources to guarantee this right, particularly by providing free services to women who would otherwise not have access to these services due to the lack of financial means.[174]

Art. 16(1)(e) guarantees women's right to decide on the number and spacing of their children.[175] This right includes guaranteed access and availability of sex education, family planning services, including contraceptives.[176] In light of this, the Committee has frequently highlighted the need for access to contraceptives to prevent unsafe abortions and counteract high maternal mortality rates.[177] However, it has been reluctant to address access to abortion as part of this right, merely calling on states to consider removing restrictive abortion laws which punish women who sought abortions.[178] In fact, the Committee never expressed that access to safe, legal abortion is a necessity[179] but emphasizes that unwanted pregnancy should primarily be addressed through family planning and sex education.[180]

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[168] Hellum and Sinding (n 166) para 237.
[169] Plata (n 165) 515.
[170] Convention on the Elimination of All Forms of Discrimination against Women (opened for signature 1 March 1980, entered into force 3 September 1981) 1249 UNTS 14 art 12(1).
[171] Hellum and Sinding (n 166) 237.
[172] UN Committee on the Elimination of Discrimination Against Women (n 124) para 29.
[173] Convention on the Elimination of All Forms of Discrimination against Women (opened for signature 1 March 1980, entered into force 3 September 1981) 1249 UNTS 14 art 12(2).
[174] UN Committee on the Elimination of Discrimination Against Women (n 124) para 27.
[175] Convention on the Elimination of All Forms of Discrimination against Women (opened for signature 1 March 1980, entered into force 3 September 1981) 1249 UNTS 14 art 16(1).
[176] Maja Kirilova Eriksson, 'Abortion and Reproductive Health: Making International Law More Responsive to Women's Needs' in Kelly D Askin and Dorean M Koenig (eds), *Women and International Human Rights Law* (Volume 3, Transnational Publishers 2001) 17.
[177] Zampas and Gher (n 50) para 272.
[178] UN Committee on the Elimination of Discrimination Against Women (n 124) para 31(c).
[179] Zampas and Gher (n 50) para 272.
[180] UN Committee on the Elimination of Discrimination Against Women (n 124) para 31(c).

It can therefore be stated that the CEDAW creates similar state obligations concerning SRHR as the ICESCR or the ICCPR, namely access to reproductive services, contraceptives, quality-based information, and education. Its scope is slightly broader as it explicitly highlights the importance of family planning. However, it could be more explicit regarding the obligation to ensure access to safe and legal abortion.

3.1.6 SRHR in other international conventions (CRC, ICERD, CAT)

Further references to SRHR can be found in various other international treaties, which will only be mentioned briefly in order to not exceed the scope of this thesis. The CRC[181] contextualizes the importance of adequate maternal health care and education on family planning education and access to reproductive health services within the child's right to the enjoyment of the highest attainable standard of health.[182] The ICERD[183] does not explicitly guarantee SRHR, but certain equality provisions have been applied to the right to health of vulnerable groups.[184] As mentioned before, the CAT[185] is relevant for the protection of SRHR, as women may be subjected to gender-specific torture or ill-treatment when seeking reproductive care.[186]

3.1.7 Conclusion: The protection of SRHR on the international level

To conclude, over time, a broad range of rights guaranteed by numerous human rights treaties has been applied to secure SRHR on the international level. However, certain aspects, such as the right to abortion on request, are not comprehensively guaranteed. For this thesis, particularly noteworthy state obligations are ensuring (equal) access to reproductive health services, including maternal and newborn health care services, as well as the access and availability of contraceptives as part of the right to health; access to safe and legal abortion as

[181] Convention on the Rights of the Child (opened for signature, ratification and accession on 20 November 1989, entered into force on 2 September 1990) 1577 UNTS 3 (CRC).
[182] Convention on the Rights of the Child (adopted 20 November 1989, entered into force on 2 September 1990) 1577 3 UNTS (CRC) art 24.
[183] International Convention on the Elimination of All Forms of Racial Discrimination (adopted and opened for signature and ratification on 21 December 1965, entered into force on 4 January 1969) 660 UNTS 195 (ICERD).
[184] Isfahan Merali, 'Advancing Women's Reproductive and Sexual Health Rights: Using the International Human Rights System' (2000) 10 Development in Practice 609, 619.
[185] Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted and opened for signature, ratification and accession on 10 December 1984, entered into force 26 June 1987) 1465 UNTS 85 (CAT).
[186] UN Human Rights Council, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez' (2013) UN Doc A/HRC/22/53 paras 45-46, with examples of human rights violations such as forced sterilization or abortion, and the denial of life-saving post-abortion care to obtain a confession.

part of civil and political rights; as well as the obligation to provide education and quality-based information on the matter.

3.2 SRHR at the Council of Europe level

3.2.1 SRHR in the ECHR

On the regional level of the Council of Europe, the ECHR[187] does not explicitly guarantee the right to health or reproductive rights.[188] Neither has the European Court on Human Rights (ECtHR) acknowledged reproductive rights as human rights in its jurisprudence.[189] However, through the interpretation of existing provisions of the ECHR, such as the right to life (art. 2), the prohibition of torture and inhuman or degrading treatment (art. 3) and the right to private life (art. 8), certain aspects of SRHR are protected.[190]

The right to respect for private and family life enshrined in art. 8 ECHR provides the frame for most cases concerning reproductive health.[191] This right to privacy has been interpreted broadly by the ECtHR, setting out the positive obligation to protect the individual's autonomy and physical and psychological integrity.[192] This understanding of art. 8 reflects the expansive notion of SRHR going beyond the mere management of reproductive functions. While the right to private life protects the individual's decision to have or not to have children, it also protects the individual's autonomy, including one's gender identification, sexual orientation, sexual life, and ability to develop relationships with other human beings.[193]

Until today, one of the most controversial issues within sexual and reproductive rights in Europe is the right to abortion. In 2008, the Parliamentary Assembly of the Council of Europe (PACE) passed the resolution *"Access to safe and legal abortion in Europe"*.[194] In this resolution, the PACE set out several guiding objectives for member states. Generally, abortion

[187] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR).
[188] Nedim Malovic, 'Access to Abortion Services in the Council of Europe: A Critical Analysis of Women's Reproductive Rights' [2015] European Human Rights Law Review 505, 507.
[189] Liiri Oja and Alicia Ely 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' (2016) 32 Columbia Journal of Gender & Law 62, 63.
[190] Malovic (n 188) 507.
[191] Oja and Yamin (n 189) 71.
[192] *X and Y v. The Netherlands* (1985) App No 8978/80 (A/91) para 22.
[193] *Dudgeon v. The United* Kingdom (1981) app. no. 7525/76 para 41; R.*R. v. Poland* (2011) app no 27617/04, para 180; *Evans v. The United Kingdom* (2007) app no 6339/05) para 71.
[194] Parliamentary Assembly of the Council of Europe (PACE), 'Access to Safe and Legal Abortion in Europe' (2008) Resolution 1607.

is not to be seen as a family planning method and should be avoided.[195] Most importantly, the number of unintended pregnancies, and thus also abortions, is to be reduced through sex education.[196] Within the Council of Europe, most states have legalized some form of abortion, but in practice, many obstacles remain in place for women to exercise this right.[197] In light of this, the PACE calls on member states to reduce de jure and de facto barriers to access safe and legal abortion.[198] Through a revision of very restrictive provisions, maternal mortality due to clandestine abortions, and the phenomenon of women having to travel abroad to seek care, is to be counteracted.[199]

However, the ECtHR's interpretation of the ECHR does not seem to reflect these relatively progressive views yet. In fact, the ECtHR has shown great hesitancy to establish substantive obligations concerning SRHR. For example, as decided in *A, B, and C. v. Ireland,* the right to privacy in art. 8 does not include a right to abortion.[200] The reason given by the ECtHR for this is that, while most European countries have legalized abortion to a certain extent, there is no clear consensus on when life begins.[201] By ignoring the European consensus to legalize abortion to some extent and shifting the focus on the contested question of the beginning of life, the ECtHR grants member states a wide margin of appreciation and avoids establishing substantive state obligations. Thus, *A, B, and C v. Ireland,* in the case of two applicants seeking abortions abroad because Ireland did not allow abortions for economic and social reasons, the ECtHR deemed the restrictive Irish abortion laws within the states' margin of appreciation and did not find a violation of art. 8 .[202] However, some case law indicates that the ECtHR might recognize a limited right to abortion in the future, namely that a total abortion ban without exceptions for severe threats to the mother's life or health is impermissible under art. 8.[203] It is also conceivable that such restrictive laws could affect the mother's right to life (art. 2)[204] or the right to an effective remedy (art. 13) in case of rape or incest, but the ECtHR has not dealt with these questions yet.[205]

Instead, the ECtHR primarily relies on procedural obligations to address specific reproductive health issues. For example, as soon as a state decides to legalize abortion within

[195] ibid 1.
[196] ibid 5.
[197] ibid 2–3.
[198] ibid 7.4.
[199] ibid 4.
[200] *A, B and C v. Ireland* (2010) app no 25579/05 para 214.
[201] *A, B and C v. Ireland* (2010) app no 25579/05 paras 235-237.
[202] *A, B and C v. Ireland* (2010) app no 25579/05 para 241.
[203] Zampas and Gher (n 50) 277.
[204] ibid.
[205] ibid 282–283.

its margin of appreciation, the procedural obligation to ensure access to this service arises under art. 8 ECHR.[206] As a consequence of this obligation, states must implement a framework that allows women to obtain information on whether they qualify for an abortion within the scope of the law.[207] For example, this means that if abortion is legalized in cases of fetal malformation, the state has the obligation to provide a framework in which women can access all relevant information concerning the health of the fetus.[208] In *A, B, and C v. Ireland,* the ECtHR found such a procedural violation of art. 8 only in the case of one applicant, a woman who sought an abortion abroad because she had cancer and could not determine whether she qualified for a lawful abortion in Ireland.[209]

Rarely, other provisions, such as art. 3 (prohibition of torture, inhuman or degrading treatment or punishment) or art. 14 (non-discrimination) come into play. This was the case in *R.R. v. Poland*[210], which concerned a woman unable to obtain genetic testing in time to access an abortion because providers intentionally delayed the process. While the ECtHR found a procedural violation of art. 8, it additionally found a violation of the prohibition of degrading treatment (art. 3) due to the disrespectful treatment she received from her doctors.[211] This is one of the few examples in which the ECtHR has deemed the infringement of the applicant's rights as sufficient to fulfill the threshold of severity of art. 3. This is not always a given; contrary to what one would expect, the ECtHR has previously negated a violation of art. 3 in the case of a woman who could not access abortion, although she had good reason to fear losing her eyesight if the pregnancy continued.[212] Moreover, the reluctance to examine complaints not only under art. 8, but also under the prohibition of discrimination is striking.[213] For example, contrary to expectations, the ECtHR did not see the need to examine the wider societal, discriminatory aspect of Roma women suspecting that they had undergone coercive sterilization, refusing to examine their complaints under art. 14 or art. 1 of Protocol no. 12 to the ECHR.[214]

Only in extreme cases, in which the state in question failed to provide access emergency obestric services because the mother was unable to pay the full amount beforehand, a

[206] Lebret (n 50) 15.
[207] *A, B and C v. Ireland* (2010) app no 25579/05 para 200.
[208] *A, B and C v. Ireland* (2010) app no 25579/05 para 200.
[209] *A, B and C v. Ireland* (2010) app no 25579/05 para 267.
[210] *R.R. v. Poland* (2011) app no 27617/14.
[211] *R.R. v. Poland* (2011) app no 27617/14 para 160-161.
[212] *Tysiąc v. Poland* (2007) app no 5410/03 para 66.
[213] Lebret (n 50) 31.
[214] European Court of Human Rights, 'Guide on Article 14 of the European Convention on Human Rights and on Article 1 of Protocol No. 12 to the Convention' (2020) para 111; *I.G. and Others v. Slovakia* (2012) app no 15966/04 para 167.

violation of the right to life (art. 2) was found.[215] Thus, in its case law the ECtHR has established a minimum standard when it comes to the provision of health care, however, the details of this standard are unclear.[216] The finding of a substantive violation of art. 2, however, suggests that at least the provision of emergency obestric care is obligatory.

To summarize the protection of SRHR through the ECHR, several observations can be made. Although the Convention implicitly guarantees certain aspects of SRHR, such as access to legal abortion, compared to the international framework, the ECHR does not provide a similarly comprehensive framework of protection for sexual and reproductive rights. This can be awarded to the reluctance of the ECtHR to incorporate an expansive concept of SRHR in its interpretation of the ECHR. Additionally, as *"*[…] *the Convention does not guarantee as such a right to any specific level of medical care* […]*",*[217] the ECHR falls short of establishing certain obligations, for example, a right to access contraceptive services.[218]

3.2.2 SRHR in the European Social Charter

However, to a certain extent, the European Social Charter (ESC)[219] compensates for the lacking right to health in the ECHR. The ESC is intended to complement the ECHR, although it should be noted that individual complaints are not allowed; supervision is conducted solely through collective complaints and national reports.[220] The Charter includes several provisions related to health, ranging from health in the workspace, to special provisions for children, women and the elderly, as well as the protection of public health.[221]

In art. 11, the ESC recognizes the right to the protection of health.[222] It aims at ensuring health for the population as such,[223] and thus obliges states to remove possible causes of ill-health, to provide advisory and educational facilities, and to prevent as far as possible

[215] Ingrid Leijten, 'Core Socio-Economic Rights in the Case Law of the ECtHR', *Core Socio-Economic Rights and the European Court of Human Rights* (Cambridge University Press 2017) 253.
[216] ibid 254.
[217] *Tysiąc v. Poland* (2007) app no 5410/03 para 107.
[218] Magda Krzyżanowska-Mierzewska, 'How to Use the European Convention for the Protection of Human Rights and Fundamental Freedoms in Matters of Reproductive Law: The Case Law of the European Court of Human Rights Guide' (*ASTRA*, 2004) ch III.1 <http://astra.org.pl/pdf/publications/astra_guide.htm>.
[219] European Social Charter (revised) (opened for signature on 3 May 1996, entered into force on 1 July 1999), ETS 163.
[220] European Social Committee, 'The Right to Health and the European Social Charter' (2009) 1 <https://www.ilga-europe.org/sites/default/files/right_to_health_and_esc.pdf> accessed 5 May 2021.
[221] ibid.
[222] European Social Charter (revised) (opened for signature on 3 May 1996, entered into force on 1 July 1999), ETS 163, art 11.
[223] Claire Lougarre, 'What Does the Right to Health Mean? The Interpretation of Article 11 of the European Social Charter by the European Committee of Social Rights' (2015) 33 Netherlands Quarterly of Human Rights 326, 329.

epidemic, endemic and other diseases, as well as accidents.[224] To assess stet parties' compliance with the European Social Charter, the treaty monitoring body, the European Committee of Social Rights, has developed certain standards. For example, states have to ensure the accessibility of their healthcare system for everyone, including disadvantaged groups, and must ensure the provision of health services without unnecessary delays.[225] The European Committee has emphasized the importance of accurate, quality-based sex and reproductive education, and the importance of awareness-campaigns about sex education for public health.[226] Additionally, infant and maternal mortality should ultimately be eliminated.[227] However, certain gaps in protection of SRHR can be identified, as the European Committee does not monitor access to safe contraception or safe abortion procedures during state assessments.[228] Thus, the ESC is much more focused on ensuring public health than addressing the individual's sexual and reproductive health.

3.2.3 SRHR in the Istanbul Convention

The Istanbul Convention[229] primarily aims to end gender-based violence by creating standards for its prevention and prosecution.[230] The Convention explicitly sets out the criminalization of forced abortion and forced sterilization, emphasizing the need for prior, informed consent of the woman.[231] Although it does not set out any more specific rules concerning SRHR, the Convention as such is essential to protecting women's SRHR, as the freedom from violence, coercion and harassment is a precondition for sexual and reproductive health. Furthermore, as highlighted in the EU's accession Resolution to the Istanbul Convention, the denial of SRHR, for example through restrictive abortion laws, is in itself a form of violence against women.[232]

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[224] European Social Charter (revised) (opened for signature on 3 May 1996, entered into force on 1 July 1999), ETS 163, art 11.
[225] Lougarre (n 223) 332.
[226] ibid 335.
[227] ibid 332.
[228] ibid 339.
[229] Council of Europe Convention on preventing and combating violence against women and domestic violence (opened for signature and accession on 11 May 2011, entered into force on 1 August 2014) CETS no 210 (Istanbul Convention).
[230] Rosamund Shreeves and Ulla Jurvise, 'The Istanbul Convention: A Tool to Tackle Violence against Women and Girls' (*European Parliament* 2017) 1 <http://www.europarl.europa.eu/RegData/etudes/ATAG/2017/608814/EPRS_ATA(2017)608814_EN.pdf> accessed 14 July 2021.
[231] Council of Europe Convention on preventing and combating violence against women and domestic violence (opened for signature and accession on 11 May 2011, entered into force on 1 August 2014) CETS no 210 (Istanbul Convention) art 39.
[232] European Parliament, 'EU Accession to the Istanbul Convention and Other Measures to Combat Gender-Based Violence' (2019) Resolution P9_TA(2019)0080 para 7.

Thus, SRHR and violence against women are deeply connected. As a result, the Istanbul Convention is of high importance to ensure the basis for the fulfillment of SRHR.

3.2.4 Conclusion: SRHR at the Council of Europe level

To conclude, the regional CoE-system extends some protection to SRHR. However, the level of protection afforded to SRHR on the regional level does not fully compare to the international level. In part, this lower level of protection can be attributed to the lack of an extensive right to health in the ESC, and the reluctance of the ECtHR to explicitly refer to SRHR in its interpretation of the ECHR, oftentimes solely finding procedural violations of human rights. Additionally, it should be kept in mind that the ESC does not allow for individual applications.[233] Therefore, it is even less possible for the individual to claim his or her own rights. Nevertheless, certain state obligations are noteworthy, for example the procedural obligation to ensure access to safe and legal abortion under art. 8 ECHR. Additionally, the Istanbul Convention is noteworthy as it guarantees the absence of violence, coercion and harassment, which forms the foundation for women's sexual and reproductive health.

[233] European Social Committee (n 220) 1.

4 SRHR during the COVID-19 pandemic

In response to the COVID-19 outbreak in early 2020, the UN High Commissioner for Human Rights expressed that "[…] *an emergency situation is not a blank check to disregard human rights obligations*".[234] But what exactly does international human rights law allow states to do in terms of responding to the current crisis? Under what circumstances might restrictions or derogations be permissible? These questions are explored in this chapter.

It is important to note that the COVID-19 pandemic is an ongoing and wave-like process. What may be justified in the event of an exceptionally high level of infection might lose its justification as the situation progresses and improves. Each restriction and derogation has to be analyzed individually, taking into account the duration and timing of the implemented measure. Therefore, the following explanations only serve to lay out the general requirements that states have to adhere to during public health emergencies, including minimum standards concerning SRHR that must be upheld at all times. Only in a later step, this knowledge can be applied to assess whether restrictions or a derogation in a *concrete case* are compatible with human rights obligations.

4.1 Limitations of SRHR in the absence of emergencies

4.1.1 Limitations in general: 3-Step-Assessment

Not every restriction of human rights amounts to a corresponding human rights violation.[235] Thus, in principle, certain interferences with SRHR are permissible. Generally, limitations of human rights are justified if they fulfill the following three requirements: (1) legality, which describes that a restriction was prescribed by law, (2) legitimacy, describing that the restriction pursues a legitimate aim, and (3) proportionality.[236]

[234] OHCHR, 'COVID Is "a Colossal Test of Leadership" Requiring Coordinated Action, High Commissioner Tells Human Rights Council: COVID-19 Pandemic - Informal Briefing to the Human Rights Council. Statement by Michelle Bachelet, UN High Commissioner for Human Rights' (*OHCHR*, April 2020) <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25785&LangID=E> accessed 25 May 2021.
[235] Michael Lysander Fremuth, '»Coronavirus Und Menschenrechte« Die Bekämpfung Des Coronavirus - Menschenrechtliche Grundlagen Und Grenzen' (*Ludwig Boltzmann Institut*, 2020) 11 <https://bim.lbg.ac.at/sites/files/bim/attachments/bim_fremuth_bekampfung_des_coronavirus_und_menschenrechte-final.pdf> accessed 21 March 2021.
[236] De Schutter (n 101) 344.

Most rights allow limitations in the public interest, such as for public health reasons, or if another individual is affected in the exercise of their rights.[237] In the context of COVID-19, public health, which has equally been identified as a legitimate aim to restrict rights in the ECHR[238] and the ICCPR[239], is relevant. Lastly, the measure has to be proportionate. Although each treaty monitoring body and human rights court does not always follow the same steps in the proportionality assessment,[240] certain general features can be identified. Proportionality requires (1) that the restriction serves a legitimate purpose, (2) that it is the least restrictive of all available measures, and (3) that the means are not disproportionate to the end.[241]

Although the ECtHR uses different terms and steps, it applies similar criteria by analyzing the balance between the restricting measure and the legitimate aim pursued.[242] The ECtHR primarily focuses on the question of whether the action in question was "necessary in a democratic society", which can be demonstrated in the form of a "pressing social need".[243] Additionally, the ECtHR grants states a margin of appreciation in assessing the necessity of human rights limitations, as they are generally deemed in a better position to evaluate the situation in their territory, taking into account their national constitution and legal traditions.[244]

4.1.2 No limitation of absolute rights

Absolute rights form an exception, as they cannot be restricted under any circumstance.[245] An example of such an absolute right is the ICCPR prohibition of torture or other cruel, inhuman, or degrading treatment or punishment (art. 7).[246] This may well become relevant for SRHR, as the aforementioned case-law of the Human Rights Committee showed that the prevention of access to legal abortion may affect this right.

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[237] Kimberley Trapp, 'Exemptions, Qualifications, Derogations, and Excuses in International Human Rights Law' in Lorand Bartels and Federica Paddeu (eds), *Exceptions in International Law* (Oxford University Press 2020) 309.
[238] see Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 8(2).
[239] see International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 12(3), 18(3), 21, 22(2).
[240] Trapp (n 237) 309.
[241] ibid.
[242] Yutaka Arai-Takahasi, 'Structural Principles: Proportionality' in Dinah Shelton (ed), *The Oxford Handbook of International Human Rights Law* (Oxford University Press 2013) 454.
[243] ibid.
[244] Janneke Gerards, 'Margin of Appreciation and Incrementalism in the Case Law of the European Court of Human Rights' (2018) 18 Human Rights Law Review 495, 498.
[245] Fremuth (n 235) 12; Trapp (n 237) 305.
[246] De Schutter (n 101) 307.

4.1.3 Limitations and retrogressive measures under the ICESCR

Furthermore, the limitation of economic, social and cultural rights represents a particular case. In this regard, two norms are relevant: art. 2 and art. 4 ICESCR.

Art. 2 defines the principle of progressive realization, according to which states must fulfill economic, social, and cultural rights to the maximum of their available resources.[247] It also strongly discourages states from taking retrogressive measures due to economic difficulties.[248] However, suppose a state party does not have any other option but to introduce new barriers to information, goods and services relevant for sexual and reproductive health. In that case, it carries the burden of proof to establish the measure's necessity.[249] In any case, retrogressive measures are only permissible if they are temporary, non-discriminatory, and do not disproportionately affect marginalized individuals or groups.[250]

Art. 4 ICESCR serves as a general limitation clause. It sets out that limitations are permissible only in so far as this *"*[…] *may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society"*.[251] In contrast to other human rights treaties, this article only identifies the promotion of the general welfare of society as a legitimate aim for limitations.[252] These requirements of a justification under art. 4 may sound stricter than those of the ECHR or ICCPR; however, ultimately, the same 3-step-test assessing the legality, legitimacy, and proportionality of restricting measures is applied.[253]

The relationship between art. 2 and art. 4 ICESCR provisions remains contested.[254] While the CESCR differentiates between retrogressive measures for economic reasons under art. 2 and limitations under art. 4, others rightly argue that it is not always possible to draw a clear distinction in practice.[255] Restrictive measures in the current pandemic are a prime example for this – are government-ordered deferrals of "non-essential" surgeries retrogressive

[247] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) art 2.
[248] UN Committee on Economic Social and Cultural Rights, 'General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)' (1990) UN Doc E/1991/23 para 9.
[249] UN Committee on Economic Social and Cultural Rights, 'General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)' (n 125) para 38.
[250] ibid.
[251] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) art 4.
[252] see also Amrei Müller, 'Limitations to and Derogations from Economic, Social and Cultural Rights' (2009) 9 Human Rights Law Review 557, 570, who additionally highlights the exception of art 8 ICESCR, which contains additional interests that may justify limitations of this right.
[253] Murphy (n 53) 75.
[254] ibid 79.
[255] Müller (n 252) 584–585.

measures due to the limited resources available, or should they be seen as limitations supporting the struggling health care systems, in order to ensure the general welfare of society? Due to this difficulty to distinguish the two in practice, *Müller* argues for the application of uniform criteria, namely those established in art. 4 ICESCR, to assess the legality of both, retrogressive measures and limitations.[256]

Without going into the background of this discussion in more detail, the question at hand is rather whether the application of the criteria under art. 2 or 4 would lead to different results for SRHR during COVID-19. Most importantly, the question is whether both types of restrictions require the guarantee of different minimum standards. Under art. 4, limitations must be *"*[…] *compatible with the nature of these rights* […]*"*.[257] This has been interpreted as a safeguard for minimum core obligations, highlighting that no limitation may infringe on them.[258] When it comes to art. 2, the limits of retrogressive measures are less clear, as the statements of the CESCR are contradictory.[259] At times the CESCR indicated that even the failure to meet core obligations can be justified with the lack of resources;[260] while at other times, it clearly condemned such a failure as a human rights violation[261]. As a result, the CESCR has not yet drawn a very clear line for the outer limits of retrogressive measures. However, as such, these statements indicate that particularly drastic retrogressive measures, falling entirely short of meeting core obligations, are not compatible with the ICESCR.[262] Therefore, both art. 2 and art. 4 encompass a prohibition of limitations or retrogressive measures that undermine minimum core obligations.[263] Thus, the application of either article leads to the same limits regarding core obligations.

This is of particular importance for SRHR, as the access to health facilities, goods and services on a non-discriminatory basis, and the provision of essential drugs, have been

[256] ibid 590.
[257] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) art 4.
[258] Müller (n 252) 579-580.
[259] ibid 588.
[260] See Committee on Economic Social and Cultural Rights, 'General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)' (n 213) para 10: *"*[…] *In order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligation*s.*"*.
[261] See Committee on Economic Social and Cultural Rights, 'General Comment No. 14: The Right to the Hightest Attainable Standard of Health (Art. 12)' (n 141) para 48: *"*[…] *The adoption of any retrogressive measures incompatible with the core obligations under the right to health outlined in paragpaph 43 above, constitutes a violation of the right to health"*.
[262] Müller (n 252) paras 588-589.
[263] ibid 589.

identified as core obligations under the right to health.[264] Additionally, at least minimum essential levels of the right to sexual and reproductive health, including access to affordable, acceptable and quality sexual and reproductive health services, goods and facilities, as well as the prevention of unsafe abortions have been highlighted as core obligations.[265] Consequently, these obligations cannot be completely undermined by limitations or retrogressive measures.

Therefore, even SRHR that are protected by the ICESCR can also be subject to limitations and retrogressive measures during normal times, as long as states can prove their legality, legitimacy and proportionality, and do not interfere with core obligations under the ICESCR.

4.1.4 Conclusion: Limitations of SRHR during normal times

To conclude, most SRHR are relative rights that can be subject to limitations during normal times. However, special attention should be paid to certain absolute rights, such as the prohibition of torture, inhuman or degrading treatment or punishment, as well as core obligations concerning the right to (sexual and reproductive) health under the ICESCR.

4.2 Derogations

4.2.1 Derogation clauses in international human rights law

Furthermore, most international and regional human rights treaties, such as the ICCPR, the ECHR, or the ESC, contain so-called derogations clauses, allowing states to defer from human rights obligations in times of exceptional emergencies.[266] What makes derogations unique compared to limitations is their differing aim. While limitations preserve the status quo, an adequate balance between various interests, derogations aim to restore normalcy.[267] Any state wishing to derogate is required to formally notify the Secretary-General of the

[264] Committee on Economic Social and Cultural Rights, 'General Comment No. 14: The Right to the Hightest Attainable Standard of Health (Art. 12)' (n 141) paras 43(a), 43(d).
[265] Committee on Economic Social and Cultural Rights, 'General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)' (n 125) paras 49(c), 49(e).
[266] For example, see the derogation clauses in the following: International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 4; Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 15; European Social Charter (revised) (opened for signature on 3 May 1996, entered into force on 1 July 1999), ETS 163, art 30.
[267] Trapp (n 237) 313.

Council of Europe, or the United Nations Secretary-General, respectively.[268] Each derogations clause contains a list with non-derogable rights, although it should be noted that these non-derogable rights vary by treaty.[269] The ICCPR and the ECHR both qualify certain rights relevant to SRHR as non-derogable, for example the right to life, the prohibition of torture or cruel, inhuman, or degrading treatment or punishment.[270] Generally, derogations are only permissible if they are strictly necessary, non-discriminatory, proportionate, time-limited, and compatible with other obligations the state may have under international law.[271]

4.2.2 ICESCR: Derogations without a derogation clause?

A key question regarding the protection of sexual and reproductive health during COVID-19 concerns the permissibility of derogations from economic and social rights, particularly the right to health. As the ICESCR does not contain a derogations clause,[272] the first question that arises is whether this results in a total prohibition of derogations from economic, social and cultural rights. Additionally, this leads to a significant follow-up problem: derogation clauses in other human rights treaties, such as the ICCPR or ECHR, require compliance with all other obligations the state may have under international law.[273] This means that, if no derogations from economic and social rights are permissible, any derogation under art. 4 ICCPR or art. 15 ECHR could automatically be impermissible as well.

To answer these questions, it is necessary to have a closer look at the drafting process of the ICESCR. During the drafting process of the Covenant, derogations were most likely not addressed, because even the inclusion of a general limitation clause was contested and, by some states, seen as unnecessary in the first place.[274] In light of this, *Alston* and *Quinn* offer a combination of several possible explanations as to why derogations might not have been

[268] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 15(3); International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 4(3); European Social Charter (revised) (opened for signature on 3 May 1996, entered into force on 1 July 1999), ETS 163, art 30(2).
[269] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 4(2); Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 15(2).
[270] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 4(2); Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 15(2).
[271] Edith Zeller, 'Gerichtsbarkeit in Europa in Und Nach Der COVID-19-Pandemie - Längerfristige An- Und Aussichten' in Gavin Barrett and others (eds), *The Future of Legal Europe: Will We Trust In It?* (Springer 2021) 855.
[272] Murphy (n 53) 77.
[273] De Schutter (n 101) 646; also compare the wording of the Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 15(1): *"*[…] *provided that such measures are not inconsistent with its other obligations under international law."*.
[274] Müller (n 252) para 591.

discussed: *"*[…] *(1) the nature of the rights contained in the Covenant and the fact that the case for derogation in times of emergency from, for example, the rights to food and health care would seem inherently less compelling than the case for derogation from the right to peaceful assembly or the right to vote; (2) the existence of a general limitations clause in the Covenant, unlike the approach adopted in the Covenant on Civil and Political rights, and (3) the more flexible and accommodating nature of the basic obligation contained in Article 2(1) of the Covenant."*.[275]

Nevertheless, the absence of an explicit derogation clause does not necessarily imply the impermissibility of derogations.[276] There is some support for the possibility of derogations to the ICESCR, claiming that crises usually affect the economy and thus the availability of resources.[277] It is unlikely that rights enshrined in the ICESCR would remain unaffected.[278] Therefore, in line with the general aim of derogations, the use of derogations could aid to overcome the emergency and to return to normal times.[279]

Furthermore, some argue that doctrines as part of general public international law support the permissibility of derogations even in the absence of such a clause, particularly the doctrine of necessity and the doctrine of force majeure.[280] For example, likewise, the International Labour Organization (ILO) refers to the doctrine of force majeure to permit derogations from ILO Conventions that do not explicitly allow for derogations, while applying the principles on derogations established under the ICCPR and ECHR.[281] Likewise, in their state reports, some states seem to assume the derogability of art. 6-8 ICESCR.[282]

Ultimately, the CESCR's has not clearly stated its position on the matter, mostly not addressing the issue at all.[283] In rare instances, such as in its General Comment on the right to health, it has stated that core obligations are non-derogable.[284] One reason for this behavior might be that the CESCR does not deem emergency measures necessary, as the principle of progressive realization and the general limitation clause already leaves states room for

[275] Philip Alston and Gerard Quinn, 'The Nature and Scope of States Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights' (1987) 9 Human Rights Quarterly 156, 217.
[276] Manisuli Ssenyonjo, 'Reflections on State Obligations with Respect to Economic, Social and Cultural Rights in International Human Rights Law' (2011) 15 International Journal of Human Rights 969, 989.
[277] Müller (n 252) 592.
[278] ibid 593.
[279] ibid 592.
[280] ibid 595.
[281] ibid 595–596.
[282] Amrei Müller, 'Limitations and Derogations from Economic, Social and Cultural Rights', *The Relationship Between Economic, Social and Cultural Rights and International Humanitarian Law: An Analysis of Health Related Issues in Non-International Armed Conflicts* (BRILL 2013) 143.
[283] ibid.
[284] Committee on Economic Social and Cultural Rights, 'General Comment No. 14: The Right to the Hightest Attainable Standard of Health (Art. 12)' (n 141) para 49.

flexibility.[285] This is supported by the fact that, even if one were to allow derogations from economic, social and cultural rights, these measures would have to fulfil similar criteria concerning their necessity and proportionality as elaborated before. It is unlikely that a state of emergency would come with the necessity to *suspend* rights such as the right to health, food, water and education in order to protect the general population.

Thus, the CESCR's statements illuminate that core SRHR, such as ensuring the access to health facilities, goods and services on a non-discriminatory basis, and the provision of essential drugs have to be upheld at all times, even during COVID-19. As a result, in order to fulfill the requirement of compliance with *"*[…] *other obligations under international law* […]*"*[286], any derogation under the ICCPR or ECHR has to adhere to core obligations under the ICESCR, if the state is party to this treaty.

4.2.3 COVID-19 as a public emergency?

When it comes to explicit derogations clauses of the ICCPR or ECHR, the first question that arises in the context of COVID-19 is whether it qualifies as a situation that allows for derogations, thus as an emergency that threatens the life of a nation. As such interpretative questions arise, it is crucial to remember that in theory, each treaty and convention may be subject a different, independent interpretation of such terms, although it is to be said that treaty monitoring bodies and human rights courts, go through a certain "dialogue" and might de facto influence each other's definition.

According to the Siracusa Principles, which serve as a guide to interpreting derogations clauses, a public emergency which threatens the life of the nation exists under two conditions, namely if it affects the whole of the population and the state territory, either as a whole or in part, and if additionally, the physical integrity of the population, the state's political independence or the territorial integrity, or if the existence or functioning of institutions indispensable to ensure and protect the rights recognized in the Covenant are at risk.[287]

The derogations clause of the ECHR allows for derogations in times of war and in times of public emergencies that threaten the life of the nation. Although some European countries used war-like rhetoric, for example by considering the situation a war or fight against the

[285] Müller (n 282) 143.
[286] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 15(1); International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 4(1).
[287] UN Human Rights Commission, 'The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights' (1984) Annex, E/CN.4/1985/4 para 39.

virus, war requires some form of armed conflict, which is why the COVID-19 pandemic cannot be subsumed under the first option.[288] However, it is conceivable that the pandemic constitutes a severe threat to public health in the sense of the ECHR.[289] The ECtHR further elaborated its understanding of "other public emergencies threatening the life of the nation" as an exceptional situation or crisis affecting the whole population that threatens the organized life of the community.[290] In this regard, it should be mentioned that the ECtHR grants states a broad margin of appreciation in determining whether there is an emergency situation in its territory. As the COVID-19 pandemic affects every member state of the Council of Europe, significantly challenging the capacities of public health systems with its high mortality rate across the elderly population, it can be seen as such an exceptional situation, particularly as it calls the organized life of the community into question with its easy transmission. One could argue that COVID-19 does not significantly affect younger generations, as their mortality rate is comparatively much lower. However, this would disregard the risk of long-term damages that an infection may cause even in young people (particularly "Long Covid"), for which there is no sufficient data available yet. As the ECtHR grants states a wide margin of appreciation to determine whether a public emergency exists on its territory,[291] it is likely that these reasons would be sufficient. For these reasons, COVID-19 represents a public emergency during which derogations are, in principle, permissible.

However, even if this is the case, states have to prove that the general provisions allowing for restrictions are not adequate to meet the challenge of the emergency.[292] Essentially, the implementation of derogations under art. 15 ECHR must remain the last resort.[293] In light of this, it should be mentioned that during the last year, only few CoE-members even considered the use of derogations, while most relied on the limitations available during normal times.[294]

4.2.4 Conclusion: Derogations from SRHR during COVID-19

In conclusion, while COVID-19 is an emergency situation that in principle allows for derogations, they should be seen as a measure of last resort. Especially in relation to SRHR protected by the ICESCR, it is not only questionable whether derogations are permissible in

[288] Audrey Lebret, 'COVID-19 Pandemic and Derogation to Human Rights' (2020) 7 Journal of Law and the Biosciences 1, 4-5.
[289] Fremuth (n 235) 13.
[290] *Lawless v. Ireland* (1961) app no 332/57 para 28.
[291] *A and Others v. UK* (2009) app no 3455/05 para 173.
[292] Fremuth (n 235) 13.
[293] ibid.
[294] ibid.

the first place; additionally, states would face the difficult task of proving the necessity of derogations. In the case of the CoE, such situations seem highly unlikely, as states should be able to rely on either limitations or retrogressive measures only.

In any case, attention has to be paid to non-derogable SRHR, whether it is in form of minimum core obligations under the ICESCR, or non-derogable rights, such as the prohibition of torture and cruel, inhuman or degrading treatment or punishment in the ICCPR. During any emergency situation, access to sexual and reproductive health facilities, goods and services on a non-discriminatory basis, and the provision of essential drugs must be ensured.

4.3 Conclusion: Limitations and Derogations of/from SRHR during COVID-19

Even if SRHR can be limited or even derogated from to a certain extent during COVID-19, states are not completely free from their human rights obligations. Therefore, even during COVID-19, states have the obligation to prevent unsafe abortion and thus have to ensure access to sexual and reproductive health services.[295] In fact, the pandemic comes with additional obligations for states, as they have to ensure that any emergency response measure does not have a discriminatory impact – which also includes the impact on women and their health.[296]

[295] Todd-Gher and Shah (n 10) 29.
[296] ibid.

5 SRHR during Covid-19: Case studies

5.1 Introduction – comparison in practice

In this chapter, the approaches to SRHR during COVID-19 by Poland, the Netherlands, and the UK are examined and compared. As common points of comparison, each case study will address (1) briefly the situation of SRHR before the pandemic, (2) whether legal or regulatory changes affecting SRHR have been implemented during the pandemic, particularly access to legal abortion, and (3) how these consequences for SRHR can be evaluated with regards to derogations and permissible restrictions of human rights.

Whenever the comparative law method is applied, it is necessary to not only pay attention to existing legal provisions in the respective country but also to be aware of its historical and cultural background that forms their foundation. As the very existence of the margin of appreciation doctrine of the ECtHR proves, the histories, cultures, and traditions within the Council of Europe are diverse. Thus, when it comes to SRHR during COVID-19, it is crucial to remember that there is more than one possible way to fulfill respective human rights obligations. As different forms of action are identified, one should always remain critical about whether the same solution could even be applied to another country to achieve similar results. This is especially important when assessing countries' reactions during COVID-19, as the virus hit each country to different extents.

In this regard, it is important to mention that, unlike traditional comparisons, this thesis does not always apply the same parameters of comparison to each case study, for example, the changes in the legal framework concerning sex education, the right and access to safe and legal abortion, and so on. The reason for this is that, while all countries analyzed are part of the Council of Europe, they have a different history regarding SRHR, which has led to differing challenges during COVID-19. As one common parameter, states' efforts in ensuring access to safe and legal abortion are compared. Additionally, however, to achieve a more informed and broader perspective on the protection of SRHR within the Council of Europe during COVID-19, it is necessary to look beyond topics common to all three countries and pay attention to developments in the legal framework unique to only some of the analyzed countries. As a result, additional parameters are taken into account only when it is necessary due to special local circumstances.

5.2 Poland

5.2.1 Access to abortion and contraceptives before COVID-19

Poland has ratified most international human rights treaties relevant to sexual and reproductive health.[297] Initially, during socialism, Poland's abortion law was very liberal.[298] However, through its active role in the movement against communism, the Catholic Church has become an influential player in the public sphere.[299] Today, Poland's national identity is predominantly catholic,[300] and the country is known for having one of the most restrictive abortion laws within the CoE.

Before 2020, abortion in Poland was only permitted if the mother's health or life was at risk, if the fetus was severely and irreversibly impaired, or if the pregnancy resulted from incest or rape.[301] For many years, there has been a concern about attempts to limit the already restrictive abortion laws even further.[302] As could be seen in *R.R. v. Poland*[303] and *Tysiąc v. Poland*[304], these already limited options are difficult to access in practice. As a result, even before COVID-19, the UN Human Rights Committee has criticized the high number of unsafe abortions, the lack of access to legal abortion and contraceptives.[305] Providers frequently invoke conscientious objection without being obliged to refer women to other providers that perform abortions, resulting in the unavailability of abortion services in an entire institution or region.[306] This use of conscientious objection is not entirely based on traditional values only; often, doctors face stigmatization and fear criminal prosecution.[307]

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[297] such as the ICCPR (since 1977) the ICESCR (since 1977), the CEDAW (since 1980), CRC (since 1991), ICERD (since 1968), the CRPD (since 2012), the CAT (since 1989). However, it has not ratified the Optional Protocol to the ICESCR, which would allow for individual complaints to the CESCR, see: OHCHR, 'Status of Ratification: Interactive Dashboard: Poland' <https://indicators.ohchr.org/> accessed 2 June 2021.
[298] Iga Kozlowska, Daniel Béland and André Lecours, 'Nationalism, Religion, and Abortion Policy in Four Catholic Societies' (2016) 22 Nations and Nationalism 824, 830.
[299] ibid.
[300] ibid.
[301] UN Human Rights Council, 'Visit to Poland: Report of the Working Group on the Issue of Discrimination against Women in Law and Practice' (2019) UN Doc A/HRC/41/33/Add.2 para 49.
[302] UN Committee on Economic Social and Cultural Rights, 'Concluding Observations on the Sixth Periodic Report of Poland' (2016) UN Doc E/C.12/POL/CO/6 para 47(c).
[303] *R.R. v. Poland* (2011) app no 27617/14.
[304] *Tysiąc v. Poland* (2007) app no 5410/03.
[305] UN Human Rights Committee, 'Concluding Observations on the Seventh Periodic Report of Poland' (2016) UN Doc CCPR/C/POL/CO/7 paras 23-24.
[306] ibid 23; UN Committee on Economic Social and Cultural Rights, 'Concluding Observations on the Sixth Periodic Report of Poland' (n 302) para 46.
[307] UN Human Rights Council (n 301) para 51.

The European Contraception Policy Atlas assesses access to contraceptives in Poland as "very poor", reaching the lowest rank in Europe. [308] This low evaluation can be explained by the lack of reimbursement policies and quality information about contraceptive methods.[309] Additionally, women seeking emergency contraception do not only have to acquire a prescription first,[310] they additionally face the hurdle of pharmacists invoking conscientious objection, refusing to sell the medication (although this is technically not covered by the conscientious objection clause).[311]

These represent only some of the barriers to the fulfillment of SRHR. However, they illustrate Poland's skeptical and restrictive attitude towards women's rights, predating the pandemic. They highlight the particular difficulties which undocumented migrant women, women with disabilities, and women with a low socioeconomic status face in exercising their sexual and reproductive rights.[312] Women with disabilities have been significantly affected in their free choices, being subject to forced and coerced sterilizations.[313]

5.2.2 Legal and regulatory changes and their impact on SRHR during COVID-19

5.2.2.1 Poland's immediate response to COVID-19

As a response to COVID-19, Poland did not explicitly invoke a state of emergency under its constitution or officially derogate from human rights treaties.[314] Instead, a state of emergency was declared under the infectious disease statute (2008), which is part of statutory law and enables the government to issue decrees to prevent the further spread of the virus.[315] In early March 2020, a new COVID-19 law was introduced.[316] This law amended the 2008 infectious

[308] European Parliamentary Forum for Sexual & Reproductive Rights, 'Limited Access: Europe's Contraception Deficit' (2018) 5; 'European Contraception Policy Atlas - Poland' (*European Parliamentary Forum for Sexual & Reproductive Rights*, 2019) <https://www.epfweb.org/node/745> accessed 3 June 2021.
[309] 'European Contraception Policy Atlas - Poland' (n 308).
[310] ibid.
[311] UN Human Rights Council (n 301) para 47.
[312] UN Committee on the Elimination of Discrimination Against Women, 'Concluding Observations on the Combined Twenty-Second to Twenty-Fourth Periodic Reports of Poland' (2019) UN Doc CERD/C/POL/CO/22-24 para 23(d); UN Committee on the Rights of Persons with Disabilities, 'Concluding Observations on the Initial Report of Poland' (2018) UN Doc CRPD/C/POL/CO/1 para 9(c); Human Rights Council (n 301) para 52.
[313] UN Committee against Torture, 'Concluding Observations on the Seventh Periodic Report of Poland' (2019) UN Doc CAT/C/POL/CO/7 para 35(b).
[314] Jakub Jaraczewski, 'An Emergency By Any Other Name? Measures Against the COVID-19 Pandemic in Poland' (*Verfassungsblog*, 2020) <https://verfassungsblog.de/an-emergency-by-any-other-name-measures-against-the-covid-19-pandemic-in-poland/> accessed 2 June 2021.
[315] ibid.
[316] Patrycja Pendrakowska, 'The Polish Example: Defending the Castle in the European East' (*Observer Research Foundation*, 2020) <https://www.orfonline.org/expert-speak/the-polish-example-defending-the-castle-in-the-european-east-64189/> accessed 1 June 2021.

disease statute and gave the government additional powers to limit human rights.[317] Under these laws, measures that significantly impacted the exercise of human rights were taken, such as a blanket ban of personal movement with only few exceptions. As a result of imprecise formulations and broad powers awarded to the government, the constitutionality of these laws and the lockdown measures based on them has been called into question.[318]

5.2.2.2 Discussion of draft legislation affecting SRHR in Parliament

Coinciding with the pandemic, three legislative changes directly affecting SRHR were debated by the Polish parliament, namely the "Stop Pedophilia", "Stop Abortion", and "Yes to family, no to Gender" bills. These initiatives are not new – "Stop Abortion" was introduced as early as 2018.[319] Both the "Stop Pedophilia" and the "Stop Abortion" bill stemmed from citizens' initiatives, meaning that the parliament was obliged to discuss them.[320]

According to the "Stop Pedophilia" bill, *"anyone who promotes or approves the undertaking by a minor of sexual intercourse or any other sexual activity"* would be punishable under criminal law.[321] However, due to the broad wording of the article, it can significantly hinder youth from accessing information about sexual and reproductive health.[322] Anyone teaching sexual education in schools, or professionals such as doctors or social workers, could be seen as violating this provision, and thus, risk punishment.[323] Additionally, surrounding the bill's debate, LGBTI-hostile language was used, which included claims that sex education was misused by members of the LGBTI community to "groom" them for their purposes.[324] The chilling effect of possible prison sentences for teachers and health care providers is likely result in the de facto prohibition of information about sexual and reproductive health, including information and access to contraception for youth. This would

[317] Jaraczewski (n 314).
[318] ibid; Pendrakowska (n 316).
[319] OHCHR, 'Poland Urged Not to Criminalise Sex Education or Tighten Access to Abortion' (2020) <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25796&LangID=E> accessed 1 June 2021.
[320] Selen Eşençay, 'When COVID-19 Becomes a Political Ally: Poland's Law on Abortion' (*The London School of Economics and Political Science*, 23 June 2020) <https://blogs.lse.ac.uk/gender/2020/06/24/when-covid-19-becomes-a-political-ally-polands-law-on-abortion/> accessed 3 June 2021.
[321] Hillary Margolis, 'Polish Parliament Should Scrap Bill Against Sex Education' (*Human Rights Watch*, 2019) <https://www.hrw.org/news/2019/10/18/polish-parliament-should-scrap-bill-against-sex-education#> accessed 2 June 2021.
[322] European Parliament, 'Criminalisation of Sexual Education in Poland' (2019) Resolution P9_TA(2019)0058 para 2.
[323] OHCHR (n 319); European Parliament (n 322) para F.
[324] Rachel Savage, 'Poland Mulls Law Denouncing Sex Educators as Paedophiles and Gay Activists' (*Reuters*, 15 April 2020) <https://www.reuters.com/article/us-poland-lgbt-education-trfn-idUSKCN21X2ZA> accessed 3 June 2021.

significantly affect their right to quality-based, comprehensive sexual education, which is contrary to the core obligations under art. 12 ICESCR to eliminate laws that undermine access to reproductive health facilities, services, goods and information; and to ensure access to comprehensive information and education on the matter.[325] Further, comprehensive sex education and access to information about contraceptives is an integral part of preventing unintended pregnancies and clandestine abortions.[326] Thus, the new law would go against a multitude of SRHR, such as the right to life, right to health, right to education, right to information, as mentioned and described above under the ICCPR, ICESCR, CRC, and CEDAW.

The "Stop Abortion" bill set out the prohibition of abortion in cases of severe or fatal fetal anomalies.[327] Thus, abortion would only remain legal when the mother's health or life is at risk or if the pregnancy resulted from incest or rape. As a result, women would knowingly have to carry a non-viable pregnancy or a child that might die immediately after birth to term. In practice, this bill makes abortion in Poland effectively illegal, as most performed abortions are based on fetal abnormality grounds.[328] The impact on sexual and reproductive rights of this prohibition will be analyzed in the next chapter in further detail.

The focus of the "Yes to family, no to Gender" bill is Poland's withdrawal from the Istanbul Convention.[329] Proponents of this bill claim that the Istanbul Convention goes against religion and promotes unwelcome "gender ideologies".[330] Instead, they advocate for a new (regional) convention to protect women from violence.[331] It is not guaranteed, however, that such a convention would be implemented at all, let alone have the same effectiveness. Rather, the withdrawal from the Istanbul Convention would be a clear statement against international standards, withdrawing from the international monitoring framework. Especially in view of the overall development of women's rights during the last years, Poland would likely use this lack of supervision and accountability to further undermine sexual and reproductive rights.

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[325] Committee on Economic Social and Cultural Rights, 'General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)' (n 125) para 49(a).
[326] ibid 28.
[327] 'Poland: Reject New Curbs on Abortion, Sex Ed' (*Human Rights Watch*, 2020) <https://www.hrw.org/news/2020/04/14/poland-reject-new-curbs-abortion-sex-ed#> accessed 2 June 2021.
[328] 'Number of Legal Abortions Reported in Poland from 1994 to 2019, by Reason' (*statista*, 2021) <https://www.statista.com/statistics/1111281/poland-legal-abortions-number-by-reason/> accessed 3 June 2021.
[329] Sandrine Amiel, 'Istanbul Convention: Poland Moves a Step Closer to Quitting Domestic Violence Treaty' (*Euronews*, 1 April 2021) <https://www.euronews.com/2021/04/01/istanbul-convention-poland-moves-a-step-closer-to-quitting-domestic-violence-treaty> accessed 3 June 2021.
[330] ibid.
[331] Jo Harper, 'Poland Pitches "Warsaw Convention" as Turkey Exits Istanbul Version' (*Emerging Europe*, 22 March 2021) <https://emerging-europe.com/news/poland-pitches-warsaw-convention-as-turkey-exits-istanbul-version/> accessed 3 June 2021.

Additionally, given the fact that the European Union has acceded to the Istanbul Convention in 2018,[332] the withdrawal would be in conflict with European values, shedding light on the further dissociation from the rule of law and the European Union.

Ultimately, all three bills were referred to the Polish parliamentary committee for "further work"; the "Stop Pedophilia" and "Stop Abortion" in April 2020,[333] the "Yes to family, no to Gender" bill in March 2021.[334] Although this represents a postponement on any decision, it does not mean that the bills failed.[335] They could be taken up again at a later point in time, as it has happened in previous years.

5.2.2.3 Restriction of the abortion law by the Polish constitutional court

In the meantime, the anti-abortion movement found an alternative way to implement changes through the constitutional court. Members of the Polish Sejm (Parliament) filed an application to the Constitutional Tribunal in which they sought a constitutionality review of the current abortion law. The Family Planning Act allowed abortion if *"*[…] *there is a high probability of the foetus's severe and irreversible impairment or of the foetus's life-threatening incurable illness"*.[336] On October 22, 2020, the court ruled that this (as it was called in the application) *"eugenic practice"* violates the Polish constitution.[337] The court argued that, as subjects of the law, the dignity of unborn children must be protected.[338] It did not deem abortion as a deprivation of the right to life of the unborn child, however, according to the court abortion would prevent the legal protection of its life and dignity.[339] The decision became legally binding on January 27, 2021.[340] As of this date, abortion in Poland is only allowed if the health or life of the mother is at risk, or if the pregnancy resulted from rape or incest.

Although this decision of the constitutional court does not have an explicit connection to COVID-19, the question arises of how this change in abortion law can be evaluated under

[332] European Parliament (n 232).
[333] 'Poland: Reject New Curbs on Abortion, Sex Ed' (n 327).
[334] Amiel (n 332).
[335] 'Poland: Reject New Curbs on Abortion, Sex Ed' (n 327).
[336] Trybunał Konstytucyjny, 'Family Planning, the Protection of Foetuses, and Grounds for Permitting the Termination of a Pregnancy ' (2020) <https://trybunal.gov.pl/en/news/press-releases/after-the-hearing/art/11299-planowanie-rodziny-ochrona-plodu-ludzkiego-i-warunki-dopuszczalnosci-przerywania-ciazy> accessed 3 June 2021.
[337] Trybunał Konstytucyjny [2020] judgment no. K 1/20, 22 X 2020 <https://trybunal.gov.pl/en/hearings/judgments/art/11300-planowanie-rodziny-ochrona-plodu-ludzkiego-i-warunki-dopuszczalnosci-przerywania-ciazy> accessed 3 June 2021.
[338] Trybunał Konstytucyjny (n 336).
[339] ibid.
[340] 'Poland Enforces Controversial Near-Total Abortion Ban' (*BBC News*, 28 January 2021) <https://www.bbc.com/news/world-europe-55838210> accessed 3 June 2021.

international human rights law. Thus, it will be analyzed whether the decision of the constitutional court is a derogation or restriction, and whether it is compatible with human rights standards.

As could be seen before, the main difference between derogations and restrictions of human rights is that derogations aim to return to normal times from an exceptional state.[341] Restrictions as such are aimed at preserving the status quo of human rights protection by establishing a balance between affected rights that is upkept in the long term.[342] In this case, the constitutional court declared part of the abortion law in place as unconstitutional, which will impact the abortion law in the long term and stay place even after the pandemic. Additionally, the court did not take the decision as part of a response to COVID-19. This indicates that the change in legislature is not a derogation – or if anything, a derogation not fulfilling any of the basic requirements – but rather a restriction that has to be measured against the criteria of legality, legitimacy, and proportionality. This restriction of abortion rights has to be analyzed against the backdrop of the ongoing COVID-19 pandemic and the rule of law crisis that has developed in Hungary and Poland in the last years.

In the light of the rule of law crisis in Poland, it is questionable how the ruling Peace and Justice Party influenced the constitutional court's decision. At the beginning of 2021, the ECtHR finally made a key decision in its *Xero Flor* judgment[343], emphasizing that the composition of the current Polish constitutional tribunal is no longer lawful. Since then, the ECtHR has notified Poland of five pending cases that also concern the lack of judicial independence.[344] It is critical to note that before being appointed to the constitutional court, one of the judges involved was actually a signatory of the motion that led to the constitutionality review of the Polish abortion law.[345]

In any case, the de-facto prohibition of abortion cannot be seen as a proportional restriction or necessary derogation. In its judgment, the constitutional court emphasized that the right to life of the fetus, particularly the legal protection of this right, is deprived by abortion.[346] This very restrictive abortion law disregards the immense psychological and physical pain caused to women who are now forced to wait until their fetus is miscarried or until they give birth. It is likely that more women will resort to unsafe, illegal abortions as

[341] Trapp (n 237) 313.
[342] ibid.
[343] *Xero Flor w Polsce sp. z o.o. v. Poland* (2021) app no 4907/18.
[344] European Court of Human Rights, 'ECHR Gives Notification to Poland of Five Cases Concerning Alleged Lack of Judicial Independence' (2021) ECHR 140.
[345] Neil Datta, 'Four Reasons Why Poland's War on Abortion Should Scare You' (*European Parliamentary Forum for Sexual & Reproductive Rights*, 2021) <https://www.epfweb.org/node/799> accessed 21 June 2021.
[346] Trybunał Konstytucyjny (n 336).

there are no longer other options. Even before the pandemic and the tightening of abortion laws, Polish women traveled abroad to obtain abortions – these numbers have now been increasing.[347] However, Poland's efforts to limit access to legal abortion do not stop there – as the Czech Republic is planning to clarify the legal rules for Polish women seeking an abortion, Poland has gone as far as questioning Czech-Polish relations and condemning support for "abortion tourism".[348] It is essential to highlight the fact that this will have a disproportionate impact on women with a low socioeconomic status, as the cost of traveling to seek legal abortion abroad poses an additional hurdle. This results in inequalities regarding access to SRHR for women with a low socio-economic status, without any kind of objective reasoning or justification, thus violating their right to equal treatment under art. 26 ICCPR.

Further, as highlighted in *Mellet v. Ireland*, forcing a woman to carry a non-viable pregnancy to term, regardless of the potential physiological and psychological pain inflicted on her, supports the existing gender stereotype of women being selfless mothers, caregivers, and reproductive instruments.[349] Thus, such restrictions do not only have significant short-term consequences for SRHR of individuals, but are simultaneously a consequence and undue reinforcement of gender inequality in society.

Therefore, the de facto prohibition of abortion in Poland is contrary to Poland's obligations to ensure access to safe and legal abortion and to prevent unsafe abortion and maternal mortality as part of women's SRHR, such as the right to equality[350], the right to be free from torture, cruel, inhuman and degrading treatment[351], the right to privacy[352], the right to sexual and reproductive health[353], and potentially the right to life[354].

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[347] Claudia Ciobanu, 'Poland's Government Requests Czechia Stop Offering Abortions to Polish Women' (*Reporting Democracy*, 3 May 2021) <https://balkaninsight.com/2021/05/03/polands-government-requests-czechia-stop-offering-abortions-to-polish-women/> accessed 3 June 2021.

[348] ibid; Benedetta Pisani, 'Polish Diplomats Protest At "Abortion Tourism" in The Czech Republic' (*Brno Daily*, 7 May 2021) <https://brnodaily.com/2021/05/07/news/polish-diplomats-protest-at-abortion-tourism-in-the-czech-republic/> accessed 4 June 2021.

[349] *Mellet v. Ireland* (2013) comm no 2324/2013 UN Doc CCPR/C/116/D/2013, Annex II, para 4.

[350] Such as International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 26.

[351] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 7.

[352] Such as Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 8(1).

[353] Such as International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) art 12(1).

[354] Such as International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 6(1).

5.2.3 Conclusion: Unlawful restrictions of SRHR

Although only the further restriction of the Polish abortion law was successful, the debate of the various initiatives illuminates where the country is headed. Frequent attempts to restrict access to essential SRHR, such as access to quality-based sexual education and legal abortion, coincided with the COVID-19 pandemic. As most initiatives stemmed from citizens' initiatives and had been debated prior to the pandemic, it would be hasty to claim that it was merely the government using the backdrop of the pandemic for its own purposes. Instead, one should take into account the wider picture of the backsliding rule of law in Poland and Hungary, the re-traditionalization of society, and the removal of European values contained therein. However, it cannot be denied that the pandemic opened up a significant window of opportunity for the ruling party to move forward with legislative changes that support its conservative agenda.[355] Social-distancing and lockdown measures, as well as the fear of exposure to the virus, affect the right to assembly and can deter the organization of protests in favor of sexual and reproductive rights. Additionally, after the frequent failed attempts of introducing the de facto abortion ban through legislation, the constitutionality review of the abortion law by a constitutional tribunal that can no longer be seen as independent is suspicious, at the very least.

Of particular note, however, is the fact that these potential attempts by the government were not completely successful, as many people participated in demonstrations against the discussed bills and in the aftermath of the constitutional court's decision.[356] As these women's rights protests were ongoing, the government reacted by involving the military gendarmerie to "protect the safety and public order" in light of COVID-19, emphasizing that it is part of standard activities to support the police force.[357]

One can only speculate on the extent to which the current pandemic played into the hands of the restriction of SRHR. What is clear, however, is the regressive trend of Poland's legislation that violates human rights standards. To meet its human rights obligations not only in times of a public health emergency, but in the future, Poland should explicitly reject the draft laws on sex education, the exit of the Istanbul Convention, and change its legislation to guarantee access to safe and legal abortion again.

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[355] Eşençay (n 320).
[356] 'Poland: Events of 2020' (*Human Rights Watch*) <https://www.hrw.org/world-report/2021/country-chapters/poland> accessed 5 June 2021; 'Poland Abortion: Protesters against Ban Defy Coronavirus Lockdown' (*BBC News*, 15 April 2020) <https://www.bbc.com/news/world-europe-52301875> accessed 5 June 2021.
[357] 'Żandarmeria Wojskowa Skierowana Do Pomocy Policji. Ministerstwo Obrony: To Standardowe Działania' (*TVN24*, 26 October 2020) <https://tvn24.pl/polska/zandarmeria-wojskowa-skierowana-do-pomocy-policji-ministerstwo-obrony-to-standardowe-dzialania-4732574> accessed 5 June 2021.

5.3 The United Kingdom

5.3.1 Access to legal abortion before COVID-19

As previously mentioned, the following case study is focused on the UK's constituent parts Northern Ireland and England. The Irish abortion law was only relaxed in July 2019, which came into force in March 2020, with no gestational limit in cases of severe threats to the woman's physical or mental health or life or in case of severe fetal impairment or abnormality.[358] Previously, women in Northern Ireland usually traveled to England to access abortion care.[359]

Under the 1967 Abortion Act, women in England can access abortion for up to 24 weeks if two doctors agree that continuing the pregnancy would be riskier to their physical or mental health.[360] No gestational limit exists if the life of the woman is at risk, if there is a significant threat to her mental or physical health or in case of fetal abnormality.[361]

5.3.2 Legal and regulatory changes and their impact on SRHR during COVID-19

5.3.2.1 Facilitated access to self-managed medical abortion in England

As a consequence of the pandemic, there was a great public concern to ensure access to legal abortion in England.[362] For example, as staff was sick or in isolation due to COVID-19, the British Pregnancy Advisory Service, one of the major abortion providers in England, was forced to close 23 % of its clinics.

One solution identified to facilitate access to abortion services throughout the pandemic was early medical abortion via telemedicine. Medical abortion is induced by taking two different medications, Mifepristone and Misoprostol. In theory, it would be possible to prescribe and provide this medication after online consultations. However, restrictions

[358] The Abortion (Northern Ireland) Regulations 2020 9.
[359] Elizabeth Rough, 'Abortion in Northern Ireland: Recent Changes to the Legal Framework - Briefing Paper No. CBP 8909' (2021) 3.
[360] 'What Are the UK's Laws on Abortion?' (*BBC News*, 22 October 2019) <https://www.bbc.com/news/health-19856314> accessed 13 June 2021; Rosalind English, 'Abortion "Pills by Post": Approval of Procedure Not Unlawful - Court of Appeal - UK Human Rights Blog' (*UK Human Rights Blog*, 2020) <https://ukhumanrightsblog.com/2020/10/21/abortion-pills-by-post-approval-of-procedure-not-unlawful-court-of-appeal/> accessed 28 March 2021.
[361] 'What Are the UK's Laws on Abortion?' (n 360).
[362] English (n 360).

prohibiting at-home use of Mifepristone and/or Misoprostol are significant hurdles. Often, at least one of the medications is to be taken under the supervision of a medical provider.[363]

Although abortion via telehealth sounds like a new concept, it is in fact not. States and women's health organizations have gained extensive experience in this service. For example, variations of this telehealth system to provide abortion care have been successfully used in US states during the last years, especially in rural areas where geographical distances hinder access to surgical abortion.[364] Additionally, in countries in which legal abortion is not available, the organization Women on Web is implementing fully remote abortion services.[365] This form of telemedical health care is supported by studies proving that the risks associated with medical abortion at home are similar to in-person service, with the procedure generally being remarkably safe and with a low risk of complications.[366] In fact, after many years of experience with medical abortion, the WHO advises making self-medicated abortion available, as *"*[…] *self-management and self-assessment approaches can be empowering and also represent a way of optimizing workforce resources and sharing of tasks".*[367] Medical abortion via telemedicine allows for easier and faster access to abortion care, which avoids riskier abortions at a more advanced point in gestation.[368]

As a result of public pressure, England allowed medical abortion via telemedicine on March 23, 2020, but shortly after, this statement was withdrawn as mistakenly published.[369] This led to confusion and criticism from providers; however, in the end, telemedical abortion services were finally introduced on 30 March 2020.[370] Under the new guidelines, women in England can access consultations and the needed medication via telemedicine in determined low-risk cases even without ultrasound examinations.[371] After approval, the drugs are delivered to the home of the woman.[372] This allows fully remote access to early medical abortions until nine weeks and six days of gestation as long as the COVID-19 pandemic is

[363] Kelly Cleland and Nicole Smith, 'Aligning Mifepristone Regulation with Evidence: Driving Policy Change Using 15 Years of Excellent Safety Data' (2015) 92 Contraception 179, 180.
[364] Megan K Donovan, 'Improving Access to Abortion via Telehealth' (*Guttmacher Policy Review*, 16 May 2019) <https://www.guttmacher.org/gpr/2019/05/improving-access-abortion-telehealth#> accessed 13 June 2021; Romanis, Parsons and Hodson (n 18) 5.
[365] Romanis, Parsons and Hodson (n 18) 5.
[366] Daniel Grossman, Kate Grindlay and Kathleen Lane, 'Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine' (2011) 118 Obestrics & Gynecology 296, 302; Cleland and Smith (n 366) 180; M Endler and others, 'Telemedicine for Medical Abortion: A Systematic Review' [2019] BJOG 1094, 1100.
[367] World Health Organization, 'WHO Consolidated Guideline on Self-Care Interventions for Health' (2019) 67 <https://apps.who.int/iris/bitstream/handle/10665/325480/9789241550550-eng.pdf?ua=1> accessed 16 March 2021.
[368] Romanis, Parsons and Hodson (n 18) 13–14.
[369] ibid 7.
[370] English (n 360).
[371] Moreau and others (n 9) 5.
[372] ibid.

ongoing.[373] Until today, the measure has had a positive effect on access to abortion, with a record number of British women having sought an abortion in 2020, out of which 46 % of the procedures in England were provided with the use of telemedicine.[374] In turn, the number of requests for the provision of medical abortion pills through the organization Women on Web, which usually provides medical abortion via telemedicine, especially in countries with restrictive abortion laws, has drastically reduced to almost zero in England.[375]

From a human rights perspective, ensuring women's right to access legal abortion through the use of medical abortion via telemedicine has a positive effect on the fulfillment of SRHR, especially the right to reproductive health as part of art. 12 ICESCR. The pandemic comes with undeniable factors that hinder access to abortion, from the fear of contracting the virus and spreading it to family members to more difficult initial social and economic conditions. With families being required to shelter in place, it can be more difficult for women to access abortions without family members knowing and potentially prevent access to abortion care. Additionally, given the school closures in most European countries, there is an increased difficulty for women to organize and afford child care for the time they would have to leave the house to seek care. Particularly for women with low socioeconomic status, this has the potential to create an insurmountable hurdle; and to create further discrimination for women depending on their race, class, and gender. Given that core rights cannot be restricted or derogated from in times of emergency, it is even more important for states to take additional measures to ensure compliance with their human rights obligations. The lack of access to legal abortion has a significant impact on almost all human rights linked to sexual and reproductive health – such as the right to life, the right to be free from torture and inhuman or degrading treatment, the right to privacy, and the right to health, protected through the interplay between international and regional treaties such as the ICCPR, ICESCR, CEDAW and the ECHR.

By relying on telemedicine to provide access to medical abortion, care can be ensured without using public transport and leaving one's home. This is in line with stay-at-home orders and significantly reduces the risk of infection for health care professionals, as well as persons seeking care and their families. Enabling women to access care through telemedicine can be crucial to ensure timely treatment for women who are in quarantine or not able to leave their house and otherwise might not be able to seek care on time. Thus, through the use of

[373] ibid; Romanis, Parsons and Hodson (n 18) 9.
[374] Sarah Marsh 'Record Number of Women in England and Wales Had Abortions in 2020' (*The Guardian,* 10 June 2021) <https://www.theguardian.com/world/2021/jun/10/record-number-of-women-in-england-and-wales-had-abortions-in-2020> accessed 13 June 2021.
[375] Aiken and others (n 16) 1.

telemedicine and self-administered medical abortion, unnecessary delays which could make a riskier surgical abortion necessary[376] or abortion impossible altogether can be avoided. Furthermore, it is less straining on a state's resources during a pandemic, as telemedicine allows for medical personnel to keep a safe distance to potentially COVID-infected patients – which means that the risk of health personnel having to go into self-isolation as part of quarantine measures decreases. For these reasons, given the proven safety of medical abortion up to nine weeks into a pregnancy, it is no longer viable to require on-site pickup or intake of Mifepristone, especially during the pandemic.

Thus, the reaction of England to temporarily allow medical abortions via telemedicine was a significant advancement of the protection of SRHR, supported by the high number of women relying on this service during the last year, proving its success. This is also an important development in light of ongoing anti-abortion campaigns, which advocated for the suspension of abortion services during COVID-19.[377]

However, England's approach can be criticized in that the initial legalization of telemedical abortion in March was withdrawn only shortly after, confusing patients and providers. Furthermore, it is important to highlight that the British regulation allowing medical abortions through telemedicine is only temporary and will expire as the COVID-19 pandemic ends. Currently, the British government is evaluating the results of a consultation on whether medical abortion via telemedicine should remain a permanent option. However, no outcome has been published yet.[378] Not making the option of medical abortion via telemedicine permanent disregards the fact that this form of treatment could even be of value in times after the pandemic, allowing for easier, faster and nevertheless safe access. Making medical abortion via telemedicine available during normal times would thus be in line with the state obligation to ensure *evidence*-based, quality health care services as part of the right to health.

[376] Romanis, Parsons and Hodson (n 18) 13-14.
[377] Center for Reproductive Rights, 'News in Brief on COVID-19 & SRHR in Europe: 2nd Edition: 10 April - 3 May 2020' 1 <https://rm.coe.int/news-in-brief-covid-19-srhr-europe-2nd-edition/16809e4c6c> accessed 27 June 2021.
[378] Department of Health and Social Care, 'Closed Consultation: Home Use of Both Pills for Early Medical Abortion' (*gov.uk*, 2020) <https://www.gov.uk/government/consultations/home-use-of-both-pills-for-early-medical-abortion> accessed 17 June 2021.

5.3.2.2 Inactivity and lack of access to reproductive health care in Northern Ireland

The situation of access to legal abortion in Northern Ireland during COVID-19 varied greatly. The pandemic coincided with a time when abortion had only recently been legalized, and abortion services were not established yet.[379] Thus, despite its legalization, the lack of service providers meant that many women seeking care had to travel to England after all.[380] Apart from the general issues of affordability, unclear travel regulations during the pandemic complicated access to abortion abroad. In fact, there was confusion about whether or not seeking an abortion in England is classified as an urgent medical service and whether or not negative PCR tests have to be provided upon arrival in each country.[381] As a result, there were reports of women seeking abortion or women who just had an abortion in England to be refused entry on the flight either to or back from England.[382] This uncertainty had a chilling effect on access to abortion for Irish women: the comparison of the first months of 2019 with 2020 shows that the number of women who traveled to England for an abortion halved[383] – not because services were available in Northern Ireland, but most likely because of the uncertainty of the pandemic and travel restrictions. The concern that women would not be able to access abortion at all, or resort to illegally ordering abortion pills online, is a very viable one.

Until today, the availability of abortion services remains inadequate. This can partly be explained by looking at the structure and organization of the health care system. The Northern Ireland Department of Health is responsible for health and social care.[384] However, these duties are distributed onto the Health and Social Care Board, the Public Health Agency and several Health and Social Care bodies, which include trusts.[385] Trusts primarily provide health and social care services.[386] The lack of abortion services despite its legalization can be explained by the inactivity of the Northern Irish Department of Health, not having

[379] Maya Oppenheim, 'Coronavirus Chaos Could Force Women in Northern Ireland to Resort to Dangerous Back-Street Abortions' *The Independent* (19 March 2020) <https://www.independent.co.uk/news/uk/home-news/coronavirus-abortion-northern-ireland-republic-pregnancy-a9410126.html> accessed 7 June 2021.
[380] ibid.
[381] Kitty Holland, 'Calls for Clarity on Whether Abortion an "Urgent" Medical Service' (*The Irish Times*, 3 March 2021) <https://www.irishtimes.com/news/social-affairs/calls-for-clarity-on-whether-abortion-an-urgent-medical-service-1.4553734> accessed 16 June 2021.
[382] ibid.
[383] Kitty Holland, 'Covid Restrictions Make It Difficult for Irish Women Seeking Abortions to Travel' *The Irish Times* (28 October 2020) <https://www.irishtimes.com/news/social-affairs/covid-restrictions-make-it-difficult-for-irish-women-seeking-abortions-to-travel-1.4391601>.
[384] 'Health and Social Care in Northern Ireland' (*Northern Health and Social Care Trust*) <http://www.northerntrust.hscni.net/about-the-trust/trust-overview-2/health-and-social-care-in-northern-ireland/> accessed 16 June 2021.
[385] ibid.
[386] ibid.

commissioned abortion services centrally, aiding health and social care trusts in allocating resources to SRHR in a time in which resources are already scarce.[387] Since then, the various bodies of the Northern Irish health system have remained inactive in the funding and commissioning of abortion services, continuously deferring responsibility for this to others.[388] As a result, in certain regions, no termination services were available for women for months at a time.[389] This is particularly problematic since access to contraceptives was not always guaranteed, even before the pandemic.[390]

In this regard, it is essential to highlight that, unlike in England, medical abortion through telemedicine remained explicitly prohibited.[391] The first pill has to be taken under medical supervision, and only the second one can be taken at home.[392] Many providers resisted this persistent prohibition and openly stated that they would nonetheless ensure such care if the health or life of the mother is at significant risk.[393] Some attempts to establish abortion services were successful: In one region, the Northern Ireland Abortion and Contraception Task Group established a temporary service that allowed women to access medical abortions. However, this is not a permanent solution as the Department of Health does not provide any funding for the program.[394] In most other regions, the situation was even direr. Some trusts refused treatment due to the lack of resources, with one trust unable to provide early medical abortion because one doctor went on maternity leave.[395] Nevertheless, there was a demand for self-managed early medical abortion, as reflected in the increased number of requests at Women on Web.[396]

One real-life example of the lack of access to safe and legal abortion during COVID-19 is provided by the Northern Ireland Human Rights Commission (NIHRC), which took legal action on behalf of a woman who could not access abortion in Northern Ireland. As her local

[387] Northern Ireland Human Rights Commission, 'Monitoring Report on Reproductive Healthcare Provision in NI' (2021) para 6.8 <https://nihrc.org/uploads/publications/Reproductive-Healthcare-Monitoring-Report-FINAL.pdf> accessed 10 July 2021.
[388] 'Human Rights Commission Legal Action on Lack of Abortion Services in NI Begins' (*Northern Ireland Human Rights Commission*, 25 May 2021) <https://nihrc.org/news/detail/human-rights-commission-legal-action-on-lack-of-abortion-services-in-ni-begins> accessed 16 June 2021.
[389] Northern Ireland Human Rights Commission (n 387) para 6.5.
[390] ibid 5.101.
[391] Rough (n 359) 21.
[392] ibid.
[393] Romanis, Parsons and Hodson (n 18) 9.
[394] Siobhan Kirk and others, 'Introduction of the National Health Service Early Medical Abortion Service in Northern Ireland – an Emergency Response to the COVID-19 Pandemic' (2021) 0 BMJ Sexual & Reproductive Health 1, 2-3.
[395] Alexandra Topping, 'UK Ministers Face Legal Action over Lack of Abortion Services in Northern Ireland' (*The Guardian*, 10 January 2021) <https://www.theguardian.com/world/2021/jan/10/uk-ministers-face-legal-action-over-lack-abortion-services-northern-ireland> accessed 16 June 2021.
[396] Aiken and others (n 16) 1.

trust suspended services, no abortion services were available.[397] Instead, she was advised to travel to England, which the woman refused because she feared contracting COVID-19 and did not want to explain to her workspace why she needed time off to travel during an ongoing global pandemic.[398] Finally, she resorted to illegally ordering abortion pills online.[399] In the legal action, the NIHRC claims that the Northern Ireland Executive, the Department of Health, and the Northern Ireland Secretary have failed to establish adequate abortion services by commissioning and funding abortion services in Northern Ireland.[400] At the time of writing, the decision of the court is still pending. Beyond the fact that Northern Ireland has failed to establish abortion services on time, which is contrary to the human rights obligation to ensure access to legal abortion, one should additionally pay attention to the unequal consequences this failure will have on women as such. Similar to experiences from *Mellet v. Ireland*[401], one can only imagine the immense distress that traveling abroad to seek an abortion during COVID-19 would cause. However, further, it must be kept in mind that women with a low socioeconomic status are, in light of the economic downturn, even less likely to be able to seek abortions abroad.

5.3.2.3 Telemedicine as part of a human-rights-based approach to ensuring SRHR?

The comparison between Northern Ireland and England illuminates a large discrepancy in access to legal abortion during COVID-19. Access to legal abortion was impacted by states' reactions in both countries. In England, telemedical abortion was not available previous to the pandemic, and not for several weeks when there was confusion about the legalization of abortion via telemedicine in March 2020. After, great improvements were made when medical abortion via telemedicine was made available. In Northern Ireland, 2020 was marked by the failure to establish sufficient abortion services, and additionally, the lack of mitigating measures such as making early medical abortion via telemedicine available.

The following question, therefore, is how England's and Northern Ireland's behavior can be evaluated from a feminist human rights-based perspective. It is crucial to keep in mind that

[397] Northern Ireland Human Rights Commission, '2021 Fact Sheet: Human Rights Commission Legal Action on Lack of Abortion Services in NI' (2021) <https://nihrc.org/uploads/publications/11.01.21_Fact_Sheet_Human_Rights_Commission_Legal_Action_on_Lack_of_Abortion_Services_in_NI_.pdf>.
[398] 'Human Rights Commission Legal Action on Lack of Abortion Services in NI Begins' (n 388).
[399] Northern Ireland Human Rights Commission (n 397).
[400] 'May 2021 Fact Sheet: Human Rights Commission Legal Action on Lack of Abortion Services in NI' (*Northern Ireland Human Rights Commission*, 19 May 2021) <https://nihrc.org/news/detail/may-2021-fact-sheet-human-rights-commission-legal-action-on-lack-of-abortion-services-in-ni> accessed 16 June 2021.
[401] *Mellet v. Ireland* (2013) comm no 2324/2013 UN Doc CCPR/C/116/D/2013.

during public emergencies, states still have to fulfill their core human rights obligations and adhere to the principles of necessity and proportionality. In England and Northern Ireland, the (in)accessibility of legal abortion potentially affected a broad range of human rights during COVID-19: from the right to health, the right to life, the right to privacy, to the right to be free from torture or inhuman and degrading treatment under international and regional treaties such as the ICCPR, ICESCR, ECHR, and so on. As previously established, once a state has decided to legalize abortion, it has the duty to ensure equal access to quality-based care.[402]

Restrictions or derogations from this obligation are only permissible under specific circumstances. Using the example of the right to privacy under art. 8 ECHR, several interferences from England and Northern Ireland can be identified. Firstly, in the case of both, although for England only temporarily, the decision not to legalize medical abortion at home, making it impossible to access via telemedicine. Additionally, one has to see Northern Ireland's failure to commission and fund adequate abortion services. Such interferences can only be justified under the requirements of art. 8(2) ECHR or art. 15 ECHR. However, no legitimate aim enumerated in art. 8(2) would be suitable. Solely the protection of health would be in question, but in fact, given that these interferences coincided with a global pandemic, legalizing medical abortion via telemedicine would not have harmed health but rather improved it by limiting possible exposure to the virus.[403]

The only other option to legally interfere with the right to privacy would be in the form of a derogation under art. 15 ECHR. However, neither the formal requirement of a notification to the Secretary-General of the CoE has been met, nor would such interference be required by the emergency.[404] In fact, as has previously been shown, medical abortion via telemedicine would have upheld human rights obligations concerning sexual and reproductive health while limiting the further spread of the virus. Apart from the fact that abortions can only be deferred for a limited time, the negative impact on a woman's health (and potentially, life) may well exceed the risk of contracting the virus.[405] Thus, such measures be disproportionate; in reality, states have to take additional steps to ensure access to abortion during emergencies. Thus, the procedural and substantive requirements of a derogation are not met in the cases of England and Northern Ireland.

Furthermore, in their emergency responses, states must ensure that their measures are non-discriminatory and do not undermine core human rights obligations, such as the

[402] For example, as part of a procedural obligation under art 8(1) ECHR.
[403] Romanis, Parsons and Hodson (n 18) 18–19.
[404] ibid 17.
[405] Todd-Gher and Shah (n 10) 29.

prevention of unsafe abortions by providing access to critical abortion services.[406] As highlighted before, limited access to abortion services has a disproportionate effect on women who were marginalized even before the pandemic. Traveling abroad to seek care, as it was recommended to women in Northern Ireland during 2020, is more likely only to be an option for women who can afford travel costs and other potential costs, such as for child care. Thus, as there were no sufficient abortion services established in Northern Ireland yet, telemedicine services could have filled an important gap to make care available to everyone. Therefore, the limitation of medical abortion via telemedicine does not only negatively impact women's access to abortion, but it has disproportionate consequences for women with a low socio-economic background, who might not be able to access legal abortion at all without telemedicine. To conclude, the restriction of medical abortion via telemedicine is an often discriminatory, disproportionate response to the pandemic, especially in countries in which no alternative methods are available or would not be equally safe, for example, in light of high COVID-19 incidence rates. For this reason, it can be held that Northern Ireland did not lawfully restrict or derogate from human rights. In fact, it failed to comply with its human rights obligations concerning SRHR. Overall, England's approach was highly recommendable, as it was a speedy and well-accepted preventive measure following medical standards.

5.3.3 Conclusion: Pioneering the protection of SRHR through telemedicine: An example within the CoE

In summary, the current case study illuminated that the protection of SRHR during COVID-19 in the UK was not uniform. Theoretically, in both Northern Ireland and England, the same relatively liberal abortion law existed. The only difference between the reactions of both countries is that, while the human rights violations in Northern Ireland continued over the last year, England reacted quickly and adapted its framework to ensure its respect for human rights obligations in relation to SRHR. The number of requests received by the organization Women on Web illuminates the fact that England successfully enabled women to seek abortion care within the legal framework and the health system, while more women in Northern Ireland showed increased interest in methods outside the realm foreseen by the health system.

[406] Todd-Gher and Shah (n 10) 29.

During a pandemic, states should evaluate whether their legal frameworks still enable compliance with human rights obligations concerning sexual and reproductive rights, and if necessary, they have to take additional measures to address new challenges, such as ensuring access to legal abortions. During public health emergencies, states risk violating their duty to prevent unsafe abortions and maternal mortality, if the core obligation to ensure access to reproductive health services is not fulfilled. This is what has happened in Northern Ireland: As the legalization of abortion services in Northern Ireland was only recently, it struggled with its implementation, and failed to take additional measures during the COVID-19 pandemic.

On the other hand, COVID-19 posed a window of opportunity for SRHR in England and beyond, as access to abortion services via telemedicine was legalized. As this form of treatment had long been established as safe and beneficial to ensuring equal access to legal abortion, this was an important step in bringing health care up to current scientific standards. In fact, England was a pioneer within the CoE in this regard. It is very likely that the same reasoning, that the unnecessary restriction of telemedicine (not only during a pandemic!) is a disproportionate restriction or derogation from SRHR, is also transferable to other CoE countries. Evidently, proportionality assessments of restrictions or derogations aimed at protecting public or individual health always have to be conducted in light of the country-specific background, such as the respective incidence rates of the pandemic. Nevertheless, even in view of the lack of resources, for example PPE, core obligations such as preventing maternal mortality and unsafe abortions under the right to life can never be disregarded. Thus, finding an adequate balance would prove to be tricky and, when it comes to prohibiting medical abortion, unlikely to withhold a proportionality assessment. It is highly unlikely, if not impossible, to imagine a situation in which the restriction of abortion services leads to better public health outcomes.[407] In fact, there are good arguments for the legalization of early medical abortion via telemedicine during emergencies. Thus, England's innovative approach to ensuring access to abortion serve are exemplary within the CoE.

[407] Ophelia Chatterjee, Lisa Juanola and Nicole Moran, 'From Crisis to Innovation: Empowerment in Self-Administered Abortion' (*KIT Royal Tropical Institute*, 28 May 2020) <https://www.kit.nl/from-crisis-to-innovation-empowerment-in-self-administered-abortion/?setCookie=true> accessed 19 June 2021.

5.4 The Netherlands

5.4.1 Access to legal abortion and contraception before COVID-19

With one of the lowest abortion rates globally and almost no unsafe abortions, the Netherlands generally has a good track record in the protection of SRHR.[408] This can be attributed to its comparatively liberal abortion laws, the ease in accessing contraception, and an emphasis on comprehensive sex education.[409]

5.4.2 Legal and regulatory changes and their impact on SRHR during COVID-19

5.4.2.1 No special measures to ensure SRHR

In its immediate response to COVID-19, the Netherlands implemented social distancing measures and closed businesses such as restaurants, hairdressers, and others that involve close contact.[410] When it comes to ensuring SRHR, for example, access to legal abortion, the Dutch response can be seen as mixed. Despite reports that surgical abortions were less available during the pandemic, the general picture of access to abortion services does not show major difficulties in access.[411] However, in some individual cases, problems arose, for example, if a woman seeking an abortion or her family members had COVID-19 symptoms. As the Netherlands did not take any additional steps to ensure access even in such cases, for example, by making early medical abortion at home via telemedicine available,[412] women had to visit an abortion clinic in person in order to obtain the medication.[413] As a result, abortion services were not available in all cases,[414] as some women were unable to leave their house due to quarantine measures, due to domestic violence, or due to the fear of contracting COVID-19. The Dutch inactivity in ensuring access to abortion services for *all* women during

[408] Lisa Juanola and Irene de Vries, 'The Dutch Approach to Abortion: Leading or Lagging in Guaranteeing Women's Rights?' (*KIT Royal Tropical Institute*, 28 September 2020) <https://www.kit.nl/the-dutch-approach-to-abortion-leading-or-lagging-in-guaranteeing-womens-rights/> accessed 19 June 2021.
[409] ibid.
[410] 'Letterlijke Tekst Persconferentie Minister-President Rutte En Minister De Jonge over Verlenging Coronamaatregelen' (*Rijksoverheid*, 31 March 2020) <https://www.rijksoverheid.nl/documenten/mediateksten/2020/03/31/persconferentie-minister-president-rutte-en-minister-de-jonge-over-verlenging-coronamaatregelen> accessed 19 June 2021.
[411] Neva Bojovic, Jovana Stanisljevic and Guido Giunti, 'The Impact of COVID-19 on Abortion Access: Insights from the European Union and the United Kingdom' (2021) 125 Health Policy 841, 847.
[412] Moreau and others (n 9) 7.
[413] 'Dutch Judge Offers No Relief to Women Who Are Now Waiting for an Abortion and Cannot Leave Their Home.' (*Women on Waves*, 10 April 2020) <https://www.womenonwaves.org/en/page/7592/dutch-judge-offers-no-relief-to-women-who-are-now-waiting-for-an-abortion-and-ca> accessed 19 June 2021.
[414] Moreau and others (n 9) 2.

the pandemic has been challenged in a petition with more than 15.000 supporters[415] and taken to court in The Hague, as follows.

5.4.2.2 The Hague District Court: No self-managed early medical abortion

The passive response by the government was legally challenged by a Dutch woman with the alias "Trix", supported by the organization Women on Waves.[416] When Trix attempted to access abortion services in 2020, one of her children showed symptoms of COVID-19, making it necessary for the family to self-isolate. She claimed that, because she is a single mother and did not know for how long her daughter would show symptoms, and whether other family members would get sick, she feared that she could not access medical abortion on time and would have to undergo a surgical procedure at a later point in time.[417] Additionally, a medical doctor, the director of the organization Women on Web and the organization itself, claim that they want to enable women like Trix to access medical abortions but are not legally allowed to do so.[418] During the proceedings, the organization also mentioned other situations in which women supposedly struggled to access medical abortions, for example, in cases of domestic violence. Due to the stay-at-home orders, one woman could not go to an abortion clinic, as her partner controlled her reasons for leaving the house and neither allowed her to leave their home nor to access an abortion.[419] The claimants argued that the COVID-19 measures, combined with the ban of abortions outside an abortion clinic, deny women access to legal abortion and amounts to a violation of the right to privacy under art. 8 ECHR.[420]

In its judgment, the District Court of The Hague refused to grant preliminary relief as it did not find a violation of art. 8 ECHR.[421] According to the court, abortion services were not significantly impacted by the pandemic, with abortion clinics still open and no noticeable decline in the number of abortions performed.[422] Additionally, it emphasized that for women who find themselves in a situation in which they otherwise could not access services, tailor-

[415] G. Dwaars, 'Ook Nu Baas in Eigen Buik!' (*AVAAZ.org - BURGERpetities*, 16 April 2020) <https://secure.avaaz.org/community_petitions/nl/de_tweede_kamer_der_statengeneraal_ook_nu_baas_in_eigen_buik/> accessed 19 June 2021.
[416] Rechtbank Den Haag, C/09/590986, KG ZA 20-3030 <https://jure.nl/ECLI:NL:RBDHA:2020:3551> accessed 21 June 2021.
[417] ibid para 3.2.1.
[418] ibid 2.1.
[419] ibid 3.2.1.
[420] ibid 4.3.
[421] Ibid. 4.5.
[422] Ibid 4.6.

made solutions can be found in collaboration with service providers.[423] For example, one solution could be to allocate appointments at the edge of the day or to take additional protective measures.[424] In relation to medical abortion, the Dutch Minister for Health, Welfare and Sport argued that alternative methods of dispensation outside a clinical setting, such as the delivery of abortion pills via post, do not fit the Dutch view of safe and medically responsible care.[425] Further, the Minister argued that no calls for reform emerged from providers.[426]

5.4.2.3 The Dutch approach: a missed opportunity for SRHR?

In light of the Netherlands' approach to SRHR, which is usually considered very liberal, this judgment is puzzling at first and raises further questions: How can this judgment be explained, especially in comparison to the British approach, and how is it to be seen from a human rights perspective?

First of all, it should be emphasized that the judgment was made as part of preliminary proceedings, meaning that the court's decision-making options were quite limited. According to art. 94 of the Dutch constitution, a court can only declare a legal provision as inapplicable if it is *undeniably* in violation of international law treaties and decisions of international law.[427] Weighing conflicting interests and arguments should primarily remain the task of the legislature.[428] In light of the uncontested fact that abortion care, in general, was not fully suspended,[429] it is therefore difficult to argue for a clear, undeniable violation of art. 8 ECHR or other human rights provisions. Similarly, the argument that slight delays in health care may occur during a public health crisis is plausible – especially if there was no report of a single woman being forced to carry a child to term.[430] Therefore, the court's decision is plausible from a legal perspective. It is the duty of states to make sure that, if abortion is legalized, it is accessible. However, usually, it is the task of the state to define how this is to be achieved. Given the fact that there were no reports of women who could not access care despite serious risks to their health or life, or were unnecessarily subjected to undue treatment by providers or the process itself, the threshold of severity for finding a human rights violation is unlikely to

[423] Rechtbank Den Haag, C/09/590986, KG ZA 20-3030 <https://jure.nl/ECLI:NL:RBDHA:2020:3551> accessed 21 June 2021 4.7.
[424] ibid 4.7.
[425] ibid 2.11.
[426] ibid 2.11.
[427] ibid 4.2.
[428] ibid 4.2.
[429] ibid 4.8.
[430] ibid. 4.9.

be exceeded. Thus, given the fact that alternative methods were still available, the prohibition of self-managed abortion via telemedicine does not amount to an immediate violation of human rights, which is why the national judiciary could not take such a far-reaching decision.

When it comes to assessing the proportionality of the restriction to abortion services by not allowing self-managed medical abortion at home, for example, under art. 8 ECHR, it may well be within a state's margin of appreciation to define whether or not early medical abortion at home is in compliance with the country's view of quality and professional health care.

However, the judgment at hand and the current balance created by the Dutch legislature represents a missed opportunity for women's rights. Importantly, an issue that the Dutch court did not address was that of intersecting discrimination. Although the court could not establish a structural issue for women in accessing abortion care during the pandemic, more attention should have been paid to the question of *which* women are nonetheless unable to seek care. As the example of Trix showed, the COVID-19 pandemic has created more challenges for certain women to seek care, whether it is due to quarantine regulations, having to organize and afford child care, or not wanting to leave the house due to being a high-risk patient. In particular times like these, even questions such as having to rely on public transportation in order to reach a clinic becomes a critical factor. Thus, medical abortion via telemedicine could have been a crucial bridge to ensure that access to essential health care is not prevented by socio-economic factors, controlling partners or whether or not a person can afford and organize child care during the time they seek treatment. Given that self-management of abortion has proven to be safe and comes with risks comparable to in-clinic treatment, women should be empowered to assess the (very low!) risks and their needs independently. From a human rights perspective, states should refrain from unnecessarily restricting access to abortion in order to progressively reach the full realization of the right to reproductive health and work towards eliminating clandestine abortions and maternal mortality. For this reason, The Netherlands should follow England's example and react proactively by following scientific progress and eliminating barriers to SRHR.

5.4.3 Conclusion: The Dutch approach

To conclude, in their response to COVID-19, the Netherlands was generally very successful in ensuring the continuity of sexual and reproductive health services; however, an important opportunity in making abortion even more accessible was missed by not reducing barriers to medical abortion via telemedicine. This would likely have facilitated access to legal abortion, especially for women who have difficulty making local medical appointments due to COVID – whether the increased difficulty stems from a fear of contracting the virus, being subject to domestic violence, or not be able to find and afford child care for the time of treatment.

6 Protecting the rights of the future: Towards a feminist human rights-based approach to public health emergencies

6.1 The protection of SRHR is indispensable during COVID-19 and beyond

A closer analysis of the relationship between public health and international human rights law shows: Even if exceptional situations call for exceptional measures – which have undeniably saved thousands of lives during the COVID-19 pandemic – the challenging balancing act between public health and human rights must not compromise the respect for human rights obligations.

Chapter 2 highlighted the concept of sexual and reproductive rights as a very broad concept that encompasses numerous obligations that range from the prevention of violence and coercion, to ensuring access to information, education, quality-based health care, and the ability to express one's sexuality. As SRHR address issues such as maternal mortality and unsafe abortion, these human rights are closely linked to the concept of public health; however, in turn, public health measures, especially in times of public health emergencies, are not always beneficial to the fulfillment of human rights. In theory, response measures to any public health emergency like COVID-19 should respect a states' human rights obligations, however, there is a substantive risk that these obligations are set aside when "exceptional measures" are taken to address the threat of disease.

As could be seen in chapter 3, there is no single international human rights treaty that guarantees SRHR as such, neither on the international nor regional level. Rather, the protection results from an interplay of human rights norms, such as the right to life, the prohibition of torture, inhuman and degrading treatment, the right to education, the right to health, the right to respect for private and family life, as they can be found in various human rights instruments, such as the ICCPR, ICESCR, CEDAW, ECHR, and many more.

Chapter 4 highlighted that, in principle, these norms account for public health emergencies by granting states flexibility through restrictions as well as derogations in times of emergency. However, COVID-19 is not a free pass for states to undermine SRHR. The implementation of restrictions and derogations must adhere to strict requirements, which the majority of public health emergency measures adopted in response to COVID-19 within the Council of Europe most likely adhered to. In most cases, they were even necessary to ensure compliance with other human rights obligations, such as the protection of the right to life and

the right to health.[431] Nevertheless, especially with regards to SRHR, states must ensure that response measures do not have (potentially unintended) negative side effects that disproportionately impact access to sexual and reproductive health care, or undermine core obligations.

6.2 The response of CoE states: Innovative progress and dangerous regression

The comparison of the case studies in chapter 5 shows that the protection and fulfillment of SRHR were very mixed throughout the Council of Europe. Just as the countries' approaches in ensuring SRHR differed significantly, the case studies illuminate that the pandemic has led to the most diverse outcomes for human rights. The last months have illustrated that public health emergencies come with a possible de-prioritization of SRHR, which can have significant consequences for public health on its own and can lead to the violation of core human rights obligations. In short, COVID-19 represents a window of opportunity for SRHR– but it is in the states' control whether this window is used for progressive or retrogressive measures.

Understandably, in their responses to COVID-19, states primarily attempted to address the immediate threat of the new virus and implemented measures such as lockdowns and quarantine measures to slow the spread of the virus. None of the countries observed implemented restrictions on SRHR to explicitly protect public health.

England used the COVID-19 pandemic as a more than positive window of opportunity to strengthen the protection and fulfillment of SRHR. As the temporary legalization of medical abortion via telemedicine, innovative measures have ensured access to safe and legal abortion throughout the pandemic in a timely and preventive manner. The high number of women who relied on this service shows that the measure was needed and well-accepted.

In Northern Ireland, it was mainly the inaction of the health system in establishing and funding abortion services for the first time that prevented access to safe and legal abortion. Nevertheless, Northern Ireland decided not to follow England's innovative approach and refrained from legalizing early medical abortion via telemedicine, despite existing struggles in providing abortion services.

The Netherlands did not explicitly restrict access to SRHR but also did not take any additional measures in light of lockdowns, such as facilitating medical abortion via

[431] For example, the obligation under the International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) art 12(c), to prevent, treat and control epidemic and other diseases.

telemedicine, because no action was seen to be needed. However, this behavior disregarded the question of *which* women in particular – such as women with a low socioeconomic status – were in danger of being left behind. For these women, innovative and evidence-based measures, such as the introduction of early medical abortion via telemedicine, would have likely supported their fulfillment SRHR and ensured access to safe and legal abortion for *everyone*.

In the case of Poland, the attempts to limit access to comprehensive sex education and legal abortion and to leave the Istanbul Convention were never connected to the concept of public health during COVID-19; they were merely just "well-timed" and debated in a time in which the population already faced uncertainty and difficulties in protesting safely. Although the fear of COVID-19 and potentially violating lockdown measures did not keep people from exercising their right to protest after the Polish constitutional court's decision, the timing of these changes is striking and unfortunate. Until today, women in Poland are effectively denied access to legal abortion, which is a violation of their SRHR; inter alia, their right to life[432], right to be free from torture, inhuman and degrading treatment or punishment[433], as well as their right to health[434]. Thus, it can be held that Poland merely used the backdrop of lockdown measures and the population's fear of contracting the virus to implement conservative changes severely undermining sexual and reproductive rights.

It is crucial to mention that the Polish experience is not an isolated case that can be attributed to the general rule of law crisis in Eastern European countries. Other countries, too, restricted access to safe and legal abortion during the pandemic. For example, during the first wave of COVID-19, the governor of Texas issued an executive order to postpone all non-essential surgeries – which was interpreted to include abortions - in order to save personal protective equipment and hospital beds.[435] It is undeniable that the postponement of non-essential surgeries did not only affect reproductive health care services and might be an overall necessary measure in light of resource shortages. However, not classifying surgical abortion services as an essential procedure fails to recognize that abortions are time-sensitive and cannot be postponed indefinitely, not to mention the psychological burden placed on

[432] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 6(1).
[433] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 7.
[434] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) art 12.
[435] 'Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic' (*Office of the Attorney General*, 23 March 2020) <https://www.texasattorneygeneral.gov/news/releases/health-care-professionals-and-facilities-including-abortion-providers-must-immediately-stop-all> accessed 9 July 2021.

women. Women who attempted to access abortion care nevertheless had to travel outside the state but faced hurdles as public transport was reduced, quarantine measures between states were introduced, and even hotels were closed at times.[436] Thus, it could again be observed that this measure had a disproportionate impact on women with a low-socioeconomic background or those who could not leave the house due to domestic violence,[437] or those fearing to contract COVID-19. After the ban was lifted in April 2020, an increased number of second-term abortions could be observed – and while these are still generally considered safe, earlier care would have come with a lower risk and fewer appointments.[438]

Most importantly, it should be pointed out that the prohibition of abortion services was unlikely to achieve the desired effect of drastically saving personal protective equipment, as generally only very little personal protective equipment is needed to perform surgical abortions during first trimester and medical abortions.[439] This is where one can draw a connection to the cases of Northern Ireland and the Netherlands, which did not implement an absolute ban, but also hindered access to abortion by prohibiting medical abortion via telemedicine, without adhering to medical standards and knowledge and presumably with little or no benefit to public health. Thus, it is important to highlight that states should constantly re-evaluate whether their legal framework surrounding SRHR is in line with current evidence-based knowledge.

To conclude, SRHR played a very mixed role in states' responses to COVID-19. For some, it was a window of opportunity to re-assess existing medical practices and improve access to legal abortion through the use of telemedicine. Some remained inactive because they did not see any need for additional measures; or struggled with health systems that could not provide adequate care even during regular times. And finally, COVID-19 was a window of opportunity for some states to introduce restrictions violating international human rights standards – not even to the benefit of public health.

[436] Samantha Ruggiero and others, 'Access to Later Abortion in the United States during COVID-19: Challenges and Recommendations from Providers, Advocates, and Researchers' (2020) 28 Reproductive Health Matters 1774185, 32.
[437] ibid.
[438] Kari White and others, 'Changes in Abortion in Texas Following an Executive Order Ban During the Coronavirus Pandemic' (2021) 325 JAMA 691, 692.
[439] Jones, Lindberg and Witwer (n 13) 65.

6.3 A feminist human rights-based approach to public health emergencies

As the case studies have shown, despite the plentiful voices calling to guarantee SRHR in response to COVID-19, states were only partially successful in doing so. Therefore, the unique agency that women's rights have received during the COVID-19 pandemic must be used as a momentum to strengthen the role of human rights during public health emergencies. In particular, the upcoming discussion of an international pandemic treaty in November 2021[440] offers a significant opportunity to reaffirm and strengthen the role of human rights in the prevention and response to public health emergencies.

However, integrating a genuine feminist human rights-based approach means more than merely including a short reference to human rights standards, as it has happened in the International Health Regulations in 2005. It must be understood that there is no appropriate public health emergency response without respect for international human rights law, as human rights and public health are intrinsically linked. Human rights should not be seen as a framework outside public health emergency preparedness, but as its necessary foundation. Placing human rights at the foundation would significantly enhance the prevention, preparation, and mitigation of future public health emergencies.

By applying a feminist human rights-based approach to SRHR during public health emergencies, four key lessons can be identified, which are still relevant as the COVID-19 pandemic progresses and are likely transferrable to future public health emergencies.

First, it is necessary to clarify states' obligations under international human rights law during public health emergencies, particularly in relation to core obligations and non-derogable rights. The thesis at hand is only one contribution to this process of clarification, exploring the role of SRHR in particular. Through clear guidelines, compatibility of public health emergency measures and human rights can be encouraged, and it is easier to hold states accountable to their obligations. However, this relates to many more areas of the human rights framework beyond the topic of SRHR, which is why further research is needed.

Secondly, sexual and reproductive health services must be classified as essential. In order to fulfill human rights obligations additional resources must be allocated to SRHR, not away from it. States must ensure that all public health emergency measures are compatible with core SRHR obligations and do not infringe upon non-derogable rights. It is contrary to core human rights obligations to effectively prohibit access to legal abortion in order to protect public health, as it has happened in Poland.

[440] 'An International Treaty on Pandemic Prevention and Preparedness' (*Council of the European Union*, 2021) <https://www.consilium.europa.eu/en/policies/coronavirus/pandemic-treaty/> accessed 10 July 2021.

Thirdly, states must develop and implement their responses through a gender lens, addressing different outcomes and risk factors. Only then, disproportionate direct and indirect consequences for sexual and reproductive health of certain groups can be identified and prevented. In the long run, a gender-sensitive approach requires actions to ensure the right to equality and non-discrimination – through which structural inequalities that exacerbate the impact of public health emergencies would have to be addressed. Thus, states would have to become active *before* any crisis to tackle and prevent unequal vulnerabilities, burdens, and consequences. In the long run, states should take the lessons learned from cases such as *Mellet v. Ireland*[441], and work towards abolishing legal regulations that support gender stereotypes, including restrictive abortion laws which illustrate a woman's only task to be a selfless mother. Additionally, *during* emergencies, human rights standards act as a safeguard for the necessity, proportionality, and effectiveness of public health measures; in particular, discriminatory measures or measures that disproportionately cause harm to certain groups cannot be implemented. For these reasons, focusing on the gender aspect of human rights would ensure a fairer, more sustainable response.

Lastly, it must be emphasized that restrictions and derogations are not the only solution to public health emergencies – and not the enemy of human rights. If they are well-implemented, in line with international human rights standards, they provide states with the needed flexibility to save many lives and prevent the spread of infectious diseases. However, beyond this, as the example of England showed, public health emergencies come with the opportunity to re-evaluate the existing legal framework of sexual and reproductive health. Sometimes, instead of introducing additional restrictions, the legalization of innovative technologies such as early medical abortion via telemedicine may lead to better public health *and* human rights outcomes. For example, the legalization of self-managed early medical abortion via telemedicine does not only save critical resources that may be scarce during a pandemic, but simultaneously addresses other public health issues such as maternal mortality or unsafe abortion. For this reason, a new pandemic treaty should not only focus on human rights as a framework that slows down the ability of states to react to COVID-19 and other emergencies but instead as a framework that encourages gender-sensitive, evidence-based, and innovative policies.

[441] *Mellet v. Ireland* (2013) comm no 2324/2013 UN Doc CCPR/C/116/D/2013.

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