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Article

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A right to health case for access to affordable procreative assistance

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ABSTRACT

This article contends that States have procedural and aspirational obligations towards the provision of affordable procreative assistance. I locate this obligation on a normative understanding of the human right to reproductive health that accounts for lived experiences of reproductive decision-making and involuntary childlessness. I argue that while involuntarily childlessness should not be viewed as a disease or pathology, there is nevertheless, a healthcare entitlement to procreative assistance as a means of furthering valued liberties and autonomies.
Further, this article argues that involuntary childlessness arising from 'social' reasons is sufficiently similar to instances where it is caused by physiologically diagnosable infertility. Drawing on this, I make a case for parity in access for same sex couples, older women, single women, and seekers from underserved communities.

KEYWORDS: right to health, reproductive justice, procreative assistance, socio-economic rights, IVF, fertility.

1. INTRODUCTION

In this article, I argue that the right to health under Article 12 of the International Covenant of Economic, Social, and Cultural Rights (ICESCR) includes an entitlement to access procreative assistance through Assisted Reproductive Technologies (ART(s)). This includes pregnancy producing ARTs (including intra-uterine insemination, artificial insemination, in-vitro fertilisation) and fertility preserving ARTs (including gamete cryopreservation and storage). Healthcare justice requires allocation of resources for the advancement and equalisation of biological functions and capabilities that are valued by people and society. I develop a socially-embedded, contemporary account of reproductive decision-making to argue that reproductive systems are special because they function within bodies and also within societies to enable individuals' pursuit valued capabilities. Based on this functional account of reproductive health, I propose an argument for locating an entitlement to access assisted reproduction within Article 12. To achieve this, I bring together philosophical approaches to just healthcare distribution, sociological approaches to embodiment, and the World Health Organisation (WHO) definition of reproductive health.

Unpacking the right to fulfil Article 12 demonstrates the importance of assisted reproduction at the individual level, and simultaneously, provides guidance on the design of healthcare

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rationing and policy. This paper's contextually informed characterisation of the reproductive health has several implications. Chief among these is that states should take progressive steps to ensure that ARTs are accessible for all those who seek them, unless there are strong justifications to deny provision. I argue for parity in access to pregnancy producing ARTs for those who can be physiologically diagnosed as infertile, as well as those who are involuntarily childless for other reasons. Similarly, I argue for parity in access to fertility preserving ARTs, irrespective of peoples' reason for seeking them. I base this claim on the idea that assisted reproduction is, by design, a means to equalise relevant health capabilities across groups disproportionately affected by reproductive pressures.

2. A BRIEF OVERVIEW OF THE RIGHT TO REPRODUCTIVE HEALTH

2.1. Origin and evolution of the right to reproductive health

Until recently, recognition of reproductive health as a human right 'remain(ed) in flux, its development unfinished, its contours uncertain, and its widespread international acceptance tenuous'.[1] The phrase reproductive health does not appear in any international human rights treaty. International programmes of action adopted at conferences held in Cairo and Beijing in the years 1994 and 1995, however, defined reproductive health (ICPD definition), and affirmed that it is part of the right to the highest attainable standard of health.[2] While it was mentioned in several international programmes of action, the treatment of reproductive health has been 'sporadic, piecemeal, and indirect'.[3] The international legal community is yet to develop the content of normatively and legally independent right to reproductive health.[4]

In fact, it was only in 2016, that the Committee on Economic, Social, and Cultural Rights (CESCR) of the United Nations adopted General Comment 22, clarifying that reproductive health is an integral part of individuals' right to the highest attainable standard of health under Article 12.[5] It recommends states obligations towards provision and fulfilment, and not mere non-interference; aspects relevant to ART provision. Since general comments have a role in 'legal analysis, policy recommendation, and practice direction',[6] they serve the purpose of articulating what the law should be.[7] They 'stimulate' the activities of governments towards protecting and promoting rights through law and policy.[8] The role of general comments in policy recommendation and practice direction is linked closely to their authoritative value. Otto and others have asserted that general comments have hard interpretive power, because without them, treaty committees such as the CESCR would not be able to perform their human rights monitoring and enforcement functions. [9] For instance, by devising guidance on what the right to health includes, the CESCR is able to monitor the extent to which individual jurisdictions meet their obligations relating to the right. This function is especially meaningful for socio-economic rights whose fulfilment necessitates active state participation. The right to

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1 Gable, 'Reproductive Health as a Human Right' (2010) 60 Case *Western Reserve Law Review* 957 at 959.

2 McGovern and Ahmed, 'Equity in Health' in Gostin and Meier (eds), *Foundations of Global Health and Human Rights* 307 (2020).

3 Gable supra n 1at 959.

4 ibid.

5 Art. 12, International Covenant on Economic, Social and Cultural Rights, 1966 993 UNTS 3 (ICESCR): '*The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*'

6 ibid.

7 Gerber et al., 'General Comment 16 on State Obligations regarding their impact of the business sector on children's rights: What is its standing, meaning, and effect?' (2013) 14 *Melbourne Journal of International Law* 2 at 8.

8 ibid.

9 Otto, "Gender Comment': Why Does the UN Committee on Economic, Social and Cultural Rights Need a General Comment on Women?' (2002) 14 *Canadian Journal of Women and the Law* 1 at 13; Meron, *Human Rights Law-Making in the United Nations: A Critique of Instruments and Process* (1986) at 10; Gerber, supra n 7.

health, including reproductive health, is one such right. Not only does Article 12 recognise a human interest in reproductive health, as stated in the Cairo and Beijing declarations, it also recognises a positive state obligation to take steps towards its realisation.[10] The CESCR is entrusted with the responsibility of monitoring these steps, thereby lending authority to the general comments that it formulates on the right. General Comment 22 throws interpretive and persuasive light on what these steps should look like, as far as they relate to reproductive health. Since my argument encourages policy change towards realising reproductive health under Article 12, the role of general comments in stimulating state practice and policy holds significance.

States have significant autonomy in interpreting the substantive scope and meaning of socio-economic rights. General comments themselves are viewed as having some plasticity because their authoritativeness changes according to context.[11] It follows, that the scope of the right to health varies across jurisdictions, based on social attitudes, bioethical acceptability, and economic practicalities; themes that I return to later in this article. States have significant autonomy in determining the entitlements flowing from the right to health.[12] Vast differences in socio-cultural attitudes towards ARTs would imply that there would be jurisdictional variations on them being considered healthcare entitlements. Nevertheless, it is my claim that the ART access should be viewed as Article 12 entitlements globally. Despite their plasticity, general comments represent the 'lowest common denominator [. . .] of consensus' on treaty obligations.[13] Here, I argue that access to pregnancy promoting ARTs and fertility preserving ARTs should be considered part of the consensus on obligations arising out of Article 12, to be progressively realised.

General Comment 22's articulation of a specific right to reproductive and sexual health is significant. No other aspect of health has received specific recognition and consideration in this manner. While Article 12 recognises a general right to the highest attainable standard of health. The special recognition of reproductive and sexual health as part of Article 12 carves out a special political and legal status for these rights. In the next section, I draw on the definition of reproductive health to show that its focus on the reproductive system's functions distinguishes it from other aspects of the right to health, leading to a special case for access to assisted reproduction.

2.2. The highest attainable standard of health and flexible positive obligations

General Comments 14 and 22 both recommend 'fulfilling' obligations for States, which go beyond more limited responsibilities of protection and non-interference.[14] While leading scholars as well as commentary by the CESCR and other international bodies[15] agree that Article 12 raises some positive obligations, there is disagreement on what these commitments should entail.[16] Particularly, there is disagreement on the granular details of what healthcare services

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[10] Meier, 'Global health governance and the contentious politics of human rights: Mainstreaming the right to health for public health advancement' (2010) 46 *Stanford Journal of International Law* 1.

[11] Blake, 'Normative Instruments in International Human Rights Law: Locating the General Comment' (2008) 6 Working Paper No 17, Centre for Human Rights and Global Justice, New York University School of Law.

[12] Daniels, 'A Progressively Realizable Right to Health and Global Governance' (2015) 23 *Health Care Analysis* 330.

[13] *In Larger Freedom: Towards Security, Development and Human Rights for All—Report of the Secretary-General of the United Nations*, UN GAOR, 59th sess, Agenda Items 45 and 55, UN Doc A/59/2005 (21 March 2005); Buergenthal, 'The UN Human Rights Committee' (2001) 5 *Max Planck Yearbook of United Nations Law* 341 at 388.

[14] CESCR 'General Comment 14: The Right to the Highest Attainable Standard of Health' (11 August 2000) E/C.12/2000/4 (*General Comment 14*).
CESCR 'General Comment 22: Right to sexual and reproductive health' (2 May 2016) E/C.12/GC/22 (*General Comment 22*).

[15] General Comment and United Nations Human Rights Council, 'The Right to Health' Fact Sheet No. 31 (2008).

[16] Daniels, supra n 12; Ruger, 'Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements' (2006) 18(2) *Yale Journal of Law and Humanities* 273; Tobin, 'The Meaning of the Highest Attainable Standard of Health' in *The Right to Health in International Law* (2011) at 121.

should be provided, and how they should be prioritised. Tobin, for instance, echoes the language of General 22 and recommends that states work towards ensuring the availability, accessibility, acceptability, and quality of health services.[17] Ruger takes on the view that states should priorities those healthcare services that equalise peoples' healthcare capabilities.[18] According to Norman Daniels, granular details of the right to health should be worked out at the state level through deliberative, democratic processes.[19] Despite this, the consensus on a general commitment to positive health obligations have caused Article 12 to be described as an 'incompletely theorised agreement', the details of which bear 'working out'.[20] The only guidance provided by both General Comments is that lies in their affirmation of the interconnected nature of human rights, and clarification that the right to health is best achieved in tandem with other rights guaranteed within the wider human rights framework. While a list of core priorities is provided, [21] they are non-exhaustive and merely elucidatory.[22]

Instead of developing a complete theory of what such obligations should be here, I ask whether such they should include an entitlement to access procreative assistance. To answer this, I first respond to two distinct queries. First, whether procreative assistance can be considered 'health' as envisaged under Article 12—the complete fulfilment of which states should work towards progressively, but not as a matter or priority? And second, whether and when should access to procreative assistance be prioritised as part of the 'highest attainable standard of health'. To answer the first question, I will draw on philosophical accounts of the right to health, to develop a theory of reproductive health as it relates to ARTs. To answer the second, I draw on conceptions of human rights as indivisible as well as on theories of healthcare justice.

2.3. Conditions arising from the definition of reproductive health

Before getting into a theoretical discussion on obligations and entitlements arising from the right to health, it is necessary to discuss the definition of reproductive health, to frame the terms of this discussion. General Comment 22 refers to an idea of reproductive health that was originally formulated by the ICPD, which is set out below.

> 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes'.[23]

This definition builds on the WHO's definition of health—that it is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[24] It has widely been criticised by its interpretive community on account of its overbreadth.[25] Narrower definitions of health focus on the maintenance of bodies' normal functioning.[26] The definition

[17] Tobin supra n 16

[18] Ruger, supra n 16.

[19] Daniels, supra n 12.

[20] Ruger, supra n 16.

[21] Art. 12, International Covenant on Economic, Social and Cultural Rights, 1966 993 UNTS 3.

[22] Bueno de Mesquita, Lougarre, et al., 'Lodestar in the Time of Coronavirus? Interpreting International Obligations to Realise the Right to Health During the COVID-19 Pandemic' (2023) 23(1) *Human Rights Law Review* 1 and Lougarre, 'Clarifying the Right to Health through Supranational Monitoring: The Highest Standard of Health Attainable' (2015) 11(3) *Public Health Ethics* 251.

[23] International Conference on Population and Development Cairo (ICPD), 'Programme of Action' (5–13 September 1994) 7 (*ICPD Programme of Action*).

[24] World Health Organization, '1946 Constitution of the World Health Organization' (adopted 22 July 1946) 14 UNTS 185.

[25] Tobin, 'supra n 16 at 121; Marks, 'The Emergence and scope of the Human Right to Health' in Zuniga, Marks, and Gostin (eds), *Advancing the Human Right to Health* (2013) at 5.

[26] Daniels, 'Capabilities, Opportunity, and Health', in Harry Brighouse and Ingrid Robeyns (eds) *Measuring Justice* (2012) at 131.

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of reproductive health, though similar in structure, has not received similar criticism. Its scope is limited to only those matters which relate to the reproductive system, its functions, and its processes.[27] As shown by the history of its evolution, the definition has neither been disputed, nor critiqued by interpretive communities, even as levels of academic engagement with the phrase have been low.[28] Not only does the circumspection of the definition's scope make reproductive health more 'manageable', but it also makes a special case for access to healthcare interventions which relate to the functions and processes of the reproductive system. Overall, reproductive health relates to individuals 'capability to reproduce' and to make free, informed, and responsible reproductive decisions. This includes a range of reproductive health facilities and services to enable people to make free and informed reproductive decisions.

(i) It follows from the definition of reproductive health reproduced above that, to be included within the right to reproductive health—it [assisted reproduction] should sufficiently relate to the functions and processes of the reproductive system

The right to reproductive health also includes a right to the means to reproductive health.[29] General Comment 22 supplements the ICPD's definition by clarifying that reproductive health relates to individuals' 'capability to reproduce and the freedom to make informed, free and responsible decisions'[30] and to 'access [. . .] a range of reproductive health information, goods, facilities and services [that] enable individuals to make informed, free and responsible decisions about their reproductive behaviour'.[31] Reproductive health care is defined as the 'constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems'.[32]

Based on the definitions above, it is clear that access to assisted reproduction can only be considered a part of reproductive health if it satisfies one of the two conditions set out below:

(ii) it [assisted reproduction] either prevents or cures a disease or infirmity afflicting the reproductive system; or
(iii) it [assisted reproduction] is a means to furthering the overall reproductive wellbeing of its seekers, including their reproductive capabilities and ability to make free and informed reproductive decisions

While responses to these questions are far from settled in the affirmative, even if we were to assume that they are, there are some additional questions to be answered before access to reproduction can be seen as a part of the right to reproductive health under Article 12. The right under Article 12 is not to reproductive health, per se, but to the highest attainable standard of it. This is not a right to an objectively defined standard of health. The highest attainable standard of health does not merely relate to a person's own conditions and needs, but also takes into account

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27 ICPD Programme of Action, supra n 23.

28 Tobin, 'A Methodology to Produce a Meaning for the Right to Health' in The *Right to Health in International Law* (2011) at 75: argues that the process of giving meaning to the right to health requires an interpretive community to constructively engage to give the right a meaning that is manageable and context sensitive. This community could include states as well as non-state actors interested in protection and administration of the right.
In the case of reproductive health, this effort was undertaken by the ICPD, and most recently the Guttmacher-Lancet report. See also Department of Economic and Social Affairs, 'Transforming Our World: the 2030 Agenda for Development', A/RES/70/1.

29 Ruger, supra n 16.

30 General Comment 22.

31 ibid.

32 ICPD Programme of Action, supra n 23.

resources available within a state.[33] Accordingly, a final condition to be satisfied for access to assisted reproduction to be considered part of the right to reproductive is heath is:

(iv) it [assisted reproduction] must be part of the highest attainable standard of health considering individuals' needs as well as the resources available with the state

Textual analyses of Article 12, General Comment 22, or other authoritative material on the right to reproductive health, leave significant gaps in our understanding of each condition. Especially contentious are questions including: What constitutes a valid function of the reproductive system? Do ARTs cure a disease afflicting the reproductive system or further an individual's welfare? What does the highest attainable standard of health mean? How should countries prioritise between various healthcare services? Without answering these questions, we cannot determine, with clarity, whether conditions (a), (d), as well as either (b) or (c) are met, for there to be a case for access to assisted reproduction. In the next section, I draw on philosophical accounts to develop an account of the right to reproductive health within which we can locate an entitlement to access assisted reproduction.

3. THEORETICAL APPROACHES TO HEALTHCARE ENTITLEMENTS

In this section, I outline general accounts of the right to health as well as leading philosophical accounts of healthcare justice, to show that they together provide significant, but incomplete, direction to understanding the right to reproductive health. The body and its functions are central to such approaches, but they throw inadequate light on the reproductive system's approaches. To fill this gap, I draw on Bryan Turner's sociology of the body to a develop an accurate functional account of reproductive health.

3.1. Tobin's general theory of the right to health

Scholars have traced the origins of the right to health to a commitment to freedom from want, in the period following the second world war and decolonisation of many countries in the global south.[34] John Tobin, in 'The Right to Health in International Law' provides a leading account of Article 12, its development, and its implications. Drawing on the right's history and bringing together Articles 2 and 12 of the ICESCR, he asserts that 'the duty upon states to protect the right to health in international law requires the allocation of resources to achieve the progressive realisation of the highest attainable standard of health.'[35] Article 12(1) requires states to recognise 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[36] To Tobin, inherent to the 'highest attainable standard' is active participation by states to provide health services, but there is flexibility on the extent to which each state allocates resources towards such provision. He writes that 'the right to health imposes on states a number of procedural and substantive obligations that have the potential to transform the way in which health policy is formulated and implemented.'[37]

Tobin's account is a thin, procedural version of the right but does not provide a philosophical basis for understanding health. He only provides limited answers to questions such as: What is health and who should be entitled to it? Given that healthcare resources are usually fixed

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[33] Tobin, supra n 28.

[34] Tarantola, 'A Perspective on the History of Health and Human Rights: From the Cold War to the Gold War (2008) 29 *Journal of Public Health Policy* 1.

[35] Art. 12, International Covenant on Economic, Social and Cultural Rights, 1966 993 UNTS 3

[36] ibid.

[37] Tobin, 'The Meaning of the Highest Attainable Standard of Health' in *The Right to Health in International Law* (2011) at 121.

and limited, how should they be distributed fairly? How should resources be distributed among people who have differing health needs? Is the need for assisted reproduction significant enough to justify public expenditure? Among all those who seek access to assisted reproduction, whose claims should be given greater weightage? The next few subsections discuss ideas of just resource distribution to the extent that it is necessary to make a case for considering ARTs an aspect of Article 12.

3.2. Theories of just healthcare allocation

Two views dominate the philosophical discussion on just resource allocation in healthcare, and under Article 12. Both views justify the allocation of resources to fund health interventions by arguing that health has a special status. These are the approaches of (i) Daniels, whose framework is based on a biostatistical model of medicine; and (ii) Ruger, whose account develops the capabilities approach proposed by Sen and Nussbaum. Both approaches distinguish themselves from the WHO definition of health,[38] and propose alternate views on what should constitute a healthcare entitlement. In addition, they advance frameworks for individual jurisdictions to select which healthcare services should be offered as part of their domestic policies.[39] That Article 12(1) raises obligations to allocate resources towards the positive provision of health services is a view echoed by both Jennifer Prah Ruger and Norman Daniels. Daniels characterises Article 12 as raising a 'demand for equality of access or entitlement to health service'[40] Ruger goes a step beyond to describes states' obligation towards the 'highest attainable standard of health' as 'an ethical demand for equity in health' necessitating state action towards coordination, regulation, and participation.[41] To her, Article 12(1) raises a positive right, obliging states to commit finances to health, either through universal health programmes or other mechanisms.

Considering the similarities in how both accounts are structured, I discuss them parallelly in this section. However, it is important to note that each account addresses a distinct aspect of Article 12. While Daniels considers whether specific interventions and arrangements should be viewed as health or healthcare, Ruger addresses whether these interventions form part of the 'highest attainable standard' in each jurisdiction.

Both Daniels' and Ruger's approaches lend themselves to arguments in favour of including assisted reproduction within Article 12, but to differing extents. In this section I show that both make a weak and incomplete case for such inclusion. Neither account adequately captures social dimensions of the lived experience of reproductive decision making and involuntary childlessness. I then develop an alternate approach for understanding what we mean by the 'functioning of the reproductive system' flowing from the definition of reproductive health, and grounded in Turner's approach to biological functionalism.

3.3. The centrality of the reproductive system's 'functions'

I previously showed that the definition of reproductive health is limited by the language of 'reproductive system, and its functions and processes'. The textual focus on the functions of the reproductive system brings together the WHO/ICPD definitions on one side and Daniels' and Rugers' approaches on the other. The concept of function is central to normative discussions on resource distribution, including those led by Daniels and Ruger.

Daniels' argues that the purpose of health is to protect the 'normal functioning' of an individual, thereby making possible an equality of opportunities, which lies at the core of Rawls theory

[38] Ruger, supra n 16; Daniels, supra n 12.
[39] ibid.
[40] Daniels, supra n 12.
[41] Ruger, supra n 16.

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of justice.[42] According to him, states are obliged to protect and promote 'normal functionings' of people, through fair resource distribution to foster a fair equality of opportunities.[43] This lends to health its special moral status.[44] To Daniels, a health need is a requirement which arises from deviations from the functions typical to an organism. He claims that this affects peoples' opportunity or ability to live a good life, denying them equal opportunity.[45] According to him, 'infertility is a departure from normal functioning that reduces an individual's fair share of the normal opportunity range and gives rise to claims for assistance'.[46] This is a biostatistical approach, conceptualising normal as the state in which most human bodies exist.[47] McMillan, who further develops Daniels' theory, asserts that not being able to reproduce when people would typically be able to, and the consequent impact on their lives, is a departure from normal functioning.[48] A reading of his early work on whether the government should fund IVF shows that he sees the normal human function as that of 'being able to reproduce when they (including single women and same sex couples) are of childbearing age'.[49] Deviations from this, regardless of whether they stem from physiological reasons or social causes, meet Daniels' requirement of a deviation from normal functionality. For those who conceptualise the good life as including parenthood, accessing assisted reproduction, therefore, becomes a matter of medical need or healthcare entitlement.[50] The normal function approach, as it was traditionally characterised, did not distinguish between health and the absence of disease. In such accounts, deviation from normal functionality have been mischaracterised as diseases, worthy of medical treatment[51]—a criticism which I agree with, and return to, later in this paper.

The capabilities approach is an alternative to the normal functions approach, advanced by Nussbaum and Sen and applied to the global healthcare context by Ruger.[52] Instead of focusing on ensuring an equality of health, the capabilities approach focuses on protecting 'the freedom to lead the kind of lives they [persons] value – and have reason to value'.[53] At the heart of this approach lie functionings or 'doings and beings' that are valued by people. Distributive policy should focus on an equality of capabilities and not merely opportunities.[54] Sen's account acknowledges that capabilities exist within the personal and social contexts of people, and an equality of capabilities does not necessarily imply that the same resources, or even opportunities, should be made available to all people.[55] The distribution of resources, therefore, should consider individuals' personal and social situations.[56]

While Sen and Nussbaum do not directly discuss health, Ruger develops the capabilities approach in the context of healthcare.[57] She argues that human heterogeneity and differences in need should be taken into account in health distribution. Just healthcare should result in an equality of healthcare capabilities, and not merely universal access to all services.[58] The

[42] McMillan, 'Allocating fertility services by medical need' (2001) 4(1) *Human Fertility*, 11 at 13.
[43] Daniels, supra n 26.
[44] ibid.
[45] ibid.
[46] Daniels, *Just Health: Meeting Health Needs Fairly* (2008) at 43.
[47] Marks, supra n 25.
[48] McMillan, supra n 42.
[49] ibid.
[50] ibid.
[51] , 'Should Fertility Treatment be State Funded?' (2015) 32 *Journal of Applied Philosophy* 227.
[52] Ruger, *Global Health Justice and Governance* (2018) at 81; Daniels, supra n 12.
[53] Sen, 'Equality of What?' *The Tanner Lectures on Human Values* 1 (22 May 1979) at 215.
[54] ibid.
[55] ibid.
[56] ibid.
[57] Ruger, supra n 52; Ruger, supra n 16.
[58] Ruger, supra n 16.

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right to health, therefore, should remedy shortfalls in capabilities.[59] While I broadly agree with the capability approach's acknowledgement of human heterogeneity, I disagree with Ruger's characterisation of what constitutes a healthcare capability. Ruger identifies certain types of capabilities as healthcare capabilities, qualifying them for protection under Article 12.[60] This includes the capabilities to be nourished, to avoid early mortality, to avoid morbidity, to participate in community life, and to engage in various forms of social interaction.[61] While an entitlement to access assisted reproduction can be grounded in the capability to engage in various forms of social interaction, without considered explanation, it makes a weak case for such access. Later in this article, I argue for an expanded understanding of what should be considered a relevant healthcare capability, based on contemporary healthcare experiences and developments in human rights jurisprudence. I argue that the right to health brings together individuals' bodily capabilities and furtherance of their human rights guarantees within lived social contexts. This should include the ability of individuals to fulfil pursue their procreative liberties through ARTs.

A wider discussion on the capabilities approach and how it differs from the Rawlsian framework is outside the scope of this article. However, what constitutes capabilities can help us to understand what is meant by the functions of the reproductive system under the ICPD definition. If the ability to have biologically related children is viewed as a relevant function or 'valued doing', and genetic parenthood a valued state of being, then resources should be distributed in ways that enables genetic parenthood for everyone. Access should be enabled irrespective of what impedes people's ability to have biologically related children and be parents. This goes beyond Ruger's characterisation of healthcare capabilities as those which nourish the body, prevent early morbidity and facilitate social interaction. Accordingly, not only those who suffer from involuntarily childlessness on account of physiological reasons should have access to assisted reproduction, but also those who are so for 'social' or personal reasons such as being in same sex relationships or for not having found the right partner at a specified life stage. The capabilities approach implies that seekers should not be distinguished based on impediments to their ability to have biologically related children, but instead, entitles them to equal access to assisted reproduction.

4. FUNCTIONALISM IN REPRODUCTIVE HEALTH: FROM DANIELS AND RUGER TO TURNER

4.1. The reproductive system's functions and alternations in embodied experiences of involuntary childlessness

Reproductive systems do not function merely within the human body, but within social frameworks and contexts. Functionalism views the function of a system or entity as the role it plays in a 'system, of which it is part'.[62] Both approaches discussed above adopt a biophysical view of functions—under which the reproductive system's function is the role it plays within the body of an individual. However, in 'The Body and Society', Bryan Turner stresses upon the importance of examining and analysing the body and its organ systems as functioning in society and culture.[63] While Daniels' and Ruger's accounts are cognisant of society and its structures, they place limited importance on the social determinants of embodiment. In differentiating disease-absence from wellness on the basis of medical need, Daniels' model renders social context

[59] Ruger, supra n 52.
[60] Ruger, supra n 16.
[61] ibid.
[62] Levin, 'Functionalism' in Edward N. Zalta (ed) *The Stanford Encyclopedia of Philosophy* (Winter 2021 Edition), available at: plato.stanford.edu/archives/win2021/entries/functionalism/ [last accessed 9 May 2022]
[63] Turner, *The Body and Society: Explorations in Social Theory* 2nd edn. (1996).

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irrelevant to health. Ruger accounts for social factors in determining capability, but does not critique social factors in constructing definitions and imaginaries of bodily capabilities. Instead, the capabilities approach centres individuals as participants of society. Turner's sociology of the body, in contrast, places society, including its cultural, political, economic, and historical dimensions centre stage. In doing so, he contradicts Daniels' distinction between medical and other needs,[64] while filling a gap left by Ruger. To him, bodies as well as individual organs function within society. Sociological determinants regulate reproduction and its trends. They also act, as medicalised forces, to distinguish between illness and disease.[65] Following this, it is my argument that reproductive systems do not merely function within peoples' bodies but also in society, as well as in legal systems and cultures. Social factors form frameworks within which reproductive decisions are made. While all physiological systems function within society, the reproductive system's functions are inherently linked to family formation, gender identity, personal fulfilment, and societal organisation, and the 'capacity to conceive is necessarily collaborative'.[66] The intrinsically and essentially social nature of the reproductive system's functions leads to reproductive health's special status under Article 12. Reproductive systems also function to further other rights and procreative liberties, playing an important enabling function within liberal legal fabrics.

Despite developments in this area, people continue to make reproductive decisions within contexts which expect them to conceive naturally within predetermined reproductive windows. Though society influences peoples' decisions to have children differently based on gender, race, class, marital status, and sexual orientation,[67] most people are subject to reproductive expectations in some way or another.[68] Childlessness is stigmatised and can damage peoples' social identities and senses of self.[69] Rebecca Brown highlights a very visible social element of involuntary childlessness by examining the language used by people to describe their experiences with involuntary childlessness. Their terms are powerful and resembles those used grief or bereavement. Effected people struggle with maintaining good interpersonal relationships and even leaving home.[70]

In general, women feel society's push to form heteronormative familial relationships and have children during their 20s and 30s, more intensely than men. Where an opposite sex couple is either voluntarily or involuntarily childless, it is the women who face the pressure to have children as well as sufferings associated with childlessness more strongly than their male partners.[71] Those unable to conceive for 'medical' or physiological reasons are sometimes considered ill and diseased, and treatment is recommended.[72] They are encouraged to access pregnancy producing ARTs whereas those who choose to focus on their careers, while criticised, are encouraged to postpone parenthood through fertility preserving ARTs, but not abandoning the idea entirely.[73] Not only is this pressure social, but it is also intensified and exacerbated

64 ibid 76.
65 ibid.
66 Jackson, 'Conception and the Irrelevance of the Welfare Principle' (2002) 65(2) *Modern Law Review* 176.
67 Bell, 'Beyond (financial) accessibility: inequalities within the medicalisation of infertility' (2010) 32(4) *Sociology of Health and Illness* 631.
68 Shapiro, 'Voluntary childlessness: A critical review of the literature' (2014) 6 *Studies in the Maternal* 1.
69 Brown, 'Reframing the Debate Around State Responses to Infertility: Considering the Harms of Subfertility and Involuntary Childlessness' (2016) 9 *Public Health Ethics* 290.
70 ibid
71 Inhorn, 'Right to Assisted Reproductive Technology: Overcoming infertility in low resource countries' (2009) 106 *International Journal of Gynaecology and Obstetrics* 172.
72 Becker and Nachtigall, 'Eager for medicalisation: the social production of infertility as a disease' (1992) 14(4) *Sociology of Health and Illness* 456.
73 Bell, 'Diagnostic diversity: The role of social class in diagnostic experiences of infertility' (2014) 36(4) *Sociology of Heath and Illness* 516; Shapiro, supra n 68.

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through limited funding policy and discriminatory regulatory frameworks. Under Turner's framework, such changes in technology are related to changes in embodiment itself.[74] Just as the possibility of surgical gender reassignment has altered the experience of embodiment,[75] the ubiquity of ARTs has altered the experience of involuntary childlessness. While many argue that the gender reassignment surgery has altered embodiment in a favourable way, my argument about ARTs is more limited. I do not argue that the changes in ART availability are either good or bad. Instead, it is my argument that they have changed bodily experiences, as well as our understanding of functions of the human body and its organs.

The pressure to have children, while pervasive, is stratified; and such stratification advances Turner's general observation that some bodies are more subject to socio-contextual control than others.[76] Even though motherhood is seen as central to meaningful womanhood in most communities, most societies and cultures, paradoxically, also perpetuate the view that not all women should be mothers. [77] These opinions are clearly registered in discussions and practices relating to reproductive health management. Sociological research shows that access to fertility care and adoption is designed to exclude women from minority groups, sexual orientations, lower socio-economic status and those who are too old or too young.[78] Women who face the pressure to have children most intensely are the ones most likely to be excluded from accessing ARTs. Women from underserved communities are rarely encouraged to focus on their careers or postpone motherhood with the help of fertility preserving ARTs. Sociological studies tell us that clinical practices also discourage their access to ARTs.[79] Same sex couples', single women's, and older women's desire to have children are often met with criticism,[80] implying often, that their sexuality, singlehood, or age is to 'blame' for their childlessness.

Despite stratified access, the use of pregnancy producing ARTs (especially IVF) is ubiquitous,[81] and considered ethically and legally acceptable everywhere in the world.[82] More than 9 billion babies have now been born through IVF.[83] For couples who are unable to conceive naturally, IVF promises recourse from anguish, both personal and social. With the use of donor gametes, it is the only means to biological parenthood for same sex couples and single individuals. While rules relating to the use of using donor gametes for IVF differs across jurisdictions, only a handful of jurisdictions prohibit them entirely.[84] Same sex couples and single individuals are disproportionately affected by rules prohibiting IVF with donor gametes. Similarly, when IVF is expensive, it disproportionately affects underserved communities, who are also those affected most by social pressures surrounding childbirth.

74 Turner, supra n 63 at 76.
75 ibid.
76 Turner, supra n 76 at 127.
77 Bell, supra n 73; Shapiro supra n 68.
78 ibid.
79 ibid.
80 Shapiro supra n 68.
81 Jackson, 'The Legacy of the Warnock Report' in Dove and Shuibhne (eds), *Law and Legacy in Medical Jurisprudence* (2021).
82 Mora-Bermudez, 'World's last *in vitro* fertilisation ban falls' (2016) 536 *Nature* 274.
83 ESHRE Fact Sheet, supra n 15.
84 Calhaz-Jorge, De Geyter, et al., 'Survey on ART and IUI: legislation, regulation, funding and registries in European countries: The European IVF-monitoring Consortium (EIM) for the European Society of Human Reproduction and Embryology (ESHRE)' (2020) *Human Reproduction Open* 1.

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Similarly, fertility preserving ARTs have gained currency, and in most countries, are allowed for non-medical or social reasons.[85] Where permitted, they are expensive, and therefore concentrated within society's elite.[86] Usually paid for by premium insurance packages,[87] corporate employers,[88] or out of pocket, social reasons for gamete cryopreservation most often resonate the career needs and relationship choices of wealthy women.[89] This makes gamete cryopreservation an accepted and prevalent way in which reproductive decisions are made, but only by the wealthy elite. Barriers that prohibit access for women from underserved communities, with lower incomes, for whom postponing childbirth might be an equivalent or higher priority. As a result, while what is perceived to be a 'normal reproductive age' has transformed, only some women can access fertility preserving ARTs to postpone parenthood.

4.2. Functions, disease, illness, and unhealth

At this stage, it is essential to clarify that functions, defined socially, are not norms. It follows that a physiological inability to perform a function without assistance, is also not a deviation from what is 'normal'. Turner criticises normativism in health for being unhelpful and incoherent.[90] There appears to be no justified basis for treating some biological behaviours (including reproductive) as normal. They only appear to be normal because they are, or were at some point in time, common. As society develops, and comes to recognise and celebrate different ways of living and being, the idea that common is normal becomes increasingly problematic. As Nietzsche states, 'the more we allow the unique and incomparable to raise its head [. . .] the more must the concept of a normal health, along with a normal diet, and the normal course of an illness, be abandoned'.[91] While unassisted sexual reproduction among heteronormative couples was common at a time, it can no longer considered the only type of 'normal' reproductive behaviour. It follows that deviations from it should not be considered 'disease' as Daniels had suggested.

Daniel's disease-based model of medical need suffers from this shortcoming of normativism. His approach is biostatistical and conflates what is (or was) biologically common with norm. The term of 'disease' as a physiological deviation from the common, is therefore more descriptive than it is evaluative or explanatory.[92] The term illness is an alternative, which describes the social experience of unwellness.[93] Even our limited discussion of involuntary childlessness in this paper shows that the physiological and social are not distinct categories. Further, just like 'disease', the term 'illness' is also descriptive, and is not grounded normatively. Recognising this, Boorse suggests the most blended, functional concept of 'unhealth'. It includes physiologically observed 'disease', personally experienced 'illness', and socially expressed 'sickness'.[94] Involuntary childlessness brings together each of these dimensions.

Discussions in previous sections show that involuntary childlessness is both embodied and social. Further, it is often personally and socially experienced as a clinically solvable condition.

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[85] White Paper on Singapore Women's Development, submitted to the Singaporean Parliament on 28 March 2022: Very few countries prohibit egg freezing for non-medical reasons. Singapore is one of the latest jurisdictions to legalise 'social' egg freezing in 2022.

[86] Inhorn, Birenbaum-Carmeli et al. 'Elective egg freezing and its underlying socio-demography: a binational analysis with global implications' (2018) 16 *Reproductive Biology and Endocrinology* 70.

[87] Wiel 'The speculative turn in IVF: egg freezing and the financialisation of fertility' (2020) 39 (3) *New Genetics and Society* 306.

[88] Gilchrist, 'Egg freezing, IVF and surrogacy: Fertility benefits have evolved to become the ultimate workplace perk', *CNBC* (22 March 2022), available at: www.cnbc.com/2022/03/14/egg-freezing-ivf-surrogacy-fertility-benefits-are-the-new-work-perk.html [last accessed 9 May 2022].

[89] Inhorn supra n 86.

[90] Turner, supra n 63.

[91] Nietzsche and Kaufmann, *The Gay Science: with a prelude in rhymes and an appendix of songs*, 1st Edition (1974).

[92] Turner, supra n 63.

[93] Turner, supra n 63.

[94] Boorse, 'On the distinction between disease and illness' (1975) 5(49) *Philosophy and Public* 68.

While characterising it as a disease is sometimes unhelpful, it is important to speak of involuntary childlessness in health terms for various reasons, including that of locating a right or entitlement to it. While Boorse's account was intended to provide guidance to participants of the healthcare system (doctors, patients, and pathologists), his language helps us understand health more broadly as a global priority. Although significantly less sophisticated, the WHO conception of health is a neat foil to Boorse's health. The absence of personally experienced, physiologically determined, as well as socially constructed unhealth should be considered health. As the WHO definition suggests, this is not merely the absence of disease.[95]

Since functions are not normatively prescriptive, deviations from it, on an individual level, should not be seen as diseases or illnesses—but merely as inabilities to engage with the world effectively, based on how it is designed. This corresponds, nevertheless, with the WHO's biopsychosocial model of disability and health.[96] McTernan, who concedes similarities between the social model of disability and infertility, argues in favour of tackling social structures and not enabling access to assisted reproduction.[97] My approach acknowledges her concerns, but points towards different outcomes. I agree that it is important to transform social norms when they are unfair, discriminatory, or infringe on human liberties. Social mores that pressure some women to have children but inhibit others' access to reproductive services have significant shortcomings and are in need of change. However, there remains a time lag before social mores surrounding reproduction undergo effective transformation. In this duration, access to ARTs have a significant role to play in equalising reproductive capabilities and ameliorating the suffering of involuntary childlessness.

5. IS PROCREATIVE ASSISTANCE REPRODUCTIVE HEALTH?

5.1. The first three conditions

At the start of this article, I identified four conditions to be satisfied in order to include assisted reproduction within the right to reproductive health under Article 12. Here, I draw on the discussion in previous sections to establish satisfaction of the first three conditions.

5.1.1. [Assisted reproduction] should sufficiently relate to the functions and processes of the reproductive system

In previous sections, I discussed what is meant by the functions of the reproductive system. I showed that prevailing biophysical views of the reproductive system's functions do not accurately capture the lived experience of reproductive decision making and involuntary childlessness. Medical practice standards have evolved to view ARTs as ready and ubiquitously resorted to remedies to involuntary childlessness[98] and previously in this article, I analysed how everyday reproductive choices are made in contexts of ART availability and awareness. Nevertheless, there remains a lag between the reproductive expectations of society and the lived experiences of reproductive decision making. Social barriers which stratify access to assisted reproduction complicate how reproductive systems function in society. ARTs mitigate the effects of such social barriers, affording people control over their reproductive timelines, and enabling biological childbirth for same sex couples, subfertile couples, and single individuals.

[95] WHO, 'Towards a Common Language for Functioning, Disability and Health: The International Classification of Functioning, Disability and Health' (2002) (ICF).

[96] ibid.

[97] McTernan, supra n 51.

[98] Gilbert and Pinto-Correia, *Fear, Wonder, and Science in the New Age of Reproductive Biotechnology* (2017); Jackson, supra n 81.

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5.1.2. [Assisted reproduction] either prevents or cures a disease or infirmity afflicting the reproductive system

In previous sections, I cautioned against classifying either voluntary or involuntary childlessness as diseases while adopting a social view of the reproductive system's function. While I take the view that the social function of a reproductive system is linked to the ability to have biologically related children, I do not contend that this should be viewed as a norm. Instead, I contest McMillan's position that the ability to have children is a normal function of the reproductive system. Daniels' approach classifies any deviation from a body's normal functioning as a disease, in need of treatment or curing.[99] In this, he adopts a biostatistical and physiological view of what is normal, classifying infertility as a disease.[100] Even the WHO and National Institute for Health and Care Excellence in England define infertility as a disease afflicting reproductive systems.[101] This characterisation is based on a restrictive view of people's reproductive decisions and warrants change.

Infertility is not always a useful term to understand the state of childlessness experienced by couples and individuals. Instead, here, I consider whether voluntary or involuntary childlessness can be considered a state of disease or illness. Those who, for medical reasons, are unable to conceive, but also voluntarily choose to remain childless are not harmed or hindered by this inability to conceive. As they are not in need of treatment or cure, considering them diseased is not only unhelpful, but also harmful to their senses of identity and self-worth.[102] Involuntary childlessness arising emerging from social conditions also does not appear to fit into Daniels' binary categorisation of diseased and normal, as it does not relate to the human body's physiology. Involuntary childlessness, arising from physiological or 'medical' conditions, does relate to the human body. However, as I have argued earlier, classifying human reproduction within the same category of normal as other bodily functions such as breathing, pumping blood, or digesting is inaccurate and harmful. In doing so, we would run the risk of excessive medicalisation and unjustified normativism.

Medicalisation is described as 'the process by which non—medical problems become defined and treated as medical problems, usually in terms of illnesses and disorders'.[103] When infertility or involuntary childlessness are seen as diseases or illnesses to be treated through ARTs,[104] the personal and social problem of involuntarily childlessness gets classified as medical one.[105] This can lead to some problems and inconsistencies. While the WHO defines infertility as a disease,[106] others take a softer stance, by referring to infertility as a malfunction deserving treatment.[107] The typification of infertility as a disease has repercussions on how ARTs are accessed and regulated. Soren Holmes has shown that perceptions of infertility as a disease curable by ARTs has had an overall negative effect on the individuals' freedom.[108] He contends that a diagnosis of infertility as a disease can render perceptions of women (and men) as

[99] Daniels, supra n 26.

[100] ibid.

[101] The International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) Revised Glossary on ART Terminology, 2009 (WHO Glossary); 'National Institute for Health and Care Excellence Guidelines' (NICE.org), available at: www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines [last accessed 9 May 2022] (Nice Guidelines).

[102] Letherby, 'Challenging Dominant Discourses: Identity and change and the experience of 'infertility' and 'involuntary childlessness' (2002) 11(3) *Journal of Gender Studies* 277.

[103] Conrad, '*The Medicalisation of Society: On the Transformation of Human Conditions into Treatable Disorders* (2007) at 4.

[104] NICE Guidelines, supra n 101.

[105] Holmes, 'The Medicalisation of Reproduction—A 30 year retrospective', in Simonstein (ed.), *Reprogen-Ethics and the Future of Gender* (2009) at 37.

[106] WHO Glossary, supra n 101.

[107] McMillan supra n 42.

[108] Holmes, supra n 105.

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'abnormal' or 'diseased', and result in a reduced sense of control over one's body.[109] Perceiving infertility to be a curable disease, people feel compelled to seek ARTs such as IVF,[110] to a point of addiction.[111] This may undermine peoples' choices to remain voluntarily childless. I take the view that while the clinical and bodily nature of ARTs and reproduction is somewhat inevitable, the casting of infertility as a disease raises significant problems, such as the necessitation of diagnoses and the exclusion of several people who have a right to have genetic parenthood within overarching human rights frameworks.

Another problem arising out of the treatment of infertility as a disease lies in defining it.[112] According to the WHO, infertility is defined as a 'failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.[113] Most regulatory bodies use variations of the WHO standard to determine appropriateness of offering assisted reproduction to couples seeking children.[114] By singling out this one type of involuntary childlessness as a condition worth treating, this treatment may exclude same sex couples and singles. Nevertheless, it is possible to think of assisted reproduction as a healthcare entitlement without treating it as a medicalised cure to an illness or abnormality, as was highlighted by the court in *Artavia Murillo v. Costa Rica* (2010).[115] This is to say that involuntary childlessness should be viewed as a health issue, without necessarily being pathologised as an abnormality or malfunction.

While medicalisation of ART practices can have some negative effects, as outlined in the paragraphs above, medicalisation can have some positive effects as well. Conrad points out that medicalisation increases the range of imagined possible solutions to a problem.[116] While in some cases this is a problem, ARTs do not present the same challenge. Expansion of the range of imagined solutions to involuntary childlessness is good, valuable, and equalising. The equalising nature of ARTs, especially when they are made accessible equitably, takes away from possibly exclusionary effects of expanding possibilities. Further, medicalisation is considered problematic when it depoliticises deviance and recasts it as a medical problem.[117] When it comes to ARTs, it is not deviance that gets recast as a medical problem, but morally neutral social condition that gets typified as a disease. Recasting involuntary childlessness as a condition of 'unhealth' without classifying it as a disease circumvents this criticism of medicalisation.

5.1.3. [Assisted reproduction] is a means to furthering the overall reproductive wellbeing of its seekers

The satisfaction of condition (b) above is rendered unnecessary by the alternative presented by condition (c). Since only one of (b) or (c) need to be met, it is enough for assisted reproduction to be perceived as furthering the overall reproductive wellbeing of its seekers, to justify its inclusion within the right. It is self-evident that those who seek assisted reproduction do so believing that this will result in an overall increase in their wellbeing. In addition to this subjective evaluation, conceiving and having children with the help of pregnancy producing ARTs results

[109] ibid.

[110] Warnes, 'Exploring pronatalism and assisted reproduction in UK medicine' (2019) 20(4) *Journal of International Women's Studies* 103.

[111] Frank. 'Treatment preferences of infertile couples' (1989) 2(2) *Applied Nursing Research* 94.

[112] Mladovsky and Sorenson, 'Public financing of IVF: A review of policy rationales' (2010) 18 *Health Care Analysis*, 113 at 114; Smajdor, State-funded IVF will make us rich . . . or will it? (2007) 33(8) *Journal of Medical Ethics* 468.

[113] WHO Glossary, supra n 101.

[114] NICE Guidelines, supra n 101: Women aged under 40 should be offered 3 cycles of IVF treatment on the NHS if: they've been trying to get pregnant through regular unprotected sex for 2 years. If they've not been able to get pregnant after 12 cycles of artificial insemination. Similarly, for IVF to be funded for heterosexual couples under Ontario's health framework, they should have been having regular unprotected sex for 2 years.

[115] Inter-Am Ct HR (serC) No 216 (2010).

[116] Conrad, *The Medicalisation of Society: On the Transformation of Human Conditions into Treatable Disorders* (2007).

[117] Busfield, 'The concept of medicalisation reassessed' (2017) 39 (5) *Sociology of Health and Illness* 759 and Conrad, supra n116.

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is the furtherance of individual welfare and their ability to pursue human rights priorities. Access to reproductive assistance advances individuals' reproductive autonomy and control over reproductive decision making; objectives recognised as valuable by the ICPD, CEDAW and other international interpretative instruments.[118] In a world where ARTs are readily available to those who can afford them in domestic and global markets, fetters on accessing them are harmful to one's reproductive wellbeing, especially when these barriers are discriminatory and exacerbate stratified reproductive pressures.

So far, I have argued that assisted reproduction is an entitlement that flows from the language and definition of reproductive health. This view is supported by an influential paper published by the Guttmacher-Lancet Commission in 2018, which lists 'access to services for prevention, management, and treatment of infertility' as an element of reproductive health.[119] However, to locate an entitlement to access assisted reproduction in Article 12, we must also satisfy condition (d), that ARTs should be part of the highest attainable standard of health. I discuss condition (d) in detail in the next section.

5.2. Managing policy fallouts

So far, we have argued theoretically, and on the basis of international definitions, that reproductive health includes an entitlement to access ARTs, subject to policy choices made by States. Before analysing whether it also forms part of the 'highest attainable standard of health', it is important to consider some policy fallouts of such inclusion.

5.2.1. Intensification of social pressures to have children

In grounding my arguments for funding ARTs on existing, stratified pressures to have children, is susceptible criticism on grounds of circularity. That parenthood is a serious an important life event which should be pursued at high cost only values privileges one view of the valuable life and places disproportionate burdens on women and same-sex couples.[120] Critics argue that funded ART access results in a normalisation of ART as a commonly recommended option to remedy conditions of involuntary childlessness.[121] By making ARTs commonplace, it heightens the social understanding that involuntary childlessness is a pathology, to be solved, thereby delegitimising other routes to parenthood or the choice to not have children at all. While there are no neat responses to this allegation, there are ways in which they may be managed with fairness.

Criticisms of circulatory reasoning underplay the significance of temporality in the pressure-alleviating and pressure-exacerbating effects of ART funding. As McTernan points out, there is a time lag between when the policy choice of ART funding is made, and the point when the pressures are felt.[122] It is this time gap which prevents ART funding unlike from attempts at throwing gasoline on a fast spreading fire. ART funding remains a policy choice available to states which may be supplemented by other policy measures to destabilise such pressures. Just as most public health measures include both therapeutic and preventative components, a sophisticated ART policy would include both funding as well as public education efforts against reproductive pressures.

Further, while there is considerable evidence to show indicate that the existence and marketing of ARTs has increased such pressure, there is considerably little evidence to suggest

[118] Sen, supra n 53.
[119] Stars, supra n 8.
[120] Bell, supra n 67 and McTernan, supra n 51.
[121] Warnes, supra n 110.
[122] McTernan, supra n 51.

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that funding has the same effect.[123] On the other hand, we do have evidence to suggest that where reproductive pressures are felt by disproportionately by some groups (such as same sex couples and women), some of these pressures are actually ameliorated.[124] Non-discriminatory funding of ARTs enables non-traditional families, thereby mitigating the pressure to form same-sex families.[125] In fact, 'progressive funding policy has the potential to capacitate a wider group of people as well as overcome society's exclusionary views on who should be a mother'.[126]

5.2.2. Counterintuitive prioritisation and difficult health choices

Through this paper I have held that involuntary childlessness is exactly a disease, but is a health entitlement under Article 12. Alongside the language of Article 12, ARTs go beyond the role of disease-prevention, and instead have elements of wellbeing preservation. Even the highest coverage public health systems do not fund all wellbeing preservation interventions. Instead, funding is limited on the basis of some principles of health economics. My argument I this paper does not invalidate the importance of making difficult policy choices. All that I have argued in this section is that ARTs are conceptually 'healthcare'. It remains open to deliberative processes of individual states to consider whether ARTs are a specific health intervention that they wish to fund. Should they make the choice to fund ARTs, then, it is incumbent upon them to do so in compliance with the binding commitments of Article 12, that is, those of non-discrimination and non-retrogression. The next section discusses in further detail how States should make such policy decisions.

6. THE FOURTH CONDITION AS PROCEDURAL POLICY DIRECTION

So far, I have established that assisted reproduction fits within the language and definition of reproductive health. However, to locate an entitlement to access assisted reproduction under Article 12, it should also be part of the highest attainable standard of health that can be fostered; a concept which takes into consideration the resources available with the state as well as individuals' needs. Daniels describes progressive realisation as the 'increasing satisfaction of a right to health as increases in resources and investment permit', and Ruger recommends that that the right to health be understood as a right to 'a socially manageable idea of health'[127] and an 'ethical demand for equity in health'.[128] Deviations from the highest attainable standard, where they exist, should be spread equitably across the population so that everyone can function at the same level, regardless of individual circumstances.[129] She advocates for a distribution of resources that results in an overall equality of capabilities. Others describe health equity as efforts to bring 'health differentials down to the lowest level possible' and health inequities as the unfair, unjust, unnecessary and avoidable differences in health.[130] It follows that those who are involuntarily childless for 'social' reasons should have similar health capabilities or functionalities as those who suffer from 'medical infertility', as well as those who are capable

[123] Dadiya, 'Medical need and medicalisation in funding assisted reproduction: A right to health analysis' (2022) 22(3) *Medical Law International* 249.

[124] This is similar to Gayle Letherby's approach that he 'rejects the view that all 'infertile' and involuntarily childless' women need is 'strong, deep, feminist consciousness raising' to dissuade them from the 'technological [. . .] approach is patronising, offensive and simplistic'. As quoted in Letherby, 'Challenging Dominant Discourses: Identity and Change and the Experience of 'Infertility' and 'Involuntary Childlessness" (2002) *Journal of Gender Studies* 11(3) at 277.

[125] Warnes, supra n 110.

[126] Dadiya, supra n 123.

[127] Ruger, supra n 16.

[128] Tobin, supra n 28.

[129] Ruger, supra n 16.

[130] Whitehead, 'The concepts and principles of equity and health' (1991) 6(3) *Health Promotion International* 217; Braveman, 'Health disparities and health equity: Concepts and measurement' (2006) 27 *Annual Review of Public Health* 167.

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of having biologically related children without assistance. This determination should be need-based and non-discriminatory.

There is disagreement on whether the right to health refers to specified healthcare entitlements, treatments, or services or to a more broadly encompassing idea of health.[131] Daniels made a recent modification to his approach to claim that just health distribution requires parity in health, and not healthcare services. Similarly, Ruger argues for parity in healthcare capabilities, and not services.[132] This implies that healthcare services should be distributed in ways that ensure that everyone's health capabilities or functions are equalised.

Under both Daniels' and Ruger's approaches, individual jurisdictions should, through deliberative democratic processes, select and prioritise which services, among all health services, should be made available to people.[133] It is difficult to frame an argument for global access to any specific health service,[134] and instead, it is through reflexive processes that individual states decide which services should be included within their healthcare packages. In acknowledgement of this pivotal role played by individual governments, the right to health has been described as an 'incompletely theorised agreement', the details of which are to be worked out at the state level.[135] Consequentially, the right to health takes on a procedural character. As states design their health policies and deliberate upon health priorities, they have the obligation to consider taking steps towards healthcare provision and the equalisation of health capabilities. In earlier sections, I showed that ARTs should be considered part of Article 12 on account of their potential to equalise healthcare capabilities and further valued procreative liberties. On account of their inherent nature as health, states should consider their provision and regulation at the deliberation stage.

It is only where states have committed to ART provision, either directly or other regulatory models, that Article 12's binding obligations of equitable and non-discrimination provision apply. In practice, many jurisdictions do provide ARTs. This is done in a variety of ways, including licensing, government subsidies, and direct provision. However, in most jurisdictions, there is no parity in access for all categories of seekers. Gamete cryopreservation is usually only provided to those who need it for limited medical reasons. IVF promises hope to all those who are involuntarily childless. In practice, however, they only help a small subset of all those who seek to have children but are unable to conceive naturally. Access is limited by a number of exclusionary factors. Race, finances, class, sexual orientation, marital status, disability status, age, citizenship, place of residence, as well as combinations of two or more of these grounds play a role in excluding disadvantaged groups from accessing fertility care.[136] Funding qualifications which create, exacerbate, or mitigate such exclusion are additionally detrimental to the right to reproductive health, while those which facilitate access further it.

My argument for parity in access to ARTs across all groups does not preclude the possibility of rationing publicly funded ARTs on the basis of financial need. The right to health, understood as an ethical demand for equality in health, aspires to health capabilities being equalised. Accordingly, rationing, insurance, and taxation systems, that provide greater benefits to those who cannot afford them sit well within the right to health framework.

131 Ruger, 'Toward a Theory', supra n 16; Daniels, supra n 12.
132 Ruger, 'Grounding the Right to Health' in *Health and Social Justice* 118 (2009); Ruger, supra n 16.
133 Ruger, supra n 52; Ruger, supra n 16; Daniels, supra n 12.
134 Daniels, supra n 12.
135 Ruger, supra n 16.
136 Shapiro, supra n 68; Bell, supra n 104; Bell, supra n 110.

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7. CONCLUSION

My main claim in this article is that reproductive health should viewed as having special status under Article 12, and that it should be interpreted keeping in mind the lived experiences of those who make reproductive decisions. This contention develops the idea that reproductive systems function both within bodies as well as in society, to further individuals' procreative liberties; the equalisation of which is desirable. I develop a socially embedded, functional account of reproductive health that reflects peoples' lived experiences of reproductive decision-making and involuntary childlessness. This account of cognisant of stratified, gendered pressures to have children which pervade today in society. Although they are primarily accessible to the wealthy, ARTs are intrinsic to how people make reproductive decisions today, though by no means, are they the only way in which people make these decisions. The equalising logic of Article 12 provides us with the framework of basing an argument for access in a state of health inequality.

Health is conceptualised to move away from 'disease' based approaches such as the one recommended by Norman Daniels. The notion of a single 'normal' reproductive behaviour is rejected, along with the understanding that deviations from it should be managed medically. Instead, I built on the capabilities approach of Jennifer Prah Ruger and the functional approach of Bryan turner, focusing on the potential of ARTs to equalise valued health capabilities. While I show that ART access should be considered 'healthcare', I do not recommend that they should always be funded, irrespective of policy reasoning. Article 12 is primarily a procedural right, demanding that ART access be considered as part of a state's healthcare programme. Where it is funded, however, there must be parity in access, without restrictions on single women and same sex couples.

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