REPRODUCTIVE RIGHTS AT HOME AND ABROAD

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I. Introduction

The Center for Reproductive Rights ("the Center") is a global human rights organization that uses constitutional and international law to advance reproductive freedom as a fundamental human right that all governments are obligated to respect, protect, and fulfill. Nearly twenty years ago, in 1994, the International Conference on Population and Development was held in Cairo. At this conference, 179 countries worldwide adopted a Programme of Action, which was the first international consensus document to recognize that reproductive rights are human rights.[1] The Center works to ensure that governments throughout the world are held legally accountable for the political commitments they made by adopting the Cairo Programme of Action, applying international human rights treaties to the circumstances of women's reproductive health and decision-making. In this effort, the Center has partnered with women's rights advocates around the world, working in over fifty countries, to use a range of legal and advocacy strategies—including strategic litigation, fact-finding reports, legal publications, and law reform—to advance this goal.

Strategic litigation, a core component of the Center's legal and advocacy strategies, can serve the dual goals of shaping and defining international standards and holding governments accountable when they fail to comply with these norms. On the one hand, civil society can use this norm-building tool to transform broad human rights principles into concrete protections for sexual and reproductive health. On the other hand, by presenting individual complaints before national, regional, and international adjudicatory bodies, advocates can enforce international standards by seeking redress for individual rights violations.

It is worth emphasizing that strategic litigation cannot be an isolated tactic, but rather takes place in the context of a broader

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[1] International Conference on Population and Development, Cairo, Egypt, Sept. 5–13, 1994, *Report of the ICPD*, U.N. Doc A/CONF.171/13/Rev.1 ch. 7 (1995).

advocacy strategy aimed at fostering a political, social, and cultural environment conducive to the advancement and protection of women's reproductive rights, laying the groundwork for both successful decisions and implementation of positive rulings.

The Center has litigated or supported the litigation of a number of reproductive rights cases internationally—covering such issues as access to maternal healthcare, abortion, reproductive health information, and emergency contraception, as well as the right to be free from abuse and violence in healthcare facilities—which have led to groundbreaking decisions by national, regional, and international courts. I will discuss here three of the landmark decisions that the Center has won as a way to illustrate how strategic litigation can be used to advance and protect sexual and reproductive rights. I will also discuss some of the challenges for transforming these victories into tangible protections for women's sexual and reproductive health needs.

II. Recognition of Reproductive Rights as Human Rights: Case Studies

A. K.L. v. Perú (Human Rights Committee)

Over the last fifteen years or so, the Center for Reproductive Rights has led strategies to ensure that human rights mechanisms, including United Nations (U.N.) treaty bodies and regional and national courts increasingly recognize that restrictions on access to safe and legal abortion interfere with women's enjoyment of their human rights. The groundbreaking decision by the Human Rights Committee in *K.L. v. Perú* marked the first time an international human rights body held a government accountable for failure to ensure access to abortion where it is legal.[2]

This case focused on K.L., a seventeen-year-old girl from Perú, who learned that she was pregnant with an anencephalic fetus.[3] Doctors confirmed that K.L.'s fetus would likely be born without major portions of the brain, leading to stillbirth or death and posing risks to K.L.'s life if the pregnancy continued. Thus, they advised her to terminate the pregnancy.[4] A social worker also advised K.L. to have an abortion to protect her and her family's mental health, noting that the continuation of the pregnancy "would only

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[2] Human Rights Comm., Karen Noelia Llatoy v. Perú, U.N. Doc. CCPR/C/85/D/1153/2003 (2005), *available at* http://www.umn.edu/humanrts/undocs/1153-2003.html [hereinafter K.L. v. Perú].

[3] *Id.* ¶ 2.1.

[4] *Id.* ¶ 2.2.

prolong the distress and emotional instability of [K.L.] and her family."[5]

Although abortion in Perú is illegal in most circumstances, the law recognizes a limited exception to the abortion ban in order to preserve a woman's life or health.[6] The director of one of Perú's state hospitals, however, denied K.L.'s request for an abortion, claiming it fell outside the health and life exceptions, because there is no explicit right to abortion in cases of severe fetal impairment.[7] Thus, K.L. was forced to carry her pregnancy to term and give birth. The baby died four days later and K.L. became severely depressed, requiring psychiatric treatment.[8] A psychiatrist who examined K.L. at this time concluded that "the so-called principle of the welfare of the unborn child has caused serious harm to the mother, since she has unnecessarily been made to carry to term a pregnancy whose fatal outcome was known in advance, and this has substantially contributed to triggering the symptoms of depression, with its severe impact on the development of an adolescent and the patient's future mental health."[9]

Unable to receive justice at the national level, K.L., with the assistance of the Center and local partners, filed a petition before the United Nations Human Rights Committee claiming that by denying access to therapeutic abortion, Perú violated its international obligations.

The Center chose to file this case at the U.N. Human Rights Committee because of its expansive jurisprudence in considering individual complaints. At the time, many of the other international human rights bodies had issued few decisions. Moreover, by filing the case with the U.N. Human Rights Committee, which oversees compliance with the International Covenant on Civil and Political Rights, the Center was able to invoke the articles on the rights to life,[10] privacy,[11] special protection of minors,[12] and freedom from cruel, inhuman and degrading treatment,[13] in an effort to develop

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5 *Id.* ¶ 2.4.

6 CODIGO PENAL [Criminal Code], art. 119 (Perú), *available at* http://spij.minjus.gob.pe/CLP/contenidos.dll?f=templates&fn=default-codpenal.htm&vid=Ciclope:CLPdemo.

7 *K.L. v. Perú* ¶ 2.3.

8 *Id.* ¶ 2.6.

9 *Id.* ¶ 2.5.

10 International Covenant on Civil and Political Rights art. 6, Dec. 16, 1966, 999 U.N.T.S. 171.

11 *Id.* art. 17.

12 *Id.* art. 24.

13 *Id.* art. 7.

human rights standards around denial of access to legal abortion services as violations of these rights.

In November 2005, the Human Rights Committee held that, by denying K.L. access to a legal therapeutic abortion, the State violated her rights to be free from cruel, inhuman and degrading treatment, privacy, and special protection as a minor.[14] In particular, with respect to the Article 7 right to be free from cruel, inhuman and degrading treatment, the Committee noted that Article 7 "relates not only to physical pain but also to mental suffering."[15] The Committee determined that the depression and mental anguish that K.L. suffered as a result of having to carry the pregnancy to term was a foreseeable consequence and direct result of the State's denial of the abortion.[16] Specifically, it indicated that:

> owing to the refusal of the medical authorities to carry out the therapeutic abortion, [K.L.] had to endure the distress of seeing her daughter's marked deformities and knowing that she would die very soon . . . which added further pain and distress to that which she had already borne during the period when she was obliged to continue with the pregnancy . . . . The Committee notes that this situation could have been foreseen . . . . The omission on the part of the State in not enabling the author to benefit from a therapeutic abortion was, in the Committee's view, the cause of the suffering she experienced.[17]

With respect to the right to privacy, the Committee noted that K.L. was informed by her gynecologist that she could either choose to continue with the pregnancy or terminate it, and that the State's refusal to act in accordance with her decision amounted to a violation of her Article 17 right to privacy.[18] Finally, the Committee noted that, because she was a minor, K.L. was entitled to special care under Article 24, which she did not receive during and after her pregnancy.[19]

The Committee required Perú to provide K.L. with an effective remedy, including compensation. Additionally, it recognized Perú's obligation to take steps to ensure that similar violations would not occur in the future.[20]

The Center is still negotiating with the Peruvian government

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[14] *K.L. v. Perú* ¶ 7.
[15] *Id.* ¶ 6.3.
[16] *Id.*
[17] *Id.*
[18] *Id.* ¶ 6.4.
[19] *K.L. v. Perú* ¶ 6.5.
[20] *Id.* ¶ 8.

to determine the appropriate monetary damages that should be paid to K.L. Additionally, Perú has not complied with its obligation to adopt clear legal guidelines for the provision of legal abortions. Cases like K.L.'s continue to occur. However, the Center has been consistently working for the implementation of this decision through a comprehensive strategy, including submitting memos to the Human Rights Committee on Perú's reluctance to comply with the decision, meeting with the Secretariat of the Committee to discuss this issue, and lobbying Committee members to pressure Perú to implement this decision.

Currently, K.L. is living with a relative in Spain and is studying at a university. She left Perú after her traumatic experience and has not returned since.

B. R.R. v. Poland (European Court of Human Rights)

Another piece of the Center's ongoing strategy to ensure access to safe and legal abortions has been to challenge the lack of clear legal and regulatory frameworks to implement laws permitting abortion for certain indications. In the landmark decision *R.R. v. Poland*, the European Court of Human Rights for the first time found a violation of the right to be free from inhuman or degrading treatment in an abortion-related case.[21] This was also the first time the Court recognized that states have an obligation to regulate the exercise of conscientious objection in order to guarantee patients access to lawful reproductive healthcare services.

This case focuses on R.R. who, during her eighteenth week of pregnancy, was informed that her fetus had a potentially severe malformation, and that genetic testing was required to confirm the diagnosis—information that would be crucial in her decision as to whether to carry the pregnancy to term.[22]

Abortion is legal in Poland when prenatal tests reveal a high risk that the fetus would be severely and irreversibly damaged.[23] Although R.R. was legally entitled to the genetic testing and her doctors confirmed the need for the tests, a series of doctors refused to provide her with the testing or referrals she needed. During the eight-week period that R.R. tried to access these tests, she saw six-

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[21] R.R. v. Poland, App. No. 27617/04, Eur. Ct. H.R. (2011), *available at* http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-104911.

[22] *Id.* ¶ 9.

[23] *Id.* ¶ 67; *see also* Law on Family Planning, Human Embryo Protection and Conditions of Permissibility of Abortion of January 7, 1993, as amended as of December 23, 1997, art. 4a(1)–(2), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Polish%20abortion%20act—English%20translation.pdf.

teen doctors, underwent five sonograms, and was hospitalized twice. Recognizing her need for genetic screening, all of the physicians she saw refused a referral.[24]

Unable to secure the necessary referral, she was only able to access the genetic testing she needed by going to a hospital and stating that she was in need of emergency care. This was during her twenty-third week of pregnancy.[25] Once she received confirmation that the fetus was suffering from genetic abnormalities, her requests for an abortion were denied because at that point, during her twenty-fifth week of pregnancy, the hospital determined that the fetus was already viable.[26]

A few months later, R.R. gave birth to her third child, a baby girl suffering from Turner Syndrome,[27] a genetic condition in which a female does not have the usual pair of two X chromosomes.[28] Girls with this condition are normally shorter than average, infertile and can experience health problems such as kidney and heart abnormalities.[29]

Unable to obtain sufficient redress through the Polish legal system, the Center for Reproductive Rights and local partners assisted R.R. in bringing her claim to the European Court of Human Rights, alleging that the government had violated its human rights obligations under the European Convention for the Protection of Human Rights.

In May 2011, the European Court of Human Rights found Poland to be in violation of R.R.'s right to be free from inhuman and degrading treatment and her right to privacy.[30] In its first abortion-related decision finding a violation of the Article 3 right to be free from inhuman or degrading treatment, the European Court held that the denial of health information and genetic testing services, which should have been part of normal health services, was a source of great suffering to R.R. and met the threshold of severity to find an Article 3 violation.[31] The court recognized that the fact R.R. was pregnant and deeply distressed at the potential malformation of her fetus was an aggravating factor of her suffering. R.R.'s

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24 *R.R. v. Poland* ¶¶ 12–23.

25 *Id.* ¶¶ 27-28.

26 *Id.* ¶ 33.

27 *Id.* ¶ 37.

28 *Turner Syndrome*, NAT'L INST. HEALTH, GENETICS HOME RESEARCH, http://ghr.nlm.nih.gov/condition/turner-syndrome (last visited Sept. 18, 2012).

29 *Id.*

30 *R.R. v. Poland* ¶¶ 161–62, 214.

31 *Id.* ¶¶ 159, 161.

painful uncertainty was prolonged by the physicians' repeated refusals to grant her the necessary tests.[32] Additionally, the court explicitly stated that R.R. "had been humiliated" and condemned the conduct of the health professionals involved, noting that R.R. was "shabbily treated by the doctors dealing with her case."[33] The court also explicitly noted that R.R.'s access to genetic testing "was marred by procrastination, confusion and lack of proper counseling and information,"[34] and that ultimately she received this service by "means of subterfuge."[35]

Furthermore, the court found that Poland's lack of a clear legal and procedural framework to implement access to legal abortion, denial of access to information about the fetus' health, and inadequate regulation of conscientious objection all violated R.R.'s right to respect for her private life under Article 8.[36] It held that in order to comply with its obligations under the Convention, Poland must:

> (1) provide pregnant women the practical means to establish their right of access to a lawful abortion by putting in place effective and accessible procedures to implement Poland's abortion law;[37]
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> (2) ensure an adequate legal and procedural framework to guarantee pregnant women access to diagnostic services and relevant, full, and reliable information on their pregnancy;[38]
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> (3) organize its health system in a way so that conscientious objection of health professionals does not impede access to legal health services;[39] and
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> (4) formulate provisions regulating the availability of lawful abortion in a way as to alleviate the chilling effect on doctors that current legal restrictions may have.[40]

Additionally, the court awarded 45,000 Euros to R.R. in non-pecuniary damages, as well as 15,000 Euros for legal fees.[41]

The judgment in this case was recently finalized and the Polish Ministry of Health is in the process of preparing an action plan to present to the Committee of Ministers, which oversees compliance

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[32] *Id.* ¶ 159.
[33] *Id.* ¶ 160.
[34] *Id.* ¶ 153.
[35] *R.R. v. Poland* ¶ 153.
[36] *Id.* ¶¶ 197, 200, 206, 213–14.
[37] *Id.* ¶ 213.
[38] *Id.* ¶¶ 197, 200.
[39] *Id.* ¶ 206.
[40] *R.R. v. Poland* ¶ 193.
[41] *Id.* ¶ 5.

with judgments from the European Court of Human Rights. The Center and its partners are continuing to monitor developments in this decision and are devising a strategy for its implementation.

Since giving birth, R.R. has been struggling to provide her daughter with the life-long medical care that she requires on a daily basis. Such care is costly and relatively difficult to obtain in Poland. Moreover, after the birth of the baby, R.R.'s husband left her.[42]

C. Alyne da Silva Pimentel v. Brazil (Committee on the Elimination of Discrimination against Women)

The Center has also been working for almost two decades on the recognition that maternal mortality is a human rights imperative. We advocate that U.N. treaty bodies call upon governments to ensure women's access to maternal healthcare; abolish practices that are prejudicial to women's health; and enable women to plan their pregnancies by promoting access to family planning. Just last year, the Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW") Committee issued a decision in the case of *Alyne da Silva Pimentel v. Brazil*, the first U.N. decision holding a government accountable for failing to meet its human rights obligations to combat preventable maternal mortality.[43]

Alyne, an Afro-Brazilian woman and a resident of one of Rio de Janeiro's poorest districts, was repeatedly delayed in receiving access to emergency obstetric care when she was six months pregnant with her second child. This ultimately led to her preventable death.[44]

Brazil's maternal mortality rates are considerably higher than less economically developed countries.[45] Indigenous, low-income, and Afro-descendant women are disproportionately affected by maternal mortality.[46]

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42 *Id.* ¶ 178.

43 Comm. on the Elimination of Discrimination Against Women, Views of the Committee on the Elimination of Discrimination Against Women Under Article 7, Paragraph 3, of the Optional Protocol to the Convention on the Elimination of all Forms of Discrimination Against Women Concerning Communication No. 17/2008, CEDAW/C/49/D/17/2008 (July 25, 2011), *available at* http://www2.ohchr.org/english/law/docs/CEDAW-C-49-D-17-2008.pdf [hereinafter Alyne v. Brazil].

44 *Id.* ¶¶2.1-2.12.

45 Braz. U.N. Country Team, A U.N. Reading of Brazil's Challenges and Potential: Common Country Assessment, ¶ 40 (Aug. 2005), *available at* http://www.undg.org/archive_docs/7631-Brazil_CCA.doc.

46 *See generally* COMITÉ LATINOAMERICANO Y DEL CARIBE PARA LA DEFENSA DE LOS DERECHOS DE LA MUJER (CLADEM), MONITOREANDO EL REPORTE ALTERNATIVO SOBRE LA

Alyne first sought medical attention at her local health center when she experienced vomiting and severe abdominal pain. Although these signs indicated a high-risk pregnancy, doctors performed no tests and Alyne was sent home.[47] When she returned to the health center two days later, doctors discovered that there was no fetal heartbeat.[48] A few hours later, she delivered the stillborn fetus.[49] Despite medical standards dictating that Alyne should have undergone an immediate curettage surgery to remove placental parts and to prevent hemorrhage and infection, she did not undergo surgery until approximately fourteen hours later.[50]

Following surgery, Alyne experienced severe hemorrhaging, low blood pressure, and disorientation.[51] As her condition worsened, doctors determined that she needed to be transferred from the health center to a hospital with adequate equipment to treat her condition.[52] The staff at the hospital to which she was transferred was only given a brief oral account of her medical condition and treated Alyne without knowledge that she had just delivered a stillborn fetus.[53] Although she was temporarily resuscitated, her blood pressure suddenly plummeted to zero and she was left on a makeshift bed in an emergency room hallway.[54] She died on November 16, 2002, twenty-one hours after her arrival at the hospital,[55] of an entirely preventable condition.

Alyne's mother sought redress for her daughter's death by filing a petition for civil indemnification for material and moral damages against the state-sponsored healthcare system. To date, the Brazilian judiciary has failed to provide any effective or timely remedy.[56]

The Center and its local partner filed a petition before the Committee on the Elimination of Discrimination against Women

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SITUACIÓN DE LA MORTANDAD MATERNA EN BRASIL PARA LA CONVENCIÓN INTERNACIONAL SOBRE LOS DERECHOS ECONÓMICOS, SOCIALES Y CULTURALES [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/monitoreo/informes-alternativos/Brasil/Comite_DESC/2003-Mortandad-materna-Esp.pdf.

47 *Alyne v. Brazil* ¶ 2.2.
48 *Id.* ¶ 2.4.
49 *Id.* ¶ 2.5.
50 *Id.* ¶ 2.6.
51 *Id.*
52 *Alyne v. Brazil* ¶ 2.8.
53 *Id.* ¶ 2.10.
54 *Id.* ¶ 2.9.
55 *Id.* ¶ 2.12.
56 *Id.* ¶ 3.14.

(CEDAW Committee), alleging that the Brazilian government had failed to identify and address the barriers to maternal healthcare, particularly for marginalized women. The Center chose to file this case before the CEDAW Committee, which oversees compliance with CEDAW, because of its focus on discrimination. This Committee was uniquely positioned to recognize the multiple forms of discrimination that Alyne experienced when she was denied access to maternal health services—services that only women need.

In August 2011, the CEDAW Committee held that, by failing to provide appropriate maternal health services, the Brazilian government had violated its obligations to ensure the right to health and take all appropriate measures to eliminate discrimination against women, including by private actors.[57] In particular, the CEDAW Committee found that the State had neglected its due diligence obligation to regulate and monitor the provision of healthcare services by private healthcare institutions under Article 2(e),[58] as well as its obligation to ensure appropriate services in connection with pregnancy under Article 12.[59] The Committee noted in particular that Alyne's lack of access to quality and appropriate maternal healthcare systems stemmed from multiple forms of discrimination, which the State had failed to address.[60] The Committee also held that the State had failed to ensure effective judicial protection and to provide adequate remedies to Alyne's family, in violation of the Convention.[61]

The Committee ordered that the government provide appropriate reparations to Alyne's mother and daughter, including adequate compensation.[62] The Center is in the process of negotiating with the government to determine the amount of such compensation. Additionally, the Committee ordered the government to ensure women's right to safe motherhood and affordable access to adequate emergency obstetric care, provide professional training for health workers, ensure that private healthcare facilities comply with national and international standards on reproductive healthcare, and ensure sanctions are imposed on health professionals violating women's reproductive rights.[63]

The Center, in consultation with Brazilian experts and non-

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57 *Alyne v. Brazil* ¶¶ 7.5–7.6.
58 *Id.* ¶ 7.5.
59 *Id.* ¶ 7.6.
60 *Id.* ¶ 7.7.
61 *Id.* ¶ 7.8.
62 *Alyne v. Brazil* ¶ 8(1).
63 *Id.* ¶ 8(2).

governmental organizations, has developed a 150-page document for the Brazilian government, which specifies the measures it can take to comply with this decision and is working with the Brazilian government to urge it to implement such measures. The Center, along with Alyne's family, is currently negotiating the terms of individual and symbolic reparations. The Center continues to work with the Brazilian government on how to effectively implement the remaining recommendations for general measures set forth by the CEDAW Committee.

Currently, Alyne's daughter is a high school student and resides with her maternal grandmother. They continue to live in abject poverty in Brazil. The grandmother, who is unable to work consistently because of health problems, is the sole source of support for the family.

III. Conclusion—Taking Stock of Victories and Challenges for the Future

Despite the recognition that existing human rights protections apply in the context of reproductive health and rights, transforming this promise into concrete legal protections has met with resistance, even within the mainstream human rights movement. For example, when the Center first started working on the *Alyne* case, a number of human rights experts said, "This is a medical malpractice case—why are you seeking government accountability from a human rights body for maternal mortality?"

During the past twenty years, the Center has been using its legal and advocacy strategies to give teeth to this promise, by ensuring that human rights treaties are interpreted to protect women's fundamental reproductive rights. These groundbreaking victories are a testament to the role that strategic litigation can play in promoting and protecting reproductive rights as human rights.

At the same time, these decisions demonstrate that it is a long-term struggle to ensure that women's reproductive rights are fully realized, and securing these victories does not mean that the struggle is over.

On the one hand, it is important for activists to know about groundbreaking decisions so that they can use these developments to push for changes on the ground. For example, the Peruvian government has yet to implement the *K.L.* decision, but the Human Rights Committee's ruling has had far-reaching effects, being cited, for instance, by the Colombian Constitutional Court in

its decision to liberalize Colombia's abortion law[64] and by the Slovakian Constitutional Court in its decision to uphold a law legalizing abortion in the first trimester.[65]

On the other hand, a central challenge for reproductive rights litigation, as with human rights litigation in general, is making sure that these decisions are fully implemented at the national level. This is one key area where we as advocates must remain vigilant. The Center, together with its local partners, uses sustained advocacy strategies at the national, regional, and international levels to push for implementation.

In the case of *K.L.*, for instance, the recalcitrance of the government to implement the decision led the Center to bring a similar case to the CEDAW Committee, with the aim of increasing the international pressure on the Peruvian government to ensure access to legal abortions and consolidating human rights standards across treaty bodies. This strategy led to a recent landmark decision by the CEDAW Committee in the case of *L.C. v. Perú*, handed down in November 2011—the CEDAW Committee held that Perú had violated L.C.'s right to health and to be free from discrimination.[66] The Committee also recommended that Perú decriminalize abortion where pregnancy results from rape,[67] marking the first international decision where a human rights body has recommended that a government change its abortion laws.

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64 Corte Constitucional [Constitutional Court], May 10, 2006, Sentencia C-355/06, at subsec. 8.4 (Colom.).

65 Ústavného súdu Slovenskej republiky [Constitutional Court of the Slovak Republic], Dec. 4, 2007, PL. ÚS 12/01-297 at subsec. 3.2.

66 Comm. on the Elimination of Discrimination Against Women, Views of the Committee on the Elimination of Discrimination Against Women Under Article 7, Paragraph 3, of the Optional Protocol to the Convention on the Elimination of all Forms of Discrimination Against Women Concerning Communication No. 22/2009, CEDAW/C/50/D/22/2009 (Nov. 4, 2011), *available at* http://www2.ohchr.org/english/law/docs/CEDAW-C-50-D-22-2009_en.pdf.

67 *Id.* ¶ 9(b)(iii).