

# A WAY FORWARD AFTER *DOBBS*: HUMAN RIGHTS ADVOCACY AND SELF-MANAGED ABORTION IN THE UNITED STATES

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## INTRODUCTION

A thirty-three-year-old woman living in Louisiana made the decision to terminate her pregnancy.<sup>1</sup> But her path to exercising her abortion rights was anything but smooth. After calling her gynecologist seeking advice, the receptionist was “disgusted” by her question.<sup>2</sup> She went to the only facility offering abortion care in New Orleans, where she paid \$150 to wait six hours in an overcrowded space, only to get a mere ultrasound.<sup>3</sup> On top of it all, the clinic was packed with protestors. Luckily, she had the resources and time to fly to Washington, D.C., where she was able to access same-day abortion care for a fraction of the cost for an abortion in her hometown.<sup>4</sup>

Another woman, living in Nashville, Tennessee, drove four hours and took out a “Speedy Cash loan” for a \$1,100 abortion.<sup>5</sup> Because of the lack of abortion access in her area, she could not complete her abortion close to home in the comfort of friends.<sup>6</sup>

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1. Sarah Varney, *Long Drives, Costly Flights, and Wearying Waits: What Abortion Requires in the South*, NPR (Aug. 2, 2021, 5:00 AM), <https://www.npr.org/sections/health-shots/2021/08/02/1022860226/long-drives-costly-flights-and-wearying-waits-what-abortion-requires-in-the-south>.

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

These troubling stories are in no way unique. And all occurring under the *Roe* and *Casey* regime that protected a federal abortion right, now eliminated by the Supreme Court’s *Dobbs*<sup>7</sup> decision this June. The landscape under such regime was bleak, described by Oriaku Njoku, co-founder of Access Reproductive Care Southeast: “The post-*Roe* reality that y’all are afraid of is the lived reality for folks today in the South.”<sup>8</sup> Even in the era before *Dobbs*, wherein the Supreme Court repeatedly classified abortion as a “fundamental right,”<sup>9</sup> the ability to have an abortion was inaccessible in many parts of the United States. The irony that a “fundamental right” was so difficult to exercise results from how constitutional rights are understood, which left many open-ended avenues for states to bring restrictions. International Human Rights law, however, offers a more optimistic and accountable approach to steps forward in increasing abortion access—illustrating a need to bring a human rights-based approach home. *Dobbs* has eviscerated any concept of federal protections for abortion, severely worsening the situation.<sup>10</sup> But, as demonstrated above, a lack of abortion rights was already a lived reality for many. In the wake of *Dobbs*, advocates must demand more of lawmakers by expanding the rhetoric and law surrounding abortion beyond our *Roe*-regime understanding. Moving forward, overturning *Dobbs* and going back to *Roe* is not good enough. This Note therefore calls attention to the shortcomings of the pre-*Dobbs* regime, lest they be lost in a sea of calls to “codify *Roe*.”<sup>11</sup> In the meantime, this Note provides a framework for effective human rights advocacy in the abortion context. It also documents the benefits and shortcomings of self-managed abortion care, a practice that will remain relevant in *Dobbs*’ aftermath.

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7. *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022)

8. Sarah Varney, *Long Drives, Costly Flights, and Wearying Waits: What Abortion Requires in the South*, NPR (Aug. 2, 2021, 5:00 AM), <https://www.npr.org/sections/health-shots/2021/08/02/1022860226/long-drives-costly-flights-and-wearying-waits-what-abortion-requires-in-the-south>. Access Reproductive Care-Southeast is a pro-abortion access fund located in Atlanta, Georgia. *Id.*

9. *See, e.g., Roe v. Wade*, 410 U.S. 113, 155 (1973) (holding that the right to privacy—and subsequently, the right to abortion—is a “fundamental right” protected under the Fourteenth Amendment).

10. *See infra* Part I.B (discussing the events preceding the *Dobbs* decision and its implications).

11. *See, e.g., Joe Biden (@JoeBiden)*, TWITTER (October 4, 2022, 4:15 PM), <https://twitter.com/potus/status/1577391919193329681> (“Congress should codify the protections of *Roe* once and for all.”); Darragh Roche, *ACO, Bernie Sanders Urge Roe v. Wade Be Codified to Thwart Supreme Court*, NEWSWEEK, May 3, 2022, <https://www.newsweek.com/aoc-bernie-sanders-urge-roe-v-wade-codified-supreme-court-1702813>.

Part I of this Note will first examine the evolution of United States case law and policy regarding abortion, noting the previous federal right and *Dobbs*' elimination of such protections. Part II will explain the flaws of the previous negative rights regime under *Roe* and *Casey* that created access gaps, permitted harmful restrictions, and failed to hold states accountable. Part III will compare the United States' pre-*Dobbs* approach to abortion protections to International Human Rights law and highlight the United States' express failure to ratify international treaties and adopt the positive rights approach to abortion. Highlighting the difference between a "fundamental right" before *Dobbs* and a "human right" under International Human Rights law, this Part will use this comparison to point out additional flaws and gaps created by the negative rights approach. Finally, Part IV will explain and analyze how self-managed abortion presents a potential solution to the issues posed by federal legal doctrine. This includes an examination of various self-managed abortion efforts already underway, in light of human rights advocacy goals, demonstrating the need for governmental accountability for solutions beyond what self-managed advocacy efforts may be able to achieve.

## I: HISTORY THE OF UNITED STATES ABORTION RIGHTS

The United States jurisprudence and federal policy before *Dobbs* protected a "fundamental right" to abortion that was always limited in scope. This Part will explain *Roe v. Wade*, the Supreme Court case that recognized a "fundamental right" to an abortion under the Constitution. Next, this Part will introduce *Planned Parenthood v. Casey*, which limited the scope of the right recognized in *Roe*. Finally, this Part will explain the implications of the *Dobbs* decision.

### A. *Roe and Casey: Abortion as a "Fundamental Right"*

The history of United States abortion protections begins long before the landmark 1973 Supreme Court decision in *Roe v. Wade*, as Americans for centuries have struggled with restrictions on bodily autonomy.<sup>12</sup> *Roe* marked the first time that the Supreme Court, and

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12. Sarah Kliff, *CHARTS: How Roe v. Wade Changed Abortion Rights*, WASH. POST (Jan. 22, 2013), <https://www.washingtonpost.com/world/2021/09/14/abortion-pills-texas>. In the 1960s, forty-four states banned or heavily restricted abortion; however, many states had begun lifting or liberalizing their restrictions by the 1970s when *Roe* was decided. *Id.* Though *Roe* is painted as a controversial outcome, at the time of the Court's decision, two thirds of Americans agreed that abortion should be a private decision left to the discretion of individuals and their doctors. DANIEL FARBER & NEIL S. SIEGEL, UNITED STATES CONSTITUTIONAL LAW 383 (2019).

thus federal law, acknowledged reproductive decision-making as a fundamental right.<sup>13</sup> The Court derived the right to an abortion by finding that the decision of whether to have children is protected within the zone of the right to privacy.<sup>14</sup>

But, the Court restricted the right to an abortion by finding that at a certain point in pregnancy, a state's interest in protecting both a woman's health *and* "the potentiality of human life" becomes "compelling."<sup>15</sup> In accordance with its view of these competing interests, the Court adopted a trimester system in which permissible restrictions correlated with stages of a pregnancy.<sup>16</sup>

The 1992 decision *Planned Parenthood v. Casey* left intact the basic "fundamental right" acknowledged in *Roe*, but directly overruled other aspects of *Roe*,<sup>17</sup> thereby creating new opportunities for states to restrict abortion access. Included in these changes were (1) replacement of the trimester system with a viability line,<sup>18</sup> and (2) replacement of the "strict scrutiny" standard, applied by federal courts to assess laws that limited abortion rights, with a less stringent "undue burden" standard.<sup>19</sup>

After *Casey*, states could prohibit or significantly restrict abortion access for a pregnancy that passes the undefined marker of fetal viability.<sup>20</sup> Even prior to viability, any regulations that served a valid purpose, and that did not impose an "undue burden," were allowed.<sup>21</sup>

13. *Roe*, 410 U.S. at 153–55 (analyzing whether abortion should be protected under the Fourteenth Amendment given the absence of prior cases on the matter, and concluding that the right to an abortion is secured by a "fundamental right" to privacy under the Fourteenth Amendment).

14. *See id.* at 153 ("This right of privacy . . . is broad enough to encompass a woman's decisions whether or not to terminate her pregnancy.").

15. *Id.* at 162–63.

16. *Id.* at 164–65. The Court held that States may not restrict abortions in the first trimester, may restrict abortions in the second trimester if the restrictions relate to "maternal health," and may ban abortions entirely once the fetus reaches "viability" (at approximately the end of the second trimester). *Id.*

17. *See Planned Parenthood v. Casey*, 505 U.S. 833, 845–46 (1992) (preserving the "essential holding" of *Roe*); *id.* at 873 (joint opinion) (rejecting some of the specifics of the decision).

18. *Id.* at 872.

19. *See id.* at 878 (switching from a "strict scrutiny" requirement for restrictions before viability, to an analysis under which "regulations designed to foster the health of a woman seeking an abortion are valid if they do not constitute an undue burden").

20. *See id.* ("[I]t does not at all follow that the State is prohibited from taking steps to ensure that the choice is thoughtful and informed. Even in the earliest stages of pregnancy, the State may enact rules and regulations.").

21. *Id.* Although *Casey* reaffirmed abortion access as a "fundamental" constitutional right, the Court moved away from a "strict scrutiny" basis for evaluating state-imposed restrictions on this right. *See id.* at 834 (majority opinion) (calling for re-examination of the interest involved,

### B. *Dobbs*' Evisceration of Federal Protections

In June 2022 the Court decided *Dobbs*, which overturned all federal constitutional protections for abortion found in *Roe* and *Casey*.<sup>22</sup> This case achieved political conservatives' goal of eliminating federal abortion rights, an ambition ever since *Roe* was first decided and a focal point for judicial appointments.<sup>23</sup> Many predicted the outcome from the time the Court took up the case in the spring of 2021,<sup>24</sup> and it became much more apparent with the leaked draft in May,<sup>25</sup> which tracked the final official decision. The Court in its June opinion found that “*Roe* was egregiously wrong from the start” and thus “*Roe* and *Casey* must be overruled.”<sup>26</sup> Throughout its opinion, the Court cast doubt on any foundation of a federal abortion right previously found, and instead emphasized these protections should be left to the individual states.<sup>27</sup>

## II. THE PRE-*DOBBS* UNDERSTANDING OF THE “FUNDAMENTAL RIGHT” TO AN ABORTION: FLAWS IN THE NEGATIVE RIGHTS MODEL

The main failure of America's “fundamental right” regime of abortion before *Dobbs* is that it only ever afforded a thin “negative rights” protection—a right that proved insufficient, illustrating a need for a new approach after *Dobbs*.<sup>28</sup> Under such regime, although people

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while upholding the core fundamental right). Instead, the Court introduced an “undue burden” standard: any restriction that has “the purpose or effect of placing a substantial obstacle in the path of [an] individual seeking an abortion of [a] non-viable fetus” is unconstitutional. *Id.* at 877 (joint opinion).

22. See *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2279 (2022) (“We therefore hold that the Constitution does not confer a right to abortion. *Roe* and *Casey* must be overruled, and the authority to regulate abortion must be returned to the people and their elected representatives.”).

23. See Michael Martin, *How conservatives worked for decades to fill courts with anti-abortion rights judges*, NPR, (June 26, 2022), <https://www.npr.org/2022/06/26/1107713225/how-conservatives-worked-for-decades-to-fill-courts-with-anti-abortion-rights-ju> (discussing overturning *Roe* “it’s been the goal almost since the inception. Republicans have just gotten better at it.”).

24. Adam Liptak, *Supreme Court to Hear Abortion Case Challenging *Roe v. Wade**, NY TIMES, (May 17, 2021), <https://www.nytimes.com/2021/05/17/us/politics/supreme-court-roe-wade.html>.

25. Josh Gerstein & Alexander Ward, *Supreme Court has voted to overturn abortion rights, draft opinion shows*, POLITICO, (May 3, 2022), <https://www.politico.com/news/2022/05/02/supreme-court-abortion-draft-opinion-00029473>.

26. *Dobbs*, 142 S. Ct. at 2242, 2243.

27. See *id.* at 2279.

28. See FARBER & SIEGEL, *infra* note 12, at 399 (explaining how abortion is an example of the Court's approach to negative constitutional protections, as “constitutional rights almost never

may have theoretically possessed a “right” to make reproductive decisions, the government had no obligation to take any affirmative steps to help individuals realize such a right.<sup>29</sup> Thus, while the Court may have kept states from prohibiting access, it never interfered when it came to *providing* access.<sup>30</sup> A negative rights model imposes no requirement to “take initiatives.”<sup>31</sup> This weak rights backing is demonstrated by the multitude of restrictions permitted after *Casey*. Government inaction does not ensure equality of access, as many groups of people, such as those living in poverty, often face burdens that prevent access to their rights.<sup>32</sup>

*Casey*’s move to the “undue burden” standard opened the door for additional restrictions on abortion access that previously failed under *Roe*’s “strict scrutiny” standard.<sup>33</sup> States were permitted to show a preference for childbirth in their restrictions, as long as the measures did not violate the “undue burden” standard.<sup>34</sup> Informed consent laws were a popular example of this ability under *Casey*.<sup>35</sup> These biased consent requirements,<sup>36</sup> which clearly preference childbirth, inhibit an individual from access to an abortion by infringing on their right to make an accurate and fully informed decision. *Actual* ‘informed consent’ would paint the full picture, listing the real risks of childbirth and not overemphasizing risks from an abortion.

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oblige the government to act in ways that affirmatively facilitate their exercise”).

29. See *Harris v. McRae*, 448 U.S. 297, 316 (1980) (“[A]lthough government may not place obstacles in the path of a woman’s exercise of her freedom of choice, it need not remove those not of its own creation.”).

30. See *Maher v. Roe*, 432 U.S. 464, 475 (1977) (“There is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy.”).

31. *Id.*

32. See *Rubin*, *infra* note 95, at 1691 (“To put the point another way, if people are disenfranchised by starvation, they are certainly not equal to their more prosperous co-citizens, and their essential liberty to participate has been infringed.”).

33. See, e.g., *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 419–24 (1983) (striking down both an informed consent law and a waiting period requirement under the *Roe* standard), *overruled by Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

34. *Planned Parenthood v. Casey*, 505 U.S. 833, 883 (1992), 505 U.S. at 883 (joint opinion) (“[W]e permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion.”).

35. *Id.* at 882–83.

36. See Ian Vandewalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics*, 19 MICH. J. GENDER & L. 1, 14–31 (2012) (discussing the misleading, biased, and “clearly false” information contained in many states’ informed consent requirements). See, e.g., S.D. CODIFIED LAWS § 34-23A-10.1(1)(b) (2011) (requiring that physicians provide abortion seekers with written materials stating that “the abortion will terminate the life of a whole, separate, unique, living human being.”).

*Casey*'s increased deference to the potential for life paved the way for waiting period restrictions, justified by an interest in helping individuals make full, informed, and unrushed decisions.<sup>37</sup> But, these requirements often simply force fully informed decision makers to forgo work or family obligations to attend multiple clinic visits, which often can be far from home, effectively guarding the exercise of the right with burdensome transportation costs.<sup>38</sup>

Other damaging restrictions allowed after *Casey* included "Targeted Restrictions on Abortion Providers," commonly referred to as TRAP laws.<sup>39</sup> These restrictions target a wide variety of subject matters, from physical aspects of the building where abortions are provided to clinical staff.<sup>40</sup> Some of those TRAP laws that met the "undue burden" standard led to the closure of entire clinics, eliminating abortion access to individuals in the area serviced by those clinics.<sup>41</sup>

This negative rights distinction proved significant in the cost of reproductive care. Since 1967, Congress has relied upon the Hyde Amendment to prohibit the use of federal funds for abortions.<sup>42</sup> Thus, Medicaid and Medicare programs cannot be used to cover abortions, forcing those enrolled in such programs to pay out-of-pocket.<sup>43</sup> The pre-*Dobbs* Court upheld both federal and state restrictions on abortion funding, holding that the government has no obligation to pay for

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37. See *Casey*, 505 U.S. at 882 (joint opinion) ("In attempting to ensure that a woman appreciate the full consequences of her decision, the State [by requiring informed consent] . . . reduc[es] the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."). Waiting periods are a state-imposed time limit between an initial visit and the day an individual can obtain the actual abortion procedure or medications; in *Casey*, the challenged law required that abortion seekers provide informed consent and receive "certain information at least [twenty-four] hours before an abortion is performed." *Id.* at 844 (majority opinion).

38. See generally Liza Fuentes & Jenna Jerman, *Distance Traveled to Obtain Clinical Abortion Care in the United States and Reasons for Clinic Choice*, 28 J. WOMEN'S HEALTH 1623 (2019) (discussing how individuals' ability to receive abortion care is affected by their distance from abortion facilities, access to certain modes of transportation, workplace sick policies, and access to childcare).

39. Rachel Sussman, *The Landscape of State Anti-Abortion Legislation*, 29 COLUM. J. GENDER & L. 229, 230 (2015).

40. *Id.*

41. See Sussman, *supra* note 39, at 231 (arguing that when states pass abortion restrictions ostensibly designed to make abortion facilities "safer" and "better," "the result is restricted access.").

42. *The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion*, GUTTMACHER INST., (May 2021), <https://www.guttmacher.org/fact-sheet/hyde-amendment> [hereinafter *A Discriminatory Ban on Insurance Coverage*].

43. See *id.* ("The Hyde Amendment currently affects people in 34 states and the District of Columbia. The remaining 16 states provide their own funding for abortion coverage for people enrolled in Medicaid.").

abortions despite the fact that it helps pay for childbirths.<sup>44</sup> The negative rights model meant that, even before *Dobbs*, the right to an abortion did not mean the right to government assistance to obtain one.<sup>45</sup> Funding restrictions, when paired with limits on abortion care permitted under the *Roe* and *Casey* regime, proved often to be complete barriers to access, especially due to the time limits on abortion care.<sup>46</sup>

The negative rights regime created by *Roe* and *Casey* left many individuals living in anti-abortion areas without a real right to abortion access at all. Without any obligation for their federal government to ensure equal access to abortion rights, Americans were powerless as “courts and state legislatures [] restricted access to abortion.”<sup>47</sup> Access inequalities were compounded in some states depending on local politics and the social climate concerning reproductive rights; ultimately, “a right to choose is valuable only to those who are able to buy termination services or have their rights to privacy respected by the state.”<sup>48</sup>

The Court’s understanding of the abortion right before *Dobbs* paired with federal and state legal policies, demonstrate a need for a new framework to protect the right to an abortion. Moving forward after *Dobbs* has eliminated any conception of a federal right, such

44. See *Maier v. Roe*, 432 U.S. 464, 469 (1977) (“The Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses of indigent women.”); *Harris v. McRae*, 448 U.S. 297, 326 (1980) (holding that the “fundamental rights” of the Constitution do not compel the government to provide resources to individuals to facilitate abortion access).

45. *Harris*, 448 U.S. at 316 (“[I]t simply does not follow that a woman’s freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices.”).

46. See *State Bans on Abortion Throughout Pregnancy*, GUTTMACHER INST. (Dec. 1, 2021), <https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions> (noting that many states ban abortions after twenty weeks, giving pregnant people three months or less to obtain an abortion). These time constraints are challenging because most individuals do not discover they are pregnant until after four to seven weeks’ gestation, providing little time to access abortion care. See *Pregnancy Week 5*, AM. PREGNANCY ASS’N, <https://americanpregnancy.org/healthy-pregnancy/week-by-week/5-weeks-pregnant/#:~:text=Weeks%20four%20through%20seven%20are,developing%20baby%20during%20your%20pregnancy> (last visited Dec. 31, 2021). In recent years, many states have continued to push the point of banning abortions earlier and earlier into pregnancy, further shrinking the window in which an individual knows about the pregnancy and can legally obtain an abortion. For example, the Texas Legislature recently passed a six-week ban on abortion; this law means many in the state will learn of their pregnancy just as their legal window expires, giving them little time—if any—to access abortion care. S.B. 8, 87th Leg. (Tex. 2021).

47. Rachel Rebouche, *Abortion Rights as Human Rights*, 25 SOC. & LEGAL STUD. 765, 774 (2016).

48. *Id.* at 775.



progress must be made cognizant that what we had before *Dobbs* was never sufficient protection.

### III: THE INTERNATIONAL HUMAN RIGHTS FRAMEWORK AS A CONTRASTING POSITIVE RIGHTS MODEL

The International Human Rights legal framework consists of conventions, treaties, and commissions that create binding rules and suggestions for nations that follow them. Human rights recognized under this framework differ in many ways, both substantively and procedurally, from “fundamental rights” recognized before *Dobbs*. This Part will first outline the general legal protections afforded to human rights under international law. Second, this Part will examine the inclusion of reproductive rights under International Human Rights law, and the protections afforded to them as a result. Finally, this Part will contrast these protections with the “fundamental rights” model discussed in the first Section, demonstrating problems and gaps that stem from their differences. These differences are exacerbated by the United States’ explicit rejection of treaties, and its refusal to be bound by International Human Rights law.

#### A. *General Human Rights Protections: Positive Rights Model*

International Human Rights laws afford individuals broad protections and assurances. Recognition of a human right “obligates [] authorities, both nationally and internationally, to fulfill their duties in delivering (or, in human rights language, promoting, securing, and protecting) that right.”<sup>49</sup> Such obligations are described as “positive duties” imposed on countries that accept them.<sup>50</sup> A positive right creates a “legally enforceable claim” to that right and requires government initiatives to protect it, such as funding programs to ensure that people have access to it.<sup>51</sup>

Often, treaties and comments include specific duties that provide for how a government must ensure a right.<sup>52</sup> For example, General

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49. Tatyana A. Margolin, *Abortion as a Human Right*, 29 WOMEN’S RTS. L. REP. 77, 79 (2007) (quoting ARJUN SENGUPTA, *THE RIGHT TO DEVELOPMENT AS A HUMAN RIGHT* 6 (2000)).

50. Rebouche, *supra* note 47, at 774.

51. Courtney Olson, *Finding a Right to Abortion Coverage: The PPACA, Intersectionality, and Positive Rights*, 41 SEATTLE U.L. REV. 655, 665 (2018).

52. Comments are interpretations and explanations of rights defined in treaties, often elaborating on the scope of a right, its areas of focus, and/or specific actions parties must take to protect it.

Comment No. 36 on the Right to Life imposes “an obligation for [] parties to adopt any appropriate laws or other measures in order to protect life from all reasonably foreseeable threats, including from threats emanating from private persons and entities.”<sup>53</sup> The human rights documents on the right to life thus provide expansive human rights protections, holding states responsible even for private threats if they infringe on such rights.

Another example comes from the Report by the Special Rapporteur on the right of universal enjoyment of the highest attainable standard of physical and mental health.<sup>54</sup> The comment says that individuals have an “entitlement” to such a right.<sup>55</sup> The comment also explains that governments “have a duty to devote maximum available resources, and to take legal and policy measures, to progressively realize the right to health.”<sup>56</sup> This obligation for action goes beyond merely providing minimal healthcare and requires “maximum” and “progressive” actions.<sup>57</sup> To fulfill its requirements, a government must expend resources and submit a report on what measures it actually took or plans to take.<sup>58</sup>

### *B. Reproductive Rights as Human Rights*

The right to have an abortion is widely protected under the International Human Rights law framework—in stark contrast to the negative rights model historically used by the United States. This Section will first analyze the historical basis for reproduction-related human rights and their incorporation into human rights conventions. Next, it will outline the preexisting human rights from which reproductive rights derive. Finally, it will compare the positive rights protections to the flimsy negative rights that protected abortion in the United States prior to *Dobbs*.

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53. U.N. Human Rights Comm., General Comment No. 36 Article 6: Right to Life, ¶ 18, U.N. Doc. CCPR/C/GC/35 (Sept. 23, 2019).

54. See Special Rapporteur, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶¶ 18, 19, U.N. Doc. A/61/338 (Sept. 13, 2006).

55. *Id.* ¶ 19.

56. *Id.*

57. *Id.*

58. See International Covenant on Economic, Social, and Cultural Rights art. 17, Jan. 3, 1976, 993 U.N.T.S. 3 [hereinafter ICESCR] (“The States Parties to the present Covenant shall furnish their reports in stages, in accordance with a programme to be established by the Economic and Social Council within one year of the entry into force of the present Covenant after consultation with the States Parties and the specialized agencies concerned.”).

## 1. Historical Introduction of Reproductive Rights

Reproductive rights entered the International Human Rights legal framework within the last century, but only in the 1990s began the process of embodying the full protections they are today.<sup>59</sup> Recognition of reproductive rights occurred through multinational convention meetings, as well as through elaboration of preexisting rights established in earlier treaties and their comments.<sup>60</sup>

The 1993 World Conference of Human Rights adopted a program of action focused on “accessible and adequate healthcare and the widest range of family planning services as well as equal access to education at all levels.”<sup>61</sup> Just a year later, the International Conference on Population Development (“ICPD”) created its program of action, which “clearly affirmed” reproductive rights as protected.<sup>62</sup> This program also created the “generally acknowledged” modern definition for reproductive health.<sup>63</sup> The 1995 Beijing Declaration and Platform for Action, developed at the Fourth World Conference on Women, again affirmed reproductive rights with a focus on equal access to both healthcare and reproductive health education.<sup>64</sup> The Fourth World Conference, together with the ICPD, introduced the mantra that “reproductive rights are human rights.”<sup>65</sup> Further conferences continued to secure reproductive rights as human rights into the 2000s.<sup>66</sup>

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59. THE DANISH INST. FOR HUMAN RTS. & U.N. HUMAN RTS. OFF. OF THE HIGH COMM’R, *REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS: A HANDBOOK FOR NATIONAL HUMAN RIGHTS INSTITUTIONS* 24 (2014) [hereinafter *Reproductive Rights Handbook*].

60. *See id.* at 24–28 (discussing the declarations and statements that introduced reproductive rights into International Human Rights law discourse, and discussing the treaties that later cemented reproductive rights as human rights).

61. World Conference on Human Rights, *Vienna Declaration and Programme of Action*, ¶ 41, U.N. Doc. A/CONF.157/23 (July 12, 1993).

62. *Reproductive Rights Handbook*, *supra* note 59, at 27.

63. *Id.*; *see also* 1994 International Conference on Population and Development, *Programme of Action*, ch. 7.2 (Sept. 13, 1994) (“[R]eproductive rights embrace certain human rights that are already recognized in national laws, international laws and [I]nternational [H]uman [R]ights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.”).

64. *Reproductive Rights Handbook*, *supra* note 59, at 27; *see also* Fourth World Conference on Women, *Beijing Declaration and Platform for Action*, ¶¶ 94–98 (Sept. 1995) (discussing various aspects of reproductive access, care, and education as rights).

65. Rebouche, *supra* note 47, at 767.

66. *See Reproductive Rights Handbook*, *supra* note 59, at 28 (discussing the history of the

## 2. Reproductive Rights Derived from Existing Rights: Treaties and Comments

Binding treaties and other instruments of international law clarify the scope of reproductive rights under International Human Rights law.<sup>67</sup> Reproductive rights are in part derivative, extracted through interpretation from other rights recognized by treaties and comments. For instance, Article 12 of the International Covenant on Economic Social and Cultural Rights (“ICESCR”) confers the right to “the enjoyment of the highest attainable standard of physical and mental health.”<sup>68</sup> Subsequent comments have clarified that reproductive rights are within the core scope of this right to health.<sup>69</sup> General comment 14 identifies “sexual and reproductive freedom” as entitlements and reproductive health as a “core” and “non-derogable” component of the right to health.<sup>70</sup> This component includes access to education about reproductive health.<sup>71</sup> Also, the comment emphasizes the availability and accessibility of, as well as the quality of, reproductive health.<sup>72</sup> Specific protections include accessible healthcare services and available contraceptives.<sup>73</sup> In addition, the comment stresses that countries must take measures, such as legislation, to ensure equal access to these entitlements.<sup>74</sup>

General comment 22 states that reproductive rights are “an integral part of the right to health enshrined in [A]rticle 12” of the ICESCR,<sup>75</sup> and that “minimum essential levels of satisfaction” of reproductive rights are core obligations under Article 12.<sup>76</sup> Nations are instructed “to repeal or eliminate laws, policies and practices that criminalize, obstruct

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development of reproductive rights into the 2000s, including the Millennium Summit of 2000, the 2005 World Summit, and the 2012 Amman Declaration).

67. *Id.*

68. ICESCR, *supra* note 58, at art. 12.

69. *See* U.N. Comm. on Econ., Soc. and Cultural Rts., General Comment No. 14: The Right to the Highest Attainable Standard of Health, art. 12, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment No. 14] (discussing reproductive rights as included in the right to health). *See generally* U.N. Comm. on Econ., Soc. and Cultural Rts., 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), U.N. Doc. E/C.12/GC/22 (May 2, 2016) [hereinafter General Comment No. 22] (elaborating further on sexual and reproductive health entitlements and standards under the Article 12 right to health).

70. General Comment No. 14, *supra* note 69, at ¶¶ 8, 44(a), 47.

71. General Comment No. 14, *supra* note 69, at ¶ 11.

72. General Comment No. 14, *supra* note 69, at ¶ 12d.

73. General Comment No. 14, *supra* note 69, at ¶¶ 16, 21, 34.

74. General Comment No. 14, *supra* note 69, at ¶ 35.

75. General Comment No. 22, *supra* note 69, at ¶ 1.

76. General Comment No. 22, *supra* note 69, at ¶ 49.

or undermine access . . . to sexual and reproductive health facilities, services, goods and information.”<sup>77</sup>

Reproductive rights also derive from rights protecting equality and non-discrimination. The Convention on the Elimination of All Forms of Discrimination against Women (“CEDAW”) protects these latter rights.<sup>78</sup> Article 10, focusing on the field of education, specifies that a woman’s right to education includes the right to access information about family health and planning.<sup>79</sup> Article 16 outlines the right to non-discrimination “in all matters related to marriage and family relations.”<sup>80</sup> Article 16 not only protects the right to “freely and responsibly” choose whether to have children, but also the right of “access to the information, education and means” to exercise that right.<sup>81</sup> CEDAW thus demonstrates how International Human Rights laws on equality and non-discrimination impliedly protect reproductive rights.

CEDAW also defines the extent to which nations must protect these entitlements, requiring states to take “all appropriate measures, including legislation, to ensure the full development” of CEDAW.<sup>82</sup> In addition, once a country ratifies CEDAW, it has a duty to report what it has done or plans to do in order to comply with its obligations.<sup>83</sup> Nations are instructed to “adopt all necessary measures at the national level aimed at achieving the full realization of the rights recognized in the present Convention,” thus imposing strong positive rights obligations.<sup>84</sup> These positive obligations demonstrate the strong grounding that reproductive and abortion rights have in anti-discrimination International Human Rights law. Not only is the right to have an abortion implied by rights in the existing framework, but CEDAW also explicitly lists obligations to enforce and ensure its realization.

Abortion rights also derive from the right to life that is recognized in many International Human Rights legal instruments, including Article 3 of the Universal Declaration of Human Rights (“UDHR”)

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77. General Comment No. 22, *supra* note 69, at ¶ 49(a).

78. Convention on the Elimination of All Forms of Discrimination against Women art. 10, 16, Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW].

79. *Id.* at art. 10.

80. *Id.* at art. 16.

81. *Id.*

82. *Id.* at art. 3.

83. *Id.* at art. 18.

84. *Id.* at art. 24.

and Article 6 of ICESCR.<sup>85</sup> The right to have an abortion is not inconsistent with the right to life: General comment 36 on ICESCR’s right to life outlines that the right demands “safe, legal and effective access to abortion” in certain situations, including where the health of the mother is at-risk or where continuing the pregnancy would cause “substantial pain or suffering.”<sup>86</sup> Comment 36’s mandate for abortion access further engrains the right to have an abortion into the legal framework developed by the UDHR.

Finally, the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (“CAT”) recognizes the right to be free from torture or degrading treatment.<sup>87</sup> Article 2 prohibits torture.<sup>88</sup> Other international reports have recognized that abuses in the reproductive sphere, including lack of safe abortion care or humiliation involved in abortion access, amount to torture and ill-treatment.<sup>89</sup> Thus, CAT impliedly protects reproductive rights.

This spectrum of derivative rights demonstrates solid footing of abortion rights within the International Human Rights law system.<sup>90</sup> Not only is the right to have an abortion derived from existing rights, but also certain instruments, like CEDAW, provide positive obligations on parties to enforce that right. This strong support for the right to have an abortion, and all that comes with it, directly contravenes the weak protections of United States abortion jurisprudence pre-*Dobbs*, presenting a potential path forward after.

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85. Universal Declaration of Human Rights art. 3, Dec. 8, 1948, U.N. Doc. A/810 at 71 [hereinafter UDHR]; ICESCR, *supra* note 58, at art. 6.

86. U.N. Human Rights Comm., *supra* note 53, at ¶ 8.

87. *See generally* Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, 1465 U.N.T.S. 85 [hereinafter CAT] (prohibiting various forms of torture and degrading treatment).

88. *Id.* at art. 2.

89. *E.g.*, U.N. Human Rights Council, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 44, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016).

90. Beyond the rights mentioned in the discussion above, reproductive rights encompass additional supporting rights worth noting. *See, e.g.*, Reproductive Rights Handbook, *supra* note 59, at 89–116 (discussing additional rights that reproductive rights derive from, including the right to marry and start a family, the right to privacy and family life, the right to information and education, and the right to benefit from scientific progress).

C. *Comparing Positive Human Rights with The United States' Negative "Fundamental Rights"*

Although International Human Rights laws have expanded to include increasing protections for reproductive health and decisions, these protections were never reflected in the United States' negative rights model before *Dobbs*. There is a glaring difference between the narrow support for the right to have an abortion previously found at the federal constitutional-level and the widespread backing of reproductive rights in International Human Rights law. The United States' framework only provided a negative rights protection against state interference with the singular "right to privacy" guaranteed by the Fourteenth Amendment.<sup>91</sup> In contrast, International Human Rights law protects the positive right of abortion, derivative of *several* other rights recognized in its framework. Furthermore, the modern United States Supreme Court does not recognize bodily integrity, non-discrimination, or even health as protected rights themselves.<sup>92</sup>

Moreover, the United States does not recognize many of the International Human Rights agreements that imply the right to have an abortion.<sup>93</sup> This failure to recognize further demonstrates the gap between American domestic laws and international laws that protect human rights. Without ratification of treaties, or even acknowledgement of comment interpretations, the United States evades accountability for its denial (at both the state and federal levels) of extensive reproductive protections governments must provide under International Human Rights law.

But the differences between United States and International Human Rights abortion law go beyond mere differences in treaty acceptance and interpretation. The "fundamental rights" protected by the Constitution are negative rights, different from the positive rights afforded by International Human Rights law.<sup>94</sup> Positive versus negative

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91. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

92. See Cass R. Sunstein, *Why Does the American Constitution Lack Social and Economic Guarantees*, 56 SYRACUSE L. REV. 1 (2005) (discussing how the U.S. Constitution and its interpretation lacks recognition of many social and economic rights).

93. See *Ratification Status for United States of America*, UNITED NATIONS: OFF. HIGH COMM'R FOR HUMAN RTS., [https://tbinternet.ohchr.org/\\_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=187&Lang=EN](https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=187&Lang=EN) (last visited Nov. 14, 2021) [hereinafter U.S. Ratification Status] (showing that the United States has not ratified several International Human Rights treaties, including CEDAW and ICESCR).

94. See FARBER & SIEGEL, *supra* note 12, at 399 ("The Court's abortion funding decisions reflect the great extent to which the U.S. Constitution protects 'negative' rights, not 'positive'").

protections can make a large difference in whether a person realizes their rights. Because negative rights simply prohibit restrictive actions, a government obligated to comply with only negative guarantees could meet its obligations by simply taking no action.<sup>95</sup> The United States’ approach, therefore, has “not kept pace with the positive duties that human rights laws impose on [nations] or with substantive concepts of equality.”<sup>96</sup> Simple inaction alone can thus further exacerbate inequalities in access to, and in realization of, rights.<sup>97</sup>

Both the federal and state governments have enacted statutes that infringe on abortion access,<sup>98</sup> in contrast to International Human Rights law’s emphasis on such access. Such restrictions directly conflict with international law that obligates nations to “repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access.”<sup>99</sup>

Thus, the body of law governing access much more narrowly protects the right to have an abortion, lacks positive entitlements, and rejects International Human Rights laws regarding abortion. Consequently, the United States’ legal regime before *Dobbs* created a huge gap in reproductive health equity and access. The “fundamental right” to an abortion was hollow—lacking state accountability to ensure accessible care for all.

#### IV: ASSESSING HUMAN RIGHTS ADVOCACY AND SELF-MANAGED CARE

Across the globe, advocates are working to address both violations of human rights and inequalities in accessing such rights. After *Dobbs* eliminated federal protections for abortion, the United States is in dire need of advocacy strategies to fill the gap. However, as demonstrated in prior discussion, the federal abortion right was never sufficient, and these advocacy strategies demonstrate a potential new way forward. First, this Part outlines common goals of advocacy efforts to expand access to abortion care. Second, it assesses one such effort, the

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rights.”).

95. Edward Rubin, *The Affordable Care Act, the Constitutional Meaning of Statutes, and the Emerging Doctrine of Positive Constitutional Rights*, 53 WM. & MARY L. REV. 1639, 1687 (2012).

96. Rebouche, *supra* note 47, at 774.

97. See Rebouche, *supra* note 47 (explaining that “positive rights are instrumental to participation” because people are less likely to participate in politics if they do not have basic necessities).

98. See *supra* Part II.

99. General Comment No. 22, *supra* note 69, at ¶ 49(a).



promotion of self-managed abortion care. Finally, this Part evaluates self-managed abortion care as a potential solution to restrictions on abortion access, demonstrating both how self-managed abortion care is already being used as well as barriers to its further adaptation.

### *A. Human Rights Advocacy Goals*

Human rights advocacy efforts often help people realize specific rights while simultaneously appealing to broader human rights principles. Professors Gostin and Meier’s work on human rights advocacy provides insights on the keys to successful movement-making in this realm,<sup>100</sup> as does the work of Amon, Wurth, and McLemore.<sup>101</sup> Advocacy often proves successful at increasing practical exercise of rights.<sup>102</sup> Goals of human rights efforts are broadly defined by three categories: (1) documentation of abuses and raising awareness, (2) coalition building and community engagement, and (3) reforms in “law, policy, and practice.”

The first goal of the human rights advocacy structure can be segmented between documentation and raising awareness.<sup>103</sup> Successful advocacy efforts focus on documenting a problem with credible evidence to substantiate claims of human rights abuse.<sup>104</sup> Effective advocacy demands “clear and persuasive evidence,”<sup>105</sup> which often requires identifying a violation, the violator, and various other stakeholders involved.<sup>106</sup> Evidence of abuses can come from policies and their impact, interviews and testimony of lived experiences, surveys, and media reports, among other sources.<sup>107</sup> Advocates, however, must be wary of potential biases in data collection and sources, as such biases could lead advocates to misunderstand the abuse and undermine the integrity of the documentation.<sup>108</sup> In addition, in documenting the abuse and initiating changes, it remains vital that

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100. LAWRENCE O. GOSTIN & BENJAMIN MASON MEIER, *FOUNDATIONS OF GLOBAL HEALTH & HUMAN RIGHTS* (2020).

101. See Joseph J. Amon, Margaret Wurth & Megan McLemore, *Evaluating Human Rights Advocacy on Criminal Justice and Sex Work*, 17 *HEALTH & HUM. RTS. J.* 91 (2015) (evaluating advocacy for sex workers according to a framework of goals)

102. See, e.g. Gostin, *supra* note 100, at 133 (evaluating the success of advocacy efforts in health justice in meeting human rights goals); Amon, *supra* note 101, at 91 (evaluating advocacy for sex workers according to a framework of goals).

103. Gostin, *supra* note 100, at 139.

104. Gostin, *supra* note 100, at 139.

105. Gostin, *supra* note 100, at 139.

106. Amon, *supra* note 101, at 93.

107. Gostin, *supra* note 100, at 139.

108. Gostin, *supra* note 100, at 139.

advocacy efforts focus on “elevating the voices of people affected” by such issues.<sup>109</sup>

The second component uses documentation to “name” the issue and raise awareness.<sup>110</sup> Awareness is key to both pushing those in power to implement change, as well as to bringing the problem into the public eye.<sup>111</sup> This process can involve sharing research findings with public officials and drafting policy reports or press releases.<sup>112</sup> Public campaigns are also strong tools for advocacy.<sup>113</sup> Previous public visualizations of abuse, such as mock coffins memorializing those who died from AIDS or the “maternal death clock” in Times Square to emphasize the maternal mortality crisis, produced public shock and awareness to documented human rights abuses.<sup>114</sup> In addition, the framing of the discussion impacts the degree of attention an issue receives. For example, naming an issue a “human rights violation” may bring added weight and severity to the public’s conception of it.<sup>115</sup>

The second overarching goal of human rights advocacy is community engagement and coalition building.<sup>116</sup> This goal emphasizes the importance of forming ties with other organizations and groups, which includes both engaging with other professions and connecting with local communities where the violations at issue occur.<sup>117</sup> For example, in the realm of health justice, a coalition might include healthcare providers, community organizations, scientists, and environmentalists.<sup>118</sup> Linking with other like-minded groups strengthens an advocacy movement.<sup>119</sup> Often, there already exists a strong activist community focused on the issue at the ground-level.<sup>120</sup>

109. Gostin, *supra* note 100, at 133.

110. Gostin, *supra* note 100, at 139.

111. Gostin, *supra* note 100, at 140 (“[T]hrough both private meetings and public campaigns.”); Amon, *supra* note 101, at 93–94 (“[S]ought to generate press coverage about abuses and to persuade governments to engage directly with stakeholders and advocates.”).

112. See Amon, *supra* note 101, at 94 (“Before and directly after our research was published, we shared our findings and requested meetings with advocacy targets in each city . . .”); Gostin, *supra* note 100, at 140 (discussing policy documents).

113. See Gostin, *supra* note 100, at 140–41 (discussing various methods of bringing awareness to issues including key public campaigns).

114. Gostin, *supra* note 100, at 141.

115. Amon, *supra* note 101, at 94.

116. Gostin, *supra* note 100, at 139.

117. Gostin, *supra* note 100, at 142–43.

118. Gostin, *supra* note 100, at 142.

119. See Gostin, *supra* note 100, at 143 (discussing examples of successful advocacy from coalition building).

120. See Amon, *supra* note 101, at 94 (discussing “vibrant” activist communities in the cities in which they worked on rights issues relating to HIV prevention and LGBTQ rights).

Connecting with these communities builds on a body of preexisting work and research, and also aids in centering the voices of those directly affected by the harms.<sup>121</sup>

The third element of human rights advocacy centers on reform. Reform can be as simple as implementing a preexisting, but ignored policy, or implementing a given policy more equitably.<sup>122</sup> Human rights advocates have lobbied for various types of reform, including additional constitutional protections, new legislation, changes to organizational or professional policy, and simple alterations to practice norms.<sup>123</sup> Altering existing practices within the same legal framework, undertaken at the ground-level, is important because other reforms “may not be implemented or [may not] directly affect vulnerable populations.”<sup>124</sup> This difference has been recognized by human rights advocates as “the gap between ‘laws on the books’ and laws on the streets.”<sup>125</sup> This distinction may be especially relevant in the field of healthcare, as provider practices may deviate sharply from policies.<sup>126</sup> Reform can also strengthen the normative support for and acceptance of a right, which aids access to and facilitates broad discussion about said right.<sup>127</sup> Normalization and increased public support for a right can reflect reforms and even force change.

### *B. Self-Management as an Advocacy Effort*

The United States’ current abortion law, while never sufficiently addressing access and inequality due to the flawed negative rights approach, currently stands very bare. *Dobbs* ruled that “abortion is not a fundamental constitutional right,”<sup>128</sup> leaving policy and restrictions entirely to states,<sup>129</sup> many of which are hostile and inclined to ban the medical procedure outright. Thus, for the time being the United States is left with abhorrent abortion rights protections. Human rights advocacy efforts present a potential solution to this past and present

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121. See Amon, *supra* note 101, at 94.

122. Gostin, *supra* note 100, at 145.

123. Gostin, *supra* note 100, at 144–45; see also Amon, *supra* note 101, at 95.

124. Amon, *supra* note 101, at 95.

125. Gostin, *supra* note 100, at 145.

126. Gostin, *supra* note 100, at 145.

127. See Amon, *supra* note 101, at 92 (discussing “norm internalization” of human rights and social and public spaces as an indicator of change).

128. 142 S. Ct. 2228, 2283.

129. See *id.* at 2284 (“The Constitution does not prohibit the citizens of each State from regulating or prohibiting an abortion. *Roe* and *Casey* arrogated that authority. We now overrule those decisions and return that authority to the people and their elected representatives.”).

crisis. The following subsection introduces self-management as a potential advocacy solution moving forward and evaluates its successes and shortcomings in light of overarching human rights advocacy goals.

### 1. Introduction to Self-Managed Approaches

Self-managed abortion care could potentially remedy the issues created by current state and federal law. The reality of contemporary safe self-managed care differs greatly from the common misperception that self-managed care always entails dangerous “back-alley” methods.<sup>130</sup> Medication abortion promises a safe and effective way for pregnant individuals to manage their own abortions, outside a clinic or healthcare facility. A self-managed model would provide anyone wanting to terminate their pregnancy access to these medications without relying on the formal, traditional healthcare system. Much evidence shows that individuals can safely manage abortions this way.<sup>131</sup>

Various international organizations advocate for access to self-managed abortion care to remedy reproductive rights violations. Many of these efforts consist of online consultations and delivery of medication abortion supplies to individuals seeking care their home state cannot or will not provide.

One such advocacy organization is Women on Web. Founded in 2005 by Dr. Rebecca Gomperts, this Canadian nonprofit organization provides self-managed care to individuals across the globe.<sup>132</sup> In 2017, the World Health Organization (the “WHO”) identified Women on Web as a “safe abortion” service.<sup>133</sup> Women on Web’s team consists of doctors, researchers, activists, and more.<sup>134</sup> Its services include online consultations and delivery of medication abortion or contraceptives

130. Megan K. Donovan, *Self-Managed Medication Abortion: Expanding the Available Options for U.S. Abortion Care*, 21 GUTTMAHNER POL’Y REV. 41 (2018).

131. See Lucia Berro Pizzarossa & Patty Skuster, *Towards Human Rights and Evidence-Based Legal Frameworks for (Self-Managed) Abortion: A Review of the Last Decade of Legal Reform*, 23 HEALTH AND HUMAN RIGHTS J. 199, 201 (2021) (“There is extensive evidence showing that mifepristone and misoprostol or misoprostol alone can be self-administered to induce a safe, discrete and non-invasive abortion.”).

132. *Who We Are?*, WOMEN ON WEB, <https://www.womenonweb.org/en/page/521/who-we-are> (last visited Oct. 25, 2022) The organization’s stated mission is “to provide safe, accessible and affordable online abortion care to women and people around the world.” *Id.*

133. Sarah Boseley, *Almost Half of all Abortions Performed Worldwide are Unsafe, Reveals WHO*, THE GUARDIAN (Sept. 27, 2017), <https://www.theguardian.com/world/2017/sep/27/almost-half-of-all-abortions-performed-worldwide-are-unsafe-reveals-who>.

134. *Who We Are?*, WOMEN ON WEB, *supra* note 132.

through the mail.<sup>135</sup> It also has a 24-hour “help desk” team to aid individuals throughout the self-managed process.<sup>136</sup> Each month, Women on Web receives 10,000 emails requesting help.<sup>137</sup> By 2017, after twelve years of service, Dr. Gomperts estimated that her organization assisted over 70,000 individuals in accessing self-managed abortions.<sup>138</sup>

Although Women on Web serves individuals globally, it does not ship to the United States.<sup>139</sup> Aware of the organization’s global importance, Dr. Gomperts did not want to “potentially jeopardize” its services.<sup>140</sup> Dr. Gomperts and the Women on Web team feared that the “aggressive anti-abortion movement” in the United States would try to shut down its services.<sup>141</sup> Instead, Aid Access, a separate organization with the same mission as Women on Web, serves individuals in the United States.<sup>142</sup> Aid Access functions similarly to Women on Web by providing initial consultations and then shipping medications.<sup>143</sup> In states where medications for abortion can be provided via mail, individuals are connected with a United States physician.<sup>144</sup> However, in the numerous states that have restrictions on medication access through the mail, individuals are connected to pharmacies in other countries, which provide them with the necessary medications.<sup>145</sup>

In 2017, researchers published a study of women in Ireland and Northern Ireland who used Women on Web for self-managed abortion care.<sup>146</sup> This study revealed the grave need for organizations like Women on Web, some people deeming self-managed care an “essential

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135. *Who We Are?*, WOMEN ON WEB, *supra* note 132.

136. *Who We Are?*, WOMEN ON WEB, *supra* note 132.

137. Olga Khazan, *Illegal Abortion Will Mean Abortion By Mail*, THE ATLANTIC (July 18, 2018), <https://www.theatlantic.com/health/archive/2018/07/after-abortion-is-illegal/565430/>.

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.*

142. See generally AID ACCESS, <https://aidaccess.org/en/> (last visited Oct. 25, 2022); see also Nivedita Jauakumar, *Women on Web Making Self-Managed Safe Abortion Accessible*, FEMINISM IN INDIA (Feb. 5, 2020), <https://feminisminindia.com/2020/02/05/women-on-web-self-managed-safe-abortion/> (describing the creation of a new organization to insulate Women on the Web from American anti-abortion sentiment).

143. See *Consultation*, AID ACCESS, <https://aidaccess.org/en/i-need-an-abortion> (last visited Oct. 25, 2022).

144. *Id.*

145. *Id.*

146. Abigail R.A. Aiken et. al., *Experiences and Characteristics of Women Seeking and Completing At-home Medical Termination of Pregnancy Through Online Telemedicine in Ireland and Northern Ireland: A Population-based Analysis*, 124 BJOG 1 (July 2017).

service” based on their circumstances.<sup>147</sup> The women surveyed reported “overwhelmingly positive” experiences with Women on Web, “especially in light of their alternatives.”<sup>148</sup> Of those who self-managed their care through Women on Web, 97 percent thought it was “the right choice for them” and 98 percent would recommend the service to others in similar circumstances.<sup>149</sup>

Aid Access has also met a grave need in the United States, receiving over 57,000 requests nationwide within the first two years of its existence.<sup>150</sup> Request locations have corresponded with the severity of local restrictions: areas more hostile to abortion generate more requests.<sup>151</sup> For example, Aid Access “experienced a steep increase in requests” from Texas after the state passed a law in September 2021 that banned most abortions.<sup>152</sup>

## 2. Meeting the Advocacy Goals

Self-managed advocacy efforts such as Women on Web and Aid Access respond to rights violations in ways consistent with broader human rights advocacy goals. Widespread use of its services, media attention, and individual story sharing aid the first goal of documentation and awareness, by calling attention to gaps in abortion access. Documentation of intake requests and the geographic scope of such requests reveal the state of global access to abortion care. Further, the information gathered by Women on Web and Aid Access contributes to the overall body of knowledge on reproductive rights abuses.

Both organizations’ websites also provide testimonials of individuals who accessed self-managed abortion care.<sup>153</sup> Organizational credibility is boosted by centering these individual experiences that demonstrate the need to “break[] the silence around abortions.”<sup>154</sup> These organizations also post stories and information about self-

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147. *Id.* at 6.

148. *Id.* at 7.

149. *Id.* at 5–6.

150. Samantha Schmidt & Sammy Westfall, *Abortion Pills are Booming Worldwide. Will Their Use Grow in Texas?*, WASH. POST (Sept. 14, 2021), <https://www.washingtonpost.com/world/2021/09/14/abortion-pills-texas/>.

151. *Id.*

152. *Id.*

153. *Testimonials*, AID ACCESS, <https://aidaccess.org/en/page/698623/testimonials> (last visited Oct. 25, 2022); *I Had an Abortion*, WOMEN ON WEB, <https://www.womenonweb.org/en/page/488/i-had-an-abortion> (last visited Oct. 25, 2022).

154. *I Had an Abortion*, WOMEN ON WEB, *supra* note 153.

managed care via social media to raise awareness.<sup>155</sup> Their international reaches, evidenced by data, support the claim that lack of abortion access is a global problem that cannot be avoided by simple relocation.

Self-managed advocacy efforts also engage in coalition building, consistent with the second goal of human rights advocacy. Both Women on Web and Aid Access have teams with doctors, researchers, activists, and other volunteers,<sup>156</sup> thereby strengthening advocacy by bringing diverse cross-professional voices to the discussion.

These organizational efforts also lead to changes in practice, consistent with the third goal of human rights advocacy. Instead of waiting for hostile governments to change their policies, self-managed abortion care advocates provide access from the ground-up. Although individual states may be hostile to abortion, advocacy efforts nonetheless provide individuals with accessible care. These efforts make a difference in individuals' lives by providing methods beyond those offered by restrictive medical systems. In addition, the organizations can use documented abuses and awareness in their efforts to work legal changes. For example, in 2019, Aid Access filed a complaint in Idaho federal court against restrictions on medication abortions.<sup>157</sup> Law-based approaches like these demonstrates the relationship between human rights advocacy goals and the potential for self-managed advocates to push for changes at all levels.

Women on Web's testimonials feature can also help bolster normative support for the right to have an abortion.<sup>158</sup> These testimonials state reasons for abortions beyond health justifications, centering the idea that "abortions happen for all kinds of reasons."<sup>159</sup> Emphasizing other rights such as equality and autonomy communicates that supporting the right to have an abortion extends beyond health concerns. Medical necessity is important, but it is not the only reason to support this right. Thus, these testimonials strengthen

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155. See *In the Media*, WOMEN ON WEB, <https://www.womenonweb.org/en/page/11477/in-the-media> (last visited Oct. 25, 2022) ("[W]e aim to contribute to the production and dissemination of evidence-based knowledge and a rights-based language on abortion access, and break the abortion stigma."); *Media About Aid Access*, AID ACCESS, <https://aidaccess.org/en/page/202312/media-about-aid-access> (last visited Oct. 26, 2022).

156. See *Who We Are?*, WOMEN ON WEB, *supra* note 132; *Who Are We*, AID ACCESS, <https://aidaccess.org/en/page/561/who-are-we> (last visited Oct. 26, 2022).

157. *Legal Complaint Against the FDA*, AID ACCESS, <https://aidaccess.org/en/page/302089/legal-complaint-against-the-fda> (last visited Nov. 13, 2021).

158. See *I Had an Abortion*, WOMEN ON WEB, *supra* note 153 ("Abortions are common, they are normal and they are [okay] – and there's nothing wrong with having one.")

159. *Id.*

normative support and are linked to the broader goals of changing both practice and policy. The lived experiences of those seeking an abortion are at the core of the abuses and enforcing the individual experience is at the core of the self-managed goal.

### 3. Limitations and Shortcomings

Despite all the goals met through self-managed abortion care advocacy efforts, there are also potential shortcomings with such advocacy, especially when implemented in areas with hostile governments.<sup>160</sup> For one, due to fear of being exposed, efforts to document and raise awareness are limited by anonymity. An advocacy effort's credibility can be strengthened by firsthand accounts; but these accounts are usually anonymous when it comes to self-managed care in hostile jurisdictions. Individuals in hostile countries such as Northern Ireland and the United States are encouraged to never admit to self-management, or to discuss how they obtained such medications.<sup>161</sup>

Stemming from these obstacles, many of those surveyed who used Women on Web expressed frustration and anger with their situations, reporting that they feel like “second-class citizens” because of their inability to have abortions outside of the self-managed context.<sup>162</sup> Further, self-managed care organizations also cannot provide support systems for users in jurisdictions hostile to abortion rights, despite users feeling alone and silenced because of “the social stigma and a fear of prosecution.”<sup>163</sup> This fear certainly exists for individuals seeking self-managed care in the United States, where they risk legal backlash.<sup>164</sup>

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160. For the United States specifically, since the *Dobbs* decision, hostile state governments have presented stronger obstacles than ever, attempting to ban abortion pills and self management systems. See Rachel M. Cohen, *What a Lawsuit in Mississippi Tells Us About the Future of Abortion Pills*, VOX, June 29 2022, <https://www.vox.com/2022/6/29/23186564/medication-abortion-genbiopro-roe-dobbs-pills>; *GenBioPro Gives Up Abortion Pill Suit Against Mississippi*, BLOOMBERG LAW, Aug. 19 2022, <https://news.bloomberglaw.com/health-law-and-business/genbiopro-gives-up-abortion-pill-suit-against-mississippi>. For a discussion on These battles are new, ongoing, and many strategies are not fully developed, so the outcome has yet to be established. But, the cases demonstrate that the overhaul of any federal protection creates the strong possibility of many uphill battles in access to medication abortion in hostile states for the years to come. For a discussion on the ongoing uncertainty surrounding self-managed care and the relationship between state law and the FDA, see *infra* notes 171–86.

161. See Khazan, *supra* note 137; Abortion Pills FAQ: Safety Considerations, PLAN C, <https://www.plancpills.org/guide-how-to-get-abortion-pills#faq> (last visited Oct. 26, 2022).

162. Aiken, *supra* note 146, at 7.

163. Aiken, *supra* note 146, at 9.

164. Khazan, *supra* note 137; Abortion Pills FAQ: Safety Considerations, PLAN C, <https://www.plancpills.org/guide-how-to-get-abortion-pills#faq> (last visited Oct. 26, 2022).



Self-reporting surveys also carry with them potential bias concerns. For example, the study of Women on Web users in Northern Ireland received overwhelmingly positive feedback.<sup>165</sup> But not all users followed up or identified themselves for participation in the first place, indicating a possible bias in the sample of users who opted to give feedback. Biases in documented evidence are weak spots for advocates, potentially affecting the legitimacy of the evidence they rely on to push for change.

In addition, although self-managed advocacy efforts provide strong examples of coalition building across professions and experiences, advocates may lack connection with local communities. Both Women on Web and Aid Access serve global users, a geographic scope that may impede their ability to form local connections. Although individual users do get consultations, they receive no local support. Robust local support would likely require sacrifice of geographic scope due to resource constraints. Yet, even if these organizations could overcome their resource constraints and form local community connections, they would be legally constrained: after all, local laws and restrictions are often the cause of individuals seeking out self-managed care in the first place.

Because of their global focuses, organizations such as Women on Web and Aid Access are unable to advocate for structural or policy changes in all areas they serve. The study done in Northern Ireland reported continued frustrations among individuals who successfully terminated their pregnancies through self-managed care because of local policies.<sup>166</sup> Although Women on Web may alter some access experiences, it cannot provide the *full* array of reproductive experiences and treatments.

Although these organizations have engaged in some efforts for higher-level changes,<sup>167</sup> the sheer number of locations they service limits their abilities to change access wholesale. Broader structural changes are likely difficult without local coalitions. Once again, this difficulty goes back to the total resources available to an organization. The decision to focus on actual realization of self-managed abortion care access may come at the expense of broader policy changes in some locations.

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165. Aiken, *supra* note 146, at 7.

166. Aiken, *supra* note 146, at 7.

167. *See, e.g.*, Legal Complaint Against the FDA, *supra* note 157 (advocating for a change in federal policy with regard to abortion medication).

In connection with their inability to effect structural changes, organizational efforts that enable practical access to abortions come with other limitations. The study in Northern Ireland highlighted the lack of social and economic support individuals had during the self-managed process.<sup>168</sup> Those with less financial resources were the most likely to lack such support.<sup>169</sup> The study reveals that financial inequity limits how far self-managed advocacy can go without broader structural support. Aid Access's support for users in regions of the United States hostile to abortion also faces temporal and financial constraints. Individuals in these states must order medication through foreign pharmacies that need up to three weeks to deliver the medications and charge \$105 dollars for them.<sup>170</sup> Individuals lacking financial resources, or who are further along in their pregnancies, may be unable to overcome such burdens.

Overall, self-management organizations such as Women on Web and Aid Access meet many human rights advocacy goals and provide vital resources to help bridge gaps in global abortion care access. Their advocacy efforts must continue to be flexible and adaptive in their methods, as they face hostile states and a lack of structural, political, or social support. Though these obstacles limit organizational ability to completely meet advocacy goals, these efforts remain vital, and they stand as stories of human rights advocacy successes.

### *C. Self-Managed Models in the United States*

Aid Access demonstrates how self-managed abortion is a potential solution to the access crisis stemming from United States' lack of abortion protection. Self-managed care circumvents many regulatory obstacles such as waiting periods, costs, consent requirements, and sparse clinic locations—prohibiting access before *Dobbs* and worsening in the aftermath.<sup>171</sup> Reported numbers make clear that Aid

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168. Aiken, *supra* note 146, at 9 (concluding that the study brought “attention to a profound inequity in reproductive health access.”).

169. *Id.* at 7 (“[W]omen with the fewest financial resources are still more likely to lack social and emotional support during and after at-home TOP [termination of pregnancy].”).

170. *Consultation*, AID ACCESS, *supra* note 143.

171. See, e.g., *GenBioPro Gives Up Abortion Pill Suit Against Mississippi*, BLOOMBERG LAW, Aug. 19 2022, <https://news.bloomberglaw.com/health-law-and-business/genbiopro-gives-up-abortion-pill-suit-against-mississippi> (describing the legal battle between pharmaceutical company GenBioPro and the State of Mississippi). The company voluntarily dismissed the suit in August 2022, but “GenBioPro however is signalling that it isn’t finished trying to get its product to consumers.” *Id.* Many doctors continue to prescribe abortion medication for patients who receive their self-managed option in the mail, but the *Dobbs* decision and the legal uncertainty

Access has taken steps to make self-management an increasingly accessible option.<sup>172</sup> Expansion of this organization, or the creation of additional organizations providing similar services, would likely increase the availability of medication abortion to a broad group of individuals seeking them. Self-managed care also serves Americans who distrust the medical system.

Advocacy efforts, however, face unique challenges due to laws and policies that severely restrict self-managed care. On December 16, 2021, the United States Food and Drug Administration (“FDA”) partially rolled back its long-standing restrictions on medication abortion,<sup>173</sup> permitting distribution of mifepristone through telehealth and by mail.<sup>174</sup> However, the FDA kept policies in place that regulate provider and distributor qualifications, and even created a new pharmacy certification requirement.<sup>175</sup> Additionally, the FDA’s website now contains a disclaimer specifically addressing online options for self-managed medication abortion, advising people to not buy Mifeprex<sup>176</sup> over the internet.<sup>177</sup> In 2019, the FDA issued a warning to Aid Access, demanding that it cease its services and claiming that it “violated federal law by introducing ‘misbranded and unapproved new drugs’ into interstate commerce.”<sup>178</sup> Despite these actions, however, the easing

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surrounding it has predictably chilled some patients and providers. *See* Ruth Reader, *Galvanized by Dobbs, More Doctors Are Distributing Abortion Pills by Mail*, POLITICO, (Sept. 21, 2022), <https://www.politico.com/news/2022/09/21/dobbs-abortion-pills-roe-00057877> (“Though primary care doctors could provide medication abortion, many are reluctant to do so.”).

172. Schmidt & Westfall, *supra* note 150.

173. Questions and Answers on Mifeprex, FDA (Dec. 16, 2021), <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex>. In 2000, the United States Food and Drug Administration (“FDA”) imposed burdensome Risk Evaluation and Mitigation Strategies (“REMS”) on the abortion medication mifepristone, “despite its extensive safety record.” Donovan, *supra* note 130, at 42. The original REMS severely limited who could prescribe mifepristone and where and how it could be dispensed. Mifeprex (mifepristone) Information, FDA (Apr. 13, 2021), <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information> (“Mifeprex must be ordered, prescribed and dispensed by or under the supervision of a healthcare provider who prescribes and who meets certain qualifications.”)

174. *See id.* (eliminating the “in person” requirement of the REMS).

175. *See id.* (adding the pharmacy certification requirement). *See also* Mifeprex (mifepristone) Information, FDA (Apr. 13, 2021), <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information> (listing the REMS that remain in place).

176. The brand name for mifepristone.

177. Mifeprex (mifepristone) Information, *supra* note 175.

178. Schmidt & Westfall, *supra* note 150 (quoting Warning Letter from Thomas Christi, Dir., Office of Drug Security, Integrity, and Response, U.S. Food and Drug Administration to Aidaccess.org (Mar. 8, 2019), <https://www.fda.gov/inspections-compliance-enforcement-and->

of restrictions created the potential for a federal embrace of the self-managed model.<sup>179</sup>

Unfortunately, several states have also recently added localized restrictions on abortion medications. In 2021 alone, six states passed laws with supplemental restrictions on delivery of abortion pills through the mail.<sup>180</sup> For example, Texas law bans prescribing abortion pills through mail *or* telehealth with a severe penalty: up to a \$10,000 fine and potential jail time.<sup>181</sup> And after *Dobbs* eliminated federal protections for abortion, further clearing the path to pass restrictions, many more hostile states may follow this example.

In addition to restrictions on accessing medications, individuals in many states may face a risk of criminal consequences for self-management. As of 2018, twenty-five states had some law in place that could be used to criminalize self-managed abortions.<sup>182</sup> Seven of those states had laws that directly target self-management even before the *Dobbs* decision.<sup>183</sup> Further, laws that indirectly take aim at self-management include “concealment of a birth” laws, as well as laws that prohibit improper “disposal of human remains.”<sup>184</sup> Although uncommon, enforcement of these laws does occur, and self-management does carry a real risk of criminal charges.<sup>185</sup> In the past twenty years, at least two dozen people have been prosecuted under such laws for having self-managed abortions.<sup>186</sup> These individuals include those who disposed of remains in sewers, those who confided

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criminal-investigations/warning-letters/aidaccessorg-575658-03082019).

179. While a change for the better with regard to abortion access, advocates should proceed with caution. The FDA is ultimately controlled by the President, and thus this welcome change was due to a change in administration. See Commissioner, FDA, (Feb 27, 2022), <https://www.fda.gov/about-fda/fda-organization/robert-califf> (listing Robert M. Califf as the current commissioner. The Commissioner is nominated by the president and head of the FDA). Thus, the mifepristone “in person” requirement has the potential to become yet another “political football” shifting back in forth as administrations turn over.

180. Ashley Lopez, *Prescribing Abortion Pills Online or Mailing Them in Texas Can Now Land You in Jail*, NPR (Dec. 6, 2021), <https://www.npr.org/sections/health-shots/2021/12/06/1060160624/prescribing-abortion-pills-online-or-mailing-them-in-texas-can-now-land-you-in-j>.

181. *Id.* See also S.B. 4, 87th Leg. 2d Called Sess. (Tex. 2021).

182. Donovan, *supra* note 130, at 45. These numbers have also grown in recent years. See Center for Reproductive Rights, *2021 Legislative Wrap Up*, available at <https://reproductiverights.org/wp-content/uploads/2022/01/2021-Legislative-Wrap-up.pdf>, at 4 (“In 2021 alone, [fifteen] states introduced [twenty-three] restrictive medication abortion bills, nine of which were enacted.”).

183. Donovan, *supra* note 130, at 45.

184. Donovan, *supra* note 130, at 45.

185. Abortion Pills FAQ: Safety Considerations, *supra* note 164.

186. Abortion Pills FAQ: Safety Considerations, *supra* note 164.

in friends who subsequently reported them, and those who had significant others go through their internet search histories before reporting them.<sup>187</sup> The status of the law in the United States requires has led many common online aids in obtaining self managed care to outline and explain the potential legal implications that come with such a decision.<sup>188</sup> *Dobbs*' elimination of federal protections permits states to enact new restrictions, opening the door to more self-management prosecutions moving forward.<sup>189</sup>

The unique polices and restrictions in the United States create an uphill battle for individuals seeking to obtain self-managed abortion care. Although this option is available to those who look for it, accessing self-managed abortion care poses risks. Nevertheless, organizations continue to find ways to help individuals,<sup>190</sup> yet self-management advocacy goals are unlikely to be further advanced without structural backing and legal permission. However, moving forward after *Dobbs* requires creative advocacy strategies such as self-management in order to continue abortion access for many living in areas where the right is heavily restricted or even banned.

#### CONCLUSION

Self-managed abortion care presents individuals with the means to take charge of their reproductive decisions and avoid a restrictive and often biased medical system. However, an ideal self-managed system should not mean "going it alone."<sup>191</sup> It should also not include fear of legal or criminal backlash. Unfortunately, these are the realities faced by advocacy efforts in the United States. Improvements to abortion access in the United States cannot move forward without radical changes to domestic policy. While self-managed care exists in the United States, the self-managed system needs more legal support and accountability for states. This backing was limited even before the *Dobbs* decision, and the practical limitations of self-managed care

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187. Abortion Pills FAQ: Safety Considerations, *supra* note 164.

188. See e.g., Abortion Pills FAQ: Safety Considerations, PLAN C, <https://www.plancpills.org/guide-how-to-get-abortion-pills#faq> (last visited Oct. 26, 2022).

189. <https://www.help.senate.gov/imo/media/doc/8.01.2022%20Final%20Post-Dobbs%20Report.pdf> ("Now that Roe has been overturned and states are passing more restrictive laws, even greater numbers of women are likely to be prosecuted and face potential prison sentences for seeking or obtaining abortions or for having miscarriages.").

190. Schmidt & Westfall, *supra* note 150.

191. Donovan, *supra* note 130, at 44.

remain open questions, especially after the Supreme Court eliminated any notion of a federal protection to the right to procure an abortion.

In contrast to American law, reproductive rights in International Human Rights law mandate positive obligations to provide abortion services and eliminate barriers to getting abortions.<sup>192</sup> These positive obligations, if imposed on American states, would provide needed support under a self-managed system, keeping individuals from living in fear and having to tackle the process alone. This, therefore calls for the United States to bring human rights home. The current policy landscape leaves many individuals without a choice and inhibits self-managed care. To move forward after *Dobbs*, the United States must recognize the *Roe* right was never enough, and instead adopt a positive rights model. Without the obligations that accompany a positive rights model, a state with restrictive laws will never be held accountable to whom it effectively denies the right to have an abortion. Bringing human rights home would give individuals in the United States the legal backing and additional support needed throughout their self-managed process of accessing an abortion.

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192. See Pizzarossa & Skuster, *supra* note 131, at 202–03 (discussing the reproductive rights obligations for states stemming from various treaties and comment interpretations).