

IS THE RIGHT TO HEALTH A NECESSARY PRECONDITION FOR GENDER EQUALITY?

HILARY HAMMELL*

I.	INTRODUCTION	132
II.	INTERNATIONAL HUMAN RIGHTS LAW INCLUDES THE RIGHT TO HEALTH	133
III.	THE RIGHT TO HEALTH INCLUDES THE RIGHT TO AN ABORTION.....	140
	A. Pregnancy and Abortion Are Health Issues	141
	B. Foreign Countries and International Bodies Have Recognized That the Right to Health Includes the Right to a Safe Abortion.....	146
	1. National Reforms and Jurisprudence.....	148
	a) Portugal—2007	148
	b) Nepal—2002 & 2009	149
	c) Colombia—2006.....	150
	d) Mexico—2008	152
	e) Spain—2010	155
	2. International Human Rights Cases	157
	a) <i>K.L. v. Peru</i> —Human Rights Committee (ICCPR)—2005	157
	b) <i>Tysic v. Poland</i> —European Court of Human Rights—2007.....	159
	c) <i>Paulina Ramirez v. Mexico</i> —Inter-American Commission on Human Rights—2007.....	161
	C. Conclusion.....	163
IV.	U.S. ABORTION JURISPRUDENCE IS HANDICAPPED BY THE ABSENCE OF A RIGHT TO HEALTH	164
	A. U.S. Abortion Jurisprudence Is Based on the Right to Privacy, Not the Right to Health	164
	B. U.S. Abortion Jurisprudence Permits Lawmakers to Make Abortion Inaccessible or Extremely Difficult to Obtain, Which Would Be Impermissible Under a Right-to-Health Analysis.....	168
	C. Conclusion.....	171

* University of Washington School of Law, J.D. Class of 2012. B.A., Yale University, 2004. Special thanks to attorneys Lilian Sepúlveda and Melissa Upreti, for introducing me to international human rights law and for first exposing me to the cases and reforms that inspired this article.

V. THE ABSENCE OF A RIGHT TO HEALTH IN THE UNITED STATES
 HURTS WOMEN 172
 A. U.S. Women Cannot Effectively Access Abortion 172
 B. U.S. Women Cannot Effectively Access Primary
 Reproductive Health Care 175
 C. As a Result, U.S. Women’s Health Has Declined, Rather
 Than Improved, Over the Past Twenty Years 181
 D. Conclusion 183
 VI. TOWARDS A RIGHT TO HEALTH IN THE UNITED STATES 184
 VII. CONCLUSION 191

I.
 INTRODUCTION

The right to the highest attainable standard of health has become a powerful tool for lawyers and others who advocate for women’s autonomy, liberty, and equality around the world. In recent years, advocates for women’s rights have successfully used right-to-health reasoning to persuade states to liberalize policies relating to abortion, contraception, sex education, and health care. These reforms have improved social and health outcomes for women and have provided frameworks in which women can exercise autonomous decision-making and enjoy full control over their bodies.

Unfortunately, women in the United States do not enjoy similar protections for their right to health. The United States is one of the few countries in the world that neither recognizes a right to health in its constitutional law nor has ratified the international treaties that expressly create a right to health. Instead, it locates a limited right to reproductive health care, including the right to an abortion, within the right to privacy.¹ The current U.S. approach significantly limits women’s access to needed health services, including abortion and maternal health care. This Article argues that such limitations reduce women’s liberty and autonomy and

1. “Reproductive rights” and “reproductive health” are interrelated but not synonymous concepts. For the purposes of this Article, I will assume that family planning, abortion services, and prenatal, obstetric, and postpartum care are health issues (even if they might also be other things, such as moral issues). While this point may seem axiomatic, activists and commentators who oppose abortion and family planning frequently describe these services as unrelated to health. *See, e.g.,* Magaly Llaguno, *Other Accomplices in the Plot Against Life and Family and Their Strategies*, VIDA HUMANA, <http://www.vidahumana.org/english/family/feminists.html> (last visited Feb. 8, 2011) (criticizing pro-choice organizations for conflating abortion and health issues). An argument for access to abortion or contraceptives grounded in health language would fail before these opponents because they reject the notion that abortion and family planning are health services in the first place. This Article will not confront those arguments. Instead, it will consider comparative legal contexts surrounding *access* to health rather than *definitions* of health.

thus constitute a barrier to equal citizenship. It suggests that a right to health underpins substantive gender equality, both theoretically and practically. Without admitting that a fundamental right to the highest attainable standard of health exists, the United States will not achieve real equality for women.

Part II of this Article introduces the legal framework surrounding the right to health. Part III describes three strands of reasoning used by international and foreign bodies to explain why the right to health includes a right to abortion, and provides case studies of instances in which foreign courts, legislatures, and international human rights tribunals have recognized the vital connection between these two rights. Part IV contrasts this trend with the situation in the United States, where constitutional jurisprudence grounds women's limited rights to contraception and abortion in the right to privacy, and where the lack of universal access to health care leads to widespread gender discrimination. Part V discusses the negative impact these limitations have had on women's health, rights, and equality. Part VI concludes by suggesting some avenues for right-to-health advocacy in the United States, while acknowledging that much more research and analysis needs to be done.

This Article seeks to demonstrate that, without recognizing a right to the highest attainable standard of health, the United States cannot achieve full equality, equity, and liberty for women. The right to health is thus not merely a strategic tool for women's rights advocates, but an essential legal component of any state system that purports to hold women and men as equal.

II.

INTERNATIONAL HUMAN RIGHTS LAW INCLUDES THE RIGHT TO HEALTH

The right to health is not the right to be healthy. Instead, the "right to the highest attainable standard of health" obligates states to ensure that health care is available, accessible, acceptable, and of adequate quality.² "Health" in the human rights sense goes beyond the absence of illness, encompassing the right to seek complete mental and physical well-being,³ as well as the right to those social and structural factors required to live a healthy life.⁴ Through international treaties and domestic constitutions,

2. See U.N. Comm. on Econ., Soc., & Cultural Rights, *General Comment 14, The Right to the Highest Attainable Standard of Health*, ¶ 12, U.N. Doc. E/CN.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR, *General Comment 14*] (noting that availability, accessibility, acceptability, and quality are "interrelated and essential elements" of the right to health).

3. *Id.* ¶ 4.

4. See *id.* ("[T]he right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable

discussed in more detail below, 190 of the world's 194 nation-states have recognized the right to health.⁵ The right to health is further elaborated and enforced by General Comments and Recommendations issued by treaty-monitoring bodies,⁶ Special Rapporteurs,⁷ protocols for minimum standards developed by the World Health Organization (WHO),⁸ and the

water and adequate sanitation, safe and healthy working conditions, and a healthy environment.”).

5. I estimate that 190 of the world's 194 nation-states have recognized the human right to health through international human rights treaties. The only countries that have not ratified the two international human rights treaties that most explicitly guarantee the right to health (the International Covenant on Economic, Social, and Cultural Rights (ICESCR) art. 12 and the Convention on the Elimination of Discrimination Against Women (CEDAW) art. 12) are the United States, Nauru, Tonga, and Palau. *Status of Treaties: Convention on the Elimination of All Forms of Discrimination Against Women*, U.N. TREATY COLLECTION, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&lang=en (last visited Apr. 26, 2011); *Status of Treaties: International Covenant on Economic, Social, and Cultural Rights*, U.N. TREATY COLLECTION, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en (last visited Apr. 26, 2011). However, Palau's Constitution obligates the state to provide for the free or subsidized health care of its citizens. CONST. OF THE REPUB. OF PALAU, art. VI. This constitutional provision is not framed as a “right” but as the state's obligation, which is why I have counted it as one of the four countries not recognizing a right to health. Similarly, 187 countries recognize the right to health in their domestic constitutions according to one recent count. Cynthia Soohoo & Jordan Goldberg, *The Full Realization of Our Rights: The Right to Health in State Constitutions*, 60 CASE W. L. REV. 4 (forthcoming 2011) (manuscript at 8) (on file with author) (citing Varun Gauri & Daniel M. Brinks, *Introduction: The Elements of Legalization and the Triangular Shape of Social and Economic Rights*, in *COURTING SOCIAL JUSTICE* 1, 1 (Varun Gauri & Daniel M. Brinks eds., 2008)).

6. See, e.g., CESCR, *General Comment 14, supra* note 2; U.N. Comm. on the Elimination of Discrimination Against Women, *General Recommendation 24, Women and Health*, U.N. Doc. A/54/38 (Feb. 5, 1999) [hereinafter CEDAW, *General Recommendation 24*] (describing CEDAW's recognition of a right to health, including a right to reproductive care, as a fundamental right); U.N. Human Rights Comm., *General Comment 6, The Right to Life* (Apr. 30, 1982), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.1 at 6 (1994) [hereinafter Human Rights Comm., *General Comment 6*]; U.N. Comm. on the Rights of the Child, *General Comment 4, Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, U.N. Doc. CRC/GC/2003/4 (July 1, 2003).

7. The U.N. Office of the High Commissioner of Human Rights (OHCHR) appoints Special Rapporteurs on the cross-cutting issues that transcend individual treaties, including the right to health. The Rapporteur is an independent expert, such as a lawyer or academic, whose mandate includes visiting countries and reporting to the OHCHR. *The Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, OFF. U.N. HIGH COMM'R FOR HUM. RTS, <http://www2.ohchr.org/english/issues/health/right/index.htm> (last visited Mar. 9, 2010).

8. The World Health Organization (WHO) issues medical and public health standards and protocols for its 194 member states, including the United States, many of which, if followed, promote women's reproductive health and rights. See, e.g., WHO, *SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS* (2003), <http://whqlibdoc.who.int/publications/2003/9241590343.pdf> (describing best practices for the provision of safe abortions).

jurisprudence of domestic and international courts.⁹ In international human rights law, the right to health is understood to include reproductive health.¹⁰

The right to health is contained in many of the international human rights documents signed by the vast majority of United Nations member states, including Article 25 of the Universal Declaration of Human Rights¹¹ and Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR).¹² The Convention on the Rights of the Child (CRC) recognizes the right to health for children and adolescents.¹³ Similarly, the WHO's constitution provides that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."¹⁴ Additionally, in most countries, the right to health or an analogous concept is found in domestic constitutional law.¹⁵

9. For domestic court decisions on the right to health see, e.g., *Minister of Health v. Treatment Action Campaign 2002* (10) BCLR 1033 (CC) at 78–79 (S. Afr.) (holding that the right to health care requires the government to take reasonable measures to provide HIV/AIDS testing and treatment to pregnant women and their newborn children); *Paschim Banga Khet Mazdoor Samity v. West Bengal*, A.I.R. 1996 S.C. 2426 (India) (finding that Article 21 of the Indian Constitution, which guarantees a right to life, obligates the government to "provide adequate medical services to the people" and that this obligation cannot be ignored due to "financial constraints"). For international court decisions, see *infra* Part III(B).

10. See CESCR, *General Comment 14*, *supra* note 2, ¶ 14 (describing the right to maternal, child, and reproductive health); CEDAW, *General Recommendation 24*, *supra* note 6 ("affirming that access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination"). See also U.N. Human Rights Comm'n, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 25, U.N. Doc. E/CN.4/2003/58 (Feb. 13, 2003) (noting that the right to health includes maternal, child, and reproductive health).

11. Universal Declaration of Human Rights, G.A. Res. 217 (III) A, art. 25, U.N. Doc. A/RES/217(III) (Dec. 10, 1948) ("The responsibility of the State and community for the health and safety of its people can be fulfilled only by provision of adequate health and social measures.").

12. International Covenant on Economic, Social, and Cultural Rights art. 12(1), *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976) [hereinafter ICESCR] (recognizing the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health"). The U.S. signed the ICESCR on October 5, 1977 but has not yet ratified the treaty, so it is not legally binding on the United States. See AMNESTY INT'L, ECONOMIC, SOCIAL AND CULTURAL RIGHTS: QUESTIONS AND ANSWERS 6, http://www.amnestyusa.org/escr/files/escr_qa.pdf. The Committee on Economic, Social, and Cultural Rights provides a useful explanation of the "available, accessible, affordable, quality" framework. See CESCR, *General Comment 14*, *supra* note 2, ¶ 12.

13. Convention on the Rights of the Child art. 24, *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 3 (entered into force Sept. 2, 1990).

14. WORLD HEALTH ORG. (WHO) CONST. pmb1.

15. Soohoo & Goldberg, *supra* note 5 (manuscript at 8) (stating that 187 constitutions recognize the right to health). However, in countries without a constitutional right to

Regional human rights documents and decisions similarly recognize the right to health. In the inter-American human rights system, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights (the Protocol of San Salvador) guarantees the right to health,¹⁶ and the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women (the Convention of Bélem do Pará) protects the right to health for women.¹⁷ In Africa, the African Charter on Human and Peoples' Rights (Banjul Charter) includes the right to health,¹⁸ and, in Europe, the European Social Charter recognizes it.¹⁹

Even human rights treaties that do not expressly contain a right to health, such as the International Covenant on Civil and Political Rights (ICCPR) and the European Convention on Human Rights, have been interpreted to guarantee a right to health in circumstances including abortion. Many of the ICCPR's provisions can be interpreted to require states to provide access to basic health care without sex discrimination.²⁰

health, the ratification of ICESCR, CEDAW and/or the regional treaties give constitutional rank or dimension to the rights enshrined in those treaties, including the right to health. Further, case law in states with no explicit constitutional provision for the right to health can give constitutional dimensions to this right as well. See *Circle of Rights: Module 14: The Right to Health*, UNIV. MINN. HUM. RTS. RESOURCE CTR., <http://www1.umn.edu/humanrts/edumat/HRIP/circle/modules/module14.htm> (last visited Apr. 26, 2011). See also Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT'L L. J. 285, 287 (2004) (calculating that 67.5% of the world's constitutions recognize the right to health specifically, while most other governments recognize the right via international treaties or case law).

16. American Convention on Human Rights in the Area of Economic, Social, & Cultural Rights Additional Protocol, art. 10, *opened for signature* Nov. 17, 1988, O.A.S.T.S. No. 69 (entered into force Nov. 16, 1999) [hereinafter Protocol of San Salvador] ("Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.").

17. See Inter-American Convention on the Prevention, Punishment, & Eradication of Violence Against Women, art. 6, June 9, 1994, 33 I.L.M. 1534 [hereinafter Convention of Belem do Pará] ("The right of every woman to be free from violence includes, among others: (a) The right of women to be free from all forms of discrimination; and (b) The right of women to be valued and educated free of stereotyped patterns of behavior and social and cultural practices based on concepts of inferiority or subordination.").

18. African (Banjul) Charter on Human and Peoples' Rights art. 16, *opened for signature* June 27, 1981, 1520 U.N.T.S. 217 (entered into force Oct. 21, 1986) ("Every individual shall have the right to enjoy the best attainable state of physical and mental health . . . States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.").

19. European Social Charter (revised) part I(11), May 3, 1996, 2151 U.N.T.S. 277 ("Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable.").

20. See International Covenant on Civil and Political Rights, *opened for signature* Dec. 6, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) [hereinafter ICCPR]. Article 2 of the ICCPR requires states to not just "respect" but "ensure," all of the "rights

The ICCPR is more direct when it comes to women's reproductive health: the Human Rights Committee (HRC), the body that monitors compliance with the ICCPR, has interpreted the ICCPR to grant women the right to safe pregnancy services and to impose an obligation on states to eliminate unsafe abortion and to help women prevent unwanted pregnancies.²¹ Similarly, the Council of Europe has explained that, in order to properly guarantee the right to life and to freedom from cruel, inhuman, and degrading treatment as protected by the European Convention on Human Rights, the European Social Charter must include the right to health.²² The right to abortion in the European human rights system has also been found by the European Court of Human Rights to emanate from states' positive obligations to protect the right to privacy, which includes both privacy in making decisions about child-rearing, as in American reproductive rights jurisprudence,²³ as well as privacy in making decisions about health.²⁴

International conference documents further emphasize how and why the right to health includes women's rights to reproductive health services. The Program of Action of the International Conference on Population and Development, held in Cairo in 1994, explains that women's rights to

recognized in the present Covenant" to "all individuals within its territory" irrespective of sex. *Id.* art. 2. Article 3 explicitly requires states to "undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant." *Id.* art. 3. Those substantive rights which can contain or construct a right to health or to health services under the ICCPR include the right to "self-determination," and the state's obligation not just to respect such a right but to "promote the realization" of that right, *id.* art. 1; the right to life, *id.* art. 6; the right to be free from cruel, inhuman, and degrading treatment, *id.* art. 7; the right not to be held in slavery, servitude, or to perform forced labor, *id.* art. 8; the right to liberty and security of person, *id.* art. 9; the right to respect of inherent dignity when one has been deprived of her liberty, *id.* art. 10; the right of liberty of movement, *id.* art. 12; the right to be free from arbitrary or unlawful interference with privacy, *id.* art. 17; and the right to found a family freely, *id.* art. 23. For the HRC's interpretation of some of these rights in a way that implicates reproductive health, see *K.L. v. Peru*, discussed *infra* Part III(B)(2)(a).

21. See U.N. Human Rights Comm., *General Comment 28: Equality of Rights Between Men and Women (Article 3)*, ¶ 10, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (Mar. 29, 2000) (explaining that the ICCPR's protection of the "right to life" in Article 6 implicates states' obligations to prevent maternal mortality and to help women prevent unwanted pregnancies "so that they do not have to undertake life-threatening clandestine abortions"). See also *id.* ¶ 11 (explaining that states must give access to safe abortion for women who have become pregnant as a result of rape); *id.* ¶ 15 (explaining that "pregnant women who are deprived of their liberty should receive humane treatment and respect for their inherent dignity at all times surrounding the birth and while caring for their newborn children . . ."); Human Rights Comm., *General Comment 6, supra* note 6, ¶ 5 (explaining that the right to life is not to be understood in a restrictive manner).

22. See SECRETARIAT OF THE EUROPEAN SOC. CHARTER, THE RIGHT TO HEALTH AND THE EUROPEAN SOCIAL CHARTER 2 (2009), http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/FactsheetHealth_en.pdf (explaining that Articles 2 and 3 of the European Convention give rise to the right to health under the Social Charter).

23. See *infra* section II(A) for an analysis of privacy concept in U.S. law.

24. See, e.g., *Tysi c v. Poland*, App. No. 5410/03, 2007-IV Eur. Ct. H.R. ¶ 48, 107, 116, discussed *infra* Part III(B)(2)(b).

reproductive health care and self-determination arise out of a cohort of human rights, including the right to health.²⁵ The Beijing Platform of Action, which emerged from the 1995 U.N. Fourth World Conference on Women, declares not just that “[w]omen have the right to the enjoyment of the highest attainable standard of physical and mental health,” but that “[t]he enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life.”²⁶

In line with the Beijing Platform, international human rights law recognizes that the right to health is a feature of substantive equality. The Convention on the Elimination of All Forms of Racial Discrimination (CERD), for example, requires states to guarantee equal access to public health and medical care.²⁷ The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) not only guarantees the right to the highest attainable standard of health, but explains that women’s rights to family planning, safe pregnancy, and pre- and postdelivery care are part of this fundamental human right.²⁸ The link between health and substantive equality is intrinsic not just to the treaties enacted to protect marginalized groups, such as CEDAW and CERD, but to the ICESCR’s original formulation of the right to health. In describing the ICESCR guarantee of the right to health, the U.N. Committee on Economic, Social, and Cultural Rights explained that:

The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom By contrast, the entitlements include the right to a system of health protection

25. See U.N. POPULATION FUND, KEY ACTIONS FOR THE FURTHER IMPLEMENTATION OF THE PROGRAMME OF ACTION OF THE INTERNATIONAL CONFERENCE ON POPULATION & DEVELOPMENT 2 (1999) [hereinafter Cairo Programme] (affirming that “reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents” and recognizing that these rights include “the right to attain the highest standard of sexual and reproductive health”).

26. Fourth World Conference on Women, Sept. 4–15, 1995, *Beijing Declaration and Platform for Action*, ¶ 89 (Sept. 1995) [hereinafter Beijing Platform of Action], <http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf>.

27. International Convention on the Elimination of All Forms of Racial Discrimination, art. 5(e)(iv), *opened for signature* Dec. 21, 1965, 660 U.N.T.S. 195 (entered into force Jan. 4, 1969) [hereinafter CERD] (guaranteeing the right to health without regard to race, color, or ethnic or national origin).

28. Convention on the Elimination of All Forms of Discrimination Against Women, art. 12, *opened for signature* Dec. 18, 1979, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981) [hereinafter CEDAW] (“States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. . . . States Parties shall ensure to women appropriate services in connection with pregnancy, confinement, and the post-natal period, granting free services when necessary, as well as adequate nutrition during pregnancy and lactation.”).

which provides *equality of opportunity* for people to enjoy the highest attainable level of health.²⁹

By ensuring freedom “to control one’s health and body,” the right to health evokes—and protects—a version of the individual in which women, as well as men, are equal political persons.³⁰ At the same time, in obligating states to provide for health care and ensure equality of opportunity, the right to health takes into account both bodily differences and differences arising from economic, social, and political forces. By specifically contemplating the body, the right to health acknowledges women’s bodies as the bodies of real political persons.³¹ When health care for all is made an enforceable right, states act out the idea behind substantive equality: that “equal respect” may not allow for formally equal treatment and may in fact require different treatment.³² When this understanding of “equal respect” is applied to health care, women see improvements in their health, an area where their lives and worth have traditionally been either under-prioritized or totally ignored.³³ The cases and reforms discussed in

29. CESCR, *General Comment 14*, *supra* note 2, at ¶ 8 (emphasis added).

30. The right to health thus supports the liberal approach to women’s equality and enfranchisement. *See generally* MARTHA NUSSBAUM, *The Feminist Critique of Liberalism*, in *SEX AND SOCIAL JUSTICE* 55–80 (1999) (arguing that liberalism can support feminist values because of its emphasis on “equal respect of personhood”); Martha Nussbaum, *Robin West, Jurisprudence and Gender: Defending a Radical Liberalism*, 75 U. CHI. L. REV. 985, 989–90, 993–95 (2008) [hereinafter Nussbaum, *Robin West*] (defending the “separation thesis”—a view of liberalism—as a crucial piece of the argument for abortion rights and defending liberalism as a necessary element of feminist theory while criticizing most liberal philosophers for failing to apply anti-inequality scrutiny to gender).

31. The right to health, understood in this way, thus advances the anti-subordination agenda contemplated by feminist scholars like Nancy Fraser. *See generally* Nancy Fraser, *Talking About Needs: Interpretive Contests as Political Conflicts in Welfare-State Societies*, in *FEMINISM AND POLITICAL THEORY* 159–81 (Cass Sunstein, ed., 1982) (arguing that acknowledging certain needs as politically cognizable is a way to enfranchise the formerly disenfranchised). Fraser describes the useful “politicization” that can happen when the concerns of subordinated groups become something the state takes seriously. *Id.* However, Fraser also highlights the dangers of state attempts to apply a one-size-fits-all, “expert, normalizing, therapeutic” approach to meet a “need” once it has become politically cognizable. *Id.* at 178. These concerns are worth applying to the emerging world of right-to-health enforcement by governments.

32. *See* Nussbaum, *Robin West*, *supra* note 30, at 995 (“[I]f two human beings start from very different social positions, it will often require formally different treatment to show them equal respect.”).

33. *See generally* Rebecca J. Cook & Charles Ngwena, *Women’s Access to Health Care: The Legal Framework*, 94 INT’L J. GYNECOLOGY & OBSTETRICS 216 (2006) [hereinafter Cook & Ngwena, *Women’s Access to Health Care*] (explaining how human rights law can lead to better reproductive health care services for women). Historically, societies did not prioritize women’s reproductive health, since it was seen as related to women’s “duty” to bear children and found families, and was also a taboo topic owing to its relation to sex and “morality.” Rebecca J. Cook, *International Human Rights and Women’s Reproductive Health*, 24 STUD. FAM. PLANNING 73, 73 (1993) [hereinafter Cook, *International Human Rights*]. Professor Cook outlines laws and policies that evince such a “paternalistic” view of women and shows how these laws are detrimental to women’s

Part III illustrate how the right to health leads to these political consequences and supports women's equality at the theoretical level, not just at the level of outcomes.

III.

THE RIGHT TO HEALTH INCLUDES THE RIGHT TO AN ABORTION

Feminist commentators and jurists have long argued that the right to abortion underpins women's ability to enjoy equal citizenship with men.³⁴ This Article will not make that argument, but will assume that it is true. From that assumption, I will argue that abortion rights, as one component of women's equality, cannot be fully realized without the right to health. At the same time, while the right to health can advance justice for women in many contexts, on issues such as sex education, forced sterilization, maternal health care, and employment leave policies,³⁵ abortion is one obvious place where women's interests and health intersect. In the interest of space, this Article will focus on abortion jurisprudence and access to health care, while acknowledging that "abortion" is not a proxy for reproductive rights, reproductive justice, or women's rights generally, and that this discussion will be far from comprehensive.

In this Part, I argue that pregnancy and abortion are health issues. I

health. *Id.* at 74–75.

34. See, e.g., *Gonzalez v. Carhart*, 550 U.S. 124, 172 (2007) (Ginsburg, J., dissenting) (arguing that challenges to abortion "center on a woman's autonomy to determine her life's course, and thus to enjoy equal citizenship stature"). See also Cook, *International Human Rights*, *supra* note 33, at 78 ("A restrictive abortion law exacerbates the inequality resulting from the biological fact that women carry the exclusive health burden of contraceptive failure."); Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815, 826 (2007) [hereinafter Siegel, *Sex Equality*] (describing the National Organization for Women (NOW) 1970 strike for equality, which "argued that the Nineteenth Amendment's promise of equal citizenship could not be realized unless women were given control of the conditions in which they conceived, bore, and raised children").

35. For example, sex education, forced sterilization, and access to safe maternal health services are just some issues that have been or are being litigated by women's rights advocates using right-to-health reasoning. See Luisa Cabal & Jaime M. Todd-Gher, *Reframing the Right to Health: Legal Advocacy to Advance Women's Reproductive Rights*, in REALIZING THE RIGHT TO HEALTH 120, 120–138 (Andrew Clapham & Mary Robinson eds., 2009) (providing examples of such cases). Several cases on maternal mortality and morbidity as a right-to-health issue are currently pending in India, including *Sandesh Bansal v. Union of India and Others*, W.P. (Civ.) No. 9061, 2008 (Madhya Pradesh High Court) and *Snehalata Singh v. The State of Uttar Pradesh and Others*, 2008 (Uttar Pradesh High Court), cited in CTR. FOR REPROD. RIGHTS, MATERNAL MORTALITY IN INDIA: USING INTERNATIONAL AND CONSTITUTIONAL LAW TO PROMOTE ACCOUNTABILITY AND CHANGE 49 (2008). In Nepal, the Supreme Court recently found the right to health is a basis for requiring the government to provide treatment for women with uterine prolapse. Payal Shah, *Uterine Prolapse and Maternal Morbidity in Nepal: A Human Rights Imperative*, 2 DREXEL L. REV. 491, 519–20 (2010) (citing *Prakash Mani Sharma v. Gov't of Nepal*, Writ No. 064 (2008) (SC)).

then describe three interrelated rationales for why the right to health includes the right to an abortion, and discuss instances in which states and international bodies have relied on these rationales to establish such a right in other countries.

A. *Pregnancy and Abortion Are Health Issues*

While both pregnancy and abortion may have moral, social, and religious implications, it is difficult to dispute that they are also health issues. At the most basic level, abortion is a medical or surgical procedure,³⁶ and pregnancy, childbirth, and the postpartum experience impose substantial health consequences on women for at least one year.³⁷ In addition to the normal physiological effects, which have serious impacts in their own right, dangerous complications can arise during pregnancy, leading to adverse health outcomes or maternal death.³⁸ Complications are unpredictable, and their onset can be “sudden and severe.”³⁹ Thus, all pregnant women require access to comprehensive medical care, no matter how healthy the pregnancy.⁴⁰

A normal, healthy pregnancy profoundly affects every system in the body, from the gastrointestinal system to the musculoskeletal system to the skin to the brain.⁴¹ As the uterus enlarges, a woman’s skeleton changes shape. The lower spine curves forward, the neck moves back, and shoulders hunch involuntarily.⁴² The rib cage is pushed upwards, moving the woman’s heart up and to the left,⁴³ and decreasing the amount of air her lungs can hold.⁴⁴ The heart changes structure and undergoes serious

36. See STEVEN G. GABBE, JENNIFER R. NIEBYL & JOE LEIGH SIMPSON, *OBSTETRICS: NORMAL AND PROBLEM PREGNANCIES* 624–44 (4th ed. 2002) (describing various surgical abortion procedures). In 2008, 199,000 medication-induced abortions took place outside of hospitals. Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 *PERSP. ON SEXUAL & REPROD. HEALTH* 1, 46 (2011).

37. See generally Kim Lipscomb & Miles J. Novy, *The Normal Puerperium*, in *OBSTETRICS & GYNECOLOGY: CURRENT DIAGNOSIS & TREATMENT* 222 (Alan H. DeCherney, Lauren Nathan, T. Murphy Goodwin & Neri Laufer eds., 10th ed. 2007) (describing the physical effects women experience in the postpartum period).

38. See, e.g., *Birth and Emergency Preparedness in Antenatal Care*, in *DEPT OF MAKING PREGNANCY SAFER, WHO, STANDARDS FOR MATERNAL & NEONATAL CARE 3* (2006) [hereinafter *Birth and Emergency Preparedness*], available at http://www.who.int/entity/making_pregnancy_safer/publications/Standards1.9N.pdf.

39. *Id.*

40. See *id.* at 1 (requiring that “[n]ational and local policies support all pregnant women having access to maternal and neonatal health care”).

41. Interview with Tara Cardinal, R.N., Seattle, WA (Mar. 3, 2011) (stating that “pregnancy affects every single system in the body—from the hair to the brain to the stomach to the eyes”).

42. GABBE, NIEBYL & SIMPSON, *supra* note 36, at 81.

43. *Id.* at 65.

44. *Id.* at 71.

strain.⁴⁵ The ligaments in the pelvis loosen, which commonly causes women to feel pain inside their thighs and the sensation that their bones are snapping.⁴⁶ Most women have back pain during pregnancy.⁴⁷ All but the most obese women will gain at least twenty pounds.⁴⁸ As the fetus grows in size, its head descends into the pelvic floor, putting pressure on the woman's vagina, rectum, and urethra, frequently causing pain and incontinence.⁴⁹ In even the most normal pregnancies, women can experience extreme fatigue,⁵⁰ nausea and vomiting,⁵¹ breast pain,⁵² changes in bowel movements,⁵³ frequent need to urinate,⁵⁴ rapid heartbeat,⁵⁵ and heart palpitations.⁵⁶ All of these effects are simply part of a normal, healthy pregnancy.

For the approximately twenty-five to thirty percent of women who are at risk for complications, the physical consequences of pregnancy can be much more severe.⁵⁷ These risk factors include age, genetics, and previous preterm delivery.⁵⁸ But even if a woman has no known risk factors, adverse complications can arise that are impossible to predict.⁵⁹ A woman can face potentially fatal complications such as cardiac problems, thromboembolic disease, and deep vein thrombophlebitis.⁶⁰ As philosopher Margaret Little puts it, the risks inherent in pregnancy are "a really big deal," and "the neutral language of an obstetrics text hardly captures the lived reality."⁶¹

45. *See id.* at 65 ("[T]he structural changes in the heart . . . show that the structural heart changes during pregnancy are consistent with the effects of chronic strain on the heart.").

46. *Id.* at 81.

47. *Id.*

48. *See id.* at 152 ("The total weight gain recommended in pregnancy is 25 to 35 lb for normal women.").

49. *Id.* at 77.

50. *Id.* at 152.

51. *Id.* at 80.

52. *Id.* at 86.

53. *Id.* at 79–80.

54. *Id.* at 77.

55. *See id.* at 69 (stating that normal effects on pregnant woman's heart can be similar to effects of heart disease).

56. *Id.*

57. *See id.* at 368 (stating that approximately twenty-five to thirty percent of pregnancies are "high risk").

58. *Id.* at 142–45.

59. *See, e.g., Birth and Emergency Preparedness, supra* note 38, at 3 ("Many of the complications that result in maternal deaths and many that contribute to perinatal deaths are unpredictable, and their onset can be both sudden and severe.")

60. Eileen McDonagh, *My Body, My Consent: Securing the Constitutional Right to Abortion Funding*, 62 ALB. L. REV. 1057, 1074 (1999). *See also* Telephone Interview with Rachel Siegel, Certified Nurse Midwife (Sept. 21, 2010) (discussing complications).

61. Margaret Olivia Little, *Abortion, Intimacy, and the Duty to Gestate*, 2 ETHICAL THEORY & MORAL PRAC. 295, 300 (1999) ("Now, not to put too fine a point on it, these considerations are a really big deal. For the risks aren't, of course, just about swollen

Childbirth itself is a twelve- to twenty-four hour physical, emotional, and psychological, process⁶² requiring “enormous amounts of energy.”⁶³ In regular, healthy labor, a woman experiences painful and intense contractions.⁶⁴ During this phase, the cervix, which is normally about one centimeter wide, will expand to ten centimeters until the baby passes through it.⁶⁵ Depending on how big the fetus is compared to her body, a woman may experience more pain.⁶⁶ She will also experience extreme pain as the head descends into her pelvis, and serious pain if she delivers the baby through her vagina without anesthesia as her internal and external organs are being stretched, torn, and lacerated by the process.⁶⁷ The process of childbirth can cause a woman to lose up to a liter of blood.⁶⁸

The preceding descriptions are just a sampling of the facts inherent in a normal vaginal birth of just one baby. If a woman is giving birth to twins, if the baby is in a breech position, if she has obstructed labor—or if any other irregularity exists—a woman might have to undergo a caesarean section (c-section).⁶⁹ Currently, approximately thirty-one percent of births in the United States are via c-section.⁷⁰ The surgery requires incisions in

ankles, and the neutral language of an obstetrics text hardly captures the lived reality. Anyone who has visited a friend who’s landed in a psychiatric ward from pregnancy-related psychosis knows this all too well. Or my sister, whose first trimester ‘nausea’—actually gut-wrenching dry heaves every 20-minutes and three hospitalizations—was the equal of many an experience of chemotherapy. Or another acquaintance, whose sudden onset of eclampsia during delivery brought her so close to dying that it left us all breathless.”)

62. See Carol L. Archie, *The Course & Conduct of Normal Labor & Delivery*, in *OBSTETRICS & GYNECOLOGY: CURRENT DIAGNOSIS & TREATMENT*, *supra* note 37, at 203, 204 (stating that, for a first-time pregnant woman, first-stage labor typically lasts six to eighteen hours, second-stage labor lasts thirty minutes to three hours, third-stage lasts up to thirty minutes, plus up to thirty minutes for the fourth stage, and then recuperation while the uterus begins to contract).

63. WHO, *SAFE MOTHERHOOD: CARE IN NORMAL BIRTH: A PRACTICAL GUIDE 9* (1996), http://whqlibdoc.who.int/hq/1996/WHO_FRH_MSM_96.24.pdf.

64. GABBE, NIEBYL & SIMPSON, *supra* note 36, at 353.

65. *Id.* at 363.

66. See DEBRA LEONARD LOWDERMILK & SHANNON E. PERRY, *MATERNITY NURSING* 339 (7th ed. 2006) (“[T]he relation of fetal size to the dimensions of the maternal pelvis may influence pain intensity.”)

67. See *id.* at 338 (“During the second stage of labor . . . pain results from stretching and distention of the perineal tissues and the pelvic floor to allow passage of the fetus, from distention and traction on the peritoneum and uterocervical supports during contractions, and from lacerations of soft tissue (e.g. cervix, vagina, perineum).”).

68. See GABBE, NIEBYL & SIMPSON, *supra* note 36, at 73 (“Vaginal delivery of a singleton infant at term is associated with a mean blood loss of 500 ml; an uncomplicated cesarean birth, about 1,000 ml; and a caesarean hysterectomy, 1,500 ml.”).

69. See Marc H. Incerpi, *Operative Delivery*, in *OBSTETRICS & GYNECOLOGY: CURRENT DIAGNOSIS & TREATMENT*, *supra* note 37, at 461, 469–70 (describing the medical indications for a c-section).

70. JOYCE A. MARTIN, BRADY E. HAMILTON, PAUL D. SUTTON, STEPHANIE J. VENTURA, FAY MENACKER, SHARON KIRMAYER & T.J. MATHEWS, *NAT’L VITAL STATISTICS SYST., DEPT’ OF HEALTH & HUMAN SERVS., BIRTHS: FINAL DATA FOR 2006*, at

the abdominal skin and the uterus,⁷¹ as well as anesthesia,⁷² which involves constant monitoring by an anesthesiologist. Furthermore, c-sections can predispose women to infections and complications both in recovery and in subsequent pregnancies.⁷³

The physical consequences continue after pregnancy. A new mother faces “substantial health risks,” especially vaginal bleeding and infections.⁷⁴ As the uterus shrinks back to its non-pregnant size, women will continue to feel painful cramps⁷⁵ and may require pain medication and/or heat treatment in the six weeks following birth. Tearing of the pelvic floor muscles during delivery can cause hernias.⁷⁶ The breasts undergo major physiological and anatomical changes after childbirth as they fill with milk and change shape to allow for lactation.⁷⁷ A return to normal cardiovascular functioning may require months.⁷⁸ Women who have had c-sections cannot even start physical therapy to restore their abdominal muscles for four weeks.⁷⁹ Some women may never return to their pre-pregnant state of continence.⁸⁰ Almost all women experience an increase in sexual pain and dysfunction after their first delivery and, though this decreases after the third month post-childbirth, the level of sexual function experienced by women never returns to pre-pregnancy levels.⁸¹

The psychological effects of childbirth are also worth noting. Up to seventy percent of women feel some mild postpartum sadness and anxiety for at least several weeks.⁸² A smaller number of women suffer from true postpartum depression or even psychosis.⁸³ Overweight women may suffer from depression and anxiety for up to fourteen months after giving birth.⁸⁴ Further, if a pregnancy is unwanted, its psychological effects may be especially severe: women forced to carry pregnancies to term report being

16 (2009), http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_07.pdf.

71. Incerpi, *supra* note 69, at 470.

72. LOWDERMILK & PERRY, *supra* note 66, at 801.

73. Incerpi, *supra* note 69, at 473–74.

74. WHO, WHO TECHNICAL CONSULTATION ON POSTPARTUM AND POSTNATAL CARE 1–2 (2010), http://whqlibdoc.who.int/hq/2010/WHO_MPS_10.03_eng.pdf.

75. Lipscomb & Novy, *supra* 37, at 222.

76. *Id.* at 223.

77. GABBE, NIEBYL & SIMPSON, *supra* note 36, at 109.

78. Lipscomb & Novy, *supra* note 37, at 222.

79. LOWDERMILK & PERRY, *supra* note 66, at 482.

80. *Id.*

81. See Geraldine Barrett, Elizabeth Pendry, Janet Peacock, Christina Victor, Rance Thakar & Isaac Manyonda, *Women's Sexual Health After Childbirth*, 107 BRIT. J. OBSTETRICS & GYNAECOLOGY 186, 192 (2000) (“[H]igh levels of problems were reported in the first three months after delivery, which then declined by six months but not to pre-pregnancy levels . . .”).

82. Lipscomb & Novy, *supra* note 37, at 235.

83. *Id.*

84. LOWDERMILK & PERRY, *supra* note 66, at 483.

much more depressed, and for a longer time, than mothers who wanted to be pregnant.⁸⁵ Again, these outcomes occur following “normal” pregnancies, even in the context of a developed country like the United States, where hygienic birth environments are common.

Just as pregnancy has serious health impacts on women, so does unsafe, illegal, or stigmatized abortion. An abortion can be unsafe whenever it occurs outside of safe, hygienic environments and is performed by unskilled or untrained practitioners. Some typical means of “unsafe” abortions include “treatments taken by mouth (such as quinine, turpentine or acid); treatments placed in the vagina or cervix (such as herbal preparations); intramuscular injections; foreign objects placed into the uterus through the cervix (such as a knitting needle or coat hanger); enemas and direct trauma.”⁸⁶ Some of the most frequent adverse outcomes associated with unsafe abortion are hemorrhage, sepsis, peritonitis, and trauma.⁸⁷ Other potential consequences include death resulting from septic shock, bowel injury, acute renal failure, and long-term complications such as infertility and chronic pelvic pain.⁸⁸

According to the World Health Organization (WHO), unsafe abortions cause the deaths of about 65,000–70,000 women each year and permanently or temporarily disable an additional five million women.⁸⁹ The data from around the world show that “[w]hen abortion is made legal, safe, and easily accessible, women’s health rapidly improves. By contrast, women’s health deteriorates when access to safe abortion is made more difficult or illegal.”⁹⁰

Recognizing that pregnancy is a health issue and that maternal death and disability are preventable seems obvious, but it is actually a relatively novel concept.⁹¹ Historically, childbearing was seen as a woman’s duty, and the death and suffering that arose from that “duty” were seen as “destiny and divine will.”⁹² To view pregnancy as something that happens to a person with the full complement of rights, and to position “the highest

85. Ronli Sifris, *Restrictive Regulation of Abortion and the Right to Health*, 18 MED. L. REV. 185, 200 (2010).

86. *Id.* at 196. For more about the health consequences of unsafe abortion, see generally Susan Fawcus, *Maternal Mortality and Unsafe Abortion*, 22 BEST PRACT. RES. CLIN. OBS. 533 (2008) and David A. Grimes, Janie Benson, Susheela Singh, Mariana Romero, Bela Ganatra, Friday E. Okonofua & Iqbal H. Shah, *Unsafe Abortion: The Preventable Pandemic*, 368 LANCET 1908 (2006).

87. Sifris, *supra* note 85, at 196.

88. *Id.* at 196–97.

89. WHO, UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2003, at 5 (2007).

90. Grimes, Singh, Romero, Ganatra, Okonofua & Shah, *supra* note 86, at 1909.

91. See Cook, *International Human Rights*, *supra* note 33, at 73 (explaining that women’s reproductive health has not traditionally been a major concern for governments).

92. *Id.*

attainable standard of health” as a right, are thus both important components of a political philosophy that includes women as equal citizens. Because both unsafe abortion and pregnancy seriously implicate women’s health, the right to health gives rise to a right to safe, legal abortion, as foreign courts and international human rights bodies increasingly recognize.

B. Foreign Countries and International Bodies Have Recognized That the Right to Health Includes the Right to a Safe Abortion

In recent years, foreign governments, courts, and international bodies have relied on right-to-health reasoning to liberalize access to abortion.⁹³ As the cases and reforms discussed below illustrate, the right to health requires access to safe, legal abortion for at least three related reasons. These strands of reasoning create what can be seen as a triad of right-to-health rationales. In my view, they are three different ways of looking at the same phenomenon. The three strands affirm that the right to health includes the right to make one’s own decisions about one’s health—and that, if pregnancy and abortion are health issues, it follows that the right to health means women must have the right to choose not to continue a pregnancy.

The first and most common explanation for why the right to health requires the right to an abortion is the public health explanation. The international community has widely recognized that unsafe abortion is an unacceptable and prevalent cause of maternal mortality and morbidity,⁹⁴ therefore, the right to health requires that safe abortion be available in response to this epidemiological crisis.

The second strand of reasoning is based upon the notion that, as a matter of fundamental rights, individuals should have access to the health care they need. It is often raised in cases brought by individual plaintiffs who are denied abortion services, such as Alicja Tysi c in Poland, who went nearly blind when she was forced to continue a pregnancy;⁹⁵ and K.L., a teenager in Peru, who became clinically depressed and suicidal when she

93. See *infra* Part III(B)(1)–(2) for examples of such reforms.

94. See, e.g., Beijing Platform for Action, *supra* note 26, ¶¶ 97, 106(j), 106(k); Cairo Programme, *supra* note 25, ¶ 8.25; U.N. Comm’n on the Status of Women, *Eliminating Preventable Maternal Mortality and Morbidity Through the Empowerment of Women*, U.N. Doc. E/CN.6/2010/L.6 2 (Mar. 12, 2010) (“[E]xpanding access to sexual and reproductive health information and health services are essential for achieving the Beijing Platform for Action, the Cairo Programme of Action, and the Millennium Development Goals”); Grimes, Singh, Romero, Ganatra, Okonofua & Shah, *supra* note 86, at 1908 (arguing that “[e]nding the silent pandemic of unsafe abortion is an urgent public-health and human-rights imperative”).

95. See *Tysi c v. Poland*, App. No. 5410/03, 2007-IV Eur. Ct. H.R. ¶¶ 7–31 (describing the facts of the case).

was denied an abortion and forced to give birth to an anencephalic baby that had no chance of survival outside the womb.⁹⁶ This second-strand view focuses more on the health of individual women rather than on women as public health statistics. However, due to the extreme facts of cases like *Tysic v. Poland* and *K.L. v. Peru*, where health was threatened not just by the pregnancy per se but by co-morbidities, these cases could suggest that there might be some third party or objective test to decide whether a woman's health is "actually" in jeopardy in some sense that goes beyond the risks posed by a "normal" pregnancy.

Defusing that danger is the third strand of the right to health, which explains that the right to health gives the authority to the individual, not doctors or third parties, to define the scope of health care that they need. This third strand of right to health reasoning guarantees that individuals have access to the health care they seek, without the interference of third parties, and despite economic and other barriers that might otherwise prevent them from accessing care. In this analysis, there can be no objective test about when health care is "needed" or appropriate, at least in the context of pregnancy and abortion. This perspective recognizes that pregnancy and childbirth—and the decisions to terminate or avoid the same—are *always* health issues for women, even if a pregnancy is "normal."

The cases and reforms described below illustrate how these three strands are almost always intertwined. What does it mean that the health care that an individual needs (strands one and two), and to which she is entitled according to the right to health, is the same as the care she seeks (strand three)? In the context of pregnancy and reproduction, at least, it means that the individual, rather than third parties, must determine what care is "necessary." In the right to health context, it also means that the individual must have access to the resources and advice necessary to make and carry out her fully informed decisions. In a more narrow sense, the right to health equates necessary care and desired care because a woman's health would clearly be jeopardized if she wanted an abortion but could only obtain one in a clandestine, unsafe setting.⁹⁷ In that sense, both the

96. See U.N. ESCOR, Human Rights Comm., *Views of the Human Rights Committee Under Article 5, Paragraph 4, of the Optional Protocol to the International Covenant on Civil and Political Rights Concerning Communication No. 1153/2003*, Annex, ¶¶ 2.1, 2.2, U.N. Doc. CCPR/C/85/D/1153/2003 (Oct. 24, 2005) [hereinafter *K.L. v. Peru*] (describing the facts of *K.L. v. Peru*).

97. See, e.g., *id.* ¶ 3.3 (explaining that unavailability of legal abortion "left [K.L.] with two options which posed an equal risk to her health and safety: to seek clandestine (and hence highly risky) abortion services, or to continue a dangerous and traumatic pregnancy which put her life at risk"). See also CTR. FOR REPROD. RIGHTS, BRINGING RIGHTS TO BEAR: ABORTION AND HUMAN RIGHTS 15 (2008), http://reproductiverights.org/sites/crr.civicactions.net/files/documents/BRB_abortion_hr_revised_3.09_WEB.PDF ("[R]estrictive abortion laws in Poland . . . may incite women to seek unsafe, illegal

second and third strands' goals must be achieved in order to accomplish the public-health goal of the first strand: eliminating unsafe abortion as a cause of maternal death and morbidity.

Overall, these case studies show that when countries situate pregnancy, childbirth, and abortion firmly in the context of a women's right to health, however that concept is understood, they will also take steps to protect, promote, and guarantee a woman's right to choose to terminate a pregnancy. In addition to making sure that women's reproductive health services are legal, the right to health requires states to provide such services or to make sure that they are accessible and affordable.

1. National Reforms and Jurisprudence

a) Portugal—2007

In 2007, Portugal legalized abortion upon request up to the tenth week of pregnancy and guaranteed access to abortion within the state-run health system.⁹⁸ The Portuguese reforms were motivated by all three strands of reasoning positioning abortion as a part of the right to health. Prior to the 2007 reform, Portugal was one of the few countries in the European Union to seriously restrict abortion.⁹⁹ It reformed its law largely in response to the persistent problems of unsafe abortion and maternal mortality.¹⁰⁰ In that

abortions, with attendant risks to their life and health.” (quoting U.N. Human Rights Comm., *Concluding Observations of the Human Rights Committee: Poland*, ¶ 8, U.N. Doc. CCPR/CO/82/POL/Rev.1 (2004)).

98. Exclusão da ilicitude nos casos de interrupção voluntária da gravidez, Lei No. 16/2007 de 17 de Abril (Portugal), *published in* *Diário da República*, 1o serie, No. 75, 17 de Abril de 2007 (translation by author).

99. *Portugal Will Legalise Abortion*, BBC NEWS (Feb. 12, 2007), <http://news.bbc.co.uk/2/hi/europe/6350651.stm>. See also CTR. FOR REPROD. RIGHTS, WRITTEN COMMENTS ON THE PROPOSED LEGISLATION ON VOLUNTARY INTERRUPTION OF PREGNANCY BEFORE THE SPANISH GOVERNMENT 11 (2009), <http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/Spanish%20Abortion%20Legislation%20April%2027.pdf> [hereinafter CTR. FOR REPROD. RIGHTS, COMMENTS].

100. See *In Portugal, A Fresh Opening for Abortion-Law Reform*, IPAS (Feb. 20, 2007), http://www.ipas.org/Library/News/News_Items/In_Portugal_a_fresh_opening_for_abortion-law_reform.aspx (explaining that the law is meant to combat maternal death from unsafe abortions). Portuguese activists argue that emphasizing the public-health rationale behind the reform helped the law's proponents to defeat the influential Catholic Church's campaign against liberalization. See *id.* (quoting spokesperson for Portugal's Doctors for Choice as stating that the “health-care community was successful in countering anti-choice rhetoric coming from other political parties, factions in the Roman Catholic Church and its allied organizations . . .”). See also Direção-Geral da Saude (Portugal), *Circular Normativa No. 11/SR: Organizacao dos Servicos para implementacao de Lei 16/2007 de 17 de Abril*, http://www.medicospelaescolha.pt/wp-content/uploads/dgsl_organizacao_servicos.pdf (translation by author) (explaining that reform was a vehicle to combat unsafe abortion as a cause of maternal mortality, and therefore comply with the WHO's

sense, the Portuguese reform could be categorized as relying on the first strand of abortion-and-health reasoning—i.e., the link between unsafe abortion and maternal health and mortality. However, the Health Ministry also emphasized that access to abortion had human rights as well as public health dimensions.¹⁰¹ It explained that the new law would do more than simply improve public-health indicators and provide “quality, efficient, and effective public health services.”¹⁰² Rather, the very provision of these public health services would “guarantee and respect the dignity and the rights of the woman, recognizing her capacity for choice and decision-making.”¹⁰³ The Health Ministry thus recognized that legalizing abortion would not only eradicate unsafe abortion as a cause of maternal death and morbidity; it would also provide adequate services for optimal individual health and allow women to make their own decisions about their health.

The health outcomes of the Portuguese reform were dramatic. Before 2007, when Portugal’s abortion laws were among the strictest in Europe, an estimated 20,000 illegal abortions took place each year.¹⁰⁴ Only one year after the new law went into effect, the number of complications associated with unsafe abortion, such as infection and uterine perforations, fell by more than half.¹⁰⁵ This decrease is both a public health victory and an indicator that the new law permits more women to get the care that they both need and desire.

b) Nepal—2002 & 2009

In 2002, Nepal liberalized what was formerly one of the world’s most restrictive abortion laws, amending the National Code to permit abortion on broad grounds.¹⁰⁶ Prior to the liberalization, women in Nepal were

recommendations and advance the Millennium Development Goals).

101. *Id.* (translation by author).

102. *Id.* (translation by author) (“A Lei 16/2007 da Assembleia da Republica veio criar condições para o desenvolvimento, nos serviços públicos de saúde, de um modelo de prestação de cuidados com níveis de qualidade, eficiência e eficácia, que garantam e respeitem a dignidade e os direitos da mulher, com reconhecimento da sua capacidade de escolha e decisão, e inseridos num contexto mais abrangente que contemple a perspectiva duma vida sexual e reprodutiva saudáveis.”).

103. *Id.* (translation by author) (“A Lei 16/2007 da Assembleia da Republica veio criar condições para o desenvolvimento, nos serviços públicos de saúde, de um modelo de prestação de cuidados com níveis de qualidade, eficiência e eficácia, que garantam e respeitem a dignidade e os direitos da mulher, com reconhecimento da sua capacidade de escolha e decisão, e inseridos num contexto mais abrangente que contemple a perspectiva duma vida sexual e reprodutiva saudáveis.”).

104. CTR. FOR REPROD. RIGHTS, COMMENTS, *supra* note, 99, at 11.

105. *Id.*

106. CTR. FOR REPROD. RIGHTS, LAKSHMI DHIKTA V. NEPAL: LEGAL ABORTION MUST BE AVAILABLE TO ALL WOMEN 1 (2009) [hereinafter LAKSHMI DHIKTA], <http://reproductiverights.org/sites/crr.civicaactions.net/files/flash/Toolkit-Lakshmi%20Dhikta%20v.%20Nepal%2007-2009.pdf>.

imprisoned for undergoing abortions.¹⁰⁷ The driving force behind the 2002 reform was an awareness that unsafe abortion created an unacceptable public health crisis.¹⁰⁸ However, after the 2002 reform passed, the law was unevenly implemented by the government. Abortion was often prohibitively expensive or inaccessible, and many women—especially rural women—were still unaware that abortion was legal.¹⁰⁹

In 2007, Lakshmi Dhikta, a low-income woman from a rural region of Nepal, sued the government of Nepal, arguing that the government's failure to implement the abortion law—and actually make abortion accessible to women like her—violated Nepal's human rights obligations under ICESCR and CEDAW, especially the right to health.¹¹⁰ Dhikta also argued that the government's failure to implement the law violated Nepal's Interim Constitution, which establishes the fundamental right to health and to primary health services and guarantees a woman's right to reproductive health.¹¹¹

In 2009, the Supreme Court of Nepal agreed. The court held that, in order to comply with its human rights obligations, the Nepali government must introduce a comprehensive abortion law; expand and decentralize abortion services; establish a fund to cover abortion costs; ensure strong protections for women's privacy; and provide information about safe abortion services to the public.¹¹² The Court thus evoked the second- and third-strand rationales to affirm that the right to abortion in Nepal exists as part of a woman's right to individual health and to decision-making regarding her health.

c) Colombia—2006

In a landmark 2006 decision, the Constitutional Court of Colombia interpreted the right to health and the right to non-discrimination, as guaranteed by both Colombia's Constitution and international human rights law, to include a right to abortion.¹¹³ Although it found that prenatal

107. See CTR. FOR REPROD. LAW & POLICY & THE FORUM FOR WOMEN, LAW & DEV., ABORTION IN NEPAL: WOMEN IMPRISONED 12 (2002), http://reproductiverights.org/sites/crr.civicactions.net/files/documents/nepal_2002.pdf. After legalization, at least fifty-four women were released from prison for “abortion related offenses.” See *Major Achievements through Advocacy*, F. FOR WOMEN, L. & DEV., http://www.fwld.org/achievement_advocacy.php (last visited Mar. 23, 2011)

108. See Shyam Thapa, *Abortion Law in Nepal: The Road to Reform*, REPROD. HEALTH MATTERS, Nov. 2004, at 85, 85–94 (Supp. 2004).

109. LAKSHMI DHIKTA, *supra* note 106, at 2.

110. *Id.* at 6–7.

111. *Id.*

112. *Id.* at 3.

113. See Corte Constitucional [C.C.] [Constitutional Court], mayo 10, 2006, C-355/06 (Colom.), in WOMEN'S LINK WORLDWIDE, C-355/2006: EXCERPTS OF THE CONSTITUTIONAL COURT'S RULING THAT LIBERALIZED ABORTION IN COLOMBIA 26–28 (2007) (discussing the

life has constitutionally relevant value, if not constitutional rights, the Court nevertheless concluded that “it is not proportionate or reasonable for the Colombian state to obligate a person to sacrifice her or his health in the interest of protecting third parties, even when those interests are also constitutionally relevant.”¹¹⁴ In the decision, the Court emphasized women’s right to dignity.¹¹⁵ In that vein, the Court noted that criminalizing health care that only women need, such as abortion, violates CEDAW’s prohibition of sex-based discrimination,¹¹⁶ and that forcing unwanted motherhood upon women is analogous to sexual violence.¹¹⁷ Moreover, the Court explained that the right to health requires the Colombian government not just to refrain from criminalizing abortion, but to “offer a wide range of high quality and accessible health services, which must include sexual and reproductive health services . . . [and to] eliminate all obstacles that impede women’s access to services, education, and information on sexual and reproductive health.”¹¹⁸ The Court’s decision also contained several elements designed to ensure that women could, in reality, gain access to acceptable abortion services. For example, the Court noted that institutions such as hospitals could not conscientiously object to providing abortions; while individuals may do so, those individuals who do object must provide the woman with an immediate, adequate referral.¹¹⁹

The Court’s categorization of abortion as a health issue encompasses all three strands of right-to-health reasoning. As to the first strand, the Court emphasized that unsafe abortions are a “serious public health problem in Colombia which primarily affects adolescents, displaced victims

right to health under CEDAW); *id.* at 56 (discussing the right to health under ICESCR). *See also id.* at 41 (“The Constitutional Court has said on various occasions that the right to health, even though it is not expressly found in the Constitution . . . has a fundamental character when it is in *close relation* to the right to life The Court has also said that human life as protected in the Constitution refers not only to a biological existence, but also to life with a minimum degree of dignity.”); *id.* at 54 (“[W]hen there is a risk to the health and life of the pregnant woman, it is clearly excessive to criminalize abortion since it would require the sacrifice of the fully formed life of the woman in favor of the developing life of the fetus.”).

114. *Id.* at 42. In the same vein, the Court noted that it “has held on several occasions that the state cannot oblige a person, in this case a pregnant woman, to perform heroic sacrifices and give up her own rights for the benefit of others or the benefit of society in general. Such an obligation is unenforceable, even if the pregnancy is the result of a consensual act, in light of article 49 of the Constitution, which mandates that all people take care of their own health.” *Id.* at 54.

115. *Id.* at 35 (“Human dignity warrants a sphere of autonomy and moral integrity that must be respected The sphere of protection for women’s human dignity includes decisions related to their choice of life plan, among them decisions regarding reproductive autonomy.”). *See also id.* at 41 (discussing connection between the right to life and the right to “life with a minimum degree of dignity”).

116. *Id.* at 29.

117. *Id.* at 43–44.

118. *Id.* at 28–29.

119. *Id.* at 58.

of the internal armed conflict, and those with the lowest levels of education and income.”¹²⁰ The second strand is captured by the Court’s acknowledgment that the right is about individual women’s health, not just the epidemiological problem of unsafe abortion.¹²¹

The decision is especially detailed in its use of the third strand of reasoning. The Court linked the right to health with a right to basic dignity, explaining that the Colombian Constitution recognizes a right to health “when its protection becomes necessary in order to guarantee the continuity of life in dignified conditions.”¹²² According to the Court,

[T]he right to health has a dimension related to decision-making about one’s own health, which is closely linked to autonomy and the right to the free development of the individual. Thus, the Constitutional Court has understood that every person has the autonomy to make decisions related to his or her health, and that therefore the *informed consent of the patient prevails over the views of the treating physician, and the interest of society and the state . . .*¹²³

The Court’s declaration that access to abortion implicates women’s dignity, autonomy, and “the right to free development of the individual” is in part a consequence of its recognition that the decision to continue a pregnancy is a major health question.

d) Mexico—2008

In April 2007, Mexico City (also known as the Distrito Federal (D.F.)) legalized abortion upon request during the first twelve weeks of pregnancy and implemented regulations requiring all D.F. hospitals to provide abortions in a safe and timely manner to all women who requested them within the legal time period.¹²⁴ To ensure equal access, the Mexico City law requires all public hospitals in the city to provide free abortion services to

120. *Id.* at 17.

121. *Cf. id.* at 42 (“The right to health is an integral right that includes mental and physical well-being. Furthermore, for women, it includes reproductive health, which is closely linked to both induced and spontaneous abortion.”).

122. *Id.* at 41.

123. *Id.* at 43 (emphasis added).

124. See GRUPO DE INFORMACIÓN EN REPRODUCCIÓN ELEGIDA, THE PROCESS OF DECRIMINALIZING ABORTION IN MEXICO CITY 71–74 (2008) (translating Decree Reforming the Federal District Penal Code and Amending the Federal District Health Law (April 26, 2007)). Article 16 Bis-6 of the Health Law was amended to state: “Public health institutions of the Government of the Federal District will attend to women who request termination of their pregnancy even if they have other public or private health providers.” *Id.* at 73. Requirements for safety and timeliness were given in Guidelines promulgated by the Federal District Ministry of Health. *Id.* at 75–80.

Mexico City residents.¹²⁵ Conscientious objection by practitioners is regulated so that women who request a legal abortion are guaranteed the service.¹²⁶

The reform was challenged in the Mexican Supreme Court.¹²⁷ In its argument before the court, the D.F. Legislative Assembly justified the law as necessary to protect women's right to health. The Assembly used all three types of right-to-health reasoning and emphasizing their inextricability. The President of the Legislative Assembly argued that a 1983 reform adding the right to health into the Mexican Constitution authorized state governments to legislate on health-related matters.¹²⁸ He argued that this grant of power to the District gave it the right to change abortion laws due to abortion's urgency as a health issue.¹²⁹ He further argued that the right to health gave the District not just the competence but the obligation to provide access to safe, legal abortion.¹³⁰ He told the Court that the District would be violating the right to health if it held abortion to be illegal but knew that abortions were occurring, because that

125. *Id.* at 9.

126. Article 16 Bis-6 and -7 of the Distrito Federal General Health Law provide that "conscientious objection will not be accommodated if the pregnant woman requesting the abortion is facing a risk of death or of health impairment; only the physician expected to perform the procedure can be legally exempted from participating in it on grounds of conscience; and public health facilities are compelled to ensure availability of non-objecting professionals; conscientious objectors have the legal duty to refer to non-objecting physicians." Cook & Ngweni, *Women's Access to Health Care*, *supra* note 33, at 223.

127. Acción de Inconstitucionalidad 146/2007 y Su Accumulada 147/2007, Pleno de la Suprema Corte de Justicia [SCJN] [Supreme Court], *Semanario Judicial de la Federación y su Gaceta*, Novena Época, tomo XXIX, Agosto de 2008 (Mex.) [hereinafter *Acción de Inconstitucionalidad 146/2007 y Su Accumulada 147/2007*] (translation by author), *available at* http://www.equidad.scjn.gob.mx/spip.php?page=ficha_biblioteca&id_article=111.

128. *Id.* at 180–181 (translation by author) (quoting the D.F. Legislative Assembly's arguments).

129. *Id.* at 66–67 (translation by author) ("Así, el Distrito Federal está facultado para legislar en las materias de salubridad local y salubridad general en la parte que conforme a la distribución competencial prevista en los artículos 3° y 13 de la Ley General de Salud, pertenece al ámbito de las autoridades locales . . . Conforme a los artículos 3° y 13 de la Ley General de Salud, a las entidades federativas y al Distrito Federal les corresponde organizar, operar, supervisar y evaluar la prestación de los servicios de salubridad general, entre ellos, la atención materno infantil, la planificación familiar y la coordinación de la investigación para la salud y el control de ésta en los seres humanos, por lo que conforme con ello, la Asamblea Legislativa puede expedir normas para ampliar el catálogo de prestaciones y servicios contenidos en la Ley General de Salud.").

130. *See id.* at 68–69 (translation by author) (quoting from the Legislative Assembly's argument) ("[U]na vez que la Asamblea Legislativa reformula el tipo penal para constituir como una actividad lícita la interrupción del embarazo durante las primeras doce semanas de gestación, cuando se cuenta con el consentimiento de la mujer, lógicamente la prestación de los servicios médicos necesarios para tal efecto se convierten en un componente del derecho a la protección de la salud, pues resultaría insuficiente y hasta contradictorio que se prevean los supuestos en que lícitamente puede interrumpirse el embarazo y no se garantice que las mujeres puedan disfrutar de los servicios médicos conducentes, lo que perjudicaría a las mujeres de escasos recursos económicos.").

situation would prevent women from being able to obtain abortions that are medically effective and safe.¹³¹ Finally, he argued that the right to health obligated the District not just to legalize abortion but to provide abortion services.¹³²

The Supreme Court agreed with those first- and second-strand arguments, holding that legalizing abortion was an appropriate use of D.F.'s legislative power to advance the right to health under the Mexican Constitution.¹³³ In upholding the D.F. law, the Supreme Court explained that decriminalizing abortion would promote the public health goal of stopping clandestine abortions and that it would especially help women with fewer resources to access services.¹³⁴ The Court also relied on third-strand reasoning: according to the Court, when abortion is prohibited by a state or by some third party, "the question is: who can veto the decision of whom?"¹³⁵ The Court found that, by legalizing abortion and requiring hospitals to provide it, Mexico City's law established "the rule that the final decision-maker" in cases of unwanted pregnancy is always the woman.¹³⁶

The Mexico City case stands as a concrete example of how the right to

131. *Id.* at 58 (translation by author) ("El derecho fundamental de protección a la salud se vería violentado si el Estado, sabiendo que la interrupción del embarazo se practica aunque no esté permitido, impidiera a las mujeres que deciden practicarlo el acceder a la atención médica eficaz y oportuna, cuando es conocida la problemática existente en ese rubro específico.").

132. The D.F. Legislative Assembly explained that, once abortion became legal, the provision of abortion within the legal context became a component of the right to protection of health. *Id.* at 68–69 (translation by author). Thus, it reasoned, "it would be insufficient and almost contradictory if legal conditions were provided for the licit termination of pregnancy, but it were not guaranteed that women could enjoy those medical services, which would harm women with limited economic resources." *Id.*

133. *See id.* at 180–81 (translation by author) ("[E]s posible afirmar, además, que el legislador democrático, al descriminalizar esta conducta, no tomó una decisión aislada, sino que la misma se encuentra reforzada mediante obligaciones a cargo del Gobierno del Distrito Federal y en particular de las autoridades que tienen a su cargo los servicios de salud, de proporcionar información oportuna y veraz de otras opciones que se encuentre al alcance de las mujeres . . . de este modo se hace efectiva la obligación del Estado establecida en el artículo 4 constitucional en relación con la salud, información y responsabilidad en la toma de decisiones por parte de las mujeres.").

134. *Id.* at 181–82 (translation by author) ("La justificación general de la medida resultado del ejercicio democrático llevado a cabo por la Asamblea que concluyó con la despenalización de una conducta, fue acabar con un problema de salud pública derivado de la práctica de abortos clandestinos, estimando que la despenalización del aborto permitirá que las mujeres interrumpan voluntariamente su embarazo en condiciones de higiene y seguridad; asimismo, garantizar un trato igualitario a las mujeres, en específico aquellas de menores ingresos, así como reconocerles libertad en la determinación de la forma en la que quieren tener relaciones sexuales y su función reproductiva; reconocer que no debe existir la maternidad forzada y se debe permitir que la mujer pueda desarrollar su proyecto de vida en terminus que lo estime conveniente.").

135. *Id.* at 188 (translation by author).

136. *Id.* (translation by author).

health provides a robust framework for liberalized abortion law in theory and for women's actual access to abortion services in practice.¹³⁷ As in Portugal, the reform has had immediate, quantifiable public health results. By 2008, 34,660 safe abortions had been performed in hospitals in Mexico City and 50,936 requests for abortion information had been submitted.¹³⁸

e) Spain—2010

In 2010, Spain relied on the right to health to legalize abortion upon request until the fourteenth week of pregnancy and to allow it later in pregnancy for health and other indications.¹³⁹ The text of the Spanish law reveals that the legislature was motivated in large part by the third strand of right-to-health rationale in drafting the statute. Previously, Spain criminalized abortion except in cases of rape, serious fetal abnormalities, or when a doctor determined that there was a serious risk to the mother's life or health.¹⁴⁰ In 1985, anti-abortion advocates challenged that earlier law's exceptions as violating the fetus' right to life, arguing that there should be no exceptions at all.¹⁴¹ Spain's Constitutional Court upheld the health exceptions.¹⁴² According to the Court, the woman's right to health was one of the reasons why abortion in cases where the mother's health was endangered was constitutional:

The state of "grave danger to the health of the pregnant woman" seriously affects her right to life and to physical integrity. For that reason, it is not unconstitutional for the mother's health to prevail, especially taking into account that to demand that she make an important and long-term sacrifice to her health, or face criminal sanctions, would not

137. Due to the "inverse *Roe*" posture of this case, in which the Court was asked to hold that a law allowing, rather than banning, abortion was unconstitutional, the Mexican Supreme Court was unable to hold that abortion is fundamentally protected by the Constitution. *See id.* at 177 (translation by author). However, the Court did emphatically declare abortion access was a legitimate component of a state's implementation of the right to health under Article 4. *See id.* at 180–181 (translation by author).

138. GRUPO DE INFORMACIÓN EN REPRODUCCIÓN ELEGIDA, CIFRAS SOBRE ABORTO EN EL DF 2007–2010, at 2 (2010). The availability of such data is a further benefit of the legalization of abortion. Where abortion is illegal, its public health impacts are difficult to quantify and therefore difficult to solve. *See* GRUPO DE INFORMACIÓN EN REPRODUCCIÓN ELEGIDA, HOJA INFORMATIVA: CIFRAS DEL ABORTO EN MÉXICO 1 (2008) ("Hablar del número de abortos inducidos en un país don de dicha práctica está restringida por la ley, es hablar únicamente de estimaciones.").

139. Ley Orgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo. (B.O.E. 2010, 3514) [hereinafter *Ley 2/2010*] (translation by author), available at <http://sid.usal.es/docs/F3/LYN15082/3-15082.pdf>.

140. S.T.C, April 11, 1985 (B.O.R. No. 53) (Spain), http://www.boe.es/aeboe/consultas/bases_datos/doc.php?coleccion=tc&id=SENTENCIA-1985-0053 (translation by author).

141. *See id.* (translation by author).

142. *See id.* (translation by author).

be acceptable¹⁴³

Thus, the legality of abortion in Spain was already based, at least in part, on the constitutional protection of women's health, and the Constitutional Court's understanding that a woman could not be used as a "mere instrument"¹⁴⁴ for reproduction even though, under the old law, a doctor was required to determine whether a valid health reason for abortion really existed.¹⁴⁵

The move from the old model to the current one demonstrates the crucial difference, for women, between "health" and the "*right* to health." If women are full holders of rights, if abortion and pregnancy are health issues, and if the right to health includes the right to make decisions about one's health, then it must be concluded—as the Spanish Senate did in 2010—that to allow third parties, such as doctors, to make the abortion decision "no longer makes sense."¹⁴⁶ The "purpose" section of the new law explains that its "objective . . . is to guarantee fundamental rights in the area of sexual and reproductive health."¹⁴⁷ The law then goes on to explain how decision-making is a component of the right to health.¹⁴⁸

The 2010 law's preamble contains a sophisticated synthesis of all three strands of right-to-health reasoning, which it positions as relating to two ideals: the state's commitment to public health and to providing the best, evidence-based medical services; and the state's commitment to the fundamental rights of women, including the right to health.¹⁴⁹ It explains that the history of abortion law in Spain reflects the evolving conception of women's rights in international law and in European countries' domestic

143. *Id.* § II(11) (translation by author).

144. *Id.* § II(11)(b) ("[L]a dignidad de la mujer excluye que pueda considerársele como mero instrumento.").

145. *See id.* § II(13) ("[P]or lo que se refiere al aborto terapéutico, este Tribunal estima que la requerida intervención de un médico para practicar la interrupción del embarazo, sin que se prevea dictamen médico alguno, resulta insuficiente. La protección del "nasciturus" exige que, de forma análoga a lo previsto en el caso del aborto eugenésico, la comprobación de la existencia del supuesto de hecho se realice con carácter general por un Médico de la especialidad correspondiente.").

146. COMISIÓN DE IGUALDAD, CONCLUSIONES DE LA SUBCOMISIÓN SOBRE LA REFORMA DE LA REGULACIÓN DE LA INTERRUPCIÓN VOLUNTARIA DEL EMBARAZO EN EL MARCO DE UNA NUEVA NORMA SOBRE DERECHOS Y SALUD SEXUAL Y REPRODUCTIVA 6 (2008).

147. *Ley 2/2010, supra* note 139, at 21005 (translation by author) ("Constituye el objeto de la presente Ley Orgánica garantizar los derechos fundamentales en el ámbito de la salud sexual y reproductiva . . .").

148. *See id.* at 21005–06.

149. The statute situated the law in the context of public health, as "the most effective way to prevent sexually-transmitted infections, unwanted pregnancies, and abortions." *Id.* at 21002 (translation by author). It also noted that the "fundamental rights" and "the special relationship between the rights of women and the protection of sexual and reproductive health." *Id.*

law.¹⁵⁰ It explains that this trajectory has culminated in the consensus that women are fully autonomous political and juridical individuals, and therefore holders of rights to life, health, physical integrity, and autonomous decision-making. As such, abortion decisions can only be made by the woman herself, at least early in pregnancy.¹⁵¹

Moreover, the preamble explains that the right to sexual and reproductive health requires the state not just to legalize abortion but to provide access to reproductive health services.¹⁵² In accordance with this comprehensive vision of the right to health, the Spanish law both decriminalizes abortion and creates additional measures to further reproductive health, including mandating free access to contraceptives, requiring comprehensive sex education in schools and providing for sensitivity training and clinical abortion training for health-care providers.¹⁵³ The law also requires all state-run or state-affiliated health facilities to provide abortions and strictly regulates conscientious objection on the part of health-care providers.¹⁵⁴ The legislature concluded that, while third parties, such as the state, “are obligated not to interfere in this type of decision, they at the same time must establish conditions so that these decisions can be adopted freely and responsibly, by putting medical, counseling, and information services within reach for those who need them.”¹⁵⁵

2. *International Human Rights Cases*

a) *K.L. v. Peru – Human Rights Committee (ICCPR) – 2005*

K.L., a pregnant Peruvian teenager, sought an abortion when she

150. *Id.* (translation by author)

151. *See id.* at 21002–03 (translation by author) (“La presente Ley reconoce el derecho a la maternidad libremente decidida, que implica, entre otras cosas, que las mujeres puedan tomar la decisión inicial sobre su embarazo y que esa decisión, consciente y responsable, sea respetada.”).

152. *See id.* at 21004 (translation by author) (“La Ley establece además un conjunto de garantías relativas al acceso efectivo de prestación sanitaria de la interrupción voluntaria del embarazo Con estas previsiones legales se pretende dar solución a los problemas a que había dado lugar el actual marco regulador tanto de desigualdades territoriales en el acceso a la prestación como de vulneración de la intimidad. Así, se encomienda a la Alta Inspección velar por la efectiva igualdad en el ejercicio de los derechos y el acceso a las prestaciones reconocidas en esta Ley.”).

153. *Id.* at 21006 (translation by author).

154. *See id.* art. IX, § 2. Article 12 guarantees access to abortion in the conditions in which it is legal under the law. *Id.* art. XII. Article 18 tells publicly-run health-care centers to guarantee the provision of abortion services, including all those centers under the National Health System. *Id.* art. 18. Articles 19 and 20 give more detailed regulations for how the service will in effect be guaranteed. *Id.*

155. *See Ley 2/2010, supra* note 139, at 21001 (translation by author).

found out that her fetus was anencephalic,¹⁵⁶ meaning it had no chance of survival outside the womb.¹⁵⁷ In Peru, abortion is legal only to save the life of the mother or to prevent serious damage to her health.¹⁵⁸ K.L. was refused an abortion and thus was forced to give birth to the baby.¹⁵⁹ She then had to nurse the baby for four days before it died.¹⁶⁰ Not only was she forced to deliver the baby—an especially risky activity for adolescent women, due to their higher risk of obstetric injuries¹⁶¹—but her baby’s inevitable death caused K.L. to suffer serious depression and psychological trauma.¹⁶²

In the first case on abortion before an international human rights body, K.L. petitioned the Human Rights Committee for relief under the ICCPR.¹⁶³ While the ICCPR does not explicitly recognize a right to health, K.L.’s health was the critical focal point in the petitioners’ arguments. The petitioners argued that K.L.’s health deserved special protection due to her status as a female and a minor:

In access to health services, since her different and special needs were ignored because of her sex . . . [K.L. suffered] [d]iscrimination in exercise of her rights, since although the claimant was entitled to a therapeutic abortion, none was carried out because of social attitudes and prejudices, thus preventing her from enjoying her right to life, [and] to health . . . on equal footing with men.¹⁶⁴

Petitioners also linked K.L.’s case to the problem of unsafe abortion at the public-health level. They argued that the right to life, protected by Article 6 of the ICCPR, creates a positive obligation on states to take measures to “ensure that women do not resort to clandestine abortions which endanger their life and health.”¹⁶⁵ The unavailability of legal

156. K.L. v. Peru, *supra* note 96, at ¶ 2.1.

157. *Id.* ¶ 2.7

158. *Id.* ¶ 2.3 (“[U]nder article 120 of the [Peruvian] Criminal Code, abortion was punishable by a prison term of no more than three months when it was likely that at birth the child would suffer serious physical or mental defects, while under article 119, therapeutic abortion was permitted only when termination of the pregnancy was the only way of saving the life of the pregnant woman or avoiding serious and permanent damage to her health.”).

159. *Id.* ¶ 2.2–2.6.

160. *Id.* ¶ 2.6.

161. See Agustin Conde-Agudelo, José M. Belizán & Cristina Lammers, *Maternal-Perinatal Morbidity and Mortality Associated with Adolescent Pregnancy in Latin America: A Cross-Sectional Study*, 192 AM. J. OBSTETRICS & GYNECOLOGY 342, 349 (2005), available at http://www.pec.org.ar/administracion/files/20080117041105_366.pdf (discussing risks of adverse maternal outcomes to adolescent females).

162. K.L. v. Peru, *supra* note 96, ¶ 2.6.

163. *Id.* ¶ 3.1–3.9.

164. *Id.* ¶ 3.2(a)–(b).

165. *Id.* ¶ 3.3.

abortion “left [K.L.] with two options which posed an equal risk to her health and safety: to seek clandestine (and hence highly risky) abortion services, or to continue a dangerous and traumatic pregnancy which put her life at risk.”¹⁶⁶ In this sense, they make an important connection between all three strands of right-to-health perspectives. That is, they explain that the health care K.L. seeks—an abortion—is also health care that she needs; otherwise, her health would be at risk if she underwent an unsafe abortion.

The Committee agreed. It found that K.L.’s health had not been adequately promoted or protected by the Peruvian state.¹⁶⁷ The Committee held that the state’s failure to allow K.L. to have the abortion she sought caused her mental trauma and thus constituted cruel and inhuman treatment under Article 7 of the ICCPR.¹⁶⁸ The Committee’s judgment orders Peru to furnish K.L. with an “effective remedy, including compensation,” and to take steps to ensure that similar violations do not occur again.¹⁶⁹ Since then, the organizations that filed the case, along with other Peruvian non-governmental organizations (NGOs), have been urging the government to approve a protocol for safe abortion services as one means of complying with the decision.¹⁷⁰ The U.N. Special Rapporteur on the Right to Health has also advocated that the Peruvian government implement the *K.L.* decision by making therapeutic abortion available without legal vagaries.¹⁷¹

b) *Tysi c v. Poland—European Court of Human Rights—2007*

When Alicja Tysi c, a woman with declining eyesight, became pregnant with her third child, she was told that continuing the pregnancy could cause her vision to further deteriorate.¹⁷² While abortion was legal in Poland to protect the health of the mother, doctors refused her an

166. *Id.* ¶ 3.3.

167. *Id.* ¶¶ 3.4, 6.3.

168. *Id.* The Human Rights Committee also found violations of Article 17, the right to privacy, *see id.* ¶ 6.4, and of Article 24, which provides for special protection as a minor, *see id.* ¶ 6.5.

169. *Id.* ¶ 8. To that end, the Committee instructed Peru to submit a report within ninety days of the decision explaining what measures it had taken and will take for the implementation of the *K.L.* decision, as well as to publish the Committee’s decision. *Id.* ¶ 9.

170. *See* Press Release, Estudio para la Defensa de los Derechos de la Mujer, La Resoluci n del Caso K.L. v. Per , Emitida por el Comit  de Derechos Humanos de las Naciones Unidas, Gan  el Premio Mallette de Bronce (May 12, 2009), http://www.demus.org.pe/Menu/Alertas/Aler_Premio_Mallette.pdf (translation by author). While the protocol has been written, the Ministry of Health has not yet approved it. *Id.*

171. U.N. Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶¶ 36–37, U.N. Doc. A/HRC/4/28/Add.1 (February 23, 2007).

172. *See Tysi c v. Poland*, No. 5410/03, 2007-IV Eur. Ct. H.R. ¶ 9.

abortion.¹⁷³ She gave birth to the child, and, as she had feared, she became almost blind.¹⁷⁴

Tysi c's application for relief with the European Court of Human Rights made her argument in clear right-to-health terms.¹⁷⁵ Tysi c argued that her inability to access an abortion violated her rights under Article 8 of the European Convention on Human Rights, which protects the right to respect for one's private life.¹⁷⁶ She argued that, because "the refusal to terminate her pregnancy exposed her to a serious health risk," it "amounted to a violation of her right to respect for her private life."¹⁷⁷

The Court agreed. Although the European Convention does not include an explicit right to health, the Court found a constructive right to physical and psychological integrity emanating from the right to privacy.¹⁷⁸ The *Tysi c* Court employed the first strand of right to health reasoning, expressing concern that strict abortion laws in countries like Poland "lead to high numbers of clandestine abortions with attendant risks to life and health of women."¹⁷⁹ However, the Court's holding implied that it understood the rationale for a right to an abortion more broadly. The Court held that "while the Convention does not guarantee as such a right to any specific level of medical care, . . . private life includes a person's physical and psychological integrity and that the State is also under a positive obligation to secure to its citizens their right to effective respect for this integrity."¹⁸⁰ Therefore, "[o]nce the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it."¹⁸¹ Any state restrictions on abortion must "be also assessed against the positive obligations of the State to secure the physical integrity of mothers-to-be."¹⁸² By shifting its focus from

173. *Id.* ¶¶ 13–15, 38.

174. *Id.* ¶ 146.

175. *Id.* ¶ 1.

176. European Convention on Human Rights art. 8, Nov. 4, 1950, 213 U.N.T.S. 221.

177. *Tysi c*, 2007-IV Eur. Ct. H.R. ¶ 77.

178. *See id.* ¶ 107 ("[W]hile the Convention does not guarantee as such a right to any specific level of medical care, the Court has previously held that private life includes a person's physical and psychological integrity and that the State is also under a positive obligation to secure to its citizens their right to effective respect for this integrity.").

179. *Id.* ¶ 48 (quoting U.N. Econ. & Soc. Council, Human Rights Comm., *Concluding Observations of the Human Rights Committee: Poland*, ¶ 11, U.N. Doc. CCPR/C/79/DD.110 (July 29, 1999)).

180. *Id.* ¶ 107.

181. *Id.* ¶ 116.

182. *Id.* Further explaining the link between health and the state's positive obligations to respect the right to privacy, the Court held: "The procedures in place should . . . limit or prevent damage to a woman's health which might be occasioned by a late abortion. . . . [T]he absence of such . . . procedures in the domestic law can be said to amount to the failure of the State to comply with its positive obligations under Article 8 of the Convention." *Id.* ¶ 118.

the general need for safe abortion to the need for individual women to access abortion, the Court ultimately rested its decision on second-strand reasoning.

While the *Tysi c* case mobilized right-to-health and patients' rights proponents in Poland,¹⁸³ the decision did not develop third-strand reasoning as deeply as, for example, the Colombian or Mexican reforms.¹⁸⁴ The Court held that Poland must pay damages to Tysi c for violating her rights, but allowed Poland to continue to allow third parties—doctors—to determine whether abortion was medically necessary for a woman in a given case.¹⁸⁵ However, the Court did require that Poland establish a timely appeals mechanism for women who disagree with their doctors about whether abortion should be legal in the conditions presented.¹⁸⁶ The Committee of Ministers, which monitors the Court's implementation of judgments on behalf of the Council of Europe, has been following up with the Polish Government on implementation of the judgment.¹⁸⁷

c) Paulina Ramirez v. Mexico — *Inter-American Commission on Human Rights—2007*

Paulina Ramirez was fourteen years old when she was raped by a burglar in her home.¹⁸⁸ While abortion was technically legal for rape in her state of Baja California, Mexico, public officials unlawfully interfered and prevented her from obtaining an abortion.¹⁸⁹ She not only had to carry the pregnancy to term, she had to deliver by means of a caesarean section.¹⁹⁰

183. See Anna Mokryzcka, *Patients Rights Legislation: Tysi c v. Poland*, HEALTH POL'Y MONITOR (Oct. 2009), www.hpm.org/survey/pl/a14/5 (discussing the role of the newly appointed health Ombudsman post-*Tysi c*).

184. See *supra* section (B)(1)(d)–(e).

185. This paternalistic view of health as something to be determined by doctors, rather than by women as patients, is one reason that U.S. abortion-rights advocates have shied away from “health” arguments in support of abortion, termed the “medical model.” For an analysis of the paternalism inherent in the medical model, see Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 273–79 (1992) [hereinafter Siegel, *Reasoning from the Body*]. For an overview of critiques of the “medical model,” and “critiques of the critiques,” see B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501, 510–13 (2009).

186. CTR. FOR REPROD. RIGHTS, *TYSI C V. POLAND: ENSURING ACCESS TO LEGAL ABORTION 2* (2010), http://reproductiverights.org/sites/crr.civactions.net/files/documents/Tysiac_v_Poland_print.pdf.

187. See *id.* at 4.

188. Paulina Del Carmen Ram rez Jacinto v. Mexico, Case 161-02, Inter-Am. Comm'n H.R., Report No. 21/07, OEA/Ser.L/V/II.130, doc. 22, rev.1 ¶ 9 (2007) [hereinafter Paulina Del Carmen Ram rez Jacinto v. Mexico], available at <http://www1.umn.edu/humanrts/cases/21-07.html>.

189. *Id.* ¶¶ 10–13.

190. Julia Preston, *Rape of Mexican Teenager Stirs Abortion Outcry*, N.Y. TIMES, Apr. 10, 2000, at A3.

Paulina brought a case against Mexico to the Inter-American Commission on Human Rights (IACHR).

In her complaint, Paulina evoked second- and third-strand rationales to argue that the government interfered with her right to health, as protected by international and regional treaties, by denying her an abortion.¹⁹¹ Paulina argued that her right to personal integrity included a right to emotional and mental health.¹⁹² These rights were violated when, without her consent, anti-abortion activists entered her hospital room, harassed her, and exposed her to disturbing visual material.¹⁹³ Paulina's right to health was even more crucial due to her minor status, and she argued that the failure to protect her violated the rights of children to special protections.¹⁹⁴

A major alliance of seventy NGOs from across Latin America filed a letter to the IACHR on Paulina's behalf. Using first-strand reasoning, they argued that a right to an abortion was a necessary part of the right to health because of the link between unsafe abortion and maternal death and morbidity, which is especially serious in Latin America.¹⁹⁵ Since she was a minor with few resources, Paulina could have sought a clandestine, unsafe abortion and might have ended up a maternal mortality statistic. The letter urged the IACHR to admit the case as part of the battle to eradicate unsafe abortion as a cause of maternal mortality.¹⁹⁶

Because Paulina and the government of Mexico reached a settlement mediated by the IACHR, the Commission did not issue a formal decision. However, the settlement is itself noteworthy for its specificity and enforceability. It requires the Baja California government to pay Paulina general and specific damages, to publish an "Acknowledgement of Responsibility" in the Baja California newspapers and Official Gazette, and to amend the laws to make sure that abortion would be accessible in cases of rape.¹⁹⁷ The settlement decision went beyond holding only Baja California accountable; it required the government of Mexico to expand and enhance its laws on rape and sexual violence.¹⁹⁸ It also required the

191. GRUPO DE INFORMACIÓN EN REPRODUCCIÓN ELEGIDA, PAULINA: FIVE YEARS LATER 70 (2005), http://reproductiverights.org/sites/crr.civicactions.net/files/documents/bo_paulina5years.pdf (citing the right to health under Article 10 of the Protocol of San Salvador, Article 2 of the Convention of Belem do Pará, and Article 12 of CEDAW).

192. *See id.* (discussing violations of Paulina's right to "physical, mental and moral integrity").

193. Paulina Del Carmen Ramírez Jacinto v. Mexico, *supra* note 188, at ¶ 12.

194. *Id.* ¶ 2.

195. *See* Letter from 70 Latin American NGOs to the Inter-Am. Comm. on Human Rights (Sept. 23, 2003), *in* GRUPO DE INFORMACIÓN EN REPRODUCCIÓN ELEGIDA, PAULINA: FIVE YEARS LATER 78, 81 (2005).

196. *Id.* at 83–84.

197. Paulina Del Carmen Ramírez Jacinto v. Mexico, *supra* note 188, ¶ 16.

198. *Id.*

Federal Health Secretariat to draft and send a circular on preventing violations of abortion rights to the state health agencies.¹⁹⁹

C. Conclusion

The right to health has been effective both in persuading states to liberalize abortion laws and in causing states to make abortion accessible once it is legal. These decisions stand in sharp contrast to U.S. jurisprudence, where courts have consistently held that the legality of abortion does not require the government to ensure that it is available to those who want or need it.²⁰⁰

Of course, many of the above cases and reforms do not, in theory, protect the right to abortion to the same extent as U.S. law does under *Roe v. Wade*²⁰¹ and *Doe v. Bolton*.²⁰² In the United States, it is currently constitutionally impermissible to criminalize abortion during early pregnancy.²⁰³ In later pregnancy, laws restricting access to abortion must make exceptions for the woman's life and health, including her mental health.²⁰⁴ However, states are allowed to create barriers to abortion and to advance anti-abortion "policy preferences" even early in pregnancy, so long as they do not facially outlaw it.²⁰⁵ While U.S. law remains, on its face, one of the most progressive in the world,²⁰⁶ it is harder for women in the United States to effectively exercise their right to an abortion when compared to women in many other countries who have a technically less expansive right.²⁰⁷

199. *Id.*

200. See *Webster v. Reprod. Health Servs.* 492 U.S. 490 (1989) (upholding a Missouri law restricting the use of state funds, facilities, and employees in abortions); *Harris v. McRae*, 448 U.S. 297 (1980) (upholding federal ban on Medicare funding for abortion).

201. *Roe v. Wade*, 410 U.S. 113 (1973) (holding that the right to an abortion is part of the fundamental right to privacy and that laws restricting abortion access would be subject to strict scrutiny).

202. *Doe v. Bolton*, 410 U.S. 179, 192 (1973) (requiring courts to consider "all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the wellbeing of the patient" when determining whether an abortion is necessary under the health exception to law restricting abortion).

203. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992) (upholding "the right of the woman to choose to have an abortion before viability . . . without undue interference from the State").

204. *Id.* (acknowledging "the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health"); *Doe*, 410 U.S. at 192 (explaining that "health" must extend to "psychological as well as physical wellbeing").

205. *Webster*, 492 U.S. at 506. See discussion *infra* Parts IV(B) and V(A).

206. See, e.g., CTR. FOR REPROD. RIGHTS, *THE WORLD'S ABORTION LAWS* (2007), http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Abortion%20Map_FA.pdf (categorizing U.S. abortion law as one of the world's least restrictive).

207. U.S. law is only least restrictive when it comes to abortions later in pregnancy. For example, the Spanish law allows abortion for any reason up to fourteen weeks and

IV.

U.S. ABORTION JURISPRUDENCE IS HANDICAPPED BY THE ABSENCE OF
A RIGHT TO HEALTH*A. U.S. Abortion Jurisprudence Is Based on the Right to Privacy, Not
the Right to Health*

In contrast to much of the world, where abortion rights have been established, protected, or expanded using right-to-health rationales, the United States does not recognize the right to an abortion as part of a right to health. One reason for this difference may be that the United States does not recognize a right to health under either domestic or international law, nor is it bound by the international and regional documents that guarantee the right to health. While the United States became a party to the ICCPR,²⁰⁸ it did not ratify the ICESCR.²⁰⁹ Similarly, while the ICCPR can be used effectively to protect women's rights to reproductive health, the United States has emphasized that the treaty is not "self-executing."²¹⁰ The United States is also not a party to the Protocol of San Salvador²¹¹ or the Convention of Bélem do Pára.²¹² While the United States signed the Universal Declaration of Human Rights, because the document is a declaration of the U.N. General Assembly rather than a treaty, it is not

requires that services be available to everyone, without discrimination. However, after twenty-two weeks, abortion is generally not allowed at all, and a woman must undergo induced delivery, since the fetus is "viable." *Ley 2/2010*, *supra* note 139, at 21004. The Mexico City law requires free access in Mexico City public hospitals, but after twelve weeks of pregnancy, abortion is still criminalized. GRUPO DE INFORMACIÓN EN REPRODUCCIÓN ELEGIDA, *supra* note 124, at 74 (translating Decree Reforming the Federal District Penal Code and Amending the Federal District Health Law (April 26, 2007)). Though the Colombian law was handed down with progressive language from the Constitutional Court, its holding was narrow; it held the criminalization of abortion to be unconstitutional only in situations where the mother's life or health was in danger; where the pregnancy resulted from rape, incest, or other crimes; and in situations where the fetus suffers grave abnormalities. WOMEN'S LINK WORLDWIDE, *supra* note 113, at 61.

208. The U.S. signed the ICCPR on Oct. 5, 1977, and ratified it on June 8, 1992. *Status of Treaties: International Covenant on Civil and Political Rights*, U.N. TREATY COLLECTION, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en (last visited Apr. 26, 2011).

209. *Status of Treaties: International Covenant on Economic, Social, and Cultural Rights*, U.N. TREATY COLLECTION, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en (last visited Nov. 2, 2010).

210. 138 CONG. REC. S4781-84 (daily ed. April 2, 1992).

211. *Ratifications: Protocol of San Salvador*, INTER-AM. COMMISSION ON HUM. RTS., <http://www.cidh.org/basicos/english/Basic6.Prot.Sn%20Salv%20Ratif.htm> (last visited Dec. 4, 2010).

212. *Ratifications: Convention of Belém do Pará*, INTER-AM. COMMISSION ON HUM. RTS., <http://www.cidh.org/basicos/english/Basic14.Conv%20of%20Belem%20Do%20Para%20Ratif.htm> (last visited Dec. 4, 2010).

enforceable in courts as the supreme law of the land.²¹³ Similarly, while the United States participated in the development of the Cairo Program of Action and the Beijing Platform of Action,²¹⁴ these are conference documents, not treaties, and thus also not binding.²¹⁵

Instead of a right-to-health framework, the United States' jurisprudence grounds abortion and contraceptive access in the more limited concept of the right to privacy. The first landmark Supreme Court case on reproductive choice, *Griswold v. Connecticut*, considered the constitutionality of a statute that outlawed the use of contraceptives.²¹⁶ The *Griswold* court held that the ban violated married couples' right to privacy, although the Court divided on where this right was found in the Constitution.²¹⁷ In 1971, the Court found that this right to privacy extended to unmarried couples seeking contraceptives.²¹⁸ Notably, the Court did so to protect the privacy of an individual's decision "whether to bear or beget a child," not because privacy is required more generally to make health decisions.²¹⁹ *Roe v. Wade*, the groundbreaking 1973 case holding that state bans on abortion were unconstitutional, also relied on privacy reasoning.²²⁰ When *Roe* was argued, *amici* invited the Court to find that the right to an abortion derived from constitutionally protected rights other than privacy, such as the right not to be deprived of liberty and life under the Fourteenth Amendment and the prohibition of cruel and unusual

213. The Universal Declaration of Human Rights was meant to be made binding on states through its two "implementing" treaties, the ICCPR and the ICESCR. Universal Declaration of Human Rights, G.A. Res. 217 (III) A, section F, *Preparation of a Draft Covenant on Human Rights and Draft Measures of Implementation*, U.N. Doc A/RES/217(III) (Dec. 10, 1948).

214. See Hilary Rodham Clinton, First Lady of the United States of America, Remarks for the U.N. Fourth World Conference on Women (Sept. 5, 1995), <http://www.un.org/esa/gopher-data/conf/fwcw/conf/gov/950905175653.txt>.

215. Johanna E. Bond, *International Intersectionality: A Theoretical and Pragmatic Exploration of Women's International Human Rights Violations*, 52 EMORY L.J. 71, 92 (2003) ("The [Beijing] Platform for Action is not a binding legal instrument, [but] it represents a global agenda for change that women's rights activists have used to agitate for reform in their own countries."); Sarah R. Hamilton, *The Status of Women in Chile: Violations of Human Rights and Recourse Under International Law*, 25 WOMEN'S RTS. L. REP. 111, 115 (2004) (noting that "consensus decisions reached at international meetings are not formally binding").

216. *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965).

217. Justice Douglas, writing for the plurality, found the right in the penumbras of the First, Third, Fourth, Fifth, and Ninth Amendments. *Id.* at 484–85 (Douglas, J., plurality opinion). Justice Goldberg, writing for the Chief Justice and Justice Brennan, found that it emanated from the Ninth Amendment's reservation of rights to the people. *Id.* at 486 (Goldberg, J., concurring). Justice Harlan and White found it in the Fourteenth Amendment. *Id.* at 500 (Harlan, J., concurring); *id.* at 502 (White, J., concurring).

218. *Eisenstadt v. Baird*, 405 U.S. 438, 447 (1971).

219. *Id.* at 453.

220. *Roe v. Wade*, 410 U.S. 113, 155 (1973).

punishment under the Eighth Amendment.²²¹ The Court declined the invitation, finding that the right to an abortion was grounded in the same constitutional right to privacy that gave rise to the right to purchase contraceptive pills. The Court subsequently reaffirmed *Roe* in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, but it did not expand its reasoning beyond privacy.²²²

Despite the substantial critique of *Roe* from pro-choice and feminist commentators, to my knowledge no reproductive justice organizations have linked abortion rights with the right to health or even with a universal health care movement when lobbying against abortion-restrictive legislation. Commentators after *Roe* and *Casey* have expressed concern that the U.S. abortion right is not grounded in additional constitutional principles, such as a right to sex equality under the Equal Protection Clause,²²³ a right to bodily integrity,²²⁴ or an anti-totalitarian rationale.²²⁵ But because jurists are not forced to grapple directly with the health consequences of anti-abortion legislation, they are permitted to focus on the fetus, or the abstract question of “whether and if” to procreate, rather than on the health implications for the woman whose body is directly and seriously affected by pregnancy and abortion. To paraphrase Reva Siegel, to reason about abortion without reasoning about the woman’s body turns

221. Brief for New Women Lawyers, Women’s Health and Abortion Project, Inc. & Women’s National Abortion Action Coalition as Amici Curiae Supporting Appellants at 6–7, *Roe v. Wade*, 410 U.S. 113 (1971) (No. 70-18).

222. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992) (plurality opinion). In fact, *Casey* opened the floodgates for state regulations of abortion for reasons having nothing to do with the health of the mother. Under *Casey*, states are allowed to regulate abortion as long as they do not create an “undue burden” on the woman seeking an abortion. *Id.* at 878. If *Roe* had been supported by a strong health rationale, the non-health related interventions upheld in *Casey*—such as twenty-four hour waiting periods and informed consent requirements, *id.* at 887—would be difficult to justify. But even Justice Blackmun’s concurring opinion in *Casey*—which, unlike the majority, acknowledged the equal protection implications of abortion rights—ignored the right-to-health implications of restricting abortion. *Id.* at 928 (Blackmun, J., concurring) (arguing that a “State’s restrictions on a woman’s right to terminate her pregnancy also implicate constitutional guarantees of gender equality” because “[b]y restricting the right to terminate pregnancies, the State conscripts women’s bodies into its service, forcing women to continue their pregnancies, suffer the pains of childbirth, and in most instances, provide years of maternal care”). While Blackmun’s equal protection argument is admirable for its effort to more fully contemplate all that pregnancy entails for women, even this picture fails to conceive of pregnancy and childbirth as medical issues, apart from its reference to the “pains of childbirth.”

223. *See, e.g., Siegel, Sex Equality, supra* note 34 (arguing for more expansive protections of reproductive rights based on sex equality and equal protection).

224. *See, e.g., McDonagh, supra* note 60 (arguing that women’s abortion rights should encompass right to bodily integrity under the Equal Protection Clause).

225. *See, e.g., Jed Rubenfeld, The Right of Privacy*, 102 HARV. L. REV. 737, 784 (1989) (describing the tendency of anti-abortion laws to “take over the lives of the persons involved . . . [because] [t]hey affirmatively and very substantially shape a person’s life” and noting that “[t]he danger” of such laws “is a particular kind of creeping totalitarianism”).

the woman into “empty space.”²²⁶ Guaranteeing the right to health can thus serve as a proxy for guaranteeing women’s fundamental right to be viewed as human beings under the law. For this reason, this article considers the right to health, not the right to equality, to be the real criterion for gender equality.

Without a health focus, even when abortion jurisprudence attempts to consider the rights of women, it does not adequately contemplate women’s situation. When the Supreme Court considers an individual’s decision about whether to procreate, it conflates the concept of “bear” with the concept of “beget.”²²⁷ This conflation means that to “bear” a child in one’s uterus for nine months and birth it through one’s vagina or through an incision in one’s abdomen is seen as no more difficult than to father, or “beget,” a child, and is no more relevant to the law of privacy or of other rights. Without a focus on health, the question of what is at stake when abortion is allowed or forbidden is incomplete, at least for women. As such, some feminists might argue that abortion is framed in mostly masculine terms as a question of whether or not “to procreate.”²²⁸ That is, it adequately represents the point of view of a class of people for whom procreation is not a physical *activity* but an existential *idea*. Whether or not this is a “masculine” view, it is at least an insufficient understanding of what pregnancy is for women. The right to health, in the second- and third-strand senses, solves this problem. It protects a woman’s rights to privacy and decision-making on health care, but also requires that the state acknowledge, respond to, and provide for her health needs, if and when she wants it to do so. It forces the state to make her needs, vulnerabilities, and demands politically cognizable. In contrast, the privacy framework in U.S. jurisprudence does not make abortion actually available to women, and does not fully contemplate what abortion means to women and why they need and seek it.²²⁹

226. See Siegel, *Reasoning from the Body*, *supra* note 185, at 347 (arguing that to reason about the fetus without reasoning about the woman’s body turns the woman into empty space).

227. See *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1971) (recognizing “the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child”). The “bear or beget” language is also often cited, approvingly, by jurists seeking to advance a more robust abortion right than those in the majority. See, e.g., *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 565 (1989) (Stevens, J., dissenting); *Roe v. Wade*, 410 U.S. 113, 170 (1973) (Stewart, J., concurring).

228. MacKinnon argues that “the state is male in the feminist sense: the law sees and treats women the way men see and treat women.” CATHERINE MACKINNON, *TOWARD A FEMINIST THEORY OF THE STATE* 161–62 (1989). In my view, it follows that these cases—on abortion and contraception—see and treat procreation the way men see and treat procreation.

229. There is much feminist literature critiquing the privacy framework for failing to fully and accurately embrace and protect women’s interests. Those arguments are beyond

B. U.S. Abortion Jurisprudence Permits Lawmakers to Make Abortion Inaccessible or Extremely Difficult to Obtain, Which Would Be Impermissible Under a Right-to-Health Analysis

Because the right to an abortion in U.S. constitutional law is founded on the right to privacy rather than the right to health, the Supreme Court has upheld numerous state and federal laws that make abortion increasingly inaccessible. For example, when abortion is grounded in a right to health, a state must make the exercise of that right at least reasonably accessible.²³⁰ Yet in 1980, the Supreme Court upheld the Hyde Amendment,²³¹ which prohibits federal Medicaid from covering abortion, except in cases of rape, incest, or risk to the mother's life.²³² The Court rejected the plaintiffs' equal protection challenge, concluding that a woman's freedom of choice did not entail "a constitutional entitlement to the financial resources to avail herself of the full range of protected choices."²³³ Similarly, in the 2009–2010 health care reform debate, Democratic members of Congress—who, in theory, supported expanding health care access—aimed to reduce access to abortion even beyond the Hyde Amendment's restrictions by barring some private insurers from providing abortion coverage.²³⁴ Courts could not uphold such laws if the

the scope of this Article, but, in my view, a right-to-health framework would solve many of the problems identified in those critiques. *See, e.g., id.* at 190–193; Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics*, U. CHI. LEGAL F. 139, 155–56 (1989); Nussbaum, *Robin West*, *supra* note 30, at 995; Dorothy Roberts, *Punishing Drug Addicts Who Have Babies*, in *CRITICAL RACE FEMINISM* 133 (Adrien Katherine Wing ed., 1997).

230. *See* Tysi c v. Poland, App. No. 5410/03, 2007-IV Eur. Ct. H.R. ¶ 116 (holding that once a state has made abortion legal, it "must not structure its legal framework in a way which would limit real possibilities to obtain it").

231. The Hyde Amendment was first codified into law as Hyde Amendment, Pub. L. No. 94-439, 90 Stat. 1418 (1976). Since then, it has been renewed each year, either by inclusion in the Department of Health and Human Services' annual appropriations bill or by joint resolution. The current version is found in the Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, § 508, 123 Stat. 3034, 3280 (2009). The original Hyde Amendment did not contain an exception for rape or incest, only for the mother's life. *See* Harris v. McRae, 448 U.S. 297, 302 (1980). However, subsequent versions have contained such exceptions. *Id.*

232. *Harris*, 448 U.S. at 326.

233. *Id.* at 316.

234. *See* *CTR. FOR REPROD. RIGHTS, THE STUPAK-PITTS AMENDMENT GOES FAR BEYOND THE ALREADY-PUNISHING RESTRICTIONS IN THE HYDE AMENDMENT 1* (2009), http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_fac_stupakvhyde_12.09.pdf (explaining that Congressman Bart Stupak's (D-MI) proposed amendment to 2009 health reform bill would prohibit private plans available on new national health care exchanges from offering abortion, and that this would make it extremely burdensome for health plans to offer abortion in some plans but not those sold on the exchanges and cause those insurers "coverage even from plans that are not part of the exchange").

United States recognized a right to health.²³⁵

A right to health approach would similarly have disallowed the result in *Webster v. Reproductive Health Services*.²³⁶ In *Webster*, the U.S. Supreme Court upheld a Missouri statute that defined life as beginning at conception, banned abortions from public facilities, and prohibited public health workers from performing abortions unless the mother's life was at risk.²³⁷ Much like the Hyde Amendment, the Missouri statute significantly restricted women's access to abortions by limiting who could perform them and when. Yet the Court upheld the statute.²³⁸ In so holding, the Court found that "*Roe* implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion" and construed the Missouri law as simply making such "value judgments."²³⁹ Such a policy preference would be entirely impermissible under a right to health analysis, where "the informed consent of the patient prevails over the . . . interest of . . . the state."²⁴⁰ Of course, governments could seek to reduce abortions in a way that complies with the right to health—for example, by providing counseling, contraception, and voluntary sterilization services, or by providing free, high-quality maternal health care. Indeed, governments are more likely to provide these services when abortion is understood primarily as a health issue.²⁴¹

Gonzales v. Carhart (Carhart II) has been the most recent and most serious infringement on a woman's right to health.²⁴² *Carhart II* approved a federal ban on a particular abortion practice—a method used only rarely, known to doctors as intact dilation and extraction—without providing an exception for the health of the mother.²⁴³ Rather than recognizing that individual women are best suited to make decisions about their health, Congress decided that, as a matter of "fact," the procedure in question was

235. It is important to note that at least some state supreme courts in the United States have relied on state constitutions to require states to fund abortion based on women's health interests. See, e.g., *Right to Choose v. Byrne*, 450 A.2d 925, 934 (N.J. 1982) (striking down law which allowed Medicaid funding of abortion only in those instances when the abortion was necessary to save the life of the mother as violating the New Jersey State Constitution and noting "New Jersey accords a high priority to the preservation of health"). See also Martha Davis, *Abortion Access in the Global Marketplace*, 88 N.C. L. REV. 1657, 1670 (2010) (citing examples of state-level jurisprudence).

236. *Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989).

237. *Id.* at 501.

238. *Id.* at 522.

239. *Id.* at 506.

240. WOMEN'S LINK WORLDWIDE, *supra* note 113, at 43.

241. Rebecca J. Cook & Bernard M. Dickens, *International Developments in Abortion Laws: 1977-88*, 78 AM. J. PUB. HEALTH 1305, 1310 (1988), available at <http://ajph.aphapublications.org/cgi/reprint/78/10/1305.pdf>.

242. 550 U.S. 124 (2007).

243. *Id.* at 165. Congress called the procedure at issue "partial-birth abortion," although the medical term is intact dilation and extraction. *Id.* at 136.

“never medically necessary” for a woman.²⁴⁴ The language used by the Supreme Court in its decision in this case demonstrates the consequences of its refusal to consider abortion in the context of health. The Court described abortion as something with “emotional,”²⁴⁵ rather than medical consequences; and as something having to do with the “life of the unborn”²⁴⁶ rather than the life of the woman. The Court only employed the language of health when referring to alleged post-abortion depression, despite its “find[ing] no reliable data to measure the phenomenon.”²⁴⁷ Instead, the Court relied on its own assessment that “it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained.”²⁴⁸ To base any important decision or reform on “no reliable data” seems highly problematic. Even more disturbing is that the Court admitted its failure to find or rely on evidence and then proceeded to elevate its own opinion of what occurs to women over scientific evidence or the opinion of women themselves.

The Court’s disregard for science, public health data, and women’s autonomy is further revealed by its use of non-scientific terms, such as “partial-birth abortion,” and its injection of personal opinions into the case. For instance, Justice Kennedy noted that Congress referred to the proscribed abortion methods as having a “disturbing similarity to the killing of a newborn infant.”²⁴⁹ The Court concluded that “[t]he government may use its . . . regulatory authority to show its profound respect for the life within the woman.”²⁵⁰ This reasoning is flimsy: for example, could Congress regulate in any way relating to showing its “profound respect” for life? And could it do so if the prohibited conduct were not aesthetically “disturbing”? It is highly unlikely that the statute in *Carhart II* would have survived Supreme Court review if the Constitution protected women’s right to health. In fact, the right to health might require that “profound respect” for the life of *the woman* be the governing principle.

Carhart II reveals a deeply troubling hierarchy of priorities at work in U.S. abortion jurisprudence. Without a right to health, the United States seems to be on a dangerous trajectory in which “respect for the life *within* the woman” is permitted to prevail over the law’s respect for the life of the

244. *Id.* at 165–66. While the Court did not accept this finding on its face, it ultimately concluded that there is always an acceptable alternative available to the procedure. *Id.* at 167.

245. *Id.* at 159.

246. *Id.* at 124.

247. *Id.* at 159.

248. *Id.*

249. *Id.* at 158.

250. *Id.* at 157.

woman and her status as a full holder of rights. This hierarchy of priorities would likely be impermissible under a right-to-health analysis.²⁵¹ Additionally, the principle of non-retrogression might come into play if U.S. courts adhered to international human rights law. This principle means that once states have expanded rights, there is a strong presumption that they may not then restrict or jeopardize them.²⁵²

C. Conclusion

The U.S. jurisprudential trajectory, which culminates with *Carhart II*, is the opposite of the evolution seen in traditionally Catholic countries such as Spain, Portugal, and Mexico, where an emphasis on science, women as rights holders, and the right to health as a crucial enforceable right, has resulted in the conclusion that abortion must be legal and available, without coercion, pressure, or obstacles.²⁵³ Ultimately, enshrining a third party—Congress—as the decision-maker about women’s health; the use of “emotional” and aesthetic language; and the valuing of the fetus above the woman, are just some examples of the alarming retrogressions that can occur to women in the absence of a right to health.

251. For example, the Spanish legislature explained that the protection of prenatal life would be best achieved by policies that work in support of pregnant women, not against them. *Ley Orgánica 2/2010*, *supra* note 139, at 21003. The Colombian Court explained that while fetal life had constitutionally relevant value,

when there is a risk to the health and life of the pregnant woman, it is clearly excessive to criminalize abortion since it would require the sacrifice of the fully formed life of the woman in favor of the developing life of the fetus. If the criminal penalty for abortion rests on valuing the life of the developing fetus over other constitutional interests involved, then criminalization of abortion in these circumstances would mean that there is no equivalent recognition of the right to life and health of the mother.

WOMEN’S LINK WORLDWIDE, *supra* note 113, at 54.

252. According to the CESCR Committee, “any deliberately retrogressive measures . . . would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources.” U.N. Comm. on Econ., Soc., & Cultural Rights, *General Comment 3, The Nature of States Parties Obligations*, ¶ 9 (Dec. 4, 1990), *reprinted in* *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 14, U.N. Doc. HRI/GEN/1/Rev.6 (2003) (noting the obligations of states to realize social and economic rights “progressively”). When it comes to the right to health, though, CESCR clarifies “there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible.” CESCR, *General Comment 14*, *supra* note 2, ¶ 32.

253. Of course, *Carhart II* banned a particular form of abortion that only occurs late in pregnancy, while in many of the countries cited in this Article, abortion is still not legal late in pregnancy at all. *See supra* note 207. What I mean to highlight is the *language* of the opinions and the *trends* it and other cases suggest. Health language has overtaken emotional, fetus-protecting language in the countries cited, while in the United States, emotional, fetus-protecting language is gaining ground.

V.

THE ABSENCE OF A RIGHT TO HEALTH IN THE UNITED STATES HURTS
WOMEN

In the absence of a right to health, women in the United States face numerous barriers that prevent them from realizing their highest attainable standard of health. The lack of actual equal access to abortion and to health care in the United States evidences the real limitations and inadequacies of the privacy framework as the sole guarantor of reproductive rights.

A. U.S. Women Cannot Effectively Access Abortion

While abortion has been constitutionally protected since 1973, many American women are unable to access it due to its expense; their physical distance from providers; a general shortage of providers; burdensome and intrusive state laws; and threats of harassment and violence at abortion clinics.²⁵⁴ While over one third of American women will have an abortion by age forty-five,²⁵⁵ eighty-eight percent of all U.S. counties do not have an abortion provider.²⁵⁶ Outside of metropolitan areas, the number rises to ninety-seven percent.²⁵⁷

When a woman needs an abortion in the United States, she usually must pay for it herself or rely on help from family and friends. Because the Hyde Amendment prohibits federal funding for abortion except in extreme cases of rape, incest, or risk to life, only thirteen percent of abortions are paid for by public funds, such as state Medicaid plans.²⁵⁸ Based on information from non-hospital providers, seventy-four percent of women pay for abortions completely out of pocket, either with their own money or with money from a partner or other individual.²⁵⁹ It is unknown how many of these women are eventually reimbursed by insurers. However, only thirteen percent of abortions are actually paid for directly by private insurers.²⁶⁰ Two states prohibit private insurers from offering

254. STEPHANIE MUELLER & SUSAN DUDLEY, NAT'L ABORTION FED'N, ACCESS TO ABORTION 1 (2003), http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/access_abortion.pdf.

255. *An Overview of Abortion in the United States*, GUTTMACHER INST., <http://www.guttmacher.org/media/presskits/2005/06/28/abortionoverview.html> (last visited Dec. 5, 2010).

256. MUELLER & DUDLEY, *supra* note 254, at 1.

257. *Id.*

258. *Id.* at 2.

259. Stanley Henshaw & Lawrence Finer, *The Accessibility of Abortion Services in the United States, 2001*, 35 PERSP. ON SEXUAL & REPROD. HEALTH 16, 20 (2003), available at <http://www.guttmacher.org/pubs/psrh/full/3501603.pdf>.

260. *Id.*

abortion coverage at all in state-sponsored health care exchanges.²⁶¹ This situation disproportionately burdens women as compared to men with regard to paying for their health care, since abortion services are health care services that only women need. It also puts women's health further at risk, since women who cannot afford an abortion right away must wait until they can raise the money, thus postponing the procedure until later in pregnancy, when it can be more complicated, more invasive, higher risk, and more expensive.²⁶²

Even when a woman can get the money and can physically locate and go to an abortion provider, she faces another obstacle: state laws meant to harass, inconvenience, and coerce women into not having abortions and to prevent doctors from providing abortions.²⁶³ For example, twenty-three states mandate informed consent for abortion that goes beyond the existing standards for informed consent in health care generally.²⁶⁴ Some examples of the information provisions in U.S. states include required viewings of ultrasounds of the fetus, required viewings of footage of an abortion, and the receipt of medically unsound information regarding links between abortion and breast cancer or future infertility.²⁶⁵ Most strikingly,

261. GUTTMACHER INST., STATE POLICIES IN BRIEF: RESTRICTING INSURANCE COVERAGE OF ABORTION 2 (2010), http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf (citing Louisiana and Tennessee as states prohibiting private insurers from providing abortion coverage through state health care exchanges).

262. *See, e.g.*, SUSAN DUDLEY, NAT'L ABORTION FED'N, ECONOMICS OF ABORTION 1 (2003), http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/economics_of_abortion.pdf (noting that the costs of abortion between the first six to ten weeks of pregnancy are approximately \$350 to \$500, and subsequently become more complicated and more expensive, raising the cost to \$650 to \$700 at sixteen weeks and more than \$1000 after twenty weeks).

263. These laws include those that affect patients, such as mandatory delays and mandatory information provision. *See* Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, 10 GUTTMACHER POL'Y REV. 4, 6–13 (Fall 2007), <http://www.guttmacher.org/pubs/gpr/10/4/gpr100406.pdf>. They also include laws that target physicians and medical facilities that practice abortion to an extent beyond other health care providers, such a laws requiring that abortion clinics, but not other clinics, be registered with the state. *See generally* CTR. FOR REPROD. RIGHTS, TARGETED REGULATION OF ABORTION PROVIDERS: AVOIDING THE TRAP, http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bp_avoidingthetrap.pdf (describing “laws [that] regulate the medical practices of doctors who provide abortions by imposing burdensome requirements that are different and more stringent than regulations applied to comparable medical practices”); *Targeted Regulation of Abortion Providers*, CTR. FOR REPROD. RIGHTS (Mar. 5, 2009), <http://reproductiverights.org/en/project/targeted-regulation-of-abortion-providers-trap> (providing examples of burdensome state regulations).

264. *Id.* at 7–8.

265. For example, descriptions of *all* the common abortion procedures (not just the one a patient will undergo), and descriptions of fetal development throughout pregnancy, must be provided to patients in Alabama, Alaska, Arkansas, Georgia, Idaho, Kansas, Louisiana, Minnesota, Nebraska, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia, and Wisconsin. Gold & Nash, *supra* note 263.

In 18 [U.S.] states, information about abortion techniques that the woman will *not* be having is also given. For example, information about techniques used at later gestations is mandated, even though the majority of women have terminations in the first trimester. Similarly, in 22 [U.S.] states, written information is given about the development of the fetus at two week intervals throughout the entire pregnancy. With nearly 90% of all abortions occurring at or before 12 weeks, information on the development of a fetus after that point is generally not germane to most patients.²⁶⁶

By contrast, the right to health would require that policies promote informed decision-making based on accurate information,²⁶⁷ would prohibit coercive or biased “information giving,”²⁶⁸ and would require the state not just to refrain from creating obstacles between women and their health goals, but also to actively promote women’s access to health by providing affordable services.²⁶⁹ Further, a true right to health approach privileges doctors and patients over legislators, even on controversial matters such as abortion.²⁷⁰

The United States paradox—a right to abortion without the right to access an abortion and without the right to health—leads to results that seem absurd in the eyes of the international medical community. Although *Roe* obligates states to allow abortion, *Webster* and *Casey* enable states with anti-abortion policy preferences to implement laws and policies meant to prevent or dissuade doctors from performing abortions and women from undergoing abortions.²⁷¹ Under a right to health approach,

Inaccurate information on a purported link between breast cancer and abortion is required in Alaska, Kansas, Mississippi, Oklahoma, Texas, and West Virginia. *Id.* Inaccurate information regarding future fertility is mandatorily disseminated in South Dakota and Texas. *Id.*

266. VICTORIAN (AUSTL.) LAW REFORM COMM’N, LAW OF ABORTION: FINAL REPORT 116 (2008) (underlining in original) (critiquing mandatory information legislation for its likely aim of “dissuad[ing] women from proceeding with abortion,” rather than “allowing people to make informed decisions based on accurate information”).

267. *See* CEDAW, *General Comment 24*, *supra* note 6, ¶ 20 (“Women have the right to be fully informed, by properly trained personnel . . .”).

268. *See id.* ¶ 22 (health care services must be “delivered in a way that ensures that a woman gives her fully informed consent, [and] respects her dignity . . . States parties should not permit forms of coercion . . .”).

269. *See id.* ¶ 14 (states may not create obstacles, or criminalize or refuse to provide women-specific health care); *id.* ¶ 13 (states have a duty to provide access to health care for women); *id.* ¶ 17 (states must use the maximum extent of their resources to provide health care); *id.* ¶ 21 (impermissible barriers include “high fees”).

270. *See id.* ¶ 22. *See also supra* note 121 and accompanying text.

271. *Webster v. Reprod. Health Serv.*, 492 U.S. 490, 506 (1989) (“The Court has emphasized that *Roe v. Wade* implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion”) (internal quotations and citations omitted). *See also Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (affirming

these policies would be impermissible, as they have no relationship to best medical practices and run counter to medical norms and the health interests of patients.²⁷²

B. U.S. Women Cannot Effectively Access Primary Reproductive Health Care

As noted earlier, the right to health can advance women's equality interests not just by requiring the legalization of abortion, but also by requiring equal access to sex education, family planning, counseling, sexually-transmitted infection (STI) prevention, and basic primary and preventive reproductive health care that women need and want.²⁷³ While the privatized, for-profit health care system in the United States is itself quite vulnerable to a right-to health critique,²⁷⁴ this section will comment only on the U.S. system's special burdens on women.

For women, primary care includes reproductive health care. Women require more health care services than men during their reproductive

variety of state restrictions on abortions).

272. See CESCR, *General Comment 14*, *supra* note 2, ¶ 21 ("The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."). See also CEDAW *General Comment 24*, *supra* note 6, ¶ 14 ("The obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals.").

273. Cook, *International Human Rights*, *supra* note 33, at 74 ("Services to promote and maximize reproductive health include providing appropriate sex education and counseling, and the means to prevent unintended pregnancy, to treat unwanted pregnancy, and to prevent sexually transmitted diseases . . ."). A state's failure to provide such services violates the right to health requirements set forth in CEDAW. See CEDAW, *supra* note 28, art. 12(1) (requiring states to "ensure, on a basis of equality of men and women, access to health care services, including those related to family planning"); *id.* art. 12(2) (requiring states to "ensure to women 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"). The CEDAW Committee has explained that refusing "to provide legally for the performance of certain reproductive health services for women" is discrimination against women, as is a failure to provide health services that only women need. See CEDAW, *General Recommendation 24*, *supra* note 6, ¶ 11; *id.* ¶ 14 ("Other barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures."). The CEDAW Committee further explains that women's right to health means that states must ensure women's rights to STI prevention and treatment and family planning, *id.* ¶ 23; to maternal health care, *id.* ¶ 27, and to sexuality education for adolescents, *id.* ¶¶ 18, 23).

274. In 2010, the National Economic and Social Rights Initiative (NESRI) submitted a shadow report to the United Nations on the occasion of the Universal Periodic Review of the United States. NESRI highlighted the United States's failure to recognize the human right to health, criticizing the profit-driven system for bankrupting patients and leading to poorer health outcomes than would a public system. See NESRI, TOWARD ECONOMIC AND SOCIAL RIGHTS IN THE UNITED STATES: FROM MARKET COMPETITION TO PUBLIC GOODS 7–10 (2010), http://www.nesri.org/sites/default/files/UPR_Report_NESRI_1.pdf [hereinafter NESRI, Toward Economic & Social Rights].

years, mainly due to reproductive health needs.²⁷⁵ As a result, they suffer disproportionately in two ways under the U.S. system. First, the general failings within the current U.S. system affect women more than men. For example, under the United States's employer-sponsored insurance system women spend more of their lifetimes uninsured, given that they are more likely than men to work part-time, to work at home, or to not work for pay at all.²⁷⁶ Second, once a woman has health insurance, certain practices by insurance companies discriminate against women, both intentionally and by means of unequal impact. Women in the United States are disproportionately burdened by the expensive, privately run health care system because they use more health services than men.²⁷⁷ When a woman must go to a doctor regularly for services that men do not need, and for which no male analogue exists, such as annual Pap cancer screenings or prescriptions for birth control pills, each doctor visit and service costs money due to co-payments, higher premiums, or out of pocket expenses. It is likely that this increased use of health care services causes a woman's medical costs to increase as compared to men's costs.²⁷⁸ For example, a woman who wants to have only two children must use contraception for approximately thirty years of her life.²⁷⁹ Unlike in other countries, the birth control pill is not available over-the-counter in the United States,²⁸⁰ requiring women to see doctors for prescriptions, as well as requiring that

275. SHEILA D. RUSTGI, MICHELL M. DOTY & SARA R. COLLINS, COMMONWEALTH FUND, *WOMEN AT RISK: WHY MANY WOMEN ARE FORGOING NEEDED HEALTH CARE* 1 (2009), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf (discussing women's increased need for health care during reproductive years). See also NAT'L P'SHIP FOR WOMEN & FAMILIES, *ISSUE BRIEF: HEALTH CARE REFORM: WHAT WOMEN NEED* 4 (2009), http://www.nationalpartnership.org/site/DocServer/Health_Care_Reform.What_Women_Need.June2009.pdf?docID=5041 (describing types of reproductive care needed by women).

276. ELIZABETH M. PATCHIAS & JUDY WAXMAN, THE COMMONWEALTH FUND, *WOMEN AND HEALTH COVERAGE: THE AFFORDABILITY GAP* 2-3 (2007), <http://www.nwlc.org/sites/default/files/pdfs/NWLCCCommonwealthHealthInsuranceIssueBrief2007.pdf>.

277. See, e.g., KATHARINE BARTLETT & DEBORAH RHODE, *GENDER AND LAW* 19 (5th ed. 2010) (citing a National Women's Law Center study finding that "depending upon their age, women had to pay between 6 and 45 percent more for health coverage because they use more medical services").

278. See, e.g., Felicia H. Stewart, *Values in Family Planning*, in *CONTRACEPTIVE TECHNOLOGY* 1, 4 (Robert A. Hatcher, James Trussell, Anita L. Nelson, Willard Cates, Jr., Felicia H. Stewart & Deborah Kowal eds., 19th ed. 2008) ("Women have been shortchanged in funding and insurance coverage for essential reproductive health care services that only women need: cervical cancer screening, routine exams, and contraceptives.")

279. GUTTMACHER INST., *IMPROVING CONTRACEPTIVE USE IN THE UNITED STATES* 1 (2008), <http://www.guttmacher.org/pubs/2008/05/09/ImprovingContraceptiveUse.pdf>.

280. Kelly Blanchard, *Let the Pill Go Free*, N.Y. TIMES, June 21, 2010, at A27; Interview with Don Downing, Professor of Pharmacy, University of Washington, Seattle (Jan. 27, 2011).

they have insurance, money, or access to a charitable clinic. Women's use of prescription birth control pills—and the necessity of procuring it from doctors—is one reason that women tend to see doctors more often than men and spend more on health care than men do per year.²⁸¹ Insurance companies are also allowed, in twenty-two states, to exclude contraceptives from coverage, and in the twenty-eight states that do mandate contraceptive coverage, eighteen of those states allow exceptions for, for example, “religious” employers.²⁸² Thus, only four states require insurance plans to cover contraceptives without exceptions.²⁸³ When contraceptives are not covered by insurance, women are disproportionately burdened²⁸⁴ because they incur higher costs in their basic preventive health needs by having to pay for their contraceptives out of pocket.

Additionally, women face greater risks from sexually transmitted infections (STIs) than men do, putting their health at risk and giving them a greater need for testing, prevention, and treatment.²⁸⁵ It is suspected that herpes and HIV are more easily transferred from men to women rather than from women to men.²⁸⁶ Further, STIs in women have significant adverse consequences that men do not face, including infertility, cancer, pelvic inflammatory disease, and infant death or stillbirth.²⁸⁷ For example,

281. *Id.*

282. *State Policies In Brief: Insurance Coverage of Contraceptives*, GUTTMACHER INST., Feb. 1, 2011, http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf. Hawaii, Missouri, New York, and West Virginia all require plans to cover contraceptives without exceptions.

283. *Id.*

284. See Stewart, *supra* note 278, at 4 (arguing that the United State's “[f]ailure to provide insurance coverage of contraceptives is *prima facie* evidence of the second-class status of women in this country”).

285. WHO, WOMEN AND HEALTH 45, http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf (“[W]omen suffer[] far greater morbidity due to sexually transmitted infections than men do.”).

286. See CEDAW, *General Recommendation 24*, *supra* note 6, ¶ 12(a) (States must address the health rights of women in the ways in which women differ from men, including “the higher risk of exposure to sexually transmitted diseases that women face”); WHO, WOMEN AND HEALTH, *supra* note 285, at 45 (“Some studies show that women are more likely than men to acquire HIV from an infected partner during unprotected heterosexual intercourse . . . Women are more likely than men to be infected with genital herpes . . .”); European Study Group on Heterosexual Transmission of HIV, *Comparison of Female to Male and Male to Female Transmission of HIV in 563 Stable Couples*, 304 BRIT. MED. J. 809 (1992) (finding that women were infected with HIV by their male partners 1.9 times more than men were infected by women);

287. *Sexually Transmitted Infections Fact Sheet*, WHO, <http://www.who.int/mediacentre/factsheets/fs110/en/print.html> (last visited Nov. 2, 2010) (discussing consequences of various STIs in women). See also Brenda Y. Hernandez, Lynne R. Wilkens, Xuemei Zhu, Pamela Thompson, Katharine McDuffie, Yurii B. Shvetsov, Lori E. Kamemoto, Jeffrey Killeen, Lily Ning & Marc T. Goodman, *Transmission of Human Papillomavirus in Heterosexual Couples*, 14 EMERGING INFECTIOUS DISEASES 888, 888 (2008) (“Cervical cancer remains a major source of illness and death among women globally, and infection with oncogenic human papillomaviruses (HPVs) is its principal

human papillomavirus (HPV) infection in men can lead only to warts; in women, the same virus can also lead to cervical cancer.²⁸⁸ Similarly, chlamydia in men usually leads only to itching, burning, and discomfort,²⁸⁹ in women, untreated chlamydia can also cause pelvic inflammatory disease (PID).²⁹⁰ PID is an infection of the fallopian tubes and other reproductive organs, and can lead to infertility or ectopic pregnancy.²⁹¹ Because of the extreme consequences that can result from STIs for women, they have a greater need for STI tests and reproductive health checkups.

Women's health burdens, in the United States, are not significantly reduced even when they have insurance. Insurers, under U.S. law, are allowed to practice discriminatory pricing policies and to exclude maternal and abortion care from coverage.²⁹² In the United States, an insured woman will spend approximately \$91,000 more than a similarly situated insured man on health care during her lifetime.²⁹³ But women's higher spending on basic health care is not merely due to women's more frequent visits to the doctor for basic reproductive health needs; it is also due to insurers' freedom to employ a number of discriminatory practices that would be impermissible under a right to health analysis. Insurers are allowed to charge women higher premiums through a practice known as "gender rating."²⁹⁴ Doctors and health care authorities also recommend

cause.").

288. WHO, HUMAN PAPILLOMAVIRUS AND HPV VACCINES: TECHNICAL INFORMATION FOR POLICY-MAKERS AND HEALTH PROFESSIONALS 4 (2007), http://whqlibdoc.who.int/hq/2007/WHO_IVB_07.05_eng.pdf.

289. CTR. FOR DISEASE CONTROL & PREVENTION, DEP'T OF HEALTH & HUMAN SERVS., CDC FACT SHEET ON CHLAMYDIA 1-2 (2010), <http://www.cdc.gov/std/chlamydia/ChlamydiaFactSheet-lowres-2010.pdf>.

290. *Id.*

291. *Pelvic Inflammatory Disease (PID) CDC Fact Sheet*, CENTERS FOR DISEASE CONTROL & PREVENTION (Sept. 1, 2010), <http://www.cdc.gov/std/pid/stdfact-pid.htm>.

292. NAT'L WOMEN'S LAW CTR., STILL NOWHERE TO TURN: INSURANCE COMPANIES TREAT WOMEN LIKE A PRE-EXISTING CONDITION 3 (2009) [hereinafter STILL NOWHERE TO TURN].

293. During their reproductive lifetimes, the number is probably more around \$55,000, since this \$91,000 number also takes into account the fact that women live longer than men. See Berhanu Alemayehu & Kenneth Warner, *The Lifetime Distribution of Health Care Costs*, 39 HEALTH SERVICES RES. 627, 635 (2004) (noting that insured women spend about \$361,192 on health care over the course of their lifetime, while insured men spend about \$268,679, or approximately \$305,281 when adjusted for their lifespan).

294. BARTLETT & RHODE, *supra* note 277, at 192. Under gender rating, insurers are allowed to charge women more than men for the same health care plans, which eighty-seven percent of the time do not even include maternity care. Ninety-five percent of the best-selling individual plans practice gender rating; women aged twenty-five are charged up to eighty-four percent more than men for plans that *exclude maternity coverage*. STILL NOWHERE TO TURN, *supra* note 292, at 3. Insurers practice gender rating on the individual market but also in group-employer plans; by raising rates for employers based on the number of female employees per business. Some states regulate the practice for small- and medium-sized groups, but Montana is the only state with a comprehensive ban. *Id.* at 4. This practice can inhibit companies from hiring more women workers. *Id.* at 9.

annual exams for women, which may not be covered by insurance, or at which women can also be charged co-pays.²⁹⁵ Insurers defend gender rating with a profit rationale, arguing that, “[w]omen at a certain point in their life use the health care system more than men. . . . It’s totally in the individual market. . . . There’s a higher cost associated with women’s health care.”²⁹⁶

In a system designed to promote the right to health, such a justification would be immaterial; in such a system, women’s health, and their ability to enjoy access to health free from discrimination, would be the ultimate policy goals.²⁹⁷ As the U.N. Special Rapporteur on the Right to Health has explained, “[n]on-discrimination is among the most fundamental principles of international human rights law.”²⁹⁸ Since the right to non-discrimination applies to states’ obligations regarding the right to health,²⁹⁹ states must ensure that women are not disproportionately economically burdened in seeking their “highest attainable standard of . . . health.”³⁰⁰ This reasoning would mean that the United States would either have to create a public system to replace or supplement private insurers, or if private insurers remained the only means of health care for most people, the United States would be obligated to regulate them to ensure non-discrimination on the basis of gender, including in matters related to affordability.³⁰¹ When

295. Women of reproductive age are recommended to get Pap tests every year, or every few years, to reduce the risk of reproductive cancers. After age fifty, women are recommended to get mammograms regularly. Yet, when women are required to pay for, or to pay co-pays for annual exams, in addition to their inflated premiums under the gender-rating practice, women are likely to postpone or simply go without these key cancer screenings. NAT’L P’SHIP FOR WOMEN & FAMILIES, *supra* note 275, at 4 (2009) (discussing women’s specific health care needs, particularly with regard to their reproductive health).

296. Amy Gillentine, *Gender Bias: Should Women Pay More for Insurance?*, COLO. SPRINGS BUS. J., Feb. 19, 2010, <http://csbj.com/2010/02/19/gender-bias-should-women-pay-more-for-insurance/> (quoting Rebecca Weiss, government liaison for Anthem Blue Cross Blue Shield).

297. See CESCR, *General Comment 14*, *supra* note 2, ¶ 12 (explaining that realization of the right to health requires health care that is available, accessible, acceptable, and good quality). See also HELEN POTTS, UNIV. OF ESSEX HUMAN RIGHTS CTR., ACCOUNTABILITY AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH 12 (2008), http://hrbaportal.org/wp-content/files/1233124247_8_1_1_resfile.pdf. (explaining that governments are obligated to take “necessary measures,” including those having to do with budgeting, to make sure that the right to health is attainable—that is, not prohibitively expensive).

298. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Economic, Social, and Cultural Rights: The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc E/CN.4/2003/58 (Feb. 13 2003).

299. ICESCR, *supra* note 12, art. 2(2).

300. For an analysis of the right to non-discrimination in exercise of the right to health in the context of women-specific health care, see Sifris, *supra* note 85, at 207–11.

301. See CESCR, *General Comment 14*, *supra* note 2, ¶ 8 (stating that entitlements under the right to health include “the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health”); *id.* ¶ 21

access to primary and preventive care is economically burdensome, the right to health is violated, especially when this burden is unequally distributed based on sex.³⁰²

Even more disturbing than the lack of universal access to primary and preventative health services for women is the shocking lack of maternal health care coverage in the United States.³⁰³ If a woman wants to become a mother, her access to maternal and prenatal health care will depend almost entirely on her economic wealth, her employment status, and whether she is the dependant of someone with good health insurance.³⁰⁴ On the individual health insurance market, only thirteen percent of plans available to a thirty year-old woman include maternity coverage.³⁰⁵ The average cost of delivery in a hospital is between \$7,000 and \$10,000, not including prenatal care,³⁰⁶ and complications can make the costs of pregnancy increase substantially. While some plans offer supplemental riders for maternity care, they are often extremely expensive and often require a one- or two-year waiting period.³⁰⁷ As such, they do not allow women to make decisions about parenthood in a timeframe that women choose. Further, insurers commonly reject applicants for reasons including surviving domestic violence, having had a c-section, or being pregnant.³⁰⁸ Federal law prohibits group insurance plans from considering pregnancy a “pre-existing condition” and therefore refusing to cover prenatal and maternity care,³⁰⁹ but it is legal for insurers to do so on the individual market.³¹⁰ An uninsured pregnant woman who cannot afford maternal and obstetric care has a few unappealing options: she can seek a new job, which

(“To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for *promoting women’s right to health throughout their life span*. Such a strategy should . . . provide access to a *full range* of high quality and affordable health care, *including sexual and reproductive services* The realization of women’s right to health *requires the removal of all barriers interfering with access to health services* . . . *including in the area of sexual and reproductive health*.” (emphasis added)).

302. All of the human rights treaties include a provision that all the rights must be applied without discrimination based on gender. *See, e.g.*, ICESCR, *supra* note 12, at art. 2(2).

303. STILL NOWHERE TO TURN, *supra* note 292, at 3 (stating that thirteen percent of plans on the individual market offer maternity coverage).

304. Sharon Lerner, *Why Women Need Healthcare Reform*, THE NATION (Aug. 21, 2009), <http://www.thenation.com/doc/20090831/lerner> (noting that women’s access to health insurance largely depends on economic status and employment status).

305. STILL NOWHERE TO TURN, *supra* note 292, at 3.

306. Lerner, *supra* note 304.

307. NAT’L WOMEN’S LAW CTR., NOWHERE TO TURN: NEW RESEARCH SHOWS THE INDIVIDUAL INSURANCE MARKET FAILS WOMEN 11 (2008).

308. STILL NOWHERE TO TURN, *supra* note 292, at 10.

309. 29 U.S.C. § 1181(d)(3) (2006) (“A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any pre-existing condition exclusion relating to pregnancy as a pre-existing condition.”).

310. STILL NOWHERE TO TURN, *supra* note 292, at 10.

is not easy or likely when pregnant; she can try to become poor enough to qualify for Medicaid; she can seek help from private charities; or she can resort to an abortion. However, in twenty states, Medicaid is not required to provide coverage to pregnant women while they wait for the bureaucratic Medicaid process to approve their application.³¹¹

These facts highlight women's heightened need for reproductive health services even before obstetric, delivery, and postnatal care are taken into consideration. Nor do they take into account the expense, burden, and impact that a woman suffers by having to pay, out of pocket, for her reproductive hygiene needs, such as tampons, over the course of her reproductive lifetime. Expensive doctor visits also constitute a burden on a woman's time, requiring transportation, logistical coordination, the possibility of finding childcare, and sometimes taking leave from school or work. Overall, the lack of universal, subsidized reproductive health care leaves women far more burdened than men, both economically and, due to the unmet need for contraception and for reproductive health services, physically.

C. As a Result, U.S. Women's Health Has Declined, Rather Than Improved, Over the Past Twenty Years

Perhaps because of the difficulties women face accessing adequate health care, the United States is one of the few countries in which maternal health indicators and the number of unintended pregnancies are stagnant or getting worse. While correlation does not imply causation, this striking data suggests that something the United States is doing that differs from global practices is having a visible, negative effect on women's health and rights.

In the United States, the number of unintended pregnancies has not decreased over the past twenty years.³¹² For poor women, unintended pregnancies have actually increased by twenty-nine percent.³¹³ This phenomenon is a predictable result of the economic hurdles women face in accessing contraceptives, as documented above.³¹⁴ Further, after over ten

311. See Lerner, *supra* note 304 (“[Women] can wind up without prenatal care for long periods, since twenty states lack laws allowing pregnant women to receive time-sensitive coverage while waiting for approval of their Medicaid applications.”).

312. Lawrence Finer & Stanley Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSPS. SEXUAL & REPROD. HEALTH 90, 94 (2006).

313. *Id.*

314. The relative expense and inaccessibility of birth control options might also be to blame for the much higher likelihood that women of color, as compared to white women, will experience unintended pregnancies. See *In Brief: Facts on Induced Abortion in the United States*, GUTTMACHER INST. (May 2010), http://www.guttmacher.org/pubs/fb_induced_abortion.html (finding that forty percent of pregnancies are unintended among white women, as compared to sixty-nine percent among black women and fifty-four percent

years of decline, teen birth rates in the United States have been increasing, a trend that might be linked not just to the burdens and expense of accessing contraception and abortion but to the incomplete sex education that children receive in schools under “abstinence-only” laws.³¹⁵

The rate of unintended pregnancies in the United States is likely related to the unmet need for contraceptives. Due to the extremely high costs of health care and relative inaccessibility of birth control for women in the United States, the unmet need for contraception has increased over the past twenty years.³¹⁶ The only other countries where unmet need for contraception has increased are Haiti, Benin, and Liberia.³¹⁷ The rest of the world has made striking improvements in this area.³¹⁸ For example, the unmet need for contraception in Mexico and Colombia is now half what it was in 1988; while Thailand’s unmet need was much higher than that of the United States twenty years ago, it is now lower.³¹⁹ Other countries with only a fraction of the United States’s wealth have also pulled ahead in reducing unmet need for contraceptives—Mongolia, Turkey, Vietnam, and Colombia all now have lower rates of unmet need than the United States does.³²⁰

Nor has the United States made progress in promoting and protecting maternal health. In 1999, the United States maternal mortality ratio was the same as or lower than many other wealthy, industrialized democracies, including Austria, Australia, Belgium, the Netherlands, Finland, Italy, and France.³²¹ However, by 2009, all of these countries had made major progress in eradicating maternal mortality, whereas the United States rates had not changed.³²² At the same time, while Mexico and Nepal, like many

among Latina women).

315. The American Academy of Pediatrics (AAP) has found that the most successful programs for combating teen pregnancy provide information about contraceptives as well as about abstinence. Jonathan D. Klein, *Adolescent Pregnancy: Current Trends and Issues* 116 PEDIATRICS 281, 284 (2005). The AAP also suggests that teen pregnancy rates may be higher in the U.S. than in Europe because of European teens’ superior “access to and acceptance of contraception” as well as “universal sexuality education.” *Id.* at 283. A Congressional study revealed that abstinence-only education did not stop teenagers from having sex or reduce their likelihood of having sex; nor did it increase the likelihood that they would use condoms. Laura Sessions Stepp, *Study Casts Doubt on Abstinence-Only Programs*, WASH. POST, Apr. 14, 2007, at A2.

316. U.N. DEP’T OF ECON. & SOC. AFFAIRS, POPULATION DIV., WORLD CONTRACEPTIVE USE 2009: UNMET NEED FOR FAMILY PLANNING (2010), http://www.un.org/esa/population/publications/WCU2009/Data/UNPD_WCU_2009_Unmet_need.xls.

317. *Id.*

318. *Id.*

319. *Id.*

320. *Id.*

321. U.N. POPULATION FUND, STATE OF THE WORLD POPULATION 1999, at 67–69 (2000), <http://www.unfpa.org/swp/1999/pdf/swp99.pdf> [hereinafter UNFPA 1999].

322. U.N. POPULATION FUND, STATE OF THE WORLD POPULATION 2009 80–84 (2010),

developing countries, continue to report high numbers of maternal deaths, both have nonetheless reduced maternal mortality by almost half over the last ten years.³²³ Today, the United States has some of the worst maternal mortality statistics in the developed world. In the United States, there is a one in 4,800 chance of dying during childbirth.³²⁴ While those odds may seem favorable, they are much higher than the risk in other developed countries. In Canada, the risk of dying during childbirth is one in 11,000;³²⁵ in Australia, one in 13,300;³²⁶ in Spain, one in 16,400;³²⁷ in Germany, one in 19,200;³²⁸ and in Austria, one in 21,500.³²⁹

The absence of a legally enforceable right to health in the United States could be responsible for its failure to achieve excellent public health concomitant with the country's economic resources. Women's health needs lead to especially detrimental results for them when health care is not universally accessible. The absence of a right to health in the United States has permitted practices that make health care difficult to access, thus damaging women's health in the aggregate and contravening women's ability, at the individual level, to manage their lives, and take care of their health in the manner they see fit.

D. Conclusion

In the absence of a right to health, women are financially, socially, and personally burdened by their basic primary health needs in a way that men are not. The fact that access to health is not admitted as a fundamental, legally enforceable right in the United States, therefore, could be seen as another symptom of what feminist critics call a legal system built around male norms.³³⁰ As Rebecca Cook and Mahmoud Fathalla note,

http://www.unfpa.org/swp/2009/en/pdf/EN_SOWP09.pdf [hereinafter UNFPA 2009].

323. *Id.*; UNFPA 1999, *supra* note 321.

324. *Statistics, At a Glance: United States of America*, UNICEF, http://www.unicef.org/infobycountry/usa_statistics.html (last visited Apr. 26, 2011).

325. *Statistics, At a Glance: Canada*, UNICEF, http://www.unicef.org/infobycountry/canada_statistics.html#70 (last visited Apr. 26, 2011).

326. *Statistics, At a Glance: Australia*, UNICEF, http://www.unicef.org/infobycountry/australia_statistics.html (last visited Apr. 26, 2011).

327. *Statistics, At a Glance: Spain*, UNICEF, http://www.unicef.org/infobycountry/spain_statistics.html#70 (last visited Apr. 26, 2011).

328. *Statistics, At a Glance: Germany*, UNICEF, http://www.unicef.org/infobycountry/germany_statistics.html#70 (last visited Apr. 26, 2011).

329. *Statistics, At a Glance: Austria*, UNICEF, http://www.unicef.org/infobycountry/austria_statistics.html (last visited Apr. 26, 2011).

330. *See, e.g.*, Catherine MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L.J. 1281, 1281 (1991) ("No woman had a voice in the design of the legal institutions that rule the social order under which women, as well as men, live."); Denise Réaume, *What's Distinctive About Feminist Analysis of Law?*, 2 LEGAL THEORY 265, 278 (1996) (positing that laws purporting to be "gender-neutral" are actually drafted with men as the norm); Wendy W. Williams, *The Equality Crisis: Some Reflections on Culture, Courts, and*

If women are to be equal, governments have at least the same obligation to prevent maternal death as to prevent death from disease. In fact, given that maternity, the sole means of natural human propagation, is not a disease, equity requires more protection against the risk of maternal mortality than against death from disease.³³¹

This logic works beautifully if a government admits it has, as Cook and Fathalla put it, an “obligation to prevent death from disease” in the first place—that is, a responsibility to protect an individual right to the highest attainable standard of health. In order to secure an enforceable state obligation to provide women with affordable access to needed health care, and thus to confront some of the disparities cited above, U.S. feminists and reproductive justice activists should focus on the right to health and the ongoing health care debate. Opponents of such a movement in the United States might argue that the U.S. system would have to undergo radical changes to comply with such guarantees, implicating its entire health provision model, which is built upon for-profit, private sector insurers. Proponents might respond that that is exactly the point.

VI.

TOWARDS A RIGHT TO HEALTH IN THE UNITED STATES

The lack of an explicit right to health in the text of the U.S. Constitution does not explain the gaping absence of a right-to-health critique of *Roe* and U.S. abortion jurisprudence generally. The plaintiffs in *Roe* did, in their brief, try to argue that the right to abortion emanated from the right to health, in the third-strand sense: “the right to care for and protect one’s health *in the manner one deems best*.”³³² But as Anita Hill notes, that reasoning was not adopted by the Court, and has since been “lost” or forgotten by post-*Roe* abortion-rights advocates, replaced by the familiar privacy arguments.³³³ Some reasons for the absence of a health argument are strategic. In the 1960s and ‘70s, feminists were loathe to invoke a protectionist conception of “health,” as they feared that such an approach would prioritize doctors over women and shift the focus away

Feminism, in FEMINIST LEGAL THEORY: READINGS IN LAW AND GENDER 15, 15 (Katharine Bartlett & Roseanne Kennedy eds., 1991) (“[C]ourts will do no more than measure women’s claim to equality against legal benefits and burdens that are an expression of white male middle-class interests and values.”).

331. Rebecca J. Cook & Mahmoud F. Fathalla, *Advancing Reproductive Rights Beyond Cairo and Beijing*, 22 INT’L FAMILY PLAN. PERSPS. 115, 117 (1996), available at <http://www.guttmacher.org/pubs/journals/2211596.pdf>.

332. Hill, *supra* note 185, at 508 (citing Brief for Appellants at 96, *Roe v. Wade*, 410 U.S. 113 (1973) (No. 70-18), 1971 WL 128054).

333. *Id.* at 507.

from the woman's role as paramount decision-maker.³³⁴ However, the current right-to-health understanding, especially the third strand of reasoning as developed by Spain, Colombia, and Mexico, should assuage those fears.³³⁵ As this Article has argued, the "right to health" is different from a paternalistic concept of "health;" and without a right-to-health perspective, abortion discourse does not adequately recognize the rights and humanity of women. Similarly, without a right to health, women can be burdened disproportionately by a lack of access to affordable reproductive health care in general.

Where could the right to health come from in the United States? While this question merits much more analysis than is within this Article's scope, I will offer a few thoughts.

As mentioned in Part IV(A), the United States is not a party to any of the treaties that explicitly create a right to health, but it is a party to the ICCPR. The decision in *K.L.*, along with Concluding Observations from the Human Rights Committee, suggest that the ICCPR constructs at least a minimal version of the right to health, and that right to health encompasses abortion.³³⁶ While the United States has stated that the

334. *See id.* at 510–11 (“[M]any feminist scholars have criticized the medical model of abortion presented by decisions such as *Roe* and *Doe* for its tendency to place the abortion decision primarily in the physician's hands rather than the patient's, as well as for its emphasis on the centrality of professional medical judgment as opposed to the woman's individual personal and moral judgment. They argue that *Roe* was at best incomplete and at worst reinforcing of gender inequalities when it emphasized the medical aspects of abortion rather than its importance in securing equal citizenship for women.”).

335. As I have defined it, the third strand of right-to-health reasoning emphasizes women's right to make their own decisions about their health and that once those decisions are made, states must ensure that services are available. *See infra* Part III. For example, the Spanish law explains that “public powers are obligated not just to not interfere in these types of decisions, but also to establish the conditions in which these decisions can be made freely and responsibly, putting the proper health, counseling, and information services within reach of those who need them.” *Ley Orgánica 2/2010, supra* note 139, pmb., at 21001 (translation by author). The Mexican Court explained that in legalizing abortion and making sure that services are provided, the Mexico City law ensures that “the final decision-maker” in cases of unwanted pregnancy “is always the woman.” *See Acción de Inconstitucionalidad 146/2007 y Su Accumulada 147/2007, supra* note 127, at 188 (translation by author). The Colombian Court held that “the informed consent of the patient prevails over the views of the treating physician, and the interest of society and the state” *WOMEN'S LINK WORLDWIDE, supra* note 113, at 43.

336. The Human Rights Committee (HRC), in its Concluding Observations (given to states after governments submit their periodic reports on compliance with the treaty to the Committee), has construed lack of access to safe abortion to implicate the right to life under the ICCPR, as unsafe abortion is a major cause of maternal mortality. *See, e.g., U.N. Human Rights Comm., Concluding Observations of the Human Rights Committee: Bolivia*, ¶ 22, U.N. Doc. CCPR/C/79/Add.74 (May 5, 1997); U.N. Human Rights Comm., *Concluding Observations of the Human Rights Committee: Colombia*, ¶ 24, U.N. Doc. CCPR/C/79/Add.76 (May 3, 1997); U.N. Human Rights Comm., *Concluding Observations of the Human Rights Committee: Mongolia*, ¶ 8(b) U.N. Doc. CCPR/C/79/Add.120 (April 25, 2000); U.N. Human Rights Committee, *Concluding Observations of the Human Rights Committee: Peru*, ¶ 20, U.N. Doc. CCPR/CO/70/PER (November 15, 2000). In *K.L. v.*

ICCPR is not self-executing,³³⁷ the fact that other bodies have interpreted its guarantee of “civil and political” rights as giving rise to a right to health could be useful for advocacy in the United States. *Tysiāc*’s reasoning might similarly be useful. In *Tysiāc*, the European Convention was found to construct a right to health, at least in certain abortion-related circumstances,³³⁸ even though the European Convention, like the ICCPR and the U.S. Constitution, is mainly a civil- and political-rights document that does not explicitly contain a right to health. Similarly, while the United States has not ratified the strongest gender-equality treaty, CEDAW, it has ratified CERD. CERD requires that state parties “guarantee the right of everyone, without distinction as to race, color, or national or ethnic origin, to equality . . . in the enjoyment of . . . [t]he right to public health, medical care, social security, and social services.”³³⁹ However, the U.S. Senate has declared that CERD, like the ICCPR, is “non-self-executing.”³⁴⁰

While Congress’ declarations that these treaties are non-self-executing limits the effectiveness of some forms of advocacy, it may not be an insurmountable barrier. The “non-self-executing” doctrine is a judicially-created doctrine that requires courts to wait for Congress to specifically write legislation purporting to “give effect” to the treaties.³⁴¹ One option would be for advocates to challenge the “non-self-executing” doctrine

Peru, discussed *infra* Part II(C)(2), the HRC further argued that lack of access to safe abortion implicated mental health and suffering, and therefore infringed on the right to be free from cruel, inhuman, and degrading treatment guaranteed by Article 7 of the ICCPR. For further discussion of a constructed right to reproductive health under the ICCPR’s right to life provision, see generally Dina Bogecho, *Putting it to Good Use: The International Covenant on Civil and Political Rights and Women’s Right to Reproductive Health*, 13 S. CAL. REV. L. & WOMEN’S STUD. 229 (2004).

337. See *Status of Treaties: International Covenant on Civil and Political Rights*, U.N. TREATY COLLECTION, http://treaties.un.org/Pages/ViewDetails.aspx?src=UNTSOnline&tabid=2&mtdsg_no=IV-4&chapter=4&lang=en#Participants (last visited Apr. 26, 2011) (“That the United States declares that the provisions of articles 1 through 27 of the Covenant are not self-executing.”). See also *Beazley v. Johnson*, 242 F.3d 248, 267–68 (5th Cir. 2001) (interpreting this language to mean that the Covenant cannot be enforced by U.S. courts on its face in the absence of Congressional implementing legislation).

338. *Tysiāc v. Poland*, App. No. 5410/03, 2007-IV Eur. Ct. H.R. 22, 25, ¶ 107, 116 (discussed *supra* Part III(B)(2)(b)).

339. CERD, *supra* note 27, art. 5.

340. *Status of Treaties: International Convention on the Elimination of All Forms of Racial Discrimination*, U.N. TREATY COLLECTION, http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-2&chapter=4&lang=en#EndDec, (last visited Apr. 26, 2011) (“The Senate’s advice and consent is subject to the following declaration: That the United States declares that the provisions of the Convention are not self-executing.”).

341. See RESTATEMENT (THIRD) OF THE FOREIGN RELATIONS OF THE UNITED STATES, §111 cmt. h (1987) (describing the difference between self-executing and non-self-executing international agreements). See generally Connie de la Vega, *Civil Rights During the 1990s: New Treaty Law Could Help Immensely*, 65 U. CIN. L. REV. 423, 448–51 (1997) (discussing the non-self-executing doctrine).

itself and to push for the ratification of other international human rights treaties, such as CEDAW and ICESCR. The doctrine seems to conflict with the text of Article VI of the U.S. Constitution, which states that treaties ratified by the Senate become the supreme law of the land.³⁴² Many have thus argued that this doctrine is problematic and perhaps itself unenforceable.³⁴³ Those interested in pursuing a right-to-health approach to substantive equality in the United States arising from international human rights law as treaty law may have to scrutinize the boundaries, meanings, and validity of the “non-self-executing” doctrine. These tactics may in fact be the most promising—if long-term—vehicles for achieving a right to health in the United States along the lines of the model required by international human rights law and described in this Article.³⁴⁴

Additionally, or in the alternative, advocates could attempt to use indirect methods to inject the spirit of these human rights treaties into domestic law. The limits of treaty *law* does not mean that the treaties *themselves* are meaningless. For example, international *customary* law is a source of international human rights law binding upon the United States³⁴⁵ Treaties, including those signed and ratified by the United States, can play a role in a court’s decision as to the existence and content of international customary law.³⁴⁶ Similarly, the United States’s ratification of certain treaties gives those concerned with women’s rights a useful forum—the

342. U.S. CONST. art. VI, § 1, cl. 2. (“[A]ll treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.”). See generally Carlos Manuel Vazquez, *The Four Doctrines of Self-Executing Treaties*, 89 AM. J. INT’L L. 695 (1995) (analyzing the “non-self-executing” doctrine and its development in case law).

343. See, e.g., Louis Henkin, *Rights: American and Human*, 79 COLUM. L. REV. 405, 424 (1979) (arguing that the non-self-executing provisions are “deeply troubling,” because they require Congressional “battles” after “the uphill struggle to obtain Senate consent in the first instance”); Stefan A. Riesenfeld & Frederick M. Abbott, *The Scope of U.S. Senate Control over the Conclusion and Operation of Treaties*, 67 CHI.-KENT L. REV. 571, 608 (1991) (arguing that the Senate does not have the power to unilaterally tell courts not to implement the terms of treaties, and that notwithstanding Senate declarations that treaties are “non-self-executing,” U.S. domestic courts should decide for themselves whether and to what extent to implement the terms of treaties); Nadine Strossen, *Recent U.S. and International Judicial Protections of Individual Rights: A Comparative Legal Process Analysis and Proposed Synthesis*, 41 HASTINGS L.J. 805, 813–15 (1990) (outlining different critiques of the non-self-executing doctrine, namely that it is “incoherent” and that it should not apply to human rights treaties).

344. See Henkin, *supra* note 343, at 420–24 (arguing that the United States should ratify and adhere to the U.N. human rights treaties without a “non-self-executing” doctrine).

345. RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW, §702, cmt. c (1986) (“The customary law of human rights is *part of the law* of the United States to be applied as such by State as well as federal courts.”) (emphasis added).

346. *Roper v. Simmons* is a recent example of such reasoning. 543 U.S. 551 (2005). In *Roper* the Supreme Court counted the vast number of treaties outlawing the juvenile death penalty when considering that such a norm had in fact become universal. *Id.* at 576.

United Nations—in which to raise human rights concerns with the U.S. government. States parties to the U.N. human rights treaties must submit periodic reports explaining how they are complying with the treaties.³⁴⁷ NGOs and activists are encouraged to submit third-party or “shadow reports” to the treaty-monitoring body (TMB) to inform it of certain areas where the country may not be living up to its obligations, and to fill in gaps or correct mischaracterizations in the state’s report.³⁴⁸ After a reviewing session, the TMB will issue Concluding Observations to the state with the expectation that states will take active steps to improve their compliance each year.³⁴⁹ TMBs often rely on shadow reports when producing their analysis and issuing their recommendations to the state party.³⁵⁰ If the state’s government is amenable to following international human rights law at the executive level, even if not at the judicial or legislative level, then the TMB process can be one way for activists to get results—insofar as the executive branch can act or set policy priorities in line with human rights norms.

Alternatively, U.S. actors could begin to argue that the Constitution itself gives rise to the right to health. Such a campaign will admittedly not succeed overnight and may be met with skepticism. It may be helped by a movement towards comparative constitutionalism. Those designing a strategy towards a domestic recognition of the right to health—one framed in a way that does not imply adherence to “international law” in general or acquiescence to ICESCR and the whole cohort of economic, social, and cultural rights³⁵¹—have much to gain by studying the ways in which other

347. See, e.g., ICCPR, *supra* note 20, art. 40(1) (calling for review when requested by the Committee); CERD, *supra* note 27, art. 9(1)(b) (calling for review every two years).

348. For the shadow reports submitted by U.S. NGOs to the CERD Committee on the occasion of the U.S.’s periodic review on February 21, 2008, see links at <http://www2.ohchr.org/english/bodies/cerd/cerds72-ngos-usa.htm>.

349. See, e.g., U.N. Comm. on the Elimination of Racial Discrimination, *Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States*, U.N. Doc. CERD/C/USA/CO/6 (Mar. 5, 2008).

350. See, e.g., *Producing Shadow Reports to the CEDAW Committee: A Procedural Guide*, January 2009. INT’L WOMEN’S RIGHTS ACTION WATCH, <http://www1.umn.edu/humanrts/iwraw/proceduralguide-08.html> (last visited Mar. 21, 2011).

351. Some scholars and commentators argue that the dichotomy between “civil and political rights” and “social, economic, and cultural rights” is outmoded and no longer useful; moving away from this dichotomy might provide new opportunities for U.S. advocacy and reform. See Cass Sunstein, *Why Does the American Constitution Lack Social and Economic Guarantees?*, 56 SYRACUSE L. REV. 1, 6–8 (2005) (advocating for a move away from the negative/positive rights dichotomy); Mark Tushnet, *Civil Rights and Social Rights: The Future of the Reconstruction Amendments*, 25 LOY. L.A. L. REV. 1207, 1213–18 (1992) (arguing that the distinction between civil and social rights is not as great as claimed by proponents). For refutations of the claim that economic and social rights cannot be adjudicated in courts, see generally Richard J. Goldstone, *A South African Perspective on Social and Economic Rights*, 13 HUM. RTS. BRIEF 4 (2006); Jeanne M. Woods, *Justiciable Social Rights as a Critique of the Liberal Paradigm*, 38 TEX. INT’L L.J. 763 (2003).

countries have developed the right to health as part of domestic constitutional law. In Mexico, for example, human rights are understood to stem from the country's domestic constitutionalist movement, which predates the international treaties and even the founding of the United Nations.³⁵² While Justice Scalia and other commentators believe that there is no place for comparative constitutional jurisprudence in the United States, other Supreme Court justices have disagreed, showing that the "exceptionalist" view is not as deeply entrenched in our judiciary as it might seem.³⁵³ Moreover, as the majority of the U.S. public is in favor of a right to health,³⁵⁴ the public may be less in favor of our "exceptionalism" on this issue, than, say, on our refusal to convert to the metric system.

However, it might be possible to achieve a right to health in the United States without a reliance on international law, comparative law, or international trends. The right to health could emerge as an indigenous value, based on our own unique norms and traditions. For example, Professor Hill argues that at least a "negative" right to health—one along the lines of the decision-making third-strand version, but without the guarantee of services—could exist within the contemporary constitutional doctrine.³⁵⁵ This view is promising, though it lacks the necessary conclusion that access to services would follow the achievement of a right to health. Could the government be obligated to *provide* health care services under

352. See JORGE MADRAZO, *DERECHOS HUMANOS: EL NUEVO ENFOQUE MEXICANO* 12 (1993) (stating that the Mexican Constitution of 1857 established that human rights are the base and object of social institutions) (translation by author).

353. *Compare* *Printz v. United States*, 521 U.S. 898, 921 n.11 (1997) (declaring that "comparative analysis [is] inappropriate to the task of interpreting a constitution"), *with id.* at 977 (Breyer, J., dissenting) (noting that other countries' "experience may nonetheless cast an empirical light on the consequences of different solutions to a common legal problem"). See also *Washington v. Glucksberg*, 521 U.S. 702, 785–86 (1997) (Souter, J., concurring) (discussing the Dutch approach to assisted suicide); *Thompson v. Oklahoma*, 487 U.S. 815, 839 (1988) (arguing that a comparative analysis of standards of decency is necessary to tackle the issue of whether application of the death penalty is cruel and unusual punishment); Vicki C. Jackson, *Ambivalent Resistance and Comparative Constitutionalism: Opening up Conversation on Proportionality*, 1. U. PA. J. CONST. L. 583, 638 (1999) ("[O]pen-mindedness and a willingness to be humble about the correctness of one's views may actually go farther in preserving the rightful legitimacy of the Court. I am guardedly optimistic that U.S. courts will be more open to foreign constitutional learning in the future."); Mark Tushnet, *The Possibilities of Comparative Constitutional Law*, 108 YALE L.J. 1225, 1235 (1999) ("[T]he Constitution might sometimes license comparative inquiry when other sources of constitutional interpretation run out.").

354. See THE OPPORTUNITY AGENDA, *HUMAN RIGHTS IN THE U.S.* 54 (2007), http://opportunityagenda.org/files/field_file/Human%20Rights%20Report%20-%202007%20public%20opinion.pdf (finding that seventy-two percent of Americans "strongly believe" that access to health care should be considered a human right).

355. Hill, *supra* note 185, at 502–03 ("[T]he Supreme Court's abortion jurisprudence suggests the existence of a negative right to health, but this notion has not yet been fully explored by courts or by advocates.").

U.S. constitutional law? Probably not under the current case law,³⁵⁶ but the Constitution does not seem to preclude this finding on its face, and judicial decisions can be overruled. Whether such a radical change is possible without reference to international trends, and where a right to health might come from in our own legal traditions, is beyond this Article's purview to answer.

Activists could also work at the local, state, or county level to create a "home-grown" right to health or to recognize one arising from international human rights norms. In some U.S. states, movements to recognize the right to health within state constitutions are gaining ground.³⁵⁷ Several U.S. cities, counties, and states have passed resolutions in support of international human rights treaties not ratified by the United States, such as CEDAW and the Convention on the Rights of the Child (CRC).³⁵⁸ Three of those cities—Los Angeles, San Francisco, and Berkeley, California—have taken steps to incorporate CEDAW principles into municipal law.³⁵⁹ Similarly, at least one U.S. county has recognized health as a human right and committed to developing a health care access strategy based on that principle.³⁶⁰ In Seattle, a "right to health" ballot measure was passed in 2010.³⁶¹ These efforts—both conceptually and

356. See *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 195–97 (1989) (holding that due process does not impose a duty on the state to provide adequate protective services to members of the general public).

357. See generally NESRI & NHELP, *EMBEDDING THE HUMAN RIGHT TO HEALTH CARE IN U.S. STATE CONSTITUTIONS: A PROGRESS REVIEW AND LESSONS FOR ADVOCATES* (2009) (reviewing movements to amend state constitutions in Massachusetts, Michigan, Minnesota, Oregon, North Carolina, and Florida). See also Soohoo & Goldberg, *supra* note 5, at 42–43 (arguing that state constitutions often provide broader socio-economic guarantees than does the federal constitution, thus making them more useful for right-to-health development); *id.* at 58–67 (suggesting strategies for right-to-health advocacy in state constitutional law).

358. See, e.g., San Francisco (Cal.) Mun. Code §§ 12K.1–K.6 (2000) (describing how CEDAW would be implemented within San Francisco city limits), available at <http://www.sfgov3.org/index.aspx?page=130>. See also HUMAN RIGHTS INST., *COLUMBIA LAW SCHOOL, STATE AND LOCAL HUMAN RIGHTS AGENCIES: RECOMMENDATIONS FOR ADVANCING OPPORTUNITY AND EQUALITY THROUGH AN INTERNATIONAL HUMAN RIGHTS FRAMEWORK* 25, http://www.law.columbia.edu/null/download?&exclusive=filemgr.download&file_id=153843 (listing cities, states, and counties that have incorporated CEDAW into local laws).

359. HUMAN RIGHTS INST., *supra* note 358, at 20 n.53.

360. In December of 2008, the Health Board of Lewis and Clark County, Montana, which includes the capital, Helena, adopted a resolution recognizing the human right to health, and has been developing an "action plan" to make universal health care a reality in the county using human rights principles. See *Health Reform from the Bottom Up*, HELENA INDEP. REC. (Dec. 14, 2008), http://helenair.com/news/local/article_37ec214a-197d-53fe-9eb9-7eb3364b4ccb.html.

361. Seattle passed a ballot measure in 2010 in which voters agreed that "[e]very person in the United States should have the right to health care of high quality." Seattle (Wa.) Res. 31196 (2010), available at http://clerk.ci.seattle.wa.us/~archives/Resolutions/Resn_31196.pdf.

strategically—seem especially relevant and urgent in light of the 2009–2010 health reform debate in the United States, where even among most proponents of expanded access to health care, right-to-health language was conspicuously absent.³⁶² If the 2010 health care law is repealed, advocates should reframe their arguments to include human rights language.

Currently, an emphasis on the health implications of abortion and contraceptives is seen as a supplemental or even anti-constitutional alternative to the legal-judicial strategy, where it is all but conceded that health rights will never exist within the U.S. context.³⁶³ Admittedly, the United States's historical tradition may make it seem as though U.S. law has no place for claims of rights to social services or entitlements.³⁶⁴ However, this philosophy does not have to be accepted as destiny, and “health” may be distinct from other social services or “entitlements.” Constitutions can be reinterpreted by courts or amended by the legislature; local legislation can create a right to health; international treaties can be ratified and enforced; and popular consensus can change. What if activists began to describe the health argument not just as the pragmatic sibling of the legal argument but as a legal mandate itself? The examples of the 190 other countries that recognize such a right might be a reasonable place to start, and can serve as a defense to the claim that such an idea is unprecedented and impossible.

VII. CONCLUSION

Defining pregnancy and abortion as medical issues does not concede

362. The right to health requires states to provide a national health plan as part of a “minimum core” set of obligations. POTTS, *supra* note 297, at 11. This fact means that right-to-health advocacy should be a natural component of the campaign for universal health care in the United States.

363. See generally Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, 118 YALE L.J. 1394, 1403 (2009) (“[T]he Court has consistently read the Constitution as not including positive rights to much of anything from the state, and certainly not to abortion procedures. It is so unlikely as to be a certainty that neither this Court nor likely any Court will commence a jurisprudence of positive constitutional rights, by beginning in the terrain of mandating public funds for abortions.”). West argues persuasively that the negative-right “privacy” structure in U.S. constitutional abortion law has not led to true reproductive justice for women, *id.* at 1398, but she conflates a critique of the existing constitutional framework with a critique of “constitutionalizing” the right in general. While I agree with West’s proffered strategies for democratic and legislative activity, I disagree with her conclusion that because U.S. constitutional abortion jurisprudence is unsatisfactory, constitutional law itself should be abandoned as an avenue towards reproductive justice. This Article is meant to argue that we need not “de-constitutionalize” the right to abortion, but rather become more ambitious in re-conceptualizing what our constitution means and could mean, and make serious right-to-health arguments within constitutional discourse.

364. See, e.g., *DeShaney v. Winnebago County, Dep’t of Soc. Servs.*, 489 U.S. 189, 195–97 (1989); *Harris v. McRae*, 448 U.S. 297, 316–8 (1980).

one shred of the privacy or decision-making arguments supporting a right to abortion; it simply helps to explain, more accurately, exactly what is at stake in a woman's decision to be or remain pregnant. By avoiding the health framework, the debate around abortion is incomplete, and thus abortion rights are easier to oppose. An abortion debate without a right-to-health lens propagates the fantasy, inherent in some anti-abortion rhetoric, that a pregnancy is an utterly benign process that simply happens to women, does not require their consent or energy, and does not entail any adverse physical or mental consequences.³⁶⁵ To take the discussion about pregnancy and abortion out of that incomplete, inaccurate paradigm, it must be reframed using the language of health. When abortion is a health issue, its opponents cannot so easily deny what they are really demanding—the invasion and control of every organ system in a woman's body, without her consent, for a period of at least one year.³⁶⁶

The foreign jurisprudence and reforms discussed in Part III provide compelling evidence for the proposition that the right to health causes states to acknowledge and ensure a woman's right and access to reproductive health services. As demonstrated in Part V, the opposite also seems to be true: the absence of a right to health allows for jurisprudence that increasingly restricts women's access to these services. The lack of a right to health allows a country to reduce access to reproductive health care, which, in turn, puts gender equality out of reach. This appears to be the United States situation. As such, U.S. women's rights advocates, rather than continuing to fight for enhanced rights to abortion, family planning, and other necessities within the existing constitutional doctrinal framework, should give serious attention to the idea of a right-to-health movement, potentially in concert with health care reform and universal health care activists.

The United States should not blindly follow the rest of the world for its own sake, but nor should we blindly follow our own traditions—of exceptionalism to international law, or of “negative rights”—for their own sake. We should forge a path that makes sense and leads us where we want to go, even if tradition presents a daunting obstacle. U.S. women's rights activists, anti-discrimination scholars, and lawyers should critically assess what they are demanding, what values give rise to those needs, and

365. See Caitlin Flanagan, *The Sanguine Sex*, THE ATLANTIC, May 2007, at 114 (“The demands pro-life advocates make of pregnant women are modest: All they want is a little bit of time. All they are asking, in a societal climate in which out-of-wedlock pregnancy is without stigma, is that pregnant women give the tiny bodies growing inside of them a few months, until the little creatures are large enough to be on their way, to loving homes.”).

366. Pregnancy can be characterized as having physiological consequences of at least one year, since pregnancy lasts about forty weeks, and the postpartum period, in normal cases, generally lasts from six to twelve weeks. See, e.g., Lipscomb & Novy, *supra* note 37, at 222.

develop strategies for law reform, for litigation, and for advocacy that further those values. If women in the United States feel that gender equality is a value worth fighting for, then the purpose of this Article is to attempt to marshal those activists in the campaign for the right to health.