Reframing the Right to Health: Legal Advocacy to Advance Women's Reproductive Rights

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Introduction

Historically, international human rights law was not effectively conceptualized or applied to address violations of women's human rights.[1] Women were also excluded from participating in the creation and early development of international human rights law.[2] It was not until after the 1979 United Nations (UN) General Assembly's adoption of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the "broad-based, comprehensive document [that] places women's rights at the centre of international legal discourse[,]" that women's human rights finally emerged and were given force under international human rights law.[3]

The human right to health was also narrowly interpreted to exclude women's needs and experiences, and failed to address obstacles faced by women in making decisions pertaining to health and obtaining health-related services. In this context, reproductive health was relegated to the fields of population and development, and notions of reproductive rights as human rights were non-existent. The blatant exclusion of the pillars of reproductive rights – the rights to reproductive health care and to reproduc-

tive self-determination[4] – from the human rights framework was revealing in that it exposed the biased lens with which human rights have traditionally been interpreted. As a result, violations occurring to women every day in the context of their families, the workplace and communities at-large were left unexposed and disregarded as human rights violations.

A new paradigm emerged in the 1990s, however, during two UN World Conferences held in Cairo and Beijing. Consensus documents that emerged from these conferences placed women's reproductive rights squarely within the human rights framework, and deemed those rights logically inclusive within the right to health.[5] This profound shift stemmed from the emerging international consensus that "reproductive rights embrace certain human rights that are already recognized in national law, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health."[6] Since Cairo, there has been a strong movement to give meaning to and enforce Cairo's understanding of reproductive rights, leading to an expanded body of norms and jurisprudence that have broadened human rights interpretations and affirmed the notion that reproductive decision-making and access to reproductive health care services are protected by existing human rights law.[7]

This chapter seeks to highlight some of the key cases that, in the last decade, have laid the groundwork for human rights protections found in international human rights instruments to extend to reproductive rights. The successful outcomes of these cases hinged, in part, on advocates' ability to demonstrate the interdependence among human rights, thus making it possible for courts and treaty-monitoring bodies to deem reproductive rights integral to a larger constellation of human rights. This chapter also previews the next generation of legal advocacy initiatives that is building upon earlier successes, and aims to further clarify the scope of reproductive rights and their linkages to the right to health, as well as other fundamental human rights. It is precisely these linkages that will pave the way for the right to health to be recognized as a justiciable human right in an increasing number of jurisdictions. While litigation has its limitations and is but one strategy in a larger tool kit available to activists, it can be a highly effective means for furthering the understanding and enforcement of reproductive rights as basic human rights.

Landmark cases – setting the stage for the right to health to include women's reproductive health

Once a connection was made between human rights and women's reproductive health, advocates engaged in legal advocacy in an effort to address reproductive rights violations as human rights violations, under existing treaties. Below is a discussion of four recent human rights cases that serve as crucial entry points for advancements in women's reproductive rights, as premised on the right to health, among other human rights.

Criminal abortion ban overturned – Colombia – C-355/2006

In 2006, Colombia's Constitutional Court handed down an unprecedented case overturning the country's criminal abortion ban.[8] The petition before the Court argued that Colombia's Constitution required exceptions to the abortion prohibition to protect women's fundamental rights to life, health, privacy, and dignity.[9] It further argued that Colombia's refusal to permit abortion to save a woman's life, or protect her health, or in cases of rape or foetal impairment, was out of step with widely accepted norms that recognize minimum safeguards to protect women's basic human rights.[10]

The Court's decision to overturn the ban was groundbreaking in that it rested on an extensive analysis of Colombian constitutional law, as informed by the country's international legal obligations, including with respect to the right to health. The Court confirmed that "constitutional rights and obligations must be interpreted in harmony with international human rights treaties to which Colombia is a signatory[,]" and thus, international human rights treaties limit legislators' discretion, to some extent, over criminal matters.[11] The Court further affirmed that under international law, women's reproductive rights are rooted in the right to health, among other rights. Moreover, "[t]he right to health, which includes the right to reproductive health and family planning, has been interpreted by international bodies on the basis of international treaties, including CEDAW, to include the duty of all states to offer a wide range of high quality and accessible health services."[12] The Court stated that women's sexual and reproductive rights are considered fundamental rights: "Sexual and reproductive rights also emerge from the recognition that equality in general, gender equality in particular, and the emancipation of women and girls are essential to society. Protecting sexual and reproductive rights is a direct path to

promoting the dignity of all human beings and a step forward in humanity's advancement towards social justice."[13]

After recognizing the firm grounding of reproductive rights within human rights doctrines, the Court held that "laws criminalizing medical interventions that specifically affect women constitute a barrier to women's access to needed medical care, compromising gender equality in the area of health, and amounting to a violation of states' international obligations to respect those internationally recognized rights."[14] Next, the Court turned to Colombia's constitutional law obligations. It held that while the right to health "is not expressly found in the Constitution as a fundamental right," it becomes fundamental when it is "in *close relation* to the right to life."[15] The Court went on to concede that foetuses pose competing interests during pregnancy (as they are accorded some protection under Colombia's constitutional law), but confirmed that the legislature's discretion to draft and implement criminal legislation to purportedly protect foetal interests is limited due to the likelihood of "seriously impair[ing] human dignity and individual liberties."[16] In the end, the Court held that "criminalization of abortion in all circumstances entails the complete pre-eminence of the life of the foetus and the absolute sacrifice of the pregnant woman's fundamental rights. This result is, without a doubt, unconstitutional."[17]

The Colombian Court's decision set a new standard for jurisprudence promoting and safeguarding women's reproductive rights. It reaffirmed a recognition of reproductive rights as human rights and demonstrated a progressive understanding of the interdependence of human rights and governments' responsibility to comply with both national and international law. The Court also found a right-to-health violation, despite this right not being considered a "fundamental" right in Colombia's constitution, based on the intricate connection between health and the right to life. In the end, the Court's decision was revolutionary in its recognition of the synergy between health rights and interests and other human rights, and its innovative application of international law at the domestic level.

Forced sterilization

While the Colombian Court safeguarded women's ability to terminate pregnancies in certain circumstances, other courts have advanced women's right to health in connection with their right to bear children and to make

informed choices pertaining to their reproductive health. The two cases that follow – one before the Inter-American Commission on Human Rights and the other under the Optional Protocol to CEDAW – have led to marked success in terms of recognizing women's rights to health, physical integrity, equal protection of the law, freedom from gender-based violence, access to information and advice on family planning, appropriate services in connection with pregnancy, and to freely and responsibly decide the number and spacing of their children.

María Mamérita Mestanza Chávez v. Peru

María Mamérita Mestanza Chávez was a 33-year-old rural woman from Cajamarca, Peru, who was threatened by hospital officials with being reported to the police if she did not agree to undergo surgical sterilization.[18] Mestanza was coerced to submit to a tubal ligation, without a prior medical examination and without providing informed consent to the procedure, and was then discharged after the surgery, despite experiencing serious complications. Her health deteriorated over the next few days, but physicians refused to treat her and she died.

On 15 June 1999, advocates filed a petition on Mestanza's behalf with the Inter-American Commission on Human Rights, alleging violations of the rights to life[19] and personal integrity.[20] The petition further alleged that Mestanza's right to health[21] was violated when state agents put her physical health at risk by performing unnecessary surgery without her informed consent, and that health officials violated her rights to equality[22] and non-discrimination[23] when they gave her partner the sole authority to decide whether she should undergo the invasive sterilization procedure.

In Mestanza's case, her family members did not have access to an effective judicial remedy after her death[24] because state authorities refused to conduct an impartial investigation of her wrongful death. The parties signed a friendly settlement on 26 August 2003, recognizing violations of the rights to life, physical integrity and humane treatment, equal protection of the law, and freedom from gender-based violence. The agreement provided monetary damages to Mestanza's family and called for modifications to discriminatory legislation and policies. The agreement also mandated prompt implementation of the recommendations made by Peru's Human Rights Ombudsman, which included improving pre-operative evaluations of women being sterilized, providing better training for health personnel, creating a procedure to ensure timely handling of patient com-

plaints within the health care system, and implementing measures to ensure that women give genuine informed consent, including enforcing a 72-hour waiting period for sterilization.[25]

The *Mestanza* case marks the first time that human rights advocates directly pressured a government in the Inter-American system, through human rights litigation, to concede to reproductive rights violations by state actors. Further, while the resulting agreement only conceded to violations contained in the American Convention, in which the right to health is not included, it positioned reproductive health violations within the regional human rights framework. It promoted women's health-related rights and sent a strong message to governments by validating the inherent connection between health and related human rights, rejecting coercive practices and mandating improvements in health care procedures and training for health personnel. Therefore, *Mestanza* supports the notion that health interests are integral to other related human rights, and that, over time, the right to health would be more prominent in the Inter-American context.[26]

A. S. v. Hungary

A similar case was recently brought before the CEDAW Committee against the Government of Hungary on behalf of a Hungarian Roma woman who was sterilized without her informed consent.[27] In *A. S. v. Hungary,* advocates relied upon CEDAW's explicit protection of women's right to health under Article 12.[28]

A. S. was a pregnant Hungarian woman of Roma origin, who, on 2 January 2001, was taken by ambulance to a public hospital because she was experiencing labour pain, her amniotic fluid had broken and she was bleeding heavily. When she arrived at the hospital, A. S. was dizzy, still bleeding heavily and in a state of shock. The attending physician informed A. S. that the foetus had died in her womb and that an immediate caesarean section was necessary. While on the operating table, A. S. was asked to sign a consent form, as well as a barely legible hand-written note that read: "Having knowledge of the death of the embryo inside my womb I firmly request my sterilization [a Latin term unknown to the author was used]. I do not intend to give birth again; neither do I wish to become pregnant."[29] Hospital records confirm that the caesarean, the removal of the dead foetus and placenta, and the sterilization occurred within seventeen minutes of A. S.'s arrival at the hospital.[30]

A. S. learned the meaning of the term "sterilization" only upon her departure from the hospital when she asked the doctor when she could have another baby. She later confirmed that she would never have agreed to the procedure. As a result of being sterilized, A. S. fell into a depression for which she was medically treated.[31]

After failing to obtain relief from the Hungarian courts, advocates submitted a communication to the CEDAW Committee, alleging violation of A. S.'s rights to access to information and advice on family planning,[32] to access health care services, including services in connection with pregnancy,[33] and to freely and responsibly decide on the number and spacing of her children.[34] The Committee found that Hungary had failed to provide, through hospital personnel, appropriate information and advice to A. S. on family planning.[35] It referred to General Recommendation 21, "which recognizes in the context of 'coercive practices which have serious consequences for women such as forced … sterilization' that informed decision-making about safe and reliable contraceptive measures depends upon a woman having 'information about contraceptive measures and their use, and guaranteed access to sex education and family planning services.'"[36] In making its decision, the Committee considered the fact that given A. S.'s state of health when she arrived at the hospital, any counselling that might have been provided was given "under stressful and most inappropriate conditions."[37] CEDAW protects A. S.'s right to "specific information on sterilization and alternative methods for family planning in order to guard against such an intervention being carried out without her having made a fully informed choice."[38] Hungary failed to ensure this right.

The Committee also found that by failing to ensure that A. S. provided her "fully informed consent" to be sterilized, Hungary violated A. S.'s right to access health care services, including those in connection with pregnancy.[39] For A. S. to have been able to make a "well-considered and voluntary decision to be sterilized," hospital personnel were obligated to provide A. S. "with thorough enough counselling and information about sterilization, as well as alternatives, risks and benefits."[40] Examining the circumstances, the Committee determined that it was implausible that health personnel complied with the above requirements in the hurried seventeen-minute timespan between A. S.'s arrival at the hospital and the completion of the surgeries, especially given her compromised physical and mental state.[41] The Committee further noted that A. S. did not understand the Latin term for "sterilization", as evidenced by her question to the doctor about future

pregnancies.[42] As such, under the circumstances, her signature on the consent form did not constitute consent.

Finally, the Committee found that Hungary violated A. S.'s right to freely and responsibly decide the number and spacing of her children.[43] By failing to obtain her full and informed consent to be sterilized, A. S. was "permanently deprived … of her natural reproductive capacity."[44]

As a remedy, the Committee called for Hungary to provide A. S. compensation "commensurate with the gravity of the violations of her rights."[45] The decision also requires Hungary to take the following general measures: To ensure that health centre personnel are aware of and adhere to requirements for women's reproductive health under the Convention; to review and if necessary amend legislation regarding the requirement of informed consent for sterilization, as to ensure conformity with international human rights and medical standards; and to monitor health centres performing sterilizations to ensure that fully informed consent is obtained prior to carrying out the procedures and that, in cases of the breach of this requirement, sanctions be issued.[46] Finally, the Committee stated that the decision, including the above recommendations, should be translated into Hungarian and then "widely distributed in order to reach all relevant sectors of society."[47]

Similar to the *Mestanza* case, *A. S. v. Hungary* affirms the stark infringement of human rights associated with forced sterilization. The cases also demonstrate that the right to health can be promoted through varying strategies and regardless of whether the underlying source of law contains an explicit right to health, like Article 12 of CEDAW; or through making the linkage between one's health status and a constellation of human rights, as reflected in the Mestanza settlement.

Access to abortion – K. L. v. Peru

In October 2005, the United Nations Human Rights Committee handed down a landmark decision regarding women's access to abortion in *K. L. v. Peru*.[48] In considering an individual complaint submitted under the Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR),[49] the Human Rights Committee held the Peruvian government in breach of its Covenant obligations for denying access to a therapeutic abortion permitted by its own domestic law. It ordered the state to provide the complainant with an effective remedy, including compensation, and to take steps to prevent the future occurrence of similar violations.

K. L. v. Peru involved a seventeen year-old Peruvian girl (K. L.) who became pregnant with an anencephalic foetus, which posed risks to her life and mental health if the pregnancy continued.[50] Despite medical recommendations to terminate K. L.'s pregnancy, Peru's state hospitals denied her request for an abortion because they claimed it fell outside the health and life exceptions to Peru's abortion ban, as there is no explicit exception for foetal impairment. She was compelled to give birth to the anencephalic girl and breast-feed her for the four days that she lived. After the baby's death, K. L. became severely depressed, requiring psychiatric treatment.

Three non-governmental organizations (NGOs) submitted a complaint to the Committee on K. L.'s behalf,[51] alleging that state authorities' denial of K. L.'s legal right to therapeutic abortion violated her right to have her rights ensured and respected,[52] along with her rights to equality and non-discrimination,[53] life,[54] freedom from torture and cruel, inhumane and degrading treatment,[55] privacy,[56] special measures for minors,[57] and equal protection of the law.[58]

The Committee found Peru in violation of several Covenant obligations.[59] The Committee reasoned that her depression and emotional distress were foreseeable and the state's omission in "not enabling [K. L.] to benefit from a therapeutic abortion was … the cause of the suffering she experienced."[60] Therefore, the denial of an abortion that puts at risk a woman's physical and mental health can be deemed a violation of her fundamental right to be free from cruel, inhuman and degrading treatment, as recognized under the Covenant.[61]

Notably, when deciding K. L.'s right to privacy, the Committee relied on the World Health Organization's holistic definition of health to interpret therapeutic abortion as permitted under Peruvian law; it found that since K. L. was legally entitled to an abortion, "the refusal to act in accordance with the author's decision to terminate her pregnancy was not justified …"[62] Infringing on K. L.'s rights in this regard, in turn, violated her right to privacy. The Committee also noted K. L.'s "special vulnerability" as a minor girl by recognizing the unique barriers and susceptibility to rights violations that adolescents face when attempting to access abortion.[63] Finally, the Human Rights Committee held that the state had a duty to provide a legal and administrative mechanism to prevent or redress rights violations.[64]

The significance of the *K. L.* case is immense because it marks the first time a UN human rights body has held a government accountable for failing to ensure access to reproductive health services to an individual. Under

K. L., the Human Rights Committee requires a broad reading of statutory health exceptions to include issues of mental health, the positive realization of a right to access abortion for states that permit abortions, necessary measures to guarantee adolescents' access to reproductive health services, and accessible, economically feasible procedures to appeal a doctor's refusal to perform a legal abortion.

Moreover, though the right to health is not enshrined within the ICCPR, the Human Rights Committee contributed to the understanding of this right by linking the denial of a reproductive health service that had devastating consequences for woman's health to violations of the rights to be free from cruel, inhumane and degrading treatment and to privacy, among others.

The value of the aforementioned cases cannot be overstated. These cases have expanded understandings of the meaning of human rights, laying the groundwork for further developments and interpretations of the right to health. They have also solidified international standards that have developed over the past ten years, confirming that women's reproductive rights are indeed human rights, and integral to the right to health. Finally, these cases highlight a new trend of women's rights advocates playing an active role in litigating within their own judicial systems to demand protection of reproductive health – and when their efforts fail, the willingness to seek redress within regional and international human rights systems.

The next generation – current advocacy initiatives expanding notions of the right to health while challenging restrictions on reproductive rights

Not only have there been advancements in the realm of the right to health, but a new generation of advocacy initiatives challenging reproductive rights violations is seeking to further bolster and clarify the human right to health. These initiatives include broader and more targeted allegations to further expand human rights interpretations and recognition of women's reproductive rights. They also seek to solidify a global understanding that access to quality reproductive health care is in fact a human right and one which is necessary to ensure protection of other rights such as the rights to life, health and equality and non-discrimination. Below is a brief discussion of recent initiatives to overturn a contraceptive ban, to hold a government accountable for its poor track record regarding maternal mortality, and

to mandate that a government incorporate comprehensive, non-biased, science-based sexuality and reproductive health education into its national curriculum.

Challenge to Manila City's contraception ban before the Philippine High Court

On 30 January 2008, twenty women and men from Manila filed a case in a Philippine High Court against the Office of the Mayor of the City of Manila and the City Health Department of the City of Manila arguing that the city's eight-year ban on contraception has severely and irreparably damaged their lives and health, as well as that of the majority of women in Manila City.[65]

In 2000, former Mayor Jose "Lito" Atienza issued an Executive Order declaring that "[t]he City promotes responsible parenthood and upholds natural family planning not just as a method but as a way of self-awareness in promoting the culture of life while discouraging the use of artificial methods of contraception like condoms, pills, intrauterine devices, surgical sterilization, and others."[66] While this Order did not explicitly ban "artificial" contraception, in its application, the Order prohibits city hospitals and health centres from providing "artificial" family planning services. The fact that the majority of Filipinos rely on public facilities for health care services has exacerbated the irreversible and long-term effects of the ban on women and their families. Furthermore, the Order has chilled the provision of reproductive health information and services by private facilities and NGOs, despite the fact that they are not subject to the Order.

The sweeping Order violates the Philippine Government's national and international legal obligations to, among other things, protect and ensure the rights to health and well-being, dignity, due process, privacy and equal protection of the laws. It also violates the right of spouses to "found a family in accordance with their religious convictions and the demands of responsible parenthood,"[67] the right of families to "participate in the planning and implementation of policies and programmes that affect them,"[68] as well as the obligation of local governments to ensure the availability of all methods of family planning.[69]

When the new Mayor, Alfredo S. Lim, took office in July of 2007, local NGOs called upon Mr. Lim on various occasions to revoke the ban. Local organizations Likhaan and ReproCen also partnered with the Center for

Reproductive Rights to publish a fact-finding report entitled *Imposing Misery: The Impact of Manila's Contraception Ban on Women and Families,* documenting the devastating impact of the ban on women and their families, and calling upon the local government to take action.[70] Nevertheless, after it became clear that the Mayor would not take action, ReproCen filed *Osil v. Office of the Mayor of the City of Manila, City Health Department of the City of Manila,* on behalf of twenty petitioners directly affected by the contraceptive ban.[71] The petition called upon the Philippine Court of Appeals to cease implementation of the Order while the case is pending and to ultimately issue a writ annulling the Order.[72]

The Philippine Court of Appeal recently dismissed the Petition on two procedural grounds: (1) the litigants failed to submit tax declarations to prove they were pauper litigants; and (2) the litigants should have first filed the petition before the Regional Trial Court of Manila. Soon thereafter, the petitioners filed a motion for reconsideration, asserting that the dismissal was unfounded as they had paid the necessary court filing fees, thus negating any obligation to prove that they were pauper litigants seeking exemption from fee payment. Moreover, legal precedent confirmed that both the Court of Appeal and the Supreme Court can determine petitions that have not been first adjudicated in a lower court, when there are no questions of facts but simply questions of law, specifically constitutional law. The Court of Appeal again dismissed the motion, yet it is currently unclear on what grounds. The petitioners are now strategizing what step to take next; however, if they are unable to obtain redress at the national level, recourse may be sought within the UN human rights system.

The fact that treaty-monitoring bodies have increasingly issued interpretations and jurisprudence protecting and promoting reproductive rights over the past ten years has provided groups such as ReproCen with the tools to argue, with increased credibility and force, that an order such as this one violates the human rights of women and girls. It also enables NGOs, as in this instance, to directly challenge the city government. If successful, the *Osil* case will be another example of a national forum enforcing human rights at the domestic level, while also strengthening human rights as a whole.

Challenge to Brazil's high incidence of preventable maternal mortality before the CEDAW Committee

On 30 November 2007, the Center for Reproductive Rights and Citizens' Advocacy for Human Rights (ADVOCACI) filed a complaint before the CEDAW Committee on behalf of Alyne da Silva Pimentel Teixiera (Alyne), a pregnant Afro-Brazilian woman who died of preventable maternal mortality.[73] Pregnant with her second child, Alyne arrived at a hospital on 11 November 2002, complaining of nausea. Without being admitted or examined, she was sent home with anti-nausea medication, vitamins and cream. Two days later, she learned that there was no foetal heartbeat, and after a long delay, doctors assisted her in giving birth to the stillborn foetus. Following the surgery, Alyne began to haemorrhage and her symptoms worsened, but doctors neglected to perform any tests diagnosing her illness. She died five days after her initial visit to the health centre.[74]

For four and a half years, Alyne's family sought recourse within Brazilian courts, to no avail. Human rights advocates then took up Alyne's cause by initiating international litigation before the CEDAW Committee.[75] The petition alleged that the Government violated Alyne's rights to life, health, and redress in Brazilian courts. These rights are grounded in both Brazil's constitution and international human rights treaties, CEDAW in particular.[76] The petition also highlights the racial and socio-economic factors that contribute to treatment disparities in Brazil, as indigenous, poor, single and Afro-descendent women are disproportionately affected by the country's high rates of pregnancy-related deaths. In the end, the petition requests that the Brazilian Government compensate Alyne's family, including her nine year-old daughter, prioritize the reduction of maternal mortality, including training providers and establishing and enforcing protocols, and improve care in vulnerable communities.

The *Alyne* case is significant in that it is the first petition to be filed against a Latin American country before the CEDAW Committee. Furthermore, it is the first case that has the potential to build from the CEDAW Committee's analysis and recommendations regarding preventable maternal mortality as a violation of human rights – and in so doing, confirms that there is strength behind treaty-monitoring body interpretations and jurisprudence. If successful, the *Alyne* case will lead to recognition of government accountability for preventing maternal deaths and state obligations to promote women's health.

Challenge to Croatia's biased, inaccurate sexuality education programme before the Council of Europe

On 10 October 2007, the first international legal challenge to a biased, non-science-based sexuality education programme was brought before the European Committee of Social Rights.[77] Interights, in collaboration with the Center for Reproductive Rights and the Center for Education and Counselling of Women, filed a collective complaint against the Croatian Government for its sponsorship of Teen STAR, an extra-curricular educational programme that draws from Catholic ideology to promote abstinence, to the exclusion of all other alternatives such as contraception. The complaint also challenges the Government's proposed implementation of the nearly identical GROZD (Glas Roditelja Za Djecu [Parents' Voice for Children]) programme into the country's national curriculum.

Both Teen STAR and the GROZD programme promote abstinence only, discourage contraceptive use, discount the effectiveness of condoms, disparage relationships outside of a traditional family model, analogize lesbian, gay, bisexual and transgender (LGBT) relationships to socially "deviant" phenomena, and reinforce stereotypes such as the notion that stay-at-home mothers make for better families. Despite research and public outcry criticizing the Teen STAR and GROZD programmes, including pleas by Croatia's own Ombudspersons for Children's Rights and Gender Equality, the Croatian Government has continued to promote inaccurate, biased education for the country's youth.

As a signatory of the European Social Charter, Croatia has agreed to protect the social and economic rights of its citizens, including providing young people with accurate and comprehensive sexuality education. Article 11 of the Charter requires states to take appropriate measures "to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health."[78] This commitment has been interpreted by the Committee to include the provision of sexual and reproductive health education throughout the whole period of a young person's education and as part of the school curricula. As such, human rights advocates are attempting, through international litigation, to hold the Croatian Government responsible for failing to protect the health and well-being of its citizens, and more specifically, for creating a generation of youth ignorant of the dangers of HIV/AIDS and other sexually transmitted infections, which can have devastating health consequences. This recent endeavour is groundbreaking because if the Committee decides

against Croatia, it would be the first time an international human rights body reinforced the principle that failing to provide comprehensive, science-based, non-discriminatory sexual and reproductive health education violates young people's human rights, including their right to health.

Conclusion

Over the past ten years, treaty-monitoring bodies' interpretations and jurisprudence regarding women's human rights have led to a marked expansion in recognition of the right to health, particularly as it relates to women's reproductive health. With this foundation, advocates have been given a platform to further reinforce the right to health and protections of health by making linkages to other human rights. As such, they have pressured governments to comply with their international human rights obligations related to health through litigation, as in the Colombian Constitutional Court Case C-355/2006 and *A. S. v. Hungary;* pressed for positive realization of women's reproductive health and autonomy rights through friendly settlements, as in *María Mamérita Mestanza Chávez v. Peru;* and supported an understanding and connection of a woman's health status and the broader human rights frameworks, through the lens of the ICCPR, as in *K. L. v. Peru*. In turn, all of these cases have sought to affirm the interdependence between the right to health and related fundamental human rights.

As the first phase of advocacy has led to increased recognition of the right to health, advocates must continue to devise creative strategies and pursue them in multiple fora to further promote the right to health as an independent, justiciable right, while still recognizing the intricate interdependence between all human rights. In the process, advocates should also ensure that women's experiences are addressed and redressed within the human rights framework. In the end, it is the synergy between human rights that makes the dynamic advancement of the human right to health possible.

1 See Rebecca Cook, 'Women's International Human Rights Law: The Way Forward', in R. Cook (ed.), *Human Rights of Women: National and International Perspectives* (Philadelphia: University of Pennsylvania Press, 1994) at 10.

2 See B. E. Hernandez-Truyol, 'Human Rights Through a Gendered Lens: Emergence, Evolution, Revolution', in K. D. Askin and D. M. Koenig (eds.), *Women and International Human Rights Law* (Vol.1, Ardsley, NY: Transnational Publishers, 1999) at 3. Even today, women continue to be underrepresented in key international courts and tribunals. See Christine Chinkin et al., 'Feminist Approaches to International Law: Reflections from Another Century', in D. Buss and A. Manji (eds.), *International Law: Modern Feminist Approaches* (Oxford: Oxford University Press 2005) at 20.

3 See Hernandez-Truyol, *supra* note 2, at 4; see also Convention on the Elimination of All Forms of Discrimination against Women (1979) (CEDAW).

4 For a detailed description of these principles and their grounding in human rights law, see Center for Reproductive Rights, *Gaining Ground: A Tool for Advancing Reproductive Rights Law Reform* (New York: Center for Reproductive Rights, 2006) at 14–16.

5 The advancements made during Beijing and Cairo were preceded by the 1993 Vienna World Conference on Human Rights, in which women's rights in general were positioned as human rights, thanks to the dedicated efforts of women's rights activists. See C. Romany, 'On Surrendering Privilege: Diversity in a Feminist Redefinition of Human Rights Law' in M. Schuler (ed.), *From Basic Needs to Basic Rights: Women's Claim to Human Rights* (Washington, D. C., 1995) at 544–547.

6 Programme of Action of the International Conference on Population and Development, Cairo, Egypt, 5–13 September 1994, U. N. Doc. A/CONF.171/13/Rev.1, at para. 7.3.

7 For a summary and analysis of UN treaty-monitoring body interpretations of reproductive rights, see Center for Reproductive Rights, *Bringing Rights to Bear: An Analysis of the Work of U.N. Treaty Monitoring Bodies on Reproductive and Sexual Rights* (New York: Center for Reproductive Rights, 2008.

8 See Sentencia C-355/06, Constitutional Court of Colombia (2006). Cited in Women's Link Worldwide (ed.), *C-355/2006: Excerpts of the Constitutional Court's Ruling that Liberalized Abortion in Colombia* (Spain: Women's Link Worldwide, 2007). For more information on the case, visit www.womenslinkworldwide.org.

9 See ibid. at 14–15.

10 See ibid. at 15–16.

11 See ibid. at para. 8.4, at 45.

12 See ibid. at para. 7, at 28

13 See ibid. at para. 7, at 32.

14 See ibid. at para. 7, at 29.

15 See ibid. at para. 8.3, at 41. Justiciable rights are generally deemed to be the group of rights that can be demanded before a tribunal and therefore are regarded as enforceable rights. In Colombia, these are adjudicated through the writ of protection of fundamental rights. The writ of protection of fundamental rights is found in Article 86 of the Colombian Constitution that states that through this action any individual whose fundamental rights are threatened or breached can request any judge to protect these rights. Citizens can present their claims in an informal way without the need of a lawyer. Judges have a strict term of ten days to rule on each case. Every case is sent to the Constitutional Court who can choose on a discretional basis to revise the ruling. Article 49 of Colombia's Constitution protects the right to health, which belongs to the chapter that recognizes economic, social and cultural rights in Colombia's Constitution. Therefore, it is not considered as a justiciable right by itself. Nevertheless, the Constitutional Court in Colombia has determined that there are other rights, generally the ones addressed as social rights, i.e. the right to health that can be protected by a constitutional tribunal when they have an intrinsic or close connection with fundamental rights, as the right to life or dignity.

16 See ibid. at para. 10.1, at 49.

17 See ibid. The Court found disproportionate the criminalization of abortion when the continuation of the pregnancy implied a risk to a woman's life or health because it is excessive to demand the sacrifice of a formed life to protect a developing life. It also affirmed that the prohibition of abortion under the stated circumstances would constitute a breach of the State's international obligations under different human rights' treaties. The Court explicitly acknowledged that the risk to a woman's health included mental health in accordance with Article 12 of the International Covenant on Economic, Social and Cultural Rights.

18 See *María Mamérita Mestanza Chávez v. Peru,* Case 12.191, Inter-American Commission on Human Rights, Report No. 66/00, OEA/Ser. L/V/II.111, Doc. 20 (2000) (hereinafter Friendly Settlement, *María Mamérita Mestanza Chávez v. Peru*).

19 See American Convention on Human Rights (1978), Article 4 (American Convention); Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (1994) (Convention of Belém do Pará), Articles 3, 4.

20 See American Convention, *supra* note 19, at Article 5; Convention of Belém do Pará, *supra* note 19, at Articles 1, 4, 7.

21 See Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) at Article 10; Convention of Belém do Pará, *supra* note 19, at Article 2; CEDAW, *supra* note 3, at Article 12.

22 See Convention of Belém do Pará, *supra* note 19, at Article 4.

23 See American Convention, *supra* note 19, at Article 1.

24 See Friendly Settlement, *María Mamérita Mestanza Chávez v. Peru, supra* note 18, at section IV.

25 See ibid.

26 Another case that reinforced the connection between the right to health and other fundamental rights is *Villagrán Morales et al. v. Guatemala,* in which the Inter-American Court of Human Rights concluded that the right to life includes "not only the right of every human being not to be deprived of his life arbitrarily, but also the right that he will not be prevented from having access to the conditions that guarantee a dignified existence." Such conditions include the right to health. In addition, the Court's Advisory Opinion *Juridical status and human rights of the child,* issued three years later in 2002, defines the notion of a "decent life" as including protection of the right to health, among others. See M. F. Tinta, 'Justiciability of Economic, Social, and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions' 29(2) *Human Rights Quarterly* (2007) at 446–7.

27 See *A. S. v. Hungary,* United Nations Committee on the Elimination of Discrimination against Women, Communication No. 4/2004, U. N. Doc. CEDAW/C/36/D/4/2004 (2006) (hereinafter *A. S. v. Hungary*).

28 Article 12 of CEDAW establishes that states parties must "take all appropriate measures … in the field of health care in order to ensure … access to health care services, including those related to family planning." In interpreting this provision, the Committee has established that provision of services has to guarantee women's dignity and informed consent. See Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24 on Women and Health,* U. N. Doc. A/54/38 (1999) (confirms that "acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity …").

29 *A. S. v. Hungary, supra* note 27, paras. 2.2, 2.3.

30 See ibid. at para. 2.3.

31 See ibid.

32 See CEDAW, *supra* note 3, at Article 10(h).

33 See ibid. at Article 12.

34 See ibid. at Article 16(1)(e).

35 See *A. S. v. Hungary, supra* note 27, at para. 11.2.

36 Ibid. at para. 11.2 (citing CEDAW, *supra* note 3, at Article 10(h) (emphasis added) and *General Recommendation No. 21*).

37 Ibid. at para. 11.2.

38 Ibid. at para. 11.2.

39 See ibid. at para. 11.4; see also, CEDAW Committee, *General Recommendation No. 24, supra* note 28.

40 Ibid. at para. 11.3.

41 See A. *S. v. Hungary, supra* note 27, at para. 11.4.

42 See ibid.

43 See ibid.

44 Ibid.; See also, Committee on the Elimination of Discrimination against Women, *General Recommendation No. 19 on Violence against Women,* U.N. Doc. A/47/38 (1993) at 1.

45 *A. S. v. Hungary, supra note 27,* at para. 11.5.

46 Ibid. at para. 11(5).

47 Ibid. at para. 11(6).

48 See *K. L. v. Peru,* Human Rights Committee, Communication No. 1153/2003, Doc. No. CCPR/C/85/D/1153/2003 (2005) (hereinafter *K. L. v. Peru*).

49 See International Covenant on Civil and Political Rights (1966) (ICCPR).

50 See *K. L. v. Peru, supra* note 48, at para. 2(2). Anencephaly is a foetal anomaly characterized by the absences of major portions of the brain; such foetuses are either stillborn or die soon after birth.

51 The organizations include Peruvian organizations Estudio para la Defensa de los derechos de la Mujer (DEMUS) and Latin American and Caribbean Committee on the Defense of Women's Rights (CLADEM), and the United States organization the Center for Reproductive Rights.

52 See Civil and Political Rights Covenant, *supra* note 49, at Article 2.

53 See ibid., Article 3.

54 See ibid., Article 6.

55 See ibid., Article 7.

56 See ibid., Article 17.

57 See ibid., Article 24.

58 See ibid., Article 26.

59 See *K. L. v. Peru, supra* note 48, para. 6(3). The rights violated included: Article 2 (respect and ensuring rights), Article 7 (freedom from torture and cruel, inhumane and degrading treatment), Article 17 (right to privacy), and Article 24 (special measures for minors). Alternatively, the Article 3 (equality and non-discrimination) claim was deemed substantiated and the Committed found it unnecessary to make an Article 6 (right to life) finding based on the finding of an Article 7 violation.

60 Ibid.

61 Notably, the Committee's finding did not depend on the lawfulness of the procedure, as there is no derogation from the right, which thus opened the possibility for both the legal and practical inaccessibility of a therapeutic abortion.

62 *K. L. v. Peru,* supra note 48, at para. 6.4.

63 Ibid. at para. 6.5.

64 See ibid. at para. 6.6.

65 Local NGO Reproductive Health, Rights and Ethics Center for Studies and Training (ReproCen) is serving as counsel. Attorneys with the Center for Reproductive Rights are serving as legal advisors in this matter.

66 Declaring Total Commitment and Support to the Responsible Parenthood Movement in the City of Manila and Enunciating Policy Declarations in Pursuit Thereof, Executive Order No. 003 (2000).

67 Constitution of the Philippines (1987), Article XV, section 3(1).

68 Ibid. at Article XV, section 3(4).

69 For more information on the devastating impact of the ban on women and their families, see Center for Reproductive Rights, *Imposing Misery: The Impact of Manila's Contraception Ban on Women and Families* (New York: Center for Reproductive Rights, 2007) available at http://www.reproductiverights.org/pdf/Philippines%20report.pdf.

70 See ibid.

71 See *Osil v. Office of the Mayor of the City of Manila,* Philippines Court of Appeals (filed 30 January 2008).

72 See ibid. at para. 1(1).

73 See *Alyne da Silva Pimentel v. Brazil,* United Nations Committee on the Elimination of Discrimination against Women (filed 30 November 2007).

74 Ibid. at paras. 2–21.

75 See ibid. Advocates relied on research indicating that approximately 4100 Brazilian women

die a year due to pregnancy-related complications, 98% of which could be prevented at a low cost, and on statistics confirming that Brazil accounts for one-quarter of Latin America's maternal mortality rate combined. See United Nations Population Fund (UNFPA), *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and The World Bank,* 23 (annex 3), available at http://www.unfpa.org/upload/lib_pub_file/717_filename_mm2005.pdf; see Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), *Monitoring Alternative Report on the Situation of Maternal Mortality in Brazil to the International Covenant on Economic, Social and Cultural Rights,* available at http://www.cladem.org/english/regional/monitoreo_convenios/descMMbrasili.asp.

76 Petitioners relied heavily on the CEDAW Committee's jurisprudence around Article 12, which requires that governments "take all appropriate measures to eliminate discrimination against women in the field of health care," and specifically requires that governments ensure access to "appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

77 See *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia,* Complaint No. 45/2007, European Committee of Social Rights (filed 10 October 2007).

78 European Social Charter (revised), Article 11(2).

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