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Objection ladies! Taking IPPF-EN v. Italy one step further

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Abstract: This paper proposes to reconsider the decision of the European Committee of Social Rights in *International Planned Parenthood Federation European Network (IPPF-EN) v. Italy* which addresses the regulation of the practice of the conscientious objection, using an integrated approach to human rights. More specifically, it argues that the use of different human rights instruments – broadly defined -- could have led the Committee to adopt a *gendered approach* to the legal questions it had to tackle. By adopting this approach, we intend to challenge Committee's reasoning on two fronts: first, we argue that its interpretation of *the right to health* fails to account for the specific violation of women's right to access to health services. Second, we show how this gendered approach could have modified Committee's approach to *discrimination* raised by the plaintiff.

1. Conscientious objection and reproductive rights, a global issue

The decision of the *European Committee of Social Rights in International Planned Parenthood Federation European Network (IPPF-EN) v. Italy* addresses the regulation of the practice of conscientious objection in the field of abortion procedures.¹ This is a pressing and complex legal issue arising in a highly divisive social and political global space² that has been in recent years tackled by different bodies and regimes dealing with women's sexual and reproductive rights from a general³ and more identity-based perspective,⁴ and sometimes outside the traditional human-

¹ The complaint has been brought under the Additional Protocol to the European Social Charter Providing for the System of Collective Complaint by IPPF-EN, which is one of the largest non-governmental organizations working in the field of sexual and reproductive health. This Additional Protocol entered into force on July 1st, 1998. It allows international and national non-governmental organisations and social actors, that satisfy certain requirements to lodge complaints directly with the Committee with regard to the breaches of the Charter in States that ratified the Protocol, provided that the complaint touches upon an issue for which the non-governmental organizations and social actors have a specific competence. More about the competencies of IPPF-EN and IPPF can be found on their websites: <http://www.ippfen.org/>; <http://www.ippf.org/>

² See the influence of neo-conservative groups on the ways in which the debate is shaped in Europe: Amir Hodzic, Natasa Bjelic, *Neo-Conservative Threats to Sexual and Reproductive Rights in the European Union*, CESI, 2014, at http://www.cesi.hr/attach_n/neo-conservative_threats_to_srhr_in_eu.pdf. This report is based, in part, on the monitoring of the European Humanist Federation, at <http://www.humanistfederation.eu/our-work.php?page=sexual-and-reproductive-rights-are-human-rights->

³ Eur. Ct. H. Rts., *P. and S. v. Poland*, Application No. 57375/08, judgment of 30 October 2012; Eur. Ct. H. Rts., *R.R v. Poland*, Application No. 27617/04, judgment of 28 November 2011; Eur. Ct. H. Rts., *Pichon and Sajous v. France*, Application No. 49853/55, decision of 2 October 2001 (decision on admissibility). See also Committee on the Economic, Social and Cultural Rights, Consideration of reports submitted by State parties under article 16 and 17 of the Covenant, Concluding observations of the Committee on Economic, Social and Cultural Rights, Poland, E/C12/POL/CO/15, 43rd sess., 2009; UNHRC, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Mission to Poland, A/HRC/14/20/Add.3, 14 sess., 2010 (prepared by Anand Grover) (hereinafter "UNHRC, Mission to Poland"); Parliamentary Assembly of the Council of Europe (PACE), Resolution 1607, *Access to safe and legal abortion in Europe*, 2008 at <http://assembly.coe.int/Mainf.asp?link=/Documents/AdoptedText/ta08/ERES1607.htm>; Report, Council of Europe, Social Health and Family Affairs Committee, *Women's access to lawful medical care: the problem of unregulated use of conscientious objection*, 2010, at <http://assembly.coe.int/ASP/Doc/XrefViewPDF.asp?FileID=12506&Language=EN> (Rapporteur Ms Christine McCafferty) (hereinafter "McCafferty Report"), PACE Resolution 1763, "The right to conscientious objection in lawful medical care" (2010) at <http://assembly.coe.int/main.asp?Link=/documents/adoptedtext/ta10/eres1763.htm>.

⁴ See e.g., Committee on the Elimination of Discrimination against Women (CEDAW), General Recommendation No. 24: Article 12 of the Convention; CEDAW, Concluding observations of the Committee on the Elimination of Discrimination Against Women: Slovakia, CEDAW/C/SVK/CO/4, 41st sess., 2008 (hereinafter "CEDAW, Concluding observations: Slovakia"); CEDAW, Concluding comments of the Committee on the Elimination of Discrimination against Women: Poland, CEDAW/C/POL/CO/6, 37th sess., 2007 (hereinafter "CEDAW, Concluding comments: Poland"); CEDAW, Concluding observations on the combined seventh and eighth periodic reports of Hungary adopted by the Committee at its Fifty Fourth Session, CEDAW/C/HUN/CO/7-8, 2003 (hereinafter "CEDAW, Concluding observations Hungary"); CEDAW, General Recommendation on Women and Health, No. 24, Women and Health, A/54/38/Rev., 20th sess., 1999. See also domestic courts decision: Italian Constitutional Court, judgment No. 43 of 1997; Colombian Constitutional Court, decision T-388/2009, 28 May 2009. See the comments on the Colombian Constitutional Court decision in O'Neill Institute for National and Global Law and Women's link Worldwide, "T-388/2009. Conscientious Objection and Abortion. A Global Perspective on the Colombian Experience", 2014 at http://www.womenslinkworldwide.org/wlw/new.php?modo=detalle_proyectos&dc=74&lang=en. See also, Brooke R. Johnson Jr et al., *Conscientious objection to the provision of legal abortion care*, 123 International Journal of Gynaecology and Obstetrics S60 (2013); Adriana Lamacek, *Conscientious Objection in Reproductive Health Care: Analysis of Pichon and Sajous v. France*, 15 Eur. J. Health L. 7 (2008).

rights-oriented regimes.⁵ From the methodological perspective, and following the pluralistic approach to law, the regulation of the conscientious objection in the field of reproductive rights illustrates an example of ‘regimes collision’ at the intersection of health, public policy and human rights law.⁶

Conscientious objection in reproductive health refers to the refusal of healthcare personnel, including doctors --general practitioner, gynaecologist, anaesthetics-- nurses and other non-medical staff to perform abortion or provide pre-abortion or post-abortion care on the ground of their moral, religious or philosophical beliefs.⁷ The use of conscientious objection in health care has been first raised regarding the mandatory vaccination of children and precedes the legalization of abortion.⁸ However, military service is the only area in which conscientious objection has been recognized as a human right.⁹ Currently, this is hotly debated in reproductive rights field as well,¹⁰ as neo-conservative groups are using human rights rhetoric in order to push forward their interests across various forums.¹¹

There are several difficulties in trying to transpose the debate about conscientious objection to the realm of reproductive health. The question whether or not conscientious objection should be granted plays out very differently in the two fields: military service is mandatory while no one is required by law to become a gynaecologist or an obstetrician. In addition, the impact of the use of the conscientious objection is not comparable in the two situations.¹² Objecting to providing reproductive health services greatly impairs women’s access to health services. It collides with their right to the highest attainable standard of health,¹³ which includes reproductive and sexual health and their right to personal integrity, autonomy and privacy¹⁴ recognized by different human rights instruments. Besides the psychological harm the practice of conscientious objection may entail, it also provokes undue delays, which put women’s life at risk, and may result in unsafe, clandestine and illegal abortions, which endangers women’s life, physical and mental health.¹⁵

Nowadays, in countries where induced abortion is not altogether illegal, the development of conscientious objection is one of the many barriers -- which are often designed for that purpose --

⁵ World Health Organization, *Safe Abortion: technical and policy guidance for health systems*, 2nd ed., 2002 (the technical guidelines which target policymakers and abortion providers incorporate human rights obligations in the field of public health).

⁶ Andreas Fischer Lescano & Gunther Teubner, *Regime Collisions: The Vain Search for Legal Unity in the Fragmentation of Global Law*, 25 Mich. J. Int’l L. 999 (2003-2004).

⁷ See e.g. Bernard M. Dickens, “The Right to Conscience”, in Rebecca J. Cook, Joanna N. Erdman, and Bernard M. Dickens (eds.), *Transnational Abortion Rights: Case and Controversies*, U Penn Press, 2014, p. 210.

⁸ *Id.* (explaining that in England mandatory vaccination of smallpox dates back to 1867, while the U.K. Abortion Act, which enclosed a Section 4 on conscientious objection, was adopted only in 1967).

⁹ See e.g. Eur. Ct. H. Rts., (GC), *Bayatyan v. Armenia*, Application No. 23459/03, Judgment of 7 July 2011 (the Court found that in some cases the conscientious objection can fall within the ambit of Art. 9 which guarantees freedom of thought, conscience and religion).

¹⁰ See ECSR, *Federation of Catholic Family Associations in Europe (FAFCE) v. Sweden*, Complaint No. 99/2013 decision on admissibility 10 September 2013. But see e.g. Eur. Ct. H. Rts., *Pichon and Sajous v. France*, Application No.49853/55, decision of 2 October 2001 (decision on admissibility); *Tysiack v. Poland*, Application No. 5410/03, judgment of 20 March 2007; *P. and S. v. Poland*, Application No. 57375/08, judgment of 30 October 2012; Eur. Ct. H. Rts., *R.R v. Poland*, Application No. 27617/04, judgment of 28 November 2011. Comp. with Parliamentary Assembly, Council of Europe, *The Right to Conscientious Objection in Lawful Medical Care*, Res. 1763 (7 October 2010) (stating that “the Parliamentary Assembly emphasis the need to affirm the right of conscientious objection together with the responsibility of the state to ensure that patients are able to access lawful medical care in a timely manner”); European Union Network of Independent Experts on Fundamental Rights, Opinion No. 4-2005: *The Right to Conscientious Objection and The Conclusion by EU Member States of Concordats with the Holy See*, 14 December 2005, CFR-CDF. Opinion 4-2005.doc (arguing that the right to conscientious objection should be seen as a right).

¹¹ See e.g. European Center for Law and Justice, Memorandum on the PACE Report, Doc 12347, July 20, 2010 (prepared by Gregor Puppink and Kris J. Wenberg, Esq) (claiming that conscientious objection is a human rights recognized by different international texts).

¹² Centre for Reproductive Rights, *Conscientious Objection and Reproductive Rights. International Human Rights Standards*, July 2013, p. 1, at www.reproductiverights.org.

¹³ See e.g. International Covenant on Economic, Social and Cultural Rights, Art 12, 3 January 1976, 1999 U.N.T.S 3. Committee on the Economic, Social and Cultural Rights, General Comment No.14, *The Right to the Highest Attainable Standard of Health* (Art. 12), E/C/12/2000/4, 22nd sess., 2000.

¹⁴ Eur. Ct. H. Rts., *A.B. and C. v. Ireland*, Appl. no. 25579/05, par. 212, judgment of 16 December 2010; Eur. C. S. Rts, *IPPF-EN v. Italy*, Complaint No. 87/2012, decision adopted on 10 September 2013, par. 66.

¹⁵ WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems*, *supra* (According to the WHO, and estimated number of 22 millions unsafe abortions are performed in the world each year, resulting in 22 000 deaths and disabilities for 5 millions women, mostly located in developing countries.)

that may stand in women's way to access the procedures for the termination of pregnancy, along with waiting periods, mandatory counselling and other administrative requirements.¹⁶ Many questions stem from the fact that the use of conscientious objection is highly unregulated in a great number of jurisdictions.¹⁷ Doubts persist regarding its scope (i.e. who is entitled to object and with respect to what kind of activity?) particularly in a context in which hospitals and corporations are also claiming a right to conscientious objection,¹⁸ the moment when it should be raised (i.e. does it concern urgency procedure?), the duties of the objector, and the compliance and oversight mechanisms (i.e. what type of redress is available to the patient and what kind of monitoring mechanism is put in place in order to enforce the regulation?). Beyond these legal aspects, the escalating number of objectors in some jurisdictions also produces stigmatizing effects on other health practitioners who may then use conscientious objection in order to avoid being subjected to discrimination.¹⁹

2. IPPF-EN v. Italy, a strategic case

IPPF-EN v. Italy case²⁰ addresses an instance in which the State has regulated the use of the conscientious objection. Sections 4 to 9 of the Italian Act No. 194/78²¹ regulate the abortion regime. According to the Act, the abortion is available for reasons related to women's physical and mental health, her economic and family situation and when the foetus present abnormalities. Before accessing the abortion, the woman needs to participate in a mandatory counselling, obtain an authorization from health services and undergo a mandatory seven days waiting period. Section 9 of the Italian Act No. 194/78 allows medical practitioners and other health personnel to exempt themselves from assisting abortion procedures in cases provided for in law if they raise a conscientious objection beforehand. This objection covers activities "which (are) specifically and necessary designed to bring about the termination of pregnancy" but excludes pre-abortion and post-abortion care. The law also provides that conscientious objection cannot exempt health-providers in emergency cases, and that in the case in which "their personal intervention is essential in order to save the life of the woman in imminent danger" procedures for the termination of the pregnancy must be performed. Paragraph 4 of Section 9 of the Italian Act, central to the plaintiff's complaint, provides that, in any case, hospitals and authorized nursing homes are required to ensure that women have access to abortion procedures in accordance with law. For that matter, regions have the duty to supervise and ensure the implementation of that law "if necessary by the movement of the personnel."²²

In fact, the conscientious objection is pervasive in Italy and the figures are much higher than the official data declared by the Government (for instance in the region of Rome, Lazio, the number of objectors is as high as 91,3%).²³ The number of objecting doctors skyrocketed in the past years and the health system as a whole has many downfalls: the health system is deeply influenced by the Catholic Church and therefore the new doctors are not trained to perform abortion procedures.

¹⁶ See e.g. Dickens, *supra* note 7 at 220-223; Anna Heino, Mika Gissler, Dan Apter, Christian Fiala, *Conscientious Objection and Induced Abortion in Europe*, *The European Journal of Contraception and Reproductive Health Care*, Aug 2013, Vol. 18, No. 4: 231–233.

¹⁷ See McCafferty Report, *supra* note xx.

¹⁸ Cf. controverses en Irlande et aux USA et article de Ruth Fletcher in T-388/2009. Conscientious Objection and Abortion. A Global Perspective on the Colombian Experience.

¹⁹ Anibal Faundes et al., *Conscientious Objection or Fear of Social Stigma and Unawareness of Ethical Obligations*, 123 *International Journal of Gynaecology and Obstetrics* S57 (2013). See also the claim lodged by an Italian trade union (*Confederazione Generale Italiana del Lavoro*) according to which the Italian law is in breach of Article 11 read in conjunction with article E (Complaint 91/2013 registered on 17 January 2013).

²⁰ Eur. C. S. Rts, *IPPF-EN v. Italy*, Complaint No. 87/2012, decision adopted on 10 September 2013.

²¹ Act No. 194/1978 relating to the Norms on the social protection of motherhood and the voluntary termination of pregnancy" (*Norme per la tutela sociale della maternità e sull'interruzione volontaria della gravidanza* – *Gazzetta ufficiale* 22/05/1978, n. 140).

²² See Eur. C. S. Rts., *IPPF-EN v. Italy*, Complaint 87/2012, par. 36.

²³ *IPPF-EN v. Italy*, Collective Complaint, p. 37-38, at

https://www.coe.int/t/dgh/monitoring/socialcharter/Complaints/CC87CaseDoc1_en.pdf (hereinafter "Collective Complaint").

In any case, those who are willing to do so might face discrimination at the hiring stage and in the workplace.²⁴ For IPPF, the Charter therefore provided a great opportunity for challenging the Italian system as a whole before the Committee without having to rely on an identified victim. The organization was already authorized, under the Additional Protocol²⁵ to lodge a complaint. Moreover, the action before the Committee had other strategic benefits when compared to the opportunities offered by other forums including the European Court of Human Rights (hereinafter, ECtHR). By seizing the Committee and arguing that access to abortion is a matter of right to health, the plaintiff avoided the pitfalls of the current ECtHR case law under which the issue is often framed as a question of *right to private life*²⁶ coupled with a wide margin of appreciation left to the State to define the domestic regime applicable to the termination of the pregnancy, on the ground that there is no European consensus as to when life begins.²⁷

In order to prepare the case, the organization faced a number of hurdles, especially related to evidence. This is because women who undergo abortion, and non-objecting medical staff are unwilling to reveal themselves publicly and lodge complaints against objecting medical personnel.²⁸ In its complaint, IPPF-EN argued that Section 9 of the 1978 Italian Act is contrary to Article 11 of the Charter protecting the right to health²⁹ read alone or in conjunction with the Article E, which essentially provides that the enjoyment of rights guaranteed by the Charter should be secured without discrimination.³⁰ More specifically, IPPF-EN argued that the Italian law “does not indicate the precise means through which hospitals and regional authorities are to guarantee the adequate presence of non-objecting medical personnel in all public hospitals, so as to always ensure the right of access to procedures for the termination of pregnancy.”³¹ Because of the important number of objecting health-care providers which in some parts of Italy constitutes more than 80% of the medical staff³² IPPF-EN argues that the implementation of Section 9 of the Act No. 194/78 does not guarantee the fulfilment of abovementioned rights protected by the Charter.

The Committee concluded that the Italian law violated Article 11 of the Charter (right to health) alone and read in conjunction with Article E (non-discrimination clause). It found that in light of the evidence put before it “shortcomings exist in the provision of abortion services”, and that they “appear to be the result of an ineffective implementation” of the impugned Act.³³ Moreover, the Committee found that discriminatory treatment existed on the ground of socio-economic and

²⁴ Eur. C. S. Rts., *Confederazione Generale Italiana del Lavoro (CGIL) v. Italy*, Complaint No. 91/2013 registered on 17 January 2013.

²⁵ Additional Protocol to the European Social Charter Providing for the System of Collective Complaint, *supra* note 1.

²⁶ Art. 2 (right to life) and Art. 3 (degrading and inhuman treatments) are also at stake in some cases. See, Patricia Londono, “Redrafting Abortion Rights Under the Convention: A, B, C v. Ireland”, in E. Brems (ed.), *Diversity and European Human Rights*, Cambridge University Press, 2011, p. 95-120

²⁷ See Joanna Erdmann, *The Procedural Turn in Transnational Abortion Rights: Cases and Controversies* (arguing that the ECtHR actually manages to protect pluralism in Europe by framing the access to abortion as a ‘procedural question’: once the procedure for the access to abortion is defined it needs to be implemented).

²⁸ See IPPF-EN Collective Complaint, p. 35-36.

²⁹ Article 11 reads as follows:

“ Part I: Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable.

Part II: With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed *inter alia*:

1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases.”

³⁰ Article E reads as follows:

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

A differential treatment based on an objective and reasonable justification shall not be deemed discriminatory.”

³¹ IPPF-EN Collective Complaint, p. 2, 13.

³² IPPF-EN Collective Complaint, p. 18-20. See also Eur. C. S. Rts., *IPPF- EN v. Italy*, par. 33,107-109.

³³ Eur. C. S. Rts., *IPPF-EN v. Italy*, par. 174.

territorial status, health status and gender, and that it constituted an instance of ‘overlapping’, ‘intersectional’ and ‘multiple’ discriminations.³⁴

In this paper, we do not aim to challenge the conclusion of the Committee (that we support entirely) but rather to call into question some parts of its reasoning. We plan to do so by highlighting how a more robust women’s rights perspective or gendered approach, supported both by the evolutions in other human rights regimes addressing abortion regulation³⁵ and by the practical and theoretical evolutions in the antidiscrimination field, could have been adopted to decide this highly controversial case primarily affecting women and their experiences. A reading of the case through this lens leads us to re-write paragraphs 161-165, 168, and 190-191. Our aim in this paper is twofold: we will first show how a gendered approach to human rights law could impact the interpretation of Article 11 on the one hand, and the analysis of the compatibility of the Italian law and the Charter, on the other. We will next seek to demonstrate how the antidiscrimination literature and practice could have provided a series of arguments for adopting a thicker understanding of discrimination and gender equality. This seems all the more important given that litigation in this case was a highly strategic one. The latter takes place in the Italian context, which beyond its specificity shares some characteristics with the dynamics taking place worldwide.

IPPF-EN v. Italy case provides an apt one for the methodological project explored in this monograph. It allows us to study the integration of human rights from a multilayered approach by combining domestic, regional and international texts addressing access to abortion regulation. Moreover, it helps also bridge the distinctions between different generations of human rights while suggesting how differences between regimes may play out. Finally the paper goes beyond the IPPF v. Italy case and the confined project of the book as it sheds light on the use of conscientious objection in a global perspective and the various intricate question human rights lawyers, activists, and policy makers need to grapple with.

3. Interpreting the right to health using a gendered perspective

This section argues that a more gendered approach could have been used to challenge not merely the ‘implementation’ of the impugned Italian law, as the Committee suggests, but the very legal framework put in place for regulating access to abortion in Italy. From the women’s rights perspective, the question tackled by the Committee is therefore unduly restricted.³⁶ The interpretation of the right to health should include women’s right to self-determination and autonomy, which are essential for her welfare. Accordingly, it requires that the state dismantles all barriers to the access to abortion, establishes a restrictive limitation of the use of conscientious objection, and put in place a health system which is responsive to the specific women’s needs. In the case at hand, Italian Act No.194 of 1978 fails to meet the standards set by human rights law read in accordance with a gendered legal perspective.

We first briefly present the reasoning of the Committee, before showing how a gendered perspective would have required the use of legal arguments putting women’s experiences at the heart of the legal reasoning, stemming from international and domestic legal instruments. These texts include the Convention on the Elimination of Discrimination against Women (CEDAW) and other general

³⁴ *Id.*, par. 190.

³⁵ In this case, this includes also regimes that are not directly and exclusively concerned with human rights, but have adopted the human rights norms and discourses to regulate their own sphere of competency. See for the theoretical approach Andreas Fischer Lescano & Gunther Teubner, *Regime Collisions: The Vain Search for Legal Unity in the Fragmentation of Global Law*, 25 Mich. J. Int’l L. 999 (2003-2004).

³⁶ Ruth Fletcher, Conscientious objection and Harm reduction in Europe, in T-388/2009. Conscientious Objection and Abortion. A Global Perspective on the Colombian Experience.

human rights treaties including the International Covenant for Social Economic and Culture Rights (CSECR) and the European Convention of Human Rights (ECTHR), as interpreted by the relevant human rights bodies. Global regimes such as the World Health Organization (WHO) and domestic cases including the case handed down by the Columbian Constitutional Court in 2009³⁷ have also been taken into account.

In paragraphs 160 to 168, the Committee is laying out the core of its assessment of the case. It first restates plaintiff's claim, then goes on to point that the legal stake in this claim "concerns the protection of the right to health" (par. 161). It highlights the Committee's focus, namely the "steps taken by the competent authorities to guarantee effective access to abortion services." In paragraph 162 and 163 it presents the general principles that guide its analysis, drawing upon its previous case law. According to the Committee "the implementation of the Charter requires state parties not merely to take legal action but also to make available the resources and introduce the operational procedure necessary to give full effect to the rights specified therein" and that "arrangements for access to care must not lead to unnecessary delays in its provision" (par. 162). Applying these principles to the present case "the Committee considers that the provision of abortion services must be organized so as to ensure that the needs of patients wishing to access these services are met. This means that adequate measures must be taken to ensure the availability of non-objecting medical practitioners and other health personnel when and where they are required to provide abortion services (...)" (par. 163). The Committee also states that measures to access abortion services need to be put in place, along with appropriate remedies (par. 164). Finally, it highlights the links between article 11 and conscientious objection. Article 11 is said to reflect the domestic Italian law and the decision of the Italian National Committee of bioethics according to which "conscientious objection should neither limit or hamper the exercise of the rights guaranteed by law (...)" (par 165)."

A more integrated approach to the case would have required to put forward arguments made in other legal regimes including CEDAW, CESC, and WHO, which the Committee is mentioning in its decision but not clearly using in its reasoning. These regimes emphasize a *gendered approach* to reproductive health and provide the according regulation of access to abortion and in particular the use of the conscientious objection which are barely highlighted in the Committee's assessment of the violation of Article 11.

It is well established in human rights law that women reproductive and sexual health is a human right. The question of termination of pregnancy remains debated.³⁸ The enjoyment of these rights needs moreover to be seen in connection with women's self-determination and autonomy allowing them to take decisions concerning their body and sexuality.³⁹ Reproductive choice is a key element to women's integrity and dignity and the enjoyment of the right to health should therefore not be restricted and limited in this respect. This implies for the State that it eliminates the barriers that hamper the access to abortion services throughout the health care system.

In its General Recommendation No. 24 concerning the right to health, the CEDAW Committee states that "women's health is an issue that is a central concern in promoting women's health and

³⁷ Constitutional Court [C.C.], May 28, 2009, Decision T-388/09, *Gaceta de la Corte Constitucional [G.C.C.]* n.p. (Colom.), <http://www.corteconstitucional.gov.co/relatoria/2009/t-388-09.htm>.

³⁸ See Programme for Action of the International Conference on Population and Development, Cairo, Egypt, Sept 5-3, par. 8.19, U.N. Doc. A/CONF.17/13/Rev.1 (1994) (recognizing that the right to enjoyment of the highest attainable standard of physical and mental health includes reproductive health and family planning. According to the programme for Action that "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children"). See also the General Comment No. 14 (2000) to the "The right to the highest attainable standard of health" (Article 12

³⁹ On the connection between access to abortion and individual autonomy, see e.g. Eur. Ct. Hum. Rts., *R.R v. Poland*, *supra* note 2.

well-being.”⁴⁰ Accordingly, States are required to eliminate discrimination against women in their access to health care services, particularly in the area of family planning.”⁴¹ In this context, it is discriminatory for the State to “refuse to legally provide for the performance of certain reproductive health services for women” which includes instances in which the health-care provider raise the conscientious objection.⁴² In general, the obligation to respect women’s rights to health requires States to dismantle barriers which may obstruct women’s access to health,⁴³ and ensure that the health system as a whole provides services which detect, prevent and treat illnesses specific to women. This also refers to the training of the medical personnel. The State needs to ensure that “the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women’s health and human rights (...).”⁴⁴

With respect to the regulation of the conscientious objection, this means that in cases in which health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers” (par. 11). In light of these principles, in its state reports, the CEDAW Committee urges states to adopt *concrete measures* to enhance women’s access to reproductive health services. More specifically CEDAW Committee found that States need to regulate the conscientious objection by “establish(ing) regulatory framework and monitoring mechanism of the practice.”⁴⁵ They need to ensure that the “conscientious objection is accompanied by information to women about existing alternatives and that it remains a personal decision rather than an institutionalized practice.”⁴⁶ The State needs to guarantee that the patient is referred to a non-objecting health-provider⁴⁷ so that her right to health is not impinged upon but also needs to make sure that the women are informed of alternative health- care facilities.⁴⁸

Other human rights bodies also highlighted this reading of the right to health, which incorporates women’s experiences, and therefore limits the practice of conscientious objection. For instance, the Committee on Economic, Social and Cultural Rights found that the right to health encompasses sexual and reproductive health, and that the realization of women’s right to health requires the removal of “all barriers interfering with access to health services.”⁴⁹ In its Concluding observations on Poland, the Committee stated that the State party has the duty under Article 12 of the Covenant, to take “all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection.”

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health captures the above-mentioned obligations of the State by noting that “(h)health systems should have procedures, such as administrative procedures to provide immediate alternatives to health-care users when conscientious objection would otherwise lead to a denial of services, and effective remedies, in place to ensure that in practice, legitimate conscientious objection does not obstruct the enjoyment by women and men of their sexual and reproductive health rights. States should also monitor the exercise of conscientious objection with a view to ensuring that all services are available and accessible in practice. In short, health service providers who conscientiously object to a procedure have the responsibility to treat an individual whose life

⁴⁰ CEDAW, General Recommendation No. 24, supra note xx, at 2.

⁴¹ *Id.*, par. 2.

⁴² *Id.*, par. 11.

⁴³ *Id.*, par 14.

⁴⁴ *Id.*, par 31 f).

⁴⁵ CEDAW, Observation Hungary, supra note xx.

⁴⁶ *Id.* (Obs. Hungary).

⁴⁷ CEDAW, Concluding observations: Slovakia, supra note xx par. 43.

⁴⁸ CEDAW, Art. 10 (h); CEDAW, General Comment No. 24, art 12, par. 20. See also CESCR, General Comment No. 14, par. 12.b).

⁴⁹ CESCR, General Comment No. 14, par. 14.

or health is immediately affected, and otherwise to refer the patient to another provider who will perform the required procedure.”⁵⁰ This obligation corresponds to the best practices devised by the WHO for policy-makers and abortion providers, which states that the health-provider must refer the patient to another doctor, and in addition provide necessary care in situation of emergency.⁵¹

In the European context, the European Convention of Human Rights does not protect as such the right to sexual and reproductive health. However, the Court found that the notion of *private life* guaranteed by Article 8 is broad and refers to the right to personal autonomy and development. It includes sexual life and mental and physical integrity of a person and applies to the decision regarding motherhood.⁵² In its judgments, the Court also decided that the State needs to organize the health system so as to guarantee that the practice of conscientious objection does not limit women’s access to health to which they are entitled.⁵³

Moreover, in its recent decision T-388/2009, Colombian constitutional Court set the limits to the constitutional right to conscientious objection. According to the Court the use of conscientious objection needs to be limited since it has “more or less greater social implications,”⁵⁴ and in this case it interferes with “women’s fundamental constitutional rights to health, personal integrity and life in conditions of quality and dignity. It would also violate their sexual and reproductive rights and cause them irreversible harm.”⁵⁵ The Court found that healthcare professionals who are directly involved in procedures leading to the termination of pregnancy have the right to object for reasons of conscience “if and only if there is a guarantee that the pregnant woman will have access to the procedure in conditions of quality and safety, that she will face no additional barriers that interfere with her ability to access necessary healthcare services and that her fundamental constitutional rights to life, sexual and reproductive health, personal integrity and human dignity will be respected.”⁵⁶ Health provider should moreover explain in writing the reasons why they are objecting, and refer the patient to a non-objecting doctor. The Court also indicates that in cases in which there is only one health care provider able to perform the abortion, s/he needs to do it regardless of his/her objection, as the failure to do so would endanger women’s right to health. Finally the Court offers a number of guidelines for implementing its ruling. It urges the authorities to promote comprehensive and accessible campaigns on women’s sexual and reproductive rights. It also insists that the relevant state agency takes necessary steps to ensure that health care facilities employ necessary personnel for carrying out the abortion procedures.⁵⁷

In light of our observations, the Italian law fails to meet these standards on three levels. First, it does not clearly indicate the monitoring procedure of the conscientious objection, it does not provide for a timely and systematic referral to non-objecting doctors and does not require the medical staff to provide necessary information on different alternatives that exist for women. Contrary to the Committee’s finding, the law therefore does not provide for a “balanced statutory framework” (par. 168.) Second, in line with the concurring opinion of Petros Stangos, the Italian law as a whole is putting in place a series of barriers -- namely the mandatory waiting period and the mandatory counselling -- which altogether hamper women’s access to abortion services and amounts to a “sophisticated and official system of pressure on women so that they choose not to terminate their

⁵⁰ Special Rapporteur, Poland, *supra* note 2, par. 50.

⁵¹ WHO, *Safe Abortion: Technical and Policy Guidelines*, *supra* note 3.

⁵² Eur. Ct. Hum. Rts., *R.R v. Poland*, *supra* note xx, par. 180 (2011); Eur. Ct. Hum. Rt., *A.B. and C. v. Ireland*, *supra* note 3, par. 212 (2010); Eur. Ct. Hum. Rts., *Tysiack v. Poland*, *supra* note 3, par 107 (2007).

⁵³ Eur. Ct. Hum. Rts., *P and S v. Poland*, *supra* note 3, par 106; Eur. Ct. Hum.Rts., *R. R. v. Poland*, *supra* note 3, par. 206.

⁵⁴ Colombian constitutional Court, decision T-388/2009, p. 39

⁵⁵ *Id.*, p. 40.

⁵⁶ *Id.*, p. 42

⁵⁷ *Id.*, at 53-54

pregnancies.”⁵⁸ Finally the high number of conscientious objectors (in some of the regions, it is as high as 90%) illustrates also a systematic failure of the State to organize a health system so that it is responsive to women’s needs.

161. As regards the rights which have allegedly been violated, the Committee considers that, as indicated in paragraph 68 above, the key legal issue at stake in this complaint concerns the protection of the right to health, **understood as encompassing the right to sexual and reproductive rights of women**. The Committee therefore has focused its analysis on the adequacy of the steps taken by competent authorities to guarantee effective access to abortion services, which national legislation has classified as a form of medical treatment that relates to the protection of health and individual well-being **of women**, and which therefore can be considered to come within the scope of Article 11 of the Charter.

162. The Committee recalls that “[i]n connection with means of ensuring steady progress towards achieving the goals laid down by the Charter, (...) the implementation of the Charter requires state parties not merely to take legal action but also to make available the resources and introduce the operational procedures necessary to give full effect to the rights specified therein” (International Movement ATD Fourth world v. France, Complaint No. 33/2006, decision on the merits of 5 December 2007, § 61). Furthermore, the Committee recalls that “arrangements for access to care must not lead to unnecessary delays in its provision. The management of waiting lists and waiting times in health-care are considered in the light of the Committee of Ministers Recommendation (99)21 on criteria for such management. Access to treatment must be based on transparent criteria, agreed at national level, taking into account the risk of deterioration in either clinical condition or quality of life” (cf. Conclusions XV-2, 2011, United Kingdom).

163. **Article 11 of the Charter reflects other international human rights obligations, according to which reproductive and sexual rights are key components of women’s right to health and well-being. (CEDAW, Art. 12, CEDAW Committee, General Recommendation No. 24 (Art. 12); CESCR, Art. 12; CESCR, Comment No. 12) The enjoyment of this right is crucial for women as it guarantees her right to personal autonomy and development (Eur. Ct. Hum. Rts., Tysiac v. Poland, Appl. No. 5410/03, par. 107).** In light of the above, the Committee considers, that the provision of abortion services must be organized so as to insure that the needs of patients wishing to access these services are met. **States are required to introduce concrete measures so as to guarantee women’s access to reproductive health services and their pre-abortion and post-abortion care. In the case of practice of conscientious objections this means that States are required to introduce regulatory mechanisms, which monitor the use of the conscientious objection and ensure that in practice abortion services are fully available (CEDAW, Art. 12; UNHRC, Mission to Poland). States should organize a timely and automatic referral of patients to non-objecting personnel and guarantee that women have all the necessary information regarding these alternatives. They moreover need to ensure that the conscientious objection is raised by the individual health-provider and not by the institutions.** This means that adequate measures must be taken to ensure the availability of non-objecting medical practitioners and other health personnel when and where they are required to provide abortion services, taking into account the fact that the number and timing of requests for abortion cannot be predicted in advance.

164. The Committee also considers that it would not be in conformity with the Charter if the resolution of any possible problems encountered by women with respect to gaining access to abortion procedures is left in the hands of administrative or judicial authorities to be determined after the fact. As with other health services provided under Italian law, adequate measures must be put into place to ensure that women are able to access abortion services as and when they are required: the provision of retrospective remedies after the point of demand only supplements the primary obligation under Article 11 to make health care available as it is needed, which applies with particular force to time-sensitive procedures such as abortion. In this particular context, the Committee furthermore notes that appeals represent a stressful and time-consuming measure which can be detrimental to the health of the women concerned

165. **In light of these observations, (i)n relation to the relationship between the right to protection of health set out in Article 11, international human rights instruments previously mentioned, and the exercise of conscientious objection rights guaranteed under national law, the Committee considers that, as stated by the National Committee of bioethics (Comitato Nazionale per la Bioetica, “(...) [t]he statutory protection of**

⁵⁸ According to Petros Stangos, “Through the above-mentioned provisions of the 1978 legislation, Italy operates a sophisticated and official system of pressure on women so that they choose not to terminate their pregnancies”.

conscientious objection should neither limit or hamper the exercise of the rights guaranteed by law (...)” (cf. Conscientious objection and bioethics - Obiezione di coscienza e bioetica) - p. 18). The Committee also refers to the motions presented in June 2013 within the Chamber of Deputies (see paragraphs 57 and 58 above), the wording of which can be regarded as reflecting the requirements of Article 11 of the Charter in this respect:

- “(...) [Act No. 194/1978] distinguishes between the individual right to object and women's right to freedom of choice in matters of procreation and between the individual's right to object to a law of the State and the States' obligation to provide the required service (...)” (Motion No. 1-00074);

- “(...) Health personnel are guaranteed that they will be able to raise an objection of conscience. But this is an individual right, not a right of the health care structure as a whole, which is obliged to guarantee the provision of health care services” (Motion No. 1-00045).

166. In this context, the Committee notes the Government's declaration that “[t]he aim of the law is to establish a principle, clearly specified under Article 9 of Act 194: the possibility for health-care professionals and staff to become conscientious objectors and the obligation for the Regions and the health care organizations to organize accordingly” and acknowledges that “there is no need to change the law but only to ensure that the Regions implement the procedures envisaged under Act 194/78”. In this context, the Committee also notes the opinion expressed within the Parliament pointing out that “(...) it is not the number of objectors in itself to determine the state of access to abortion procedures, but the way in which health facilities organise the implementation of Act No.194/1978” (cf. Motion 1/00079, Chamber of Deputies – see paragraph 57 above).

167. The Committee furthermore does not find that the arguments put forward by the Government with respect to a) the objectives of the complainant organisation and b) the implementation of Article G of the Charter (see paragraph 94 above) relate to the issues at stake. The complaint does not contain any reference or request aimed at impeding the exercise of the right to raise conscientious objection or at limiting the number of objecting medical practitioners and other health personnel.

[168. Paragraph deleted: Turning to the substance of the complaint, the Committee considers that the provisions of Section 9§4 establish a balanced statutory framework for the fulfillment of the goals of Act No. 194/1978. As far as the Charter is concerned, the Committee considers that: a) the obligation for hospitals and nursing homes to take steps to ensure that abortion procedures are carried out “in all cases” as laid down in Sections 5, 7 and 8 of the said act, and b) the regions' responsibility to ensure that this requirement is met, represent a suitable legal basis to ensure a satisfactory application of Article 11. Furthermore, the Committee also considers that the high number of objecting health personnel in Italy does not per se constitute evidence that the domestic legal provisions at stake are being implemented in an ineffective manner.]

168. The Committee considers that the Italian law is in violation of Art. 11 and impedes women's access to abortion services. According to the Italian law women who decide to terminate their pregnancy need to undergo a mandatory and dissuasive counselling, and the law also requires a seven-day waiting period. Moreover, the law does not provide for a clear regulatory framework that allows for a prompt referral of patients to non-objecting doctors and ensures that women have access to abortion services when required, as evidenced by the facts submitted by the Complainant and does not provide for a monitoring mechanism for supervising how conscientious objection is practiced on the ground. Finally, the high number of objecting health personnel is an evidence that the health system as a whole is not organized so as to be responsive to women's needs and that in this context the law, as it currently stands, cannot guarantee women's access to abortion. In light of these observations the State has the duty to organize its health system according to its human rights obligations and ensure that 1) women have access to abortion procedures and can effectively and freely exercise their rights throughout the health system. This includes providing a training to the health personnel which takes into account women's sexual and reproductive rights and their specific needs; 2) women receive comprehensive information about their right to access abortion services and the duty of objecting health care providers; 3) the regions guarantee that hospitals and nursing homes have necessary personnel to perform abortions at any time, and that when only one doctor is present, he/she performs the abortion irrespective of his/her beliefs. (see Columbian Constitutional Court decision T-388/2009).

4. A more robust gender equality approach relying on inter-sectionality

Barriers to abortion access amount to discrimination based on gender and are related to gender equality⁵⁹. This, however, is not clearly spelled out by the Committee in its analysis of how gender discrimination plays out in IPPF-EN v. Italy. As only women may be pregnant, women are obviously the exclusive users of abortion services. Any limitation to access these services thus impedes the full enjoyment of their rights and impact on their welfare. Links between discrimination, gender equality and reproductive rights are the most convincingly articulated in CEDAW⁶⁰. The preamble to the Convention clearly states that “the role of women in procreation should not be a basis of discrimination.” The Convention also includes considerations regarding family planning and States are urged to adopt measures that guarantee women’s rights to “decide freely and responsibly on the number and spacing of their children.”⁶¹ Moreover, in its General Comment No. 24 concerning the right to health, the CEDAW Committee considers that “States are required to eliminate discrimination against women in their access to health care services, particularly in the area of family planning.”⁶² In this context it is discriminatory for a State to “refuse to legally provide for the performance of certain reproductive health services for women” which includes instances in which the health-care provider raise the conscientious objection.⁶³

More broadly, gender equality arguments were at the heart of feminist movements that first challenged legislation criminalizing abortion in the US and Europe. They argued that criminalization of abortion and its limitations actually allow States to control women’s sexuality by enforcing traditional gender stereotypes confining women in their role of mothers.⁶⁴ Women are reduced to a ‘second-class-citizen’ status as their capacity to chose for themselves is restricted and constrained by State.⁶⁵ These gender equality arguments do not only address cultural stereotypes. They also challenge economic arrangements that bear upon the childrearing function. The criminalization of abortion, the argument goes, is only exacerbating women’s economic exclusion in a context in which pregnancy could be a cause for dismissal, or prompt other forms of discrimination in the workplace, and in which women are in charge of daily-care in the absence of child-care subsidized services. It is also in this context that differences between women was brought forward: criminalization of abortion has a more devastating effects on culturally and socially marginalized communities especially on poor communities and ethnic or racial minorities.⁶⁶

These arguments are only partly mirrored in the Committee’s decision. On one hand, the Committee is to be praised for highlighting the inter-sectional discrimination - on the grounds of gender, health status, territorial location and socio-economic status - that is at stake in the Italian situation. On the other hand, the Committee could have gone one step further in adopting a genuine gender equality approach.⁶⁷

IPPF-EN framed its second claim (alleged violation of Article E read in conjunction with article 11 of the Charter) as resulting from a double breach of the principle of non-discrimination. The first one was based on an economic and territorial ground due to the much more difficult access to abortion

⁵⁹ Reva B. Siegel, “Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression”, *Emory Law Journal*, Vol. 56, 2007, nr 4, pp. 815-842; R. Cook & S. Howard, “Accommodating Women’s differences under the Woman’s Anti-Discrimination Convention”, *Emory Law Journal*, Vol. 56, No. 4, 2007, pp. 1039-1090.

⁶⁰ M. Freeman, C. Chinkin & B. Rudolf (eds.), *The UN Convention on the Elimination of All Forms of Discrimination against Women: A Commentary*, 2012, xx.

⁶¹ CEDAW, Art. 16.

⁶² CEDAW, General Comment No. 24 to Art. 12, par. 2. (Quote to be double-checked xx).

⁶³ *Ibid*, par. 11.

⁶⁴ Reva B. Siegel, “Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression”, *op. cit.*, pp. 823-825.

⁶⁵ Rebecca J. Cook, “Stigmatized Meanings of Criminal Abortion Law”, in Rebecca J. Cook, Joanna N. Erdman, and Bernard M. Dickens (eds.), *Abortion Law in Transnational Perspective: Cases and Controversies*, U Penn Press, 2014, p. 347 & ss.

⁶⁶ See e.g., Reva B. Siegel, *Roe’s Roots: The Women’s Rights Claims that Engendered Roe*, 90 B.U. L. Rev 1875 (2010).

⁶⁷ Reva B. Siegel, “Sex Equality Arguments for Reproductive Rights: their Ciritcal Basis and Evolving Constitutional Expression”, *op. cit.*, p. 815 & ss.

services in the Southern part of Italy, coupled with the disparate impact of such a situation on women who are less well off and therefore less able to access private clinics or public hospitals in Italy, or private clinics abroad (par. 180-183). The second alleged discrimination concerns women who, due to their state of health, both physical and mental, are seeking access to abortion as compared to “women not seeking such access, whether they are pregnant or not” (par. 184).

This double claim regarding discrimination was astonishingly reformulated by the Committee as a “discrimination on the grounds of gender and/or health status between women seeking access to lawful termination procedures and *men* and women seeking access to other lawful forms of medical procedures which are not provided on a similar restricted basis” (par. 190). This was criticized by the President Luis Jimena Quasada, in the only dissenting opinion to the decision, on the ground that the terms of comparison used by the Committee were not relevant, and that the first element of the standard of non-discrimination was not fulfilled (Dissenting Opinion, § 15). Two comments will be developed here.

First, the Committee avoided the potential pitfalls of dealing with controversial comparators by opting for an “intersectional” approach of the alleged discrimination. It has reformulated the claim, stating that “certain categories of women in Italy (would be allegedly) subject to less favourable treatment in the form of impeded access to lawful abortion facilities as a result of the combined effect of their gender, health status, territorial location and socio-economic status” (par. 190 & 192). In doing so, the Committee acknowledges that the primary concern in establishing discrimination relates to a disadvantage based on one or several personal characteristics, which renders the comparator requirement unnecessary.⁶⁸

This is in line with the Canadian Supreme Court’s approach:

“It is unnecessary to pinpoint a particular group that precisely corresponds to the claimant group except for the personal characteristic or characteristics alleged to ground the discrimination. Provided that the claimant establishes a distinction based on one or more enumerated or analogous grounds, the claim should proceed to the second step of the analysis. This provides the flexibility required to accommodate claims based on intersecting grounds of discrimination. It also avoids the problem of eliminating claims at the outset because no precisely corresponding group can be posited”.⁶⁹

The Committee, however, puts in one basket intersectional and multiple discriminations. It only refers to grounds of discrimination closely linked together that constitute a “claim of ‘overlapping’, ‘intersectional’ or ‘multiple’ discrimination”. This shows once again the urge for conceptual clarifications in anti-discrimination law. While intersectional discrimination occurs when “categories of identities intersect and produce both shared and unique pattern of disadvantage”, “multiple or combination discrimination is usually understood as additive or multiplicative discrimination based on two or more grounds”.⁷⁰

Second, at the end of the decision, the Committee reintroduces the need for a comparator by holding that “the women concerned are treated differently than other persons in the same situation” (par. 191). Rather than looking for the most appropriate terms of comparison – women and/or men seeking access to other lawful forms of medical procedures -, we argue that the search for a comparator is a wrong path in the abortion context. The formal approach of “equality as conformity”

⁶⁸ S. Atrey, “Re-envisioning Discrimination Law. Making Discrimination Law respond to Intersectionality”, text presented at the Global Equality Law International Conference, May 2014, Brussels xxx .

⁶⁹ C.S.C., *Withler v Canada (Attorney General)*, 2011 SCC 12 (63).

⁷⁰ S. Atrey, “Re-envisioning Discrimination Law. Making Discrimination Law respond to Intersectionality”, *op. cit.* p. 5.

that rests on the requirement of a comparator, has been criticised as being one of the “most problematic aspects of direct discrimination.”⁷¹ Such an approach is particularly worrying regarding pregnancy discrimination as no appropriate male comparator is to be found.⁷² In this respect, after an evolution dealing with an “ill male comparator”, some courts, such as the European Court of Justice⁷³ and the Canadian Supreme Court⁷⁴ decided to eradicate the reference to a comparator altogether. Instead, they chose to focus on unfavourable treatment on the grounds of pregnancy.⁷⁵ In the EU, legislation has later on codified this approach.⁷⁶

We do not see any reason for adopting a different approach to women seeking an abortion. Since only women may be pregnant, only women may need to terminate their pregnancy. Therefore, unfavourable treatment regarding access to abortion amounts to gender discrimination. This was argued in a complaint against Peru before the UN Human Rights Committee.⁷⁷ A 17 old young girl was denied access to therapeutic abortion provided by law. The author was claiming to be a victim of a discrimination on the ground of sex “(i)n access to the health services, since her different and special needs were ignored because of her sex. In the view of the author, the fact that the State lacked any means to prevent the violation of her right to a legal abortion on therapeutic grounds, which is applicable only to women, together with the arbitrary conduct of the medical personnel, resulted in a discriminatory practice that violated her rights (...)” (point 3.2 a)). However, this part of the claim related to Articles 3 and 26 of the ICPPR was rejected as inadmissible due to the lack of “any evidence relating to the events, which might confirm any type of discrimination” (point 5.3). This rejection of the discriminatory claim is problematic in view of the Committee’s General Comment on Equality between Women and Men, as Cook and Howard stress it.⁷⁸ Nevertheless, we claim that their suggestion to focus on indirect discrimination and the disproportionate impact of conservative abortion laws on pregnant women, *as compared to law regulating men’s access to such necessary services*, still misses the point by requiring a male comparator for establishing sex discrimination.⁷⁹

Beyond the rejection of the comparator, adopting a more substantive conception of “equality as dignity”⁸⁰ could reinforce the gender equality stance.⁸¹ As Reva B. Siegel puts it, “control over whether and when to give birth is (...) a crucial dignitary importance to women. (...) It recognizes women as self-governing agents who are competent to make decisions for themselves and their families and have the prerogative to determine when and how they will devote themselves to caring for others. In a symbolic as well as a practical sense (...) reproductive rights repudiate customary assumptions about women’s agency and women’s roles”.⁸²

⁷¹ S. Fredman, *Discrimination Law*, Oxford University Press, 2d Edition, 2011, p. 168.

⁷² *Id.*, p. 169.

⁷³ ECJ, case C-177/88, *Dekker* (1990) ECR I-394, case C-32/93 *Webb* (1994) ECR I-3567.

⁷⁴ C.S.C., *Brookes v. Canadian Safeway Ltd.*, (1989) 1 SCR, 1219.

⁷⁵ S. Fredman, *Discrimination Law*, *op. cit.*, p. 170.

⁷⁶ Article 2, § 2, c) of the Directive 2006/54/EC of the European Parliament and of the Council of 5 July 2006 on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation (recast).

⁷⁷ *K.L. v. Peru*, CCPR/C/85/D/1153/2003, Nov. 22 2005.

⁷⁸ R. Cook & S. Howard, “Accommodating Women’s differences under the Woman’s Anti-Discrimination Convention”, *op. cit.*, p. 1074.

⁷⁹ Canadian Supreme Court < section 15 of the Canadian Charter (Joanna N. Erdman, “In the back alleys of health care: abortion, equality, and community in Canada”, *Emory Law Journal*, vol 56, 2007, p. 1093 & ss.

⁸⁰ S. Fredman, *Discrimination Law*, *op. cit.*, pp. 19-24

⁸¹ Cook and Howard also stress the link between equality and dignity: “the application of the right to equality in the abortion context requires examining how women experience different pathways to abortion services, the dignity denying treatment in the clinical provision of services, and the discriminatory constructions of their life options, including their choices as to whether and when to found their families” (R. Cook & S. Howard, “Accommodating Women’s differences under the Woman’s Anti-Discrimination Convention”, *op. cit.*, p. 1041).

⁸² Reva B. Siegel, “Sex Equality Arguments for Reproductive Rights: their Ciritcal Basis and Evolving Constitutional Expression”, *op. cit.*, p. 819.

189. The Committee recalls that Article E prohibits both direct and indirect discrimination. In this respect, it recalls that direct discrimination may arise when individuals and/or groups are hampered or prevented from enjoying the rights set forth in the Charter on the grounds of their status. As set forth in the Charter's appendix, a differential treatment based on an objective and reasonable justification shall not be deemed discriminatory (cf. *Autism-Europe v. France*, Complaint No. 13/2002, decision on the merits of 4 November 2003, §52). The Committee also recalls that in respect of complaints alleging discrimination, the burden of proof should not rest entirely on the complainant organisation, but should be shifted appropriately (*Mental Disability Advocacy Center (MDAC) v. Bulgaria*, Complaint No. 41/2007, decision on the merits of 3 June 2008, § 52).

190. Two primary forms of discriminatory treatment are alleged to exist in this complaint: (i) discrimination on the grounds of territorial and/or socio-economic status between women who have relatively unimpeded access to lawful abortion facilities and those who do not; (ii) discrimination on the grounds of gender and/or health status between women seeking access to lawful termination procedures and ~~men and~~ women seeking access to other lawful forms of medical procedures which are not provided on a similar restricted basis. The Committee considers that these different alleged grounds of discrimination are closely linked together and constitute a claim of 'overlapping', 'intersectional' or 'multiple' discrimination, whereby certain categories of women in Italy are allegedly subject to less favorable treatment in the form of impeded access to lawful abortion facilities as a result of the combined effect of their gender, health status, territorial location and socio-economic status: the complainant organisation in essence alleges that since women who fall into these vulnerable categories are denied effective access to abortion services as a consequence of the failure of the competent authorities to adopt the necessary measures which are required to compensate for the deficiencies in service provision caused by health personnel choosing to exercise their right of conscientious objection, this constitutes a discrimination.

191. Based on the information provided by the complainant organisation and not contradicted by the government, the Committee notes that, as a result of the lack of non-objecting medical practitioners and other health personnel in a number of health facilities in Italy, women are forced in some cases to move from one hospital to another within the country or to travel abroad (see paragraphs 110, 130, 141 and 147 above); in some cases, this is detrimental to the health of the women concerned. Therefore, the Committee holds that the women concerned are **significantly disadvantaged** [fragments deleted—~~treated differently than other persons in the same situation~~] with respect to access to health care, **which amounts to direct discrimination on the grounds of gender** without justification.