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FOLLOWING PROTOCOL: THE ROLE OF HUMAN RIGHTS LAW IN REDUCING MATERNAL MORTALITY

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Women's reproductive health risks are not mere misfortunes and unavoidable natural disadvantages of pregnancy, but rather injustices that societies are able and obligated to remedy.¹

I. INTRODUCTION

Each year at least 350,000 women around the world die from complications related to pregnancy.² Although pregnancy is not a disease, roughly 1,400 women die each day from causes such as hemorrhage, sepsis, eclampsia, obstructed delivery, unsafe abortions, or post-abortion complications.³ Most of these deaths are entirely preventable. Ensuring access to health services, including emergency obstetric care and skilled birth attendants, meeting the need for contraception, and eliminating unsafe abortions could reduce the maternal death rate by almost eighty percent—saving the lives and health of hundreds of thousands of women per year.⁴

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These interventions succeed by lowering the risks associated with pregnancy for many women around the world. In contrast however, women living in developing nations face unacceptably high risks. As the World Bank notes, "for every 100,000 live births in West Africa, 629 mothers die, compared to only seven in Western Europe."⁵ Even more troubling, women from merely six nations—Afghanistan, the Democratic Republic of Congo, Ethiopia, India, Nigeria and Pakistan—account for at least half of all maternal deaths.⁶ These grossly uneven rates of maternal mortality demonstrate that the baseline risks in pregnancy are significantly exacerbated by social, economic and political inequality.

Within nations, marginalized women are at greater risk of maternal death than women with access to resources, again demonstrating that maternal mortality is not necessary. Risk of maternal death is strongly correlated with characteristics such as: age, poverty, race, indigenous status, residence in a rural area, or other conditions of vulnerability including incarceration, HIV/AIDS, and prostitution.⁷ These relationships expose intersectional social inequalities.

Adolescents and young women are at particular risk for maternal death. According to the UNFPA,

Complications during pregnancy or childbearing are the leading cause of death for girls aged 15–19 in developing countries. Approximately 16 million girls aged 15–19 give birth each year. Girls under the age of 15 are five times more likely to die from maternal causes. Girls aged 15–19 account for 15% of unsafe abortions — which adds up to three million each year.⁸

Teen pregnancies are much more likely to result in maternal death or injury because adolescents are both more vulnerable to unsafe abortions and less likely to seek appropriate care in the event

of complications from an abortion, as well as prenatal care.⁹

II. WHY HUMAN RIGHTS?

States and international bodies have created global and regional initiatives to reduce maternal mortality. The best-known of these initiatives is Millennium Development Goal 5 (MDG 5), which laid out a target of reducing the global maternal mortality ratio by three quarters in 2015 and achieving universal access to reproductive health.¹⁰ Unfortunately, and despite tremendous work by dedicated advocates, MDG 5 remains the MDG furthest from achieving its goal, as compared to the achievements of other MDGs.¹¹ According to the World Bank, “the average maternal mortality ratio, which measures the risk of dying once a woman becomes pregnant, declined at less than [one] percent per year between 1990 and 2005.”¹² This is far below the target reduction of seventy-five percent by 2015. In some cases, the situation has worsened. In southern Africa, for example, the maternal mortality ratio increased from 171 in 1990 to 381 in 2008.¹³ To achieve a seventy-five percent reduction, the rate would have to decline by roughly five and one half percent annum.¹⁴

While the reduction is not perfectly on track, there have been major improvements and effective interventions in some regions or communities that have created dramatic results in specific cases. For example, India has experienced a four percent annual drop in the mortality ratio, despite its high numbers of maternal deaths.¹⁵ Egypt, between 1990 and 2008, experienced an annual decline of 8.4%.¹⁶ However, these successes merely serve to underscore the essential point: maternal mortality is preventable, even in developing nations.

As international bodies reaffirm their commitments to achieving MDG 5, advocates are calling for an increased role for human rights frameworks and legal strategies in the achievement of the goal. At a minimum, the human rights law that prohibits discrimination in health services on the basis of sex can: serve to articulate norms regarding access to health services, underscore the obligation to provide reproductive health care to women, provide frameworks for ensuring that health and development

projects reach all women in a nation, and provide accountability mechanisms for violations.

The first step is to establish that women and adolescent girls have rights to reproductive and sexual health. Next we must identify tools and mechanisms to enforce those rights, changing the legal, social and political contexts in which women live their reproductive and sexual lives. These processes are, of course, dialectical, and advocates have learned a great deal in the past thirty years about best practices in both medicine and law.

Four of the major international human rights treaties, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), and the Convention of the Rights of the Child (CRC) are the most frequently cited in the prevention of maternal mortality. Additionally, other treaties, including the Convention on the Elimination of All Forms of Racial Discrimination (CERD) and the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment (CAT), have been interpreted to also influence maternal mortality.

UN treaty bodies monitor compliance by States Parties to these international treaties.¹⁷ Each treaty body has issued “general comments” or “general recommendations” interpreting treaty provisions.¹⁸ Signatory nations must submit country reports to each treaty body reporting on their efforts to respect, protect, and fulfill their obligations under the specific treaty.¹⁹ The treaty body then issues “concluding observations” for each reporting government, often commenting on issues such as observable progress towards, or retrenchment, from fulfilling a particular mandate.²⁰ Some treaty bodies may also examine individual complaints and issue written decisions.²¹ These decisions, while not precedential the way judicial decisions in a common law system might be, further serve to interpret the treaty language and clarify the obligations of all States Parties.²²

Advocates have also drawn upon, and pursued cases under, regional treaties, such as the American Convention on Human Rights, and the European Convention on Human Rights. The newest of the

regional treaties, the Protocol on the Rights of Women in Africa, contains the most specific mandates regarding women's health of any international instrument.²³

III. MATERNAL MORTALITY AND MORBIDITY

The World Health Organization (WHO) defines maternal mortality as “the death of a woman while pregnant or within [forty-two] days of termination of pregnancy ... from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.”²⁴ Researchers often use the “ratio” of maternal mortality (maternal deaths per 100,000 live births) as an indicator of the outcomes of maternal health services.²⁵ This ratio includes rates of death caused by complications from abortion, as well as labor, delivery or post-partum complications.²⁶

Although preventable maternal death, and women's health more generally, is a complex matter that implicates many political, familial, legal and social structures, the next section of this background paper will focus on the human rights implications of three of the major causes of maternal mortality: (1) lack of access to pregnancy-related health services, including skilled attendants at birth and “Emergency Obstetric Care”; (2) unmet need for family planning services and contraception, either due to legal restrictions or lack of available services; and (3) complications from self-induced or poorly performed abortions when safe and/or legal abortions are not available, either due to legal restrictions or lack of available services. The final section of this paper will also introduce briefly the role that access to information and education can play in the reduction of maternal mortality. The authors intend for this section paper to be to be an introductory overview, rather than an exhaustive review.

A. Health Services, including Skilled Attendants at Birth and Emergency Obstetric Care

The majority of maternal deaths occur during and immediately after delivery. Although a wide range of services can improve outcomes, two are imperative in reducing mortality: skilled birth attendants and Emergency Obstetric Care (EmOC). The presence of skilled attendants at birth is one the most effective

methods of preventing maternal mortality, and has the additional benefit of reducing rates of infant death.²⁷ A “skilled attendant” refers to a person with midwifery skills who can manage normal labor and deliver, recognize the onset of complications, perform essential interventions and supervise referral if the mother or baby requires interventions that are beyond their expertise or are not possible in the particular setting.²⁸ A skilled attendant can manage the vast majority of complications that arise during an otherwise normal labor and delivery, and can arrange for the referral and transportation of women to facilities that can handle more complex matters, should they arise.²⁹ The presence of skilled attendants is one of the characteristics of countries that have reduced mortality ratios below one hundred.³⁰

Emergency obstetric care encompasses all of the components of basic obstetric care including: medical treatment of complications, manual procedures (such as repair of tears or removal of placenta) and monitoring of labor, as well as surgical interventions (including cesarean sections when warranted) anesthesia, and blood replacement.³¹ Noted expert Lynn Freeman writes, “if the human right in question is the right not to die of an avoidable death in pregnancy and childbirth, then the first line of appropriate measures that will move progressively toward the realization of the right is the implementation of EmOC. In a human rights analysis EmOC is not just one good idea among many. It is an obligation.”³²

The right to health, enshrined in various instruments,³³ is a useful tool in increasing access to vital services. The ICESCR, Article 12, articulates the right of all people to the highest attainable standard of physical and mental health. It is important to note that, although health care *services* are an important component of the right to health, this right is not limited to health services alone and encompasses “both freedoms and entitlements.”³⁴ In addition to rights such as a healthy environment, the right to health includes access to health-related information and education, including sexual and reproductive health.³⁵

The ESCR Committee notes that “[a]ppropriate medical benefits should be provided for women and children, including peri-natal, childbirth and postnatal care.”³⁶ It also adds that, “public

health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas.”³⁷ The ESCR Committee, which places a high priority on reproductive and maternal health care, has confirmed that reproductive and maternal health care services are *obligations*, comparable to core obligations, to be addressed *immediately* rather than progressively.³⁸ It has clarified that the treaty obliges States Parties to ensure that health facilities, goods and services are affordable to women and adolescent girls and available to all of the women of a nation, regardless of where they reside within the country (urban vs. rural) or other social disadvantages.³⁹ The ESCR has clarified that it is insufficient to distinguish general declines in maternal mortality, or adequate levels of care for many, if particular groups of women are still suffering from high rates of preventable death due to lack of access to health services.

The Convention of Elimination of All forms of Discrimination Against Women (CEDAW) “protects the right to non-discriminatory access to health care services, rather than the right to health as such.”⁴⁰ Article 12(2) explicitly requires States Parties to “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary.”⁴¹ For example, the Committee has interpreted this mandate to require Emergency Obstetrical Care, “to the maximum extent of available resources.”⁴² The Committee has also repeatedly addressed skilled birth attendants, and primary health services that could encourage safer pregnancy.⁴³ Because maternal mortality is a largely preventable cause of death, the committee considers the States Parties’ obligation to provide services required to reduce the rate *immediate*.⁴⁴

In 2011, the CEDAW Committee became the first U.N. body to issue a decision in an individual complaint regarding maternal mortality, in the groundbreaking case of *Alyne da Silva Pimentel Tiexeira v. Brazil*.⁴⁵ Ms. da Silva Pimentel Tiexeira, a Brazilian of African descent, died due to complications from fetal death during her sixth month of pregnancy.⁴⁶ Despite the fact that she was admitted to a health facility and treated, the CEDAW Committee found that Ms. da Silva Pimentel Tiexeira died as the direct

result of inappropriate emergency obstetric care.⁴⁷ During her ordeal, Ms. da Silva Pimentel Tiexeira waited for over eight hours, two of which she was in a coma, for transportation to a hospital with superior facilities.⁴⁸ She was finally transferred, but without medical records, and placed in a hallway due to lack of space.⁴⁹ After 21 hours in the hospital hallway, in which the Committee found that she was largely unattended, she died of digestive hemorrhage from the delivery of the stillborn fetus.⁵⁰

The Committee found Brazil accountable for her death, despite Brazil’s arguments that the inappropriateness of the service was imputable to a private health care institution.⁵¹ The decision established that Brazil had neglected its due diligence obligation to ensure appropriate services in connection with the pregnancy, failed to meet the specific, distinctive health needs of women, failed in its duty to regulate and monitor private health care institutions, failed to address the multiple forms of de facto discrimination against women of African descent and low socio-economic status, and failed to ensure effective judicial protection for the family.⁵²

Regional mechanisms may also provide the basis for entitlements to pregnancy-related health services. For example, the Protocol of San Salvador, which addresses economic, social and cultural rights for signatory states in the Western Hemisphere, establishes a right to health, and mandates that states guarantee this right without discrimination.⁵³ It should be noted that the Protocol of San Salvador contains a clause granting limited jurisdiction to the organs of the inter-American system, enabling them to examine individual petitions concerning the rights protected in Articles 8(a) and 13 (i.e. the right to organize and join trade unions and the right to education).⁵⁴ Therefore, the Commission does not have subject matter jurisdiction to examine alleged violations relating to the right to health under the protocol of San Salvador. However, the Commission has competence to analyze the right to health according to Article 26 of the American Convention on Human Rights and take into account other relevant regional instruments.

The Inter American Commission has noted that the right to health is linked with the right to life and personal integrity.⁵⁵ In addition, the Commission

has indicated that states' obligation to guarantee the integrity of its citizens by providing medical treatment constitutes an immediate obligation to the States Parties.⁵⁶

Numerous cases have been brought before the Inter-American Commission of Human Rights (IACHR) that have touched upon access to sexual and reproductive health services, including *María Mamérita Mestanza v. Peru*,⁵⁷ *Paulina Ramirez Jacinto v. Mexico*,⁵⁸ and *I.V. v. Bolivia*.⁵⁹ The allegations in the three cases, which were largely focused on other violations of women's rights such as forced sterilization and prevention of legal abortion, also addressed the failure to provide appropriate health care to the women involved.

B. Contraception and Family Planning

Contraceptives prevent maternal mortality in three primary ways. First, they decrease the total number of pregnancies, each one of which puts women at risk.⁶⁰ Second, they prevent unwanted pregnancies, thus reducing reliance on unsafe abortion.⁶¹ Finally, they reduce high-risk births due to maternal age, other risk factors, and timing between births.⁶²

The global need for modern contraceptives is enormous and unsatisfied. According to the UNFPA, roughly 215 million women in developing nations, who seek to avoid or delay pregnancy, do not have access to modern contraceptive methods; instead they are forced to rely upon unreliable traditional methods or no contraceptive method.⁶³ Globally, states with an unsatisfied need for contraceptives for their populations account for 82% of all unintended pregnancies.⁶⁴

Satisfying this need could significantly reduce maternal mortality and morbidity as well as reduce the rates of unsafe abortions. Women undergo forty-five million abortions per year; a significant percentage of those abortions are unsafe, resulting in the deaths of 47,000 women per year, and injury to many others.⁶⁵ Simply addressing the unmet need for contraception would reduce abortions—many of which are unsafe—by twenty-five million less per year.

Unsatisfied need of contraception stems from two sources: (1) legal bans or requirements that make contraception overly difficult to obtain; and (2)

lack of access to contraception and family planning services due to affordability, stigma, or other social barriers, including discrimination, lack of information, inability to access health services more generally, or lack of sexual education.

Women in situations of vulnerability, especially those with disabilities, racial minorities and indigenous women, refugees, women in conflict zones and women experiencing domestic violence, also have difficulty obtaining appropriate modern contraception.⁶⁶ Adolescent girls in particular face significant barriers to modern contraception, although they are the most likely benefit from delaying childbearing.⁶⁷ Stigma, parental consent laws, lack of information, and cost all contribute to high rates of teen pregnancy, abortion and early childbearing.⁶⁸

The cost of contraception is a barrier for millions of women worldwide. Despite the immense benefits of contraception for women and communities, funding for family planning services has been reduced in recent years, and is the subject of ongoing controversy in many regions of the world.⁶⁹

The Programme of Action from the International Conference on Population and Development in Cairo marked a dramatic shift in the stigma on contraceptives by recognizing reproductive rights as fundamental human rights. It identified contraceptive information and services as essential to ensuring reproductive health and rights.⁷⁰ It affirmed that “the aim of family-planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods.”⁷¹

In addition to the aforementioned access to health services mandated by Article 12(2), CEDAW was the first international treaty to specifically mandate access to family planning services. Article 12(1) of CEDAW requires that States Parties “ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.”⁷² The Committee recommends prioritization of the “prevention of unwanted pregnancy through family planning and sex education,” and has repeatedly taken

up the question of affordable family planning services in concluding observations.⁷³

Article 16 of CEDAW also requires States Parties ensure that women can control the number and spacing of their children equally with men. CEDAW is the only UN treaty to specifically address family planning as a *women's right*. While other international human rights bodies consider contraception and family planning as a subset of reproductive and sexual health services, or frame maternal health as a matter of concern, CEDAW specifically frames the issue as one of women's rights to plan and control their own reproductive lives outside of the health context.

To comply with CEDAW, access to family planning services must remain rooted in women's reproductive decision making. The CEDAW Committee has mandated that contraception and family planning must occur with the full and informed consent of the women and girls involved.⁷⁴ States that denied women, mostly those from disadvantaged social minority groups or with disabilities, the opportunity to bear children through programs of forced sterilization without their consent violate the norms set forth in CEDAW.

Other U.N. treaties have addressed access and affordability, including the CESC. For example, the WHO includes several methods of contraception on its list of "essential medicines."⁷⁵ The ESCR Committee has decided that the ESCR's promise of the right to health requires, at minimum, the provision of essential drugs on the WHO list.⁷⁶ The Committee on the Rights of the Child has also urged States Parties to "develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception."⁷⁷

Regional bodies have also encouraged access to contraception. For example, Article 14 of the Protocol on the Rights of Women in Africa specifies that the right to health of women includes "(a) the right to control their fertility; (b) the right to decide whether to have children, the number of children, and the spacing of children; (c) the right to choose any method of contraception; ... [and] (f) the right to have family planning education."⁷⁸

Some states or localities have laws specifically banning either all modern contraceptive methods,

or merely specific methods. For example, the city of Manila in the Philippines has imposed a total ban on the distribution of modern contraception in public health centers.⁷⁹ The Supreme Court of Honduras recently upheld a ban on Emergency Contraception, joining several other nations that ban the use of this specific method.⁸⁰

As previously discussed, numerous human rights bodies have confirmed that states have an obligation to eliminate legal barriers to contraceptives and family planning services. For example, in some nations where access to legal contraception is limited or specific forms of contraception are banned, legal systems may reflect religious views regarding the use of contraception that stem from a single tradition. According to the Human Rights Committee, such laws violate multiple provisions of the Covenant on Civil and Political Rights including freedom of thought, conscience and religion, in addition to interfering with the rights to health and related rights described in this paper.⁸¹ Other treaty bodies have noted that the right to privacy guaranteed by various treaties such as the ICCPR, the CRC, and the American Convention on Human Rights, protects the rights of women to make fundamental decisions about private and family lives without government interference.⁸²

The right to determine the number and spacing of children forms a central pillar of CEDAW's prohibition on discrimination against women.⁸³ State bans on contraception or specific forms of contraception contravene the rights outlined in CEDAW Article 16, as they reduce, if not eliminate, the means to effectuate it.⁸⁴

The CEDAW Committee has also addressed other legal barriers to contraception, including third party authorization requirements. State-sanctioned policies allowing spouses, parents or others to limit access to contraceptives, or limitations on contraception contingent on factors such as marital status or gender, rely on stereotypes of women as incapable of making decisions regarding their own health, and constitute impermissible discrimination under CEDAW.⁸⁵

C. Safe and Legal Abortion

Unsafe abortions are those performed by untrained personnel, and/or those executed in unhygienic

settings. The WHO estimates that women around the world undergo 19.7 million unsafe abortions each year, 19.2 of which occur in developing countries.⁸⁶ Complications from abortion account for approximately 13% of maternal deaths; 66,5000 women die each year from unsafe abortion.⁸⁷ While the number of women dying due to unsafe abortions per year is down from the 69,000 reported in 1990, the figures remain too high for an almost entirely preventable cause of death. Almost all unsafe abortions occur in developing countries.⁸⁸

Despite its potential to reduce maternal mortality, safe and legal abortion remains controversial internationally. Although there has been a general trend towards liberalization of abortion laws in many nations, women around the world continue to face barriers to safe and legal abortions in many circumstances.⁸⁹ Barriers to safe abortion care may be divided into strictly legal bans—full criminalization without exception for women and providers—and/or burdensome legal requirements and lack of access due to cost, stigma or discrimination. Advocates have pursued rights-based approaches to abortion in a variety of national and international settings, although explicit opposition from some religious entities and states has been strong.

Among the international human rights treaties, the Protocol on the Rights of Women in Africa is the only binding instrument that explicitly requires States Parties to “protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.”⁹⁰ Because this treaty, as well as the rights of women to abortion care, is new to international law, advocates should pay particular attention to how the treaty body enforces the rights of women in member states.

Despite the lack of explicit mention of abortion *per se*, some international and regional human rights advocates may reinforce women’s rights to access safe and legal abortion. Because of high rates of maternal death caused by unsafe illegal abortions, human rights treaty bodies invoke the right to life, to not be subject to degrading treatment, and to privacy, which implies the possibility to make decisions free from coercion, discrimination and violence, in connection

with safe and legal abortion.⁹¹ For example, General Comment No. 28 to the International Covenant on Civil and Political Rights (ICCPR) asserts that States Parties should report adopted measures to prevent unwanted pregnancies and ensure that women are not forced to undergo clandestine abortions.⁹²

The CEDAW Committee has expressed concern regarding the criminalization of abortion, noting that “barriers to women’s access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures.”⁹³ It also recommends that, “when possible, legislation criminalizing abortion could be amended, in order to remove punitive measures imposed on women who undergo abortion.”⁹⁴ It has repeatedly addressed the issue in Concluding Observations, encouraging states to ensure access to abortion in accordance with domestic legislation, and requesting that states remove penalties for women undergoing abortion.⁹⁵

The Convention on the Rights of the Child (CRC) addresses the adolescent girls’ right to life and survival.⁹⁶ The Committee of the CRC has expressed its concern over the differential impact of criminalization of abortion on adolescents, as well as their general lower levels of access to abortion services due to their age and lack of resources.⁹⁷

A small number of nations criminalize abortion in all circumstances. Total criminalization of abortion draws condemnation from a number of treaty bodies. For example, after Nicaragua criminalized abortion in all circumstances, including when the woman’s life is at risk and when the pregnancy is the result of rape or incest, the Committee on the Rights of the Child, the Committee against Torture, the Human Rights Committee, the Committee on Economic, Social and Cultural Rights, and the CEDAW Committee all addressed the ban.⁹⁸ The CRC, for example, noted that the ban undermined efforts to prevent child abuse, and that maternal mortality among adolescents had increased since the imposition of criminalization.⁹⁹ Similarly, with regard to El Salvador, the HRC expressed concern in 2010 that,

[t]he Current Criminal Code criminalizes all forms of abortion, given that illegal abortions have serious detrimental

consequences for women's lives, health and well being. The Committee remains concerned that women seeking treatment in public hospitals have been reported to the judicial authorities by medical staff who believe that they have been involved in abortions, that legal proceedings have been brought against some of these women, and that in some cases these proceedings have resulted in severe penalties for the offense of abortion, or even homicide, an offense interpreted broadly by the courts.¹⁰⁰

A number of states that are signatories to human rights treaties limit abortion to circumstances posing a danger to the health or life of the mother. Advocates maintain that criminalizing most abortions has a chilling effect on women who require abortions for therapeutic purposes because medical personnel are afraid to perform abortions despite the exception. Human rights bodies have specifically considered whether nations, which so limit abortion, are imposing a *de facto* total ban by failing to have in place procedures for invoking the limited right to abortion. One such case, *KL v. Peru*, reached the Human Rights Committee, under the optional Protocol of the ICCPR.¹⁰¹ In that case, medical personnel denied an abortion to a 17 year-old woman, despite the fact that the fetus she carried was anencephalic and had no chance of long-term survival.¹⁰² The pregnancy posed both physical and mental risks to the young woman¹⁰³, who was forced to carry the pregnancy to term and then nurse the baby for several days before it died.¹⁰⁴ Although abortion was generally illegal in Peru, the ban did contain an exception for therapeutic abortion in the case of risk to the mother's health.¹⁰⁵ The HRC found that the state violated woman's rights because state agents denied her an abortion that should have been considered legal under Peru's own laws.¹⁰⁶

In another recent case,¹⁰⁷ a young Argentinean woman, LMR, with a permanent mental disability became pregnant as a result of rape and sought an abortion at a public hospital. The hospital's bioethics committee approved the abortion because her case fit within the exemption to the Argentinean Criminal Code for pregnancies resulting in the rape of a woman with a mental impairment.¹⁰⁸ However, before the

procedure could be performed, judicial proceedings were initiated to prevent the abortion and the hospital was issued an injunction.¹⁰⁹ Although LMR was ultimately successful in her appeal to the Supreme Court of Justice, the hospital did not perform the abortion, due to pressure from anti-abortion groups, on the grounds that the pregnancy was too advanced at its current stage of twenty to twenty-two weeks.¹¹⁰

The Human Rights Committee concluded that Argentina, by failing to guarantee LMR's right to a legal abortion as provided for under the Criminal Code, had violated her rights.¹¹¹ The HRC deemed the physical and mental suffering LMR was forced to endure was further aggravated by her status as a woman with a disability, and confirmed that the treatment covered by Article 7 of the International Covenant of Civil and Political Rights (ICCPR) extends to acts that cause mental suffering. Additionally, the HRC concluded that LMR's right to privacy was violated by Argentina,¹¹² due to unlawful judicial interference in a matter that should have been between LMR, her legal guardian and her physicians. The HRC concluded that Argentina was in breach of Articles 7 and 17 of the ICCPR, and in breach of Article 2 of the Optional Protocol in relation to ICCPR Articles 3, 7 and 17.¹¹³

The European Court of Human Rights has similarly found that if a state "adopts statutory regulations allowing abortion in some situations, it must not structure its legal frameworks in a way that would limit real possibilities to obtain it."¹¹⁴ In the cases of *Tysiac v. Poland* and *RR v. Poland*, the court noted a positive obligation on the part of states to "create a procedural framework enabling a pregnant woman to exercise her right of success to lawful abortion."¹¹⁵ In the case of *AB & C v. Ireland*, for example, the same court found that the failure to provide "C" with a meaningful procedure to obtain an abortion within Ireland when her life was in danger resulted in "a striking discordance between the theoretical right to a lawful abortion in Ireland on the grounds of a relevant risk to the woman's life and the reality of its practical implementation."¹¹⁶

D. Access to Information and Sexual Education

Information and education play a crucial role in the efforts to reduce maternal mortality in adolescent

girls and women. Additionally, the lack of education, access to information and benefit of scientific progress deepen the vulnerability of adolescent girls and women to discrimination.¹¹⁷

The right to education encompasses an individual woman's right to accurate information regarding contraception, family planning and abortion. Human rights instruments recognize that education has direct implications on the rights to life, health, education and non-discrimination.¹¹⁸ CEDAW, for example, conditions that States Parties must provide "access to information, education, and means that enable women to decide on the number and spacing of their children."¹¹⁹ In relation to adolescent girls, the Committee on the Rights of the Child has indicated in its General Comment 4, that

States Parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs). In addition, States parties should ensure that they have access to appropriate information, regardless of their marital status and whether their parents or guardians consent. It is essential to find proper means and methods of providing information that is adequate and sensitive to the particularities and specific rights of adolescent girls and boys.¹²⁰

The ICESCR also recognizes the right to access information and benefits from the advancement of scientific progress.¹²¹

The right to information also encompasses knowledge regarding public health expenditures and disaggregated data regarding maternal mortality, health care services, contraception and abortion. Understanding how the risks of maternal death are distributed within a nation, and understanding how a state is, or is not, allocating resources to prevent maternal mortality can be a powerful tool for demanding reform.¹²²

¹ See Rebecca Cook et al., *ADVANCING SAFE MOTHERHOOD THROUGH HUMAN RIGHTS 5* (WHO) (2001) http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/RHR_01_5/en/index.html (stating that women's health issues are often avoidable and this equates to a denial of human rights and an injustice against women).

² Ban Ki-moon, *GLOBAL STRATEGY FOR WOMEN'S AND CHILDREN'S HEALTH 4* (2010) (citing UN inter-agency estimates based on 2010 data).

³ Pan American Health Organization, *PAHO REGIONAL STRATEGY FOR MATERNAL MORTALITY AND MORBIDITY REDUCTION 26* (2002) available at <http://www.paho.org/English/AD/FCH/WM/maternalmortalitystrategy.pdf> [hereinafter PAHO, Regional Strategy].

⁴ *Id.* at 25.

⁵ World Bank, *UNFINISHED BUSINESS: MOBILIZING NEW EFFORTS TO ACHIEVE THE 2015 MILLENNIUM DEVELOPMENT GOALS 8* (2010), available at <http://www.worldbank.org/mdgs/MDGPaperFINALSeptember102010.pdf> [hereinafter *Unfinished Business*].

⁶ *Id.* at 10.

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ANNEX: WORKING GROUP RECOMMENDATIONS

Listed below are recommendations that will serve to advance the use of international human rights instruments and standards as tools to review and reform health policies, plans, programs and laws.

These recommendations have been suggested by the Women and Adolescent Girls: Maternal Mortality & Morbidity that convened on March 21 and 22, 2012 at the Inaugural Conference on Global Health, Gender and Human Rights, which was organized by the American University Washington College of Law and PAHO/WHO. These recommendations do not necessarily reflect the views of the author(s) of the preceding article.

The recommendations are divided by the following set of questions based on principles extracted from the PAHO Resolution “Health and Human Rights” (CD 50 R.8), which was approved by the 50th Directing Council of the Pan American Health Organization (PAHO). This resolution urges health authorities to use human rights treaties and standards to reform health systems, collaborate with the judiciary, legislators and civil society and train health workers on human rights obligations.

All PAHO Member States recognized in the concept paper, Health and Human Rights (Document CD50/12) and in resolution CD50R8 that “[h]uman rights law, as enshrined in international and regional human rights conventions and standards, offers a unifying conceptual and legal framework for these strategies, as well as measures by which to evaluate success and clarify the accountability and responsibilities of the different stakeholders involved.”

TAKING INTO ACCOUNT THE NATIONAL CONTEXT, FINANCIAL AND LEGAL FRAMEWORK AND BUDGETARY CONSTRAINTS OF COUNTRIES:

- a. Which areas require special attention from government agencies?
 - Reinforce education in general from elementary school, focusing on rural areas

and in particular regarding reproductive and sexual health;

- Invest and allocate budget to insure access to contraception;
 - Strengthen the technical capacity of the health authority to provide support for the formulation of health policies and plans consistent with the applicable international human rights instruments related to health;
 - Promote training programs for health workers on the applicable international human rights instruments; and
 - Establish mechanisms to protect private patients’ information and provide access to their own information (medical files, etc.).
- b. What key factors should be identified and included by health authorities and other governmental actors when formulating national health policies and plans consistent with the applicable international human rights instruments that protect women and adolescents girls’ rights to physical and mental health and other related human rights?
 - Develop and enforce protocols for the implementation of right to health and other rights of women and girls;
 - Uphold the fundamental right of women to control their bodies and controlling the timing and spacing of their children;
 - Policies that empower women to participate in the design, implementation and monitoring of health policies and plans;
 - Mechanisms for meaningful accountability of duty bearers (government, health services, etc);
 - Meaningful participation and involvement of civil society; and

- Link academia with the health systems for capacity building, not just health workers, but also legal professionals, including judges, attorneys and law students.
- c. Which key provisions should be included by legislators when reviewing and reforming national health legislation and incorporating the international human rights instruments, especially those protecting women and adolescent girls? For example, consider anti-abortion legislation and access to contraception, including emergency contraception.
- Decriminalize abortion and remove from penal code when applicable;
 - Access to contraception and sexual and reproductive services;
 - Access to post-abortion care;
 - Establish clear rules about confidentiality, informed consent and information sharing; and
 - Access to comprehensive sex education.
- d. What measures should governments take to ensure the effective implementation of national health policies, plans and laws that protect women and adolescent girls?
- Increase knowledge about the human rights conventions related to women and girls in the context of reproductive and sexual health;
 - Develop educative materials where international human rights instruments are and translate them into simple language to be more accessible to the health providers;
 - Develop indicators to increase ability to quantify specific factors and identify violations of women and girls' rights, including key human rights indicators;
 - Establish training programs for technical areas, especially those most closely involved in protecting the health of women and girls, gradually incorporating the international human rights instruments related to health into their programs;
- e. Parliaments and domestic courts play a key role in promoting and protecting the human rights and fundamental freedoms of women and adolescent girls. What concrete functions and contributions can those institutions make?
- Revise/modify existing curricula in universities to include rights of women and girls in the context of health;
 - Make user friendly and efficient modules available in human rights instruments protecting human rights of women and girls.
- f. What measures could be taken by all those members of society at large who are involved in protecting the human rights of women and adolescent girls?
- Formulate and, if possible, adopt legislative, administrative, educational, and other measures to disseminate the applicable international human rights instruments on protecting the right to the enjoyment of the highest attainable standard of health and other related human rights among the appropriate personnel in the legislative and judicial branches and other governmental authorities, with a particular emphasis on human rights law obligations in the context of access to family planning, therapeutic abortion, emergency contraception and access to information on sexual health among indigenous and afro-descendant women and adolescent girls;
 - Adopt protocols for implementation; and
 - Use the bar associations to train law students and medical association to train medical students.

stigmatization, discrimination, and exclusion of women and adolescent girls;

- Promote role models—people that stand up in the community—to fight for human rights;
- Involve women in the design and monitoring of the Budget to include a gender perspective;
- Involve media to play a role in promoting women and girls' rights;
- Network healthcare associations—platform coordination; and
- Increase and advocate for the role of men in family planning.

TAKING INTO ACCOUNT THE IMPORTANT ROLE OF INTERNATIONAL ORGANIZATIONS, CIVIL SOCIETY AND ACADEMIC INSTITUTIONS ON THE PROMOTION AND PROTECTION OF THE RIGHT TO HEALTH AND OTHER RELATED HUMAN RIGHTS IN THE CONTEXT OF WOMEN AND ADOLESCENT GIRLS:

- a. What measures could be taken by PAHO and technical teams of Washington College of Law and other universities to strengthen technical cooperation with the human rights committees, organs and rapporteurships of the United Nations and Inter-American systems (such as the Inter-American Commission on Human Rights) in order to promote and protect the right to health and other related human rights of women and adolescent girls?
- Formulate technical opinions on health;
 - Participate in thematic hearings;
 - File supportive amicus briefs on human rights and right to health of women and girls;
 - Visit health centers and other institutions in countries to reduce maternal mortality;

- Make data accessible to non-health experts; and

- Support strategies and provide technical support to adopt and amend legislation to promote and protect human rights of women and girls.

- b. How could PAHO and other international agencies promote and stimulate collaboration and research with academic institutions, the private sector, civil society organizations and other social actors, when appropriate, to promote and protect human rights in keeping with the international human rights instruments that protect women and adolescent girls?

- Coordinate joint initiatives in order to set up a network for global, regional and national action;

- Develop masters programs and generate knowledge to influence the policy makers;

- Develop opportunities for student involvement with national and international organizations; and

- Conduct studies on laws and policies that have been effective.

- c. How could PAHO and other international agencies, governments and academic institutions and civil society promote the sharing of good practices and successful experiences among countries so as to prevent maternal mortality, stigmatization, discrimination and exclusion of women and adolescent girls?

- Use value added measurements to communicate effectiveness of reforms;

- Utilize online tools and discussions;

- Apply tools/publications regarding best practices; and

- Target high-profile events.