



## REPRODUCTIVE AND SEXUAL HEALTH RIGHTS

## From reproductive choice to reproductive justice

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## ARTICLE INFO

## Keywords:

Abortion rights  
Conscientious objection  
Contraception  
Developments legal  
Reproductive health

## ABSTRACT

Since the 1994 Cairo Conference on Population and Development, the human rights movement has embraced the concept of reproductive rights. These are often pursued, however, by means to which objection is taken. Some conservative political and religious forces continue to resist implementation of several means of protecting and advancing reproductive rights. Individuals' rights to grant and to deny consent to medical procedures affecting their reproductive health and confidentiality have been progressively advanced. However, access to contraceptive services, while not necessarily opposed, is unjustifiably obstructed in some settings. Rights to lawful abortion have been considerably liberalized by legislative and judicial decisions, although resistance remains. Courts are increasingly requiring that lawful services be accommodated under transparent conditions of access and of legal protection. The conflict between rights of resort to lawful reproductive health services and to conscientious objection to participation is resolved by legal duties to refer patients to non-objecting providers.

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## 1. Introduction

The successive triennial World Reports on Women's Health that the *International Journal of Gynecology and Obstetrics* (IJGO) publishes to coincide with each FIGO World Congress of Gynecology and Obstetrics update readers on developments over time. The 1994 United Nations International Conference on Population and Development, held in Cairo, marks a time from which to measure 15 years of human rights progress leading to the Cape Town Congress in 2009. Progress has undoubtedly been achieved globally, although some countries remain locked into stagnant attitudes to reproductive health, often staunchly preserving laws imposed by European colonization, and a few have adopted regressive provisions. The pervasive movement, however, has been toward implementation of the concept of reproductive health proposed at the Cairo Conference.

Some valuable advances have been achieved through political enactment of accommodating laws, but many have been through authoritative judgments of courts that build content into the principled structures of international human rights conventions. Almost all of these conventions came into legal effect before 1994, but a recent addition to the human rights armory is the UN Convention on the Rights of Persons with Disabilities, which came into force in May 2008. This covers, for instance, those with HIV/AIDS. The convention provides in Article 23 for protection of the equal rights of all disabled persons with others to marriage, family life and parenthood, and rights "to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family

planning education... and the means necessary to enable them to exercise these rights."

The major contribution of judicial decisions to protect and advance reproductive health shows the success and wider potential of advocacy that moves from a reproductive choice paradigm to an emphasis on reproductive justice. This approach has inspired judges, and guided advocates and human rights review committees. For instance, when the US reported national developments to the UN Committee on the Elimination of Racial Discrimination (CERD) in 2007, the New York based Center for Reproductive Rights filed a letter with the Committee showing that in the US, African-American women are almost 4 times more likely to die from pregnancy-related causes than white women [1].

## 2. Consent and confidentiality rights

The role of internationally-based committees in asserting human rights principles is of increasing influence. For instance, in 2006 the Committee on the Elimination of Discrimination against Women (CEDAW) held Hungary accountable for sterilization of a Roma woman without her consent while she was receiving care for a miscarriage [2], in violation of human rights, among others, to bodily integrity, security of the person, preservation of reproductive capacity, and to racial or ethnic non-discrimination. Non-discrimination on grounds of age was protected in the English High Court, according to the UN Convention on the Rights of the Child. It rejected a challenge to the 2004 Department of Health's Best Practice Guidance for Doctors on protection of confidentiality of advice to, and treatment of, those aged under 16 regarding contraception, abortion, and sexually transmitted illnesses [3]. The Guidance provides that mature minors enjoy the same protection of confidentiality as adults.

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Confidentiality of abortion, whether induced by physicians or disclosed to them when women seek post-intervention care, is contentious where, as in Argentina, physicians and government employees must report the facts to law-enforcement authorities. The Criminal Code imposing the reporting duty contains an apparently contradictory requirement of medical professional confidentiality, except when breach is considered justifiable. A conflict may arise, however, such as between law-enforcement and medical authorities, about when justification exists. In June 2008, a federal criminal court resolved the issue consistently with women's human rights to health services, by ruling that, when a medical professional reports abortion encountered in a professional capacity, no criminal proceedings can be initiated against the woman [4].

### 3. Access to contraception

In contrast to respect for women's human rights that authoritative tribunals have shown regarding consent and confidentiality, some have subordinated such rights in apparent deference to conservative religious attitudes. In 2008, the Constitutional Court of Chile, following a similar 2002 decision of the Supreme Court of Argentina, rejected scientific evidence that emergency contraception cannot dislodge an implanted zygote, and prohibited health care facility distribution by reliance on abortion laws [5]. Even more abusive of human rights and health, particularly of women, is an as yet unreversed Executive Order issued in 2000 by the former mayor of Manila in the Philippines, that has resulted in the removal of contraceptive products and services from city health centers and hospitals [6]. The ban is reported to have "contributed to high rates of unplanned pregnancy, with all of its attendant socioeconomic and health consequences, and affected poor women most severely" [7].

As against this, however, in 2008 Colombia's highest administrative court upheld a national regulation approving the distribution of emergency contraception, explaining that it is not abortifacient [8]. Similarly, as a result of legal proceedings in the US [9], the Food and Drug Administration, which had allowed access to emergency contraception without prescription to women over 18 years, was required to consider access by younger women, on scientific, not political, grounds.

### 4. Abortion

The most contentious area of human rights to reproductive health probably concerns abortion, and legislatures and national and international tribunals have been most active here. Several countries have enacted liberalized laws, and courts have recognized abortion rights and required transparency in their legal operation, awarded compensation to women denied lawful procedures, and required governments to reimburse women for services not covered by governmental health insurance programs [10].

For instance, in 2007, Portugal expanded abortion rights beyond danger to life or health, rape, and severe fetal impairment to permit abortion on request until the tenth week of pregnancy [11]. Togo amended its prohibitive law to allow the same indications that Portugal recognized before its 2007 reforms [12]. More significant for Africa was Ethiopia's amended Criminal Code, which legalized abortion in cases of danger to women's life or health, rape and incest, fetal abnormality and women's physical or mental disability, and for minors physically or psychologically unprepared to raise a child. Further, the penalty for unlawful abortion may be mitigated for social reasons, including poverty [13].

Courts, often at the highest level, are increasingly relying on human rights covenants to introduce or uphold liberalized provisions on lawful abortion. For instance, in 2006, the Constitutional Court of Colombia recognized legality to save life and health and in cases of rape, incest, and severe fetal abnormality [14]. Similarly in 2008,

the Supreme Court of Mexico invoked human rights protected by international conventions and the national Constitution to uphold a 2007 law of the Federal District of Mexico City permitting abortion on request during the first 12 weeks of pregnancy, and requiring the public healthcare system to provide reproductive and sexual health care to all without discrimination [15].

In Europe, Slovakia has been a focus of attention. In 2007, its Constitutional Court ruled that the contested 1986 Slovak law on Artificial Interruption of Pregnancy, which permits abortion on request during the first trimester, complies with the national Constitution, including its provision on the right to life, and is lawful [16]. However, in July 2008, in response to Slovakia's report, the Committee on the Elimination of Discrimination against Women issued Concluding Observations on the government's unsatisfactory compliance with the Convention on the Elimination of All Forms of Discrimination against Women. Commenting on governmental action to bring national laws, policies, and practices into compliance, the Committee explains that it is discriminatory to neglect health services to women that only they need, such as abortion, and asked Slovakia to ensure that, if conscientious objection is invoked, women are referred in good time to non-objecting providers, so that no delay frustrates lawful delivery of the service [17].

Abortion funding obstacles caused the Superior Court of Quebec, in Canada, to find in favor of an organization that brought class action proceedings against the provincial government on behalf of women unable to obtain timely services under the government's health system. The Association for Access to Abortion persuaded the Court to order reimbursement of \$13 million to almost 45 000 women compelled to pay for abortion services in private clinics. The provincial government was aware of women's need to resort to such clinics when the public system the government undertook to provide was incapable of meeting their requests, and was found improperly to have tolerated barriers to lawful access to public services [18].

The Quebec decision has important implications for women's human rights to health care in Canada. However, the most visible abortion judgment in North America has been that of the US Supreme Court, in 2007, which upheld a restrictive 2003 law that contained an exception from criminal liability for acts to save women's lives, but not to protect women's health [19]. The right to health is expressed in Article 12(1) of the International Covenant on Economic, Social and Cultural Rights, which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." However, since the US has not ratified this covenant, the Court's majority discounted it.

The name of the Partial-Birth Abortion Act of 2003 is not of medical origin, and refers not to a specific medical procedure but to a range of second trimester pregnancy termination procedures, including those clinicians find medically indicated in women's best health interests, applying the safest and most common techniques. The law does not refer to any gestational limits, but as the Court interpreted it, prohibits use only of the procedure of dilation and evacuation, as opposed to other techniques of late termination of pregnancy. Further, although the Court found that the 2003 Act was constitutionally unobjectionable as written, it acknowledged that the Act could be successfully challenged in the future on evidence that complying with its prohibition imposed an undue burden on women, including on women's physical or mental health. In that sense, the Court's decision was inconclusive on the legality of how the law might operate in practice.

Of greater concern to protection of human rights than the Supreme Court's decision itself, is the basis on which the 5 majority justices reached it. They resurrected a discredited, paternalistic rationale that the Act's prohibition is necessary to protect women from having to make a difficult decision. In denying women a choice, they also denied women the dignity of having their decisions over their own bodies and lives respected, and accepted that legislators, overwhelmingly

male, can make decisions over women's health that women themselves cannot be allowed to make. This infantilization of women offends human rights principles of adult's self-determination and dignity, as well as rights to health, to non-discrimination, and to justice.

Offensive to human rights as the Supreme Court's majority ruling is, it falls short of the violation of women's right to life itself embodied in Nicaragua's 2006 legislation. The new law amended the Penal Code to remove permission of therapeutic abortion when 3 physicians found continuation of pregnancy to endanger a woman's life, and she and her husband or nearest other relative consented to the procedure [20]. In the absence of any successful challenge to this law in Nicaragua, the prospect of just protection for women relies upon regional or international tribunals or agencies.

## 5. Transparency

Tribunals are increasingly requiring not only that human rights be accommodated in laws and governmental practices, but also that individuals receive information on how they can make their rights effective in practice. An essential aspect of justice is that its facilities and procedures be transparent. The UN Human Rights Committee, European Court of Human Rights, Constitutional Court of Colombia and, for instance, the Northern Ireland Court of Appeal, have issued rulings to compel governmental agencies to let women know under what conditions and procedures they will have access to safe abortion services without fear or risk of subjection to police investigation or of being taken to court [21].

The government of Mexico, for example, conceded in a friendly settlement of the *Paulina* case [22] before the Inter-American Commission on Human Rights that it was responsible for violation of the human rights of an adolescent rape victim by obstruction resulting in denial of abortion to which she was lawfully entitled. State health and judicial officers applied arbitrary, manipulative, and obscure explanations to so delay lawful termination of pregnancy that the procedure became therapeutically contraindicated. Mexico accepted that the State of Baja California lacked a clear procedure to operate the exception to its criminal prohibition of abortion for rape, and had no obvious, timely and effective means of medical response, or of judicial challenge and remedy to the absence or denial of such means. The terms of the settlement addressed the needs of the 13-year-old girl, and the provision of more visible and effective means to ensure respect for the human rights of access to indicated, lawful health care of future applicants.

A common fallacy about the law in many countries is that certain contested medical procedures, not only abortion but also such as contraceptive sterilization, emergency contraception, and artificial insemination are illegal. Where false lore prevails over true law, governments in general and health and law-enforcement authorities in particular bear responsibilities under human rights conventions to make laws clear and accessible. The widespread belief, for instance, that all abortion is illegal unless allowed by explicit legislation, deters women eligible for safe, lawful procedures from seeking them, physicians from performing them, and healthcare facilities from accommodating them.

Governmental and non-governmental reports from jurisdictions around the world show how not only medical professionals but sometimes lawyers naively accept that their laws require women to die or sacrifice their physical and/or mental health and the well-being of their dependent children in obedience to prohibitive criminal laws. It is almost invariably found, however, that restrictively expressed laws have implicit exceptions to protect women's human rights to life, and to preserve their health against serious, medically-established dangers, such as from continuation of or repeated pregnancy.

In Poland, for instance, where state and church reinforce each other's opposition to abortion, courts are beginning to award compensation to women wrongly denied lawful services [23]. Similarly, in Colombia,

where the church has historically been comparably implicated in politics and affairs of state, the Constitutional Court has awarded compensation against a governmental healthcare authority for explanations of unavailable services amounting to obstruction of lawful abortion, aggravated by failure of the legal system to protect an adolescent rape victim's human rights [24].

## 6. Conscientious objection

The Constitutional Court of Colombia had to address obstruction of lawful abortion by claims of conscientious objection to that procedure [24]. This exposed a conflict of human rights, where an adolescent's right to a legally justified procedure was denied by a claim to religious conscience, which is also a protected human right. The claim to conscience fits into an emerging pattern of resistance to medical procedures, with the effect if not the purpose, to subvert implementation of the right to reproductive health. The Cairo Conference recognized this right to afford individuals "the capability to reproduce and the freedom to decide if, when and how often to do so," and to include resort to "methods of family planning of their choice... and the right of access to appropriate health-care services."

The Court's judgment resolves the conflict by denying patients the right to receive care from providers of their choice, and denying providers the right to conscience that prevents their patients from receiving lawful health services. Providers who exercise their right to object to participation in medical procedures they consider unconscionable must refer their patients to providers who do not object. This requirement is basic to ethical codes that protect providers' rights to conscience [25]. The Court held that, as a human right, conscientious objection is not available to institutions, such as hospitals, and is available against participation in medical procedures but not administrative acts, such as hospital or comparable management. Accordingly, hospitals whose staff members or other service providers object to participation bear the legal duty to refer patients to providers who do not object to deliver the services to which the patients are legally entitled.

Neither patients' choice of service providers, nor providers' choice of non-involvement in their patients' access to services the providers object to perform, is absolute. A just balance results, however, of respect for providers' human rights of objection to participate in delivering offensive services, and patients' human rights of timely access to lawful healthcare procedures. This indicates the transition of a critical focus from reproductive choice to reproductive justice.

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