

Is the right to health a necessary precondition for gender equality?
*Implications for the United States from international and comparative
reproductive health law*

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The United States is one of the only nations in the world that does not recognize the right to the highest attainable standard of health. Advocates for women's rights around the world have used right-to-health reasoning to successfully persuade states to liberalize policies relating to abortion, contraception, sex education, and maternal health care, which have improved social and health outcomes for women, as well as provided frameworks in which women can exercise autonomy in decision-making. In other words, "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. However, this tool is not available to advocates in the United States, as the U.S. does not recognize a right to health in its constitutional law, nor has it ratified the international treaties that expressly create a right to health. This essay will suggest that a right to health underpins substantive gender equality, both theoretically and pragmatically, and that without admitting a fundamental "right to the highest attainable standard of health," the United States will continue to regress towards greater gender inequality, in contrast to global trends.

Part I of this paper outlines the legal framework around the right to health, and describes the emerging body of international and comparative constitutional law relating women's autonomy, liberty, and equality interests to the right to health. It gives examples of the positive impact that policy reforms built around the right to health have had on women's reproductive rights¹ in various foreign contexts. Part II contrasts this trend to the United States situation,

¹ **NOTE: "Reproductive Rights" and "Reproductive Health" are interrelated but not synonymous concepts.** For the purposes of this essay, I will accept as axiomatic that family planning, abortion services, and prenatal, obstetric, and puerperal care are "health issues." While this point may seem obvious and is made evident by public health data and medical consensus, activists and commentators who oppose abortion and family planning frequently describe these services as unrelated to "health," and instead, view them as moral issues and/or "lifestyle choices." An argument for access to abortion or contraceptives grounded in health language would fail before these opponents, not necessarily because they hold that health care, or certain types of it, should be unavailable, but because they reject the notion that abortion and family planning are "health services" in the first place. However, this argument will not be the focus of this paper. Instead, I will assume that abortion and family planning *are* health issues (even if they might *also* be other things, such as 'moral issues'), and will devote my attention to comparative legal contexts surrounding *access* to health rather than *definitions* of health. I will also assume that

where constitutional jurisprudence grounds women's right to reproductive health in the right to privacy, and where, contrary to the U.S.'s legacy as a global leader in areas of women's rights, widespread gender discrimination results from and is inflicted by the lack of universal access to health care. Part III argues that in the absence of a right to health, the U.S. will move towards the further restriction of women's access to reproductive health care, and therefore, towards further limitations on women's autonomy and equal citizenship. I conclude by arguing that without recognizing a "right to the highest attainable standard of health," the United States cannot achieve full equality, equity, and enfranchisement for women; and that the right to health is not just 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.

I. THE RIGHT TO HEALTH IN WOMEN'S RIGHTS JURISPRUDENCE AND REFORM AROUND THE WORLD

A. What is the right to health? Where does it come from?

The human right to the highest attainable standard of health is not the right to be healthy.² Instead, it consists of a state's obligation to ensure that health care is available, accessible, acceptable, and of adequate quality.³ "Health" in the human-rights sense goes beyond just the absence of illness. Health in this sense encompasses complete mental and physical wellbeing,⁴ as well as the social and structural factors required to live a healthy life.⁵ Through international

maternal/obstetric health care is agreed to be a "health issue" even by those who do not agree that abortion and family planning are.

² Committee on Economic, Social, and Cultural Rights (CESCR), *General Comment 14, The right to the highest attainable standard of health*, 22nd Sess., para. 8, U.N. Doc. E/CN.12/2000/4 (2000). "The right to health is not to be understood as the right to be *healthy*."

³ *Id.*, para. 4.

⁴ CONST., WORLD HEALTH ORGANIZATION, Preamble.

⁵ *General Comment 14, supra* note 2, para 4.

treaties and domestic constitutions, 191 of the world's 194 nation-states have recognized the right to health.⁶ The right to health is given practicability for states by various means, including General Comments issued by treaty-monitoring bodies; the appointment of Special Rapporteurs and officials; and protocols for minimum medical and technical standards developed by medical and public health professionals, including the World Health Organization.

The right to health, and the 'availability, accessibility, acceptability, and quality' framework, are contained in many of the international human rights documents signed by the vast majority of UN member states, beginning with Article 25 of the Universal Declaration of Human Rights⁷ and Article 12 of the Covenant on Economic, Social, and Cultural Rights (ICESCR).⁸ The Convention on the Elimination of All Forms of Racial Discrimination (CERD) compels states to guarantee equality in the access to public health and medical care,⁹ and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) contains not only the right to the highest attainable standard of health, but articulates that women's rights to family planning, safe pregnancy, and pre- and post-delivery care are part of

⁶ The United States of America, Nauru, and Tonga are the only nation-states without a right to health. The United States has not ratified ICESCR or CEDAW. The only other non-parties to both CEDAW and ICESCR are Nauru, Tonga, Qatar, and Palau; but Qatar's constitution obligates the state to provide for the public health (Art. 23), as does Palau's (Art. VI). However, these constitutional provisions are not framed as "rights" but as state's obligations; as such, it could be argued that Qatar and Palau should be excluded from a list of states recognizing the "right" to health, making a more conservative count 189 out of 194 nation-states rather than 191. [Iran, Sudan, and Somalia have ratified ICESCR but not CEDAW. South Africa and Cuba have ratified CEDAW but not ICESCR, and have domestic constitutional right-to-health provisions as well.] United Nations Treaty Collection, Convention on the Elimination of All Forms of Discrimination Against Women, Status of Signatories and Ratifications, *available at* http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&lang=en; United Nations Treaty Collection, International Covenant on Economic, Social and Cultural Rights, Status of Signatories and Ratifications, *available at* http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en.

⁷ Universal Declaration of Human Rights, U.N.G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948) [hereinafter UDHR].

⁸ International Covenant on Economic, Social, and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16 at 49, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976), art. 12(1) (hereinafter ICESCR). The U.S. signed the ICESCR on Oct. 5, 1977, but has not yet ratified the treaty, so it is not legally binding on the US. General Comment 14 of the Committee on Economic, Social, and Cultural Rights (CESCR) provides a useful explanation of the "available, accessible, affordable, quality" framework.

⁹ International Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106 (XX), 660 U.N.T.S. 195, Art. 5 (hereinafter CERD).

this fundamental human right.¹⁰ The link between health and substantive equality is intrinsic not just to CEDAW and CERD, but to the ICESCR's original formulation of the right to health: "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 which provides equality of opportunity for people to enjoy the highest attainable level of health."¹¹ The Convention on the Rights of the Child (CRC) recognizes the right to health for children, which includes adolescents.¹² Finally, the World Health Organization employs a right-to-health perspective; the preamble to its constitution states: "the right to 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."¹³

In addition to the international treaties, regional human rights mechanisms including the Protocol of San Salvador¹⁴ and the Convention of Belem do Pará¹⁵ in the Inter-American system, the African Charter on Human and Peoples' Rights,¹⁶ and the European Social Charter¹⁷ have

¹⁰ Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, UN GAOR, 34th Sess., Supp. No. 46 at 193, U.N. Doc. A/34/46, 1249 U.N.T.S 13 (hereinafter CEDAW). Art. 12: "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..."

¹¹ CESCR *General Comment 12*, para. 8, *supra* note 2.

¹² Convention on the Rights of the Child, G.A. Res. 44/25, annex, UN GAOR, 44th Sess., Supp. No. 49 at 166, U.N. Doc. A /44/49, Arts. 23, 24.

¹³ CONST., WORLD HEALTH ORGANIZATION, Preamble.

¹⁴ Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights ("Protocol of San Salvador"), Art. 10, The Right to Health: "Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental, and social well-being..."

¹⁵ Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women ("Convention of Belem do Pará")

¹⁶ African Charter on Human and Peoples' Rights [Banjul Charter], Art. 16: "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."

also recognized the right to health, and as these mechanisms are binding, resort to these in states where they are in force may be more effective for strategists and activists than sole reliance on the UN documents. Perhaps most importantly, as I will explore in this paper, in most countries, the “right to the highest attainable standard of health” is recognized as part of domestic constitutional law.¹⁸

It is important to point out that the U.S. is not bound by many of the aforementioned treaties and mechanisms. The Universal Declaration is technically not a treaty, but instead a declaration of the General Assembly; its two progeny treaties are the International Convention on Civil and Political Rights (ICCPR) and ICESCR. Notably, the U.S. became a state party to ICCPR but did not ratify the ICESCR.¹⁹ As the U.S. is also one of the only countries in the world not to recognize “substantive equality,”²⁰ it seems that an articulation of the right to health in the U.S. context – perhaps through domestic, state, or local mechanisms - could be a vector towards ‘substantive equality’ in fact, rather than the result of ‘substantive equality’ in the doctrinal sense.

¹⁷ Article 11 of the European Social Charter (ESC) provides for the right to the highest attainable standard of health. Notably, and potentially instructively for the U.S. context, the right to health in the ESC is explained by the Council of Europe as existing to complement Articles 2 and 3 of the European Convention on Human Rights (on the right to life and to freedom from cruel, inhuman, and degrading treatment) as interpreted by the European Court of Human Rights in case law. See Secretariat of the European Social Charter, *The Right to Health and the European Social Charter* (factsheet, May 2009), available at

http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/FactsheetHealth_en.pdf.

¹⁸ Most civil-law countries enshrine the right to health in their constitutions, whereas common-law countries generally do not. However, in common-law states, ratifications 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 this right constitutional dimensions as well. See H. FUENZALIDA-PUELMA AND H. SCHOLLE CONNOR, EDS., *THE RIGHT TO HEALTH IN THE AMERICAS: A COMPARATIVE CONSTITUTIONAL STUDY* (1989), and BRIGIT C. A. TOEBES, *THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW* (1999), cited by University of Minnesota Human Rights Resource Center, *Circle of Rights: Module 14: The Right to Health*,

<http://www1.umn.edu/humanrts/edumat/IHRIP/circle/modules/module14.htm>.

¹⁹ The U.S. signed the ICCPR on Oct. 5, 1977, and ratified it on June 8, 1992. See UN Treaty Database, *Status of Signatories, Ratifications, and Reservations*,

http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en

²⁰ See Catherine MacKinnon, *The Gender of Constitutional Jurisprudence*, 5 INT’L J. CON. L. 557, 563 (2007) (book review).

B. The major recent policy reforms and precedent cases on reproductive rights outside of the U.S have relied heavily on right-to-health reasoning. These cases and reforms have led to improved health and social outcomes for women.

The majority of recent cases and reforms around the world liberalizing access to abortion rely heavily upon right-to-health reasoning. I will highlight some of the most high-profile recent cases and reforms as examples of this trend. It is crucial to note that a health framework does not come at the expense of an equality or right-to-privacy approach; the three are usually intertwined. Further, many of the cases and reforms mentioned below do not extend the right to abortion to the full extent of the right in United States law under *Roe v. Wade*. On its face, the U.S. law remains one of the most progressive worldwide.²¹ However, as further described in Part II, the right to an abortion in the U.S. is in fact less actualized, and less practicable by women, than the technically less progressive right in many other nation-states. Further, the health reasoning underlying foreign and international abortion jurisprudence seems to result in an extremely strong and resilient ‘core’ abortion-rights framework; which even the most strategic and persuasive opponents cannot penetrate, in addition to more widespread accessibility with minimal hurdles.²² While women’s interests and health intersect over many more points than abortion, in the interest of space, I will focus on abortion jurisprudence and access to health care, while acknowledging that ‘abortion’ is not a proxy for reproductive rights generally, and that my discussion will be far from comprehensive.

²¹ Center for Reproductive Rights, *The World’s Abortion Laws*, Wall Poster (2007).

²² This approach could yield similar protections of the ‘core’ right in the U.S. *See* B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501 (2009).

1. National- & State-Level Jurisprudence & Reform

The relationship between abortion and health is axiomatic in non-U.S. judicial and political discourse. Even within legal documents that do not expressly contain a right to health, such as the ICCPR and the European Convention on Human Rights, a right to abortion has been found to emanate from the state's positive obligations around the right to privacy, which requires states to provide access to the conditions necessary for people to make and actualize decisions about their health.

The European Parliament, on January 14, 2009, in its Declaration on the Situation of Fundamental Rights in the European Union, "stresse[d] the need to raise public awareness of the right to reproductive and sexual health, and call[ed] on the Member States to ensure that women can fully enjoy these rights, to put in place appropriate sex education, information and confidential advisory services, and to facilitate access to contraception in order to prevent all unwanted pregnancies and illegal and high-risk abortions."²³ This statement can be seen as a synopsis of the rights discourse that has been developing around abortion not just in the E.U. but around the world, with the exception of the U.S., during the past twenty years, when this area of law has been rapidly evolving. The following are some of the most noteworthy recent domestic reforms and decisions along these lines.

i. Spain – 2010

In February 2010, Spain passed a groundbreaking law legalizing abortion upon request until 14 weeks of pregnancy, and later in pregnancy for health and other indications. The law will also require state health facilities to provide abortions or referrals. While as of this writing the new law has not yet been published, the legislative history overwhelmingly emphasizes a rights

²³ European Parliament Resolution of 14 January 2009 on the Situation of Fundamental Rights in the European Union 2004-2008 (2007/2145(INI)), para. 60.

rationale for the legislation – especially the right to health, and particularly the right to sexual and reproductive health. The legislation is extremely noteworthy for its in-depth exposition of “sexual rights” as related to the right to health and reproductive health. The bill’s preamble states:

[T]he objective of this law is to guarantee, in an environment entirely free from coercion, discrimination, and violence, fundamental rights in the area of sexual and reproductive health; to regulate conditions for voluntary termination of pregnancy; and to establish corresponding obligations for public agencies. [emphasis added].²⁴

The bill also provides for sexual education with a gender focus; for sensitivity- and capacity-building of public officials, including integrating sexual and reproductive health education into continuing education programs for health professionals and within curricula in graduate schools dealing with health sciences.²⁵ In a report by a Senate Commission assessing the existing abortion law, the Commission emphasized that to allow third parties to make the abortion decision, instead of women, “no longer makes sense. Today, abortion must be analyzed...in light of women’s rights to sexual freedom and to freely decide about their maternity, which is linked to Constitutional rights and freedoms, such as ... the right to health (art. 43 [of the Spanish Constitution]).”²⁶ Previously, the Spanish law treated abortion as a crime, and allowed exceptions in cases of health risks; in this sense, Spain’s tradition of abortion jurisprudence was based on an understanding that the Constitutional protection of life also implicated a protection

²⁴ Anteproyecto de Ley Orgánica de Salud Sexual y Reproductiva y de la Interrupción Voluntaria del Embarazo, Versión 14 de mayo de 2008 (Spain), available at http://www.lourdesmunozsantamaria.cat/article.php3?id_article=229.

²⁵ *Id.*

²⁶ COMISIÓN DE IGUALDAD (SPAIN), CONCLUSIONES DE LA SUBCOMISIÓN SOBRE LA REFORMA DE LA REGULACIÓN DE LA INTERRUPTIÓN VOLUNTARIA DEL EMBARAZO EN EL MARCO DE UNA NUEVA NORMA SOBRE DERECHOS Y SALUD SEXUAL Y REPRODUCTIVA 6 (2008).

of health.²⁷ The fact that abortion was already understood to exist within the ‘health’ ambit may have set the stage for the larger liberalization – and the requirement of access. The trajectory shown by predominantly-Catholic Spain strongly suggests that when abortion is understood primarily as an important individual health matter, arguments based in ‘morals’ and the value of ‘unborn life’ hold less sway.

ii. Portugal – 2007

In 2007, Portugal legalized abortion upon request up to 10 weeks, and also guaranteed access to services within the public health system.²⁸ Formerly one of the only countries in the Council of Europe (along with Malta, Ireland, and Poland) to seriously restrict abortion, the Portuguese Ministry of Health explained that one of the purposes of the new law was to comply with Portugal’s human rights commitments, including the right to health.²⁹ Prior to the liberalization, Portugal’s abortion law was one of the strictest in the Council of Europe, and women who had abortions outside of the limited set of parameters in which abortion was legal – as well as abortion providers – were actively prosecuted by the government.³⁰ Before 2007, an estimated 20,000 illegal abortions took place in Portugal each year; only one year after the new law went into effect, the Health Ministry reported that the number of complications associated with unsafe abortion, such as infection and uterine perforations, had fallen by more than half.³¹ This result

²⁷ The Constitutional Court of Spain in 1985 linked the constitutional right to life with an obligation to protect health, concluding that abortion must be allowed at least when “grave danger to the pregnant woman’s health seriously affects her right to life and physical integrity.” S.T.C. 53/1985, Apr. 11, 1985 (B.O.E., 1985, 119) (Spain).

²⁸ Lei No. 16/2007 de 17 de Abril (Portugal): Exclusão da ilicitude nos casos de interrupção voluntária da gravidez. Published in *Diário da República, 1o serie – No. 75 – 17 de Abril de 2007*.

²⁹ Direcção-Geral da Saude, Circular Normativa No. 11/SR: Organizacao dos Servicos para implementacao de Lei 16/2007 de 17 de Abril

³⁰ Letter from the Center for Reproductive Rights to the Government of Spain, Written Comments on the Proposed Legislation on Voluntary Interruption of Pregnancy (April 2009) at 11, *available at* <http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Spanish%20Abortion%20Legislation%20April%202007.pdf>

³¹ *Id.*

directly supports the notion – advanced by the international human rights bodies and the domestic legislatures described in this paper – that access to legal abortion reduces maternal mortality and morbidity.³²

iii. Colombia – 2006

In a landmark 2006 decision, the Constitutional Court of Colombia decided that a right to abortion existed as a consequence of the right to health and the right to non-discrimination, interpreting these rights in the context of Colombia's Constitution as well as its international treaty obligations.³³ The decision is well-known for its progressive language and its basis not just in the usual privacy, liberty, and health rights but in women's right to be free from gender stereotypes.³⁴ However, the groundbreaking anti-stereotyping approach is a consequence of the Court's recognition that abortion is a serious health issue, not just an abstract, existential 'decision'. The Court held:

*[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...*³⁵

The Colombian Court highlighted the fact that to criminalize health care that only women need, such as abortion, violates CEDAW's prohibition of sexual discrimination,³⁶ and, notably, that to

³² *Id.*

³³ WOMEN'S LINK WORLDWIDE, C-355/2006, EXCERPTS OF THE CONSTITUTIONAL COURT'S RULING THAT LIBERALIZED ABORTION IN COLOMBIA 41, 54 (2007) citing Constitutional Court (Colombia), Sentencia C-355, May 10, 2006. The Court found that the criminalization of abortion violated the right to health, found to emanate from article 49 of the constitution. *See also* WOMEN'S LINK WORLDWIDE, C-355/2006: Excerpts at 26-28 on the right to health under CEDAW; at 56 on the right to health under ICESCR.

³⁴ *Id.* at 35-36 (2007).

³⁵ *Id.* at 43.

³⁶ *Id.* at 29.

enforce unwanted motherhood upon women was analogous to sexual violence.³⁷ The Court's decision also contained several elements designed to make sure that women could, in reality, gain access to acceptable abortion services. To this end, the Court prohibited institutions (such as hospitals) from "conscientiously objecting", explaining that only individuals may do this, and that those individuals who do must provide the woman with an immediate, adequate referral. This logic supports the notion that the right to health can precede not necessarily the 'right' to equality or to equal treatment, but that it can give rise to the actualization of equal treatment for women. When health care is not acknowledged as a right, as in the case of the United States, the exclusion of group-specific care is not legally problematic, even if there were a right to freedom from sex discrimination.

iv. Mexico – 2008

In April 2007, Mexico City (D.F.) legalized abortion on request for the first 12 weeks of pregnancy, and also implemented detailed health regulations requiring all D.F. hospitals to provide safe, timely, and free abortions to women who requested them within the 12 week time period.³⁸ The constitutionality of the reform was challenged at the Supreme Court,³⁹ and in

³⁷ *Id.* at 44.

³⁸ Mexico, D.F., Decree Reforming the Federal District Penal Code and Amending the Federal District Health Law, art. 1 (Official Gazette of the Federal District, No. 70, April 26, 2007).

³⁹ Supreme Court (Mexico), Sentencia, Acciones de Inconstitucionalidad 146/2007 and 147/2007 [hereinafter Mexican Supreme Court Decision]. The law also required all public hospitals in the city to provide free abortion services to patients who requested them. This requirement of the availability of legal abortions was in keeping with Mexico City's law since 2003, when abortion was legal for a more restricted set of reasons, but which provided that when abortion was legally permitted, "public health institutions must perform the termination of pregnancy for no charge, in quality conditions and in a time frame not more than five days after the woman's request." (Article 16 of the New Penal Code of the Federal District (NCPF). Conscientious objection by practitioners was also regulated, so that women who requested a legal abortion would be guaranteed the service. A similar law was issued in the state of Baja California Sur, creating an obligation on state health facilities to provide abortions, when legal, without cost to the patient and under quality conditions; this law also required health services to provide emergency contraception when requested.)

August 2008 the Court upheld the law, holding, specifically, that it was an appropriate use of D.F.'s legislative power in advancing the right to health under the Mexican Constitution.⁴⁰

Both the initial reform and the Constitutional holding relied extensively on the right to health. The Legislative Assembly of Mexico City explained that part of its reasoning for wanting to legalize abortion was that “the [District] would be violating the right to health if it held abortion to be impermissible but knew that abortions were occurring, because this situation prevents women from being able to obtain abortions that are medically effective and safe.”⁴¹ The Mexico City legislators explained to the Court that the 1983 reform which wrote the right to health into the Constitution also authorized the state governments to legislate matters relating to health, and that this grant of power to the District gave them the right to change abortion laws, even those in the criminal code, due to abortion's urgency as a health issue.⁴² Without this legal framework built around the right to health, the opposition might have had more success at convincing the Court that the abortion law created by the Legislative Assembly was *ultra vires*.

The decision has had immediate, quantifiable public health results. In Mexico City, following the legalization of abortion in 2007, 34,660 safe abortions have occurred in hospitals, and 50,936 requests for abortion information were received.⁴³ A further benefit of the legalization is the availability of such data; in contrast to situations where abortion is illegal, which creates public health problems that are difficult to quantify and therefore to solve.⁴⁴ As

⁴⁰ Article 4 of the Mexican Constitution provides that women and men are equal under the law; that everyone has the right to make a free, responsible, and informed choice about the number and spacing of their children; and, in a 1983 amendment, that “everyone has the right to the protection of their health.” Mexican Supreme Court Decision *supra* note 39, at 65.

⁴¹ Mexican Supreme Court Decision, *supra* note 39 at 146.

⁴² Mexican Supreme Court Decision *supra* note 39, at 65

⁴³ Gobierno del Distrito Federal, Secretaría de Salud del Distrito Federal, Dirección General de Planeación y Coordinación Sectorial, Dirección de Información en Salud, Agenda Estadística 2008, at 86, *available at* <http://www.gire.org.mx/contenido.php?informacion=222>

⁴⁴ See GRUPO DE INFORMACIÓN EN REPRODUCCIÓN ELEGIDA, A.C. (GIRE), HOJA INFORMATIVA: CIFRAS DEL ABORTO EN MÉXICO (2008).

such, the Mexico case is a concrete example of how a right-to-health movement provided a robust framework for the liberalized abortion law in both theory and practice.⁴⁵

v. *Nepal* – 2002 and 2009

In 2002, Nepal's abortion law changed from one of the world's most restrictive to Asia's most liberal, a reform inspired by three decades of advocacy against maternal death and morbidity caused in part by unsafe abortions.⁴⁶ The reform was framed as a public health vehicle for safe motherhood, with the government acknowledging that it would have a duty to provide abortion care and resources if the reform passed.⁴⁷ Prior to the reform, Nepal's draconian law led to women's imprisoned for abortion.⁴⁸ After the reform passed, however, it was unevenly implemented, abortion was often prohibitively expensive or inaccessible, and many women – especially rural women – were unaware that it was legal.⁴⁹

In response to this situation, in 2007 a low-income woman named Lakshmi Dhikta sued the government of Nepal, claiming that the government's failure to implement the abortion law – and make abortion actually accessible – violated Nepal's human rights obligations, especially the right to health. The Supreme Court, in a 2009 decision, held in favor of Dhikta, and found that, in order to comply with its human rights obligations, including the right to health, the government of Nepal must adopt a comprehensive and detailed abortion-provision code, establish a fund to cover abortion costs, ensure strong protections for women's privacy, and

⁴⁵ Due to the "inverse *Roe*" posture of this case (the Court being 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, but the Court did announce, as emphatically as possible in a case of this posture, that abortion access was a key component to a state's implementation of the right to health under Article 4.

⁴⁶ See S. Thapa, *Abortion Law in Nepal: The Road to Reform*. REPRO HEALTH MATTERS Nov. 12, 2004 (24 Suppl) 85-94.

⁴⁷ See *id.*

⁴⁸ See CENTER FOR REPRODUCTIVE RIGHTS, *ABORTION IN NEPAL: WOMEN IMPRISONED* (2002).

⁴⁹ Center for Reproductive Rights, *Lakshmi Dhikta Case* (2010), <http://reproductiverights.org/en/case/lakshmi-dhikta-v-government-of-nepal-amici-supreme-court-of-nepal>.

provide information about safe abortion services to the public as well as to doctors and other health-care providers.⁵⁰ While Nepal has a long way to go, it provides a good example of how a firm health framework around abortion leads to progressive jurisprudence.

vi. Australia (Victoria) – 2008

Since abortion was de facto legal in Australia, but was technically a crime in some states, the state of Victoria undertook reform efforts in 2008 to completely decriminalize it.⁵¹ While Australia does not have a right to health in its constitution, it is party to the ICESCR and recognizes the right to health as stemming from that treaty.⁵² The Victorian Law Reform Commission (VLRC) produced a comprehensive, in-depth study of abortion laws and policies around the world, and concluded that the only international law giving rise to an abortion right was “the general right to health, which can be realized progressively.”⁵³

The VLRC report emphasizes that clinical best practices should govern abortion laws, as well as the principle of “allowing people to make informed decisions based on accurate information.”⁵⁴ After reviewing the U.S. restrictions on abortion (which have no analogues in New Zealand, the U.K., or Canada), the VLRC recommended the government of Victoria not to adopt any restrictions along the lines of those in the U.S., finding that in accordance with the general right to health under ICESCR, “clinical practice, rather than legislation, should govern the practice of health care.”⁵⁵

⁵⁰ *Id.*

⁵¹ VICTORIAN LAW REFORM COMMISSION (VLRC), LAW OF ABORTION: FINAL REPORT 4 (2008).

⁵² *Id.* at 162.

⁵³ *Id.* at 171.

⁵⁴ *Id.* at 16.

⁵⁵ *Id.* at 16 .

2. International human rights case law

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

KL v. Peru, the first case on abortion brought before an international human rights body, was brought under the Convention on Civil and Political Rights, which does not explicitly recognize a right to health. However, in petitioners' arguments and in the Committee's decision, KL's health was the critical focal point. A teenager who had become pregnant due to rape, KL had sought an abortion when she found out the fetus was anencephalic, meaning it had no chance of survival outside the womb. In Peru, abortion is legal for life or health indications, but KL was refused an abortion, and was forced to give birth to the baby and nurse it for four days before it died. Not only was she forced to deliver a baby – an especially risky activity for adolescent women – but her baby's inevitable death caused KL to suffer serious depression and psychological trauma.

The Committee held that Peru violated KL's right to freedom from discrimination in the exercise of her right to health:

[I]n access to health services, since her different and special needs were ignored because of her sex...[KL suffered] discrimination in exercise of her rights, since although the author 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, to health...on equal footing with men.⁵⁶

The Committee also found, as would be echoed in *Tysiack*, that the right to life creates a positive obligation for states to take measures to “ensure that women do not have to resort to unsafe, clandestine abortions, which endanger their lives and health...The fact that a legal abortion was not available to KL left her with two options which posed an equal risk to her health and safety” – to seek a clandestine, unsafe abortion, or “continue a dangerous and traumatic pregnancy

⁵⁶ *KL v. Peru*, CCPR/C/85/D/1153/2003, para 3.2(b).

which her life at risk.”⁵⁷ However, the most notable feature of the K.L. decision is the Committee’s finding of a violation of Article 7, the right to be free from cruel and inhuman treatment.⁵⁸ The Committee held that the state’s failure to allow KL to have the abortion she sought was the cause of her mental trauma, and that this constituted cruel, inhuman treatment under Article 7.⁵⁹

ii. *Tysiac v. Poland* – European Court of Human Rights

Alicja Tysiac was a woman with deteriorating eyesight who was told that to continue her pregnancy could cause her to go blind. Despite the fact that abortion in Poland was technically legal for health reasons, doctors refused her an abortion, she gave birth to the child, and her eyesight severely deteriorated. While the *Tysiac* decision did not base its holding in the right to health (since the European Convention does not include a right to health) the decision shows the Court finding a constructive ‘right to health’ to emanate from the right to privacy, leading to a declaration that: “Once the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it.”⁶⁰

The *Tysiac* Court situated its discussion in the health context by quoting the Human Rights Committee, in which the HRC “reiterated its deep concern” about the fact that strict abortion laws “lead to high numbers of clandestine abortions with attendant risks to life and health of women...”⁶¹ Tysiac argued that her right to respect for private life, under Article 8 of the Convention, had been violated, because she had been seeking to protect her health.⁶² The

⁵⁷ *Id.*, para 3.3.

⁵⁸ *Id.*, para 6.3.

⁵⁹ *Id.* The HRC also found violations of Article 17, the right to privacy, and to Article 24, for special protection as a minor.

⁶⁰ *Tysiac v. Poland*, App. No. 5410/03, Eur. Ct. H.R., para. 116 (2007).

⁶¹ *Id.* at 10.

⁶² *Id.* at para. 77. This reasoning echoes the early U.S. abortion jurisprudence, in which the right to privacy was found to entail a right to make health decisions; B. Jessie Hill has termed this a ‘negative right to health’ and argued

Court held that “while 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.”⁶³ The Court emphasized that State regulations on abortion must “be also assessed against the positive obligations of the State to secure the physical integrity of mothers-to-be.”⁶⁴

After the *Tysiacy* case, in addition to paying damages to the plaintiff, the ECtHR required Poland to establish a timely-appeals mechanism for women who disagree with their doctors about whether abortion should be legal in the conditions presented. Further, the case has been seen by Polish academics and health advocates an example of the need for better patients’ rights in Poland.⁶⁵ The Committee of Ministers – the Council of Europe body that monitors the implementation of judgments of the ECtHR – has been following up with the Polish Government on implementation of the judgment.⁶⁶

iii. *Paulina Ramirez v. Mexico* – Inter-American Commission on Human Rights

Paulina was 13 when she was raped by a burglar in her home. Abortion was technically legal for rape indications in her state of Baja California, but public officials interfered and prevented her

for activists in the U.S. to return to this framework; the *Tysiacy* decision would complement a reading of the early abortion cases in endorsing this approach, if it weren’t for the fact that *Tysiacy* emphasizes the state’s positive obligation to make services accessible. [B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501]

⁶³ *Tysiacy v. Poland*, App. No. 5410/03, Eur. Ct. H.R., 23 (2007).

⁶⁴ *Tysiacy v. Poland*, App. No. 5410/03, Eur. Ct. H.R., 23 (2007). 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...In the Court’s view, the 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. *Tysiacy* at 26.

⁶⁵ INSTITUTE OF PUBLIC HEALTH, JAGIELLONIAN UNIVERSITY MEDICAL COLLEGE, KRAKOW, HEALTH POLICY MONITOR, PATIENTS RIGHTS LEGISLATION: *TYSIAC V. POLAND*, available at http://www.hpm.org/en/Surveys/Jagiellonian_University_-_Poland/14/Patient_rights_legislation__Tysiacy_v._Poland.html

⁶⁶ CENTER FOR REPRODUCTIVE RIGHTS, *TYSIAC V. POLAND BRIEFING KIT* (2010)

from getting an abortion. While the case did not result in a decision from the IACHR, since Paulina settled with the state of Mexico, the complaint cited the right to health as one of the rights violated.⁶⁷ Paulina also argued that her right to personal integrity⁶⁸ entailed a right to emotional and mental health, which was violated when, without her consent, anti-abortion activists entered her hospital room, harassed her, and exposed her to disturbing visual material.

The right to protection of Paulina's health interest was even more crucial due to her minor status, violating the rights of the child to special protections.⁶⁹ Further, a letter from 70 Latin American NGOs urged the IACHR to admit the Paulina case, and in so doing contribute to maternal mortality eradication as mandated by the Millenium Development Goals.⁷⁰

The settlement with Mexico, mediated by the IACHR, is 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. The Settlement decision went beyond holding only Baja California accountable, however, and required the government of Mexico to expand and enhance its laws relating to rape and sexual violence. It also required the Federal Health Secretariat to draft and send a circular on preventing abortion-rights violations to the state health agencies.⁷¹ The Paulina circular was cited

⁶⁷ The right to health was cited under Article 10 of the Pact of San Salvador; Article 2 of the Convention of Belem do Pará, and Article 12 of CEDAW. Report No. 21/07, Petition 161-02, Friendly Settlement: Paulina del Carmen Ramírez Jacinto v. Mexico, *available at* <http://www.cidh.oas.org/annualrep/2007eng/Mexico161.02eng.htm> [hereinafter Paulina Case]

⁶⁸ Under Article 5 of the American Convention and Arts. 1, 4, 7 of the Convention of Belem do Pará. *Id.*

⁶⁹ Art. 19, American Convention; Art 9, Convention Belem do Para; Articles 19, 37, 39 Convention on the Rights of the Child; Art. 24, ICCPR. *Id.*

⁷⁰ Letter from 70 Latin American NGOs to the IACHR in re Paulina case, reprinted in GRUPO DE INFORMACION EN REPRODUCCION ELIGIDA (GIRE), PAULINA: FIVE YEARS LATER (2005).

⁷¹ Paulina Case, *supra* note 67.

by the Mexico City government in 2007, as part of the basis for its decision to legalize abortion in Mexico City.⁷²

As evinced by these cases and reforms, the right to health has been effective both for fueling policy change legalizing abortion; and for requiring states to make abortion accessible when it is technically legal, as in the cases of *Tysiac, K.L.*, and *Paulina*. These decisions stand in sharp contrast to the U.S. jurisprudence on the topic of legal-but-inaccessible abortion, in the absence of a right to health – such as *Harris v. McRae* and *Webster v. Reproductive Health Services*, discussed below. For this reason I suggest that a right to health in the United States is a necessary component of any strategy that seeks to end the Hyde Amendment, protect the abortion right, and abolish policies built around anti-abortion goals, rather than pro-health goals.

II. THE LACK OF THE RIGHT TO HEALTH IN THE U.S. AND ITS IMPLICATIONS FOR WOMEN

A. U.S. jurisprudence on abortion is based on the right to privacy.

In contrast to the rest of the world, the United States' jurisprudence around abortion and contraceptive access is grounded in the right to privacy, not a right to health. The first landmark Supreme Court case on these issues, *Griswold v. Connecticut*, in 1965, considered the constitutionality of a statute that outlawed the sale of contraceptives. The *Griswold* court found that this ban violated married couples' 'right to privacy,' which the Court found to emanate from the 'liberty' protected by the Due Process clause of the 14th Amendment.⁷³ *Eisenstadt* later extended this privacy right to un-married couples seeking contraceptives, but did so not for

⁷² Mexican Supreme Court Decision, *supra* note 39 at 67.

⁷³ *Griswold v. Connecticut*, 381 U.S. 479 (1965). *See, e.g.*, CASS SUNSTEIN, ONE CASE AT A TIME: JUDICIAL MINIMALISM ON THE SUPREME COURT 33 (1999) "*Griswold* was the birth of this controversial constitutional right [to privacy]."

reasons having to do with privacy as required to make health decisions, but because privacy meant the right to be free from intrusion with regard to the decision “whether to bear or beget a child.”⁷⁴ Without a health focus, this alarming conflation of “bear” with “beget” occurs. Neither is seen as more physically invasive than the other; the issue at play is simply the existential and life-plan question of whether and if to have a child. *Roe v. Wade* adopted this reasoning, and found that the right to an abortion was grounded in the same constitutional right – to privacy⁷⁵ – in spite of the fact that amici urged the Court to link abortion rights to equality and bodily inviolability, citing the Equal Protection clause and the Eighth Amendment’s prohibition of cruel, inhuman, and degrading treatment.⁷⁶ (Abortion as a form of cruel, inhuman, and degrading treatment has finally been jurisprudentially validated, almost 40 years later, in *KL v. Peru*.)

In 1992, the Court upheld *Roe* in *Casey*, but did not explicitly expand the reasoning from privacy to equal protection or to anything having to do with health. In fact, *Casey* opened the floodgates for state regulations of abortion for reasons having nothing to do with the health of the mother.⁷⁷ Under *Casey*, all regulations that states wanted to impose were allowed as long as they did not consist of an “undue burden.” If there had been a strong health rationale behind *Roe*, these types of non-health related interventions imposed by states – such as 24-hour waiting periods and consent requirements – would be impossible to justify.

While Justice Blackmun’s concurring opinion in *Casey* acknowledged the Equal Protection implication of abortion rights, the Court’s holding did not extend *Roe*’s rationale beyond privacy, and relied instead on *stare decisis*. In his concurrence Blackmun emphasized: “By restricting the right to terminate pregnancies, the State conscripts women’s bodies into its

⁷⁴ *Eisenstadt v. Baird*, 405 U.S. 438 (1971).

⁷⁵ *Roe v. Wade*, 410 U.S. 113 (1973).

⁷⁶ Brief Amicus Curiae on Behalf of New Women Lawyers et al. at 24, *Roe v. Wade*, 410 U.S. 113 (1973).

⁷⁷ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); see examples of non-health-related abortion laws *infra*.

service, forcing women to continue their pregnancies, suffer the pains of childbirth, and in most instance provide years of maternal care.”⁷⁸ However, even this picture failed to conceive of pregnancy and childbirth as *medical* issues, apart from an acknowledgement of the “pains of childbirth.”

Commentators after *Roe* and *Casey* have parsed the privacy right basis for abortion rights, and expressed concern that the U.S. abortion right is not grounded in more robust Constitutional principles, such as an equality right under an Equal Protection approach;⁷⁹ a right to bodily inviolability and freedom from cruel and inhuman treatment;⁸⁰ or an anti-totalitarian rationale⁸¹ (although this is implied by Blackmun in his concurrence in *Casey*). However, despite the substantial body of critique around *Roe* from pro-choice and feminist commentators, there has not been a movement linking abortion rights with the right to health, or even with a universal-health-care movement.⁸² Even more satisfactory cases in U.S. jurisprudence, such as *Abele v. Markle*, which did employ equality reasoning, and used the “who is the correct decision-maker” language echoed in the more recent Portuguese, Mexican, and Australian discourse – do

⁷⁸ *Id.* at 928 (Blackmun, J., concurring).

⁷⁹ See Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815 (2007)

⁸⁰ Eileen McDonagh, *My Body, My Consent: Securing the Constitutional Right to Abortion Funding* 62 ALBANY L. REV. 1057 (1999)

⁸¹ Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 740 (1989)

⁸² These critics seek to link the abortion right to “a conception of women’s equality that also include[s] a demand for a robust public role in childcare, heightened protections against rape and domestic violence, equal employment opportunities, equal pay for comparable work, and inclusion of women in the public spheres of politics and governance,” but despite this substantial body of comment and criticism, the demand – or policy preference – for state-subsidized health care, or for any type of health reform as implicated in ‘women’s equality’, (much less from with a ‘right to health’ approach) has been under-expressed in judicial, political, and popular discourse. See, e.g., Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights* 118 YALE L.J. 1394 at 1422 (2009), citing Reva Siegel, *Constitutional Culture, Social Movement Conflict and Constitutional Change: The Case of the De Facto ERA*, 94 CAL. L. REV. 1323, 1395-97 (2007). In *Webster v. Reproductive Health Services*, the National Abortion Rights Action League (NARAL) filed an amicus that became known as the “Voices Brief” in that and subsequent Supreme Court abortion cases. Brief for the Amici Curiae Women Who Have Had Abortions and Friends of Amici Curiae in Support of Appellees, *Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989) (No. 88-605), 1989 WL 1115239. The “Voices Brief” contained women’s testimonies about their own thoughts and experiences with illegal abortion. This kind of advocacy is the closest we come in the U.S. to make the health issue part of the abortion debate at the judicial level. See LAURA R. WOLIVER, *THE POLITICAL GEOGRAPHIES OF PREGNANCY* 88-92 (2002), which discusses the Voices Brief and NARAL’s similar “Silent No More” campaign.

not emphasize the health issue.⁸³ The fact that abortion cases ask “who will make this decision about *health*?” has been overlooked in the U.S. jurisprudence, even when it reaches the equality issue, which, as the *Roe* critics point out, it too often does not.

The fact that the U.S. did not have a right to health in 1973 and does not have one now does not seem to explain the gaping absence of right-to-health critique around *Roe* and the U.S. abortion situation generally. If the right to abortion was novel and could be created in 1973, why not seek a right to health also emanating from the ‘liberty’ or ‘life’ protected by the Due Process clause? Perhaps, from a theoretical perspective, feminists were loathe to evoke a protectionist paradigm; fearing that such an approach would prioritize doctors over women, and shift the focus away from the woman’s role as paramount decision-maker, which decision might have nothing to do with health. This reluctance to employ the health frame, however, left the question, and the answer, dangerously incomplete. Abortion is a medical or surgical procedure. Pregnancy, labor, and childbirth are deeply invasive bodily phenomena that require (at least emergency access to) comprehensive medical care. To define these as such does not concede one shred of the ‘privacy’ or ‘decision-making’ argument; it simply helps to explain, more concretely, exactly what a woman is making a ‘decision’ about. To avoid the health frame propagates the fantasy enjoyed by anti-abortion activists that a pregnancy is an utterly benign process for women, something that just occurs to women, that does not require their consent or energy, and does not entail any adverse or problematic physical or mental health consequences.⁸⁴ To make abortion a

⁸³ *Abele v. Markle*, 342 F. Supp. 800 (D. Conn. 1972). *Abele* struck down an abortion statute in Connecticut on the grounds that it violated women’s right to privacy and liberty under the Fourteenth and Ninth amendments.

⁸⁴ See Caitlin Flanagan, *The Sanguine Sex*, THE ATLANTIC, May 2007. Flanagan claims: “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.”

health issue makes opponents unable to deny what they are really demanding – at minimum, invasion, and control, of women’s bodies and organ systems for a period of time.

B. U.S. abortion jurisprudence and policy make abortion inaccessible or extremely difficult to obtain, results that would be impermissible under a right-to-health analysis.

The lack of a health rationale for the abortion right has led to a U.S. abortion jurisprudence that makes abortion increasingly inaccessible. The Hyde Amendment⁸⁵ prohibits federal Medicaid from covering abortion, except in cases of rape, incest, or risk to the mother’s life.⁸⁶ The current (2009-2010) health care reform debate sought to reduce access to abortion even further, as the Stupak and Nelson amendments would create disincentives for even private insurance plans to cover abortion. Under U.S. Supreme Court jurisprudence, there would probably be no constitutional problem with Stupak or Nelson. This climate, in effect, could be seen as one of “reform without rights”, in which, without a right to health, health ‘reform’ allows policymakers to promote their own personal policy preferences, which might not be the health and well-being of the female population. In 1980, the Supreme Court upheld the Hyde Amendment in *Harris v. McRae*, rejecting the plaintiffs’ Equal Protection challenge, and concluded 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.”⁸⁷ The above-cited jurisprudence from Nepal, Mexico, *Tysiac*, and *K.L.* contradicts the *Harris* decision, suggesting that if abortion were

⁸⁵ The Hyde Amendment prohibits federal funds from reimbursing state Medicaid programs for the cost of abortion. Since 1976, the Hyde Amendment has been written into the Department of Health and Human Services’s annual appropriations bill, or has been offered by joint resolution. Pub. L. 96-123, § 109, 93 Stat. 926.

⁸⁶ The Hyde Amendment originally did not contain an exception for rape or incest, only for the mother’s life. *Harris v. McRae*, 448 U.S. 297, 302 (1980).

⁸⁷ *Harris v. McRae*, 448 U.S. 297, 317 (1980)

grounded in a health right, it would be unconstitutional for the state to fail to make the exercise of that right at least reasonably accessible.

A right-to-health approach, as entailed in the foreign jurisprudence and reform cited, would also have disallowed the results in *Webster v. Reproductive Health Services*, in which 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.⁸⁸ *Webster* – and the Stupak/Nelson laws – would fail under a right-to-health analysis, or even under the more limited right-to-life analysis employed in *K.L.* and *Tysiack*, which explained that once abortion is legal, the state “must not structure its legal framework in a way which would limit real possibilities to obtain it.”⁸⁹

The most recent and most serious infringement on *Roe* has been *Gonzales v. Carhart*.⁹⁰ *Carhart* can be seen as a severe violation of women's right to health, since it approved a federal ban on a particular abortion practice without an exception for the health of the mother.⁹¹ This case is especially disturbing, coming after the reforms in Mexico, Portugal, Colombia, Spain, etc., for its language, casting abortion as something “emotional”⁹² rather than medical; something having to do with the “life of the unborn,”⁹³ rather than the life of the woman. The jurisprudential trajectory serves as an exact mirror-image of the evolution seen in those traditionally-Catholic countries. In fact, *Carhart*'s language and reasoning provide an exemplar for anti-abortion jurists as to how to eschew facts and evidence-based reasoning in favor of paternalism and personal moral intuitions: “While we find no reliable data to measure the

⁸⁸ *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989).

⁸⁹ *Tysiack v. Poland*, App. No. 5410/03, Eur. Ct. H.R., para. 116 (2007).

⁹⁰ *Gonzales v. Carhart*, 550 U.S. 124 (2007).

⁹¹ *Id.* at 125.

⁹² *Id.* at 159 (2007).

⁹³ *Id.* at 124 (2007).

phenomenon, it seems unexceptional to conclude some women come to regret their choice to abort...⁹⁴ Further, the decision favors non-scientific terms such as “partial-birth abortion” and aesthetic, personal opinions, on the part of Justice Kennedy, that a certain abortion procedure is “disturbing,” and “shocking.”⁹⁵ Because the procedure is disgusting to Kennedy or to Congress, *Carhart* concludes that “the government may use its ...regulatory authority to show its profound respect for the life within the woman.”⁹⁶ This rationale is not only confused (could Congress show its “profound respect” if the procedure *weren't* disgusting? Why are those two necessarily related?) but deeply alarming for its hierarchy of priorities. Without a right to health, then, the U.S. 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 a woman’s life and her right to manage her health decisions during it.

Thus, while the U.S. is known for having had an abortion right for longer than much of the world, in the current context, we are moving away from a secular, scientific, health-based understanding of what abortion is – which also encompasses an understanding of what women are: humans, citizens, equal holders of the full complement of constitutional rights – to an early-20th century paradigm in which abortion is an existential or moral issue to be decided on by male jurists, in a context of control of women or ‘protectionism’ at best.⁹⁷ This trend is the exact opposite of what is observed in the rest of the world, where decisions and reforms from traditionally religious, conservative countries – such as Mexico, Spain, Portugal and Colombia –

⁹⁴ *Id.* at 160.

⁹⁵ *Id.* at 160.

⁹⁶ *Id.* at 127.

⁹⁷ “Respect for human life finds an ultimate expression in the bond of love the mother has for her child...Whether to have an abortion requires a difficult and painful moral decision.” *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007). (It is noteworthy that the majority who wrote this opinion, purporting to know what abortion ‘requires’ and what a mother feels, were all men, and the sole female Justice dissented from this decision.)

are now acknowledging that abortion is a health issue, and that the key question is “who is the correct decision-maker for a woman’s health?”⁹⁸

The actual facts of access to reproductive health care for women on the ground in the U.S. are no less disturbing, and no less striking for their backward momentum in contrast to much of the rest of the world.

C. The absence of the right to health has detrimental real-life implications for women in the U.S.

1. Abortion

In spite of the fact that abortion has been held to be a constitutional right since 1973, access to it is practically nonexistent for many American women, due not only to its expense, given the Hyde Amendment, but due to physical distance from a provider, burdensome, intrusive state laws, a shortage of trained providers, and threats of harassment and violence at abortion clinics.⁹⁹ While over 1/3 of U.S. women will have an abortion by age 45,¹⁰⁰ 88% of all U.S. counties have no abortion provider; outside of metropolitan areas, that number rises to 97%.¹⁰¹ Further, young doctors in training are generally not taught to perform abortions in medical schools and less than half of ob-gyn residency programs teach first-trimester abortion techniques routinely.¹⁰²

⁹⁸ The Mexican decision reasoned that when a woman faces an unwanted pregnancy and abortion is opposed by the state or a partner: “the question is who can veto the decision of whom.” When the state obligates hospitals to provide free abortions on a timely basis with adequate quality to any woman who requests them, this, in the Mexican Supreme Court’s view, “establishes the rule that the final decision-maker in these cases is always the woman.” Mexican Supreme Court Decision, *supra* note 39 at 188.

⁹⁹ National Abortion Federation (NAF), *Abortion Access* (2008), http://www.prochoice.org/about_abortion/facts/access_abortion.html

¹⁰⁰ Alan Guttmacher Institute, *Overview of Abortion in the United States*, <http://www.guttmacher.org/media/presskits/2005/06/28/abortionoverview.html>

¹⁰¹ NAF, *Abortion Access* (2008), *supra* note 99.

¹⁰² *Id.*

When a woman needs an abortion in the U.S., she will almost always have to pay for it herself or rely on private charity. The Hyde Amendment prohibits federal funding (except for in extreme cases of rape, incest, or risk to life), and only 13% of abortions are paid for by public funds (such as state Medicaid plans).¹⁰³ Further, less than half of private insurance plans cover abortion;¹⁰⁴ some states prohibit private insurers from offering abortion coverage at all.¹⁰⁵ This situation not only disproportionately burdens women as compared to men with regard to paying for their health care; it also puts women's health at risk further, since women who can't afford an abortion right away must wait until they can raise the money, thus postponing an abortion until later in pregnancy, when it is more complicated, more invasive, higher risk, and more expensive.¹⁰⁶ For example, between 6 and 10 weeks, abortion can cost around \$350 to \$500. Later, it is more complicated and more expensive; can cost \$650 - \$700. After 20 weeks, costs exceed \$1,000, not including transport to one of the few providers in the U.S. who will perform abortions later in pregnancy.¹⁰⁷

But even when a woman can get the money and can physically gain access to an abortion provider, she faces another obstacle: state laws meant to harass, inconvenience, and coerce women into not having abortions – and meant to prevent doctors from providing abortions.¹⁰⁸ The U.S. 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. Because states, under *Roe*, are obligated to allow abortion, if state governments have

¹⁰³ ALAN GUTTMACHER INSTITUTE, FACTS IN BRIEF: INDUCED ABORTION (Jan 2003), *available at* http://www.guttmacher.org/pubs/fb_induced_abortion.html.

¹⁰⁴ Alan Guttmacher Institute, Memo on Insurance Coverage of Abortion (July 22, 2009), <http://www.guttmacher.org/media/inthenews/2009/07/22/index.html>

¹⁰⁵ ALAN GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: RESTRICTING INSURANCE COVERAGE OF ABORTION (Feb. 1, 2010), *available at* http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf.

¹⁰⁶ NAF, *Abortion Access* (2008), *supra* note 99.

¹⁰⁷ *Id.*

¹⁰⁸ See, e.g., Center for Reproductive Rights, Targeted Regulation of Abortion Providers (TRAP), *available at* <http://reproductiverights.org/en/project/targeted-regulation-of-abortion-providers-trap>

anti-abortion policy preferences, under *Webster* and *Casey* they are allowed to implement laws and policies meant to dissuade and prevent abortions from happening, or meant to at least punish – by means of logistical inconveniences and a myriad of hurdles – those who seek, and provide, abortions. Under a right-to-health hierarchy, these policies would be impermissible, as they have no relationship with best medical practices, and in fact, run counter to medical norms and the health interests of patients.

In its comparative survey, the Victorian Law Reform Commission (VLRC) in Australia cited many examples of U.S. policies that have no bearing on clinical best practices or on the best interest of the woman. One type of ‘bad example’ cited was mandatory information provision. Unlike in Australia, the U.K., and New Zealand, 23 U.S. states mandate additional “informed consent” for abortion that goes beyond the existing standards for informed consent in health care generally. Some examples of the mandatory information provisions in U.S. states include: required viewings of ultrasounds of the fetus; required viewing of footage of an abortion; medically unsound information regarding links between abortion and breast cancer, and abortion and future infertility.¹⁰⁹ Most strikingly, “in 18 [U.S.] states, information about abortion techniques that the woman will not be having is 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 states, written information is given about the development of the fetus throughout the entire pregnancy.” The VLRC points out: “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.”¹¹⁰

¹⁰⁹ VLRC, LAW OF ABORTION: FINAL REPORT, *supra* note 51, at 116.

¹¹⁰ *Id.*

Legislation shows that the policy purpose of these mandatory-information rules is to dissuade women from having abortions.¹¹¹ This policy goal does not comport with rights-based policy-making around health care, in which the right to health requires that policies promote informed decision-making based on accurate information. Further, a right-to-health approach privileges doctors over legislators, even when it comes to controversial matters such as abortions after 24 weeks. As the VLRC put it: “The commission believes that appropriately qualified medical practitioners, rather than legislators, can best determine the relevant information to be given to a patient after bearing in mind the questions asked and concerns raised by each individual.”¹¹²

2. Access to primary reproductive health care

Access to abortion and to contraception have long been understood by feminist jurists and scholars as obvious prerequisites for women’s autonomous decision-making and equal citizenship.¹¹³ But the right to health is related to achieving women’s equal citizenship stature not just for its efficacy in ensuring legal abortion and contraception, but for its requirement that states work to ensure equal access to basic primary and preventive care. As the U.S. case

¹¹¹ E.g. Women’s Right to Know Act 2003 (Texas) Texas Health and Safety Code, ch. 171, 2003. “This does not fit the policy aim of allowing people to make informed decisions based on accurate information.” VLRC, LAW OF ABORTION: FINAL REPORT, *supra* note 51, at 117.

¹¹² VLRC, LAW OF ABORTION: FINAL REPORT, *supra* note 51, at 116.

¹¹³ See, e.g., Justice Ginsburg’s dissent in *Gonzalez v. Carhart*, arguing that the abortion right protects “a woman’s autonomy to determine her life’s course, and thus to enjoy equal citizenship stature.” 127 S. Ct. 1610, 1641 (Ginsburg, J., dissenting) (2007). See also *Planned Parenthood v. Casey*: “The destiny of the woman must be shaped to a large extent by her own conception of her spiritual imperatives and her place in society.” *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 852 (1992); see also Catherine Mackinnon, *Feminism, Marxism, Method, and the State: An Agenda for Theory* at 532: “The defining theme [is] control over women’s sexuality. For example, women who need abortions see contraception as a struggle not only for control over the biological products of sexual expression but over the social rhythms and mores of sexual intercourse. These norms often appear hostile to women’s self protection even when the technology is at hand.” See also Reva Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 816 at 826, describing the 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.”

illustrates, “health care,” as an aggregate of primary care and freedom from basic, preventable illness, implicates women more than men. Women require more health care services than men during their reproductive years, mainly due to reproductive health needs.¹¹⁴ This fact means that all the hurdles and failings within the current U.S. system¹¹⁵ affect women more than men, including heightening the risks of being uninsured. Further, the fact that the U.S. system is based around employer-sponsored insurance leads to detrimental outcomes for women, since women are more likely than men to work part-time, to work at home, or not to work for pay at all, thus spending more of their lifetimes uninsured.¹¹⁶

Women in the U.S. are disproportionately burdened by the expensive, privately-run health care system in general. 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, STI tests (since male-to-female infection is more likely and more problematic than female-to-male), or prescriptions for birth control pills (unlike in most of the world, where the pill is over-the-counter), and each doctor visit costs money either as co-pay or out of pocket, this contributes to her higher lifetime medical costs. Expensive doctor visits also constitute a burden on her time, requiring transport, logistical coordination, childcare, and often require leave from school or work. Overall, the lack of universal, subsidized reproductive health care leaves women economically, as well as physically (due to unmet need for contraception and for reproductive health services) far more burdened than it does men.

¹¹⁴ SHEILA D. RUSTGI ET AL., *WOMEN AT RISK: WHY MANY WOMEN ARE FORGOING NEEDED HEALTH CARE*, COMMONWEALTH FUND ISSUE BRIEF (2009); see also NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, *ISSUE BRIEF: HEALTH CARE REFORM: WHAT WOMEN NEED 4* (2009).

¹¹⁵ For example, patient care in the U.S. is negatively affected by the facts that: doctors spend substantial time dealing with insurance companies’ restrictions on the care they are allowed to provide; less than 1/3 of U.S. doctors have arrangements for patients to receive after-hours care and avoid going to the E.R. C. Schoen et al., *A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences*, HEALTH AFFAIRS Web Exclusive (2009)

¹¹⁶ ELIZABETH M. PATCHIAS AND JUDY WAXMAN, *WOMEN AND HEALTH COVERAGE: THE AFFORDABILITY GAP*, THE COMMONWEALTH FUND ISSUE BRIEF 2 (2007).

Due to women's reproductive capacity, they require more basic health services than men, including enhanced need for regular reproductive-system checkups, STI screening, and contraception. A woman who wants to have only two children must use contraception for approximately 30 years of her life.¹¹⁷ The birth-control pill is not over-the-counter in the U.S., thus requiring women to see doctors to get prescriptions, and requiring insurance, money, or access to a charitable clinic. Women's use of the prescription birth-control pill - and the fact that it women must go to doctors to procure it - is one reason that women see doctors more than men do and spend 68% more on health care than men do per year.¹¹⁸ The pill is over-the-counter (OTC) in most of the world, and a recent study indicates that it would be safe to sell the pill OTC in the U.S.¹¹⁹ It could be argued that the hurdles to accessing birth control - along with unscientific sexual education programs - are related to the fact that in the U.S., in contrast to the rest of the world, unintended pregnancy among poor women is on the rise, and overall unintended pregnancy rates are stagnating.¹²⁰ The relative expense and inaccessibility of birth control options might also be to blame for the fact that women of color are far more likely than white women to experience unintended pregnancies.¹²¹

Additionally, most sexually transmitted infections (STIs), including HIV, are more easily transferrable from male-to-female than from female-to-male, heightening women's greater need

¹¹⁷ ALAN GUTTMACHER INSTITUTE, IMPROVING CONTRACEPTIVE USE IN THE UNITED STATES, IN BRIEF 2008 SERIES NO. 1 (2008).

¹¹⁸ See NARAL Pro-Choice America, *Birth Control*, http://www.prochoiceamerica.org/issues/birth_control/

¹¹⁹ Daniel Grossman, et al., *Self-screening for contraindications to oral contraceptive use: evidence for the safety of over-the-counter provision*, 76 *CONTRACEPTION: AN INT'L J.* 2:158 (2007)

¹²⁰ See Alan Guttmacher Institute, *An Overview of Abortion in the United States*, <http://www.guttmacher.org/media/presskits/2005/06/28/abortionoverview.html>

¹²¹ 40% of pregnancies are unintended among white women, as compared to 69% among black women and 54% among Latina women. Alan Guttmacher Institute, *Facts on Induced Abortion in the United States* (July 2008), http://www.guttmacher.org/pubs/fb_induced_abortion.html#20

for primary reproductive health care checkups as compared to men.¹²² Further, STIs in women have more adverse consequences than they do for men, including infertility, cancer, pelvic inflammatory disease, and infant death or stillbirth.¹²³ For example, for men, infection with HPV can lead only to small warts; but in women, the same virus can lead not just to warts but to cervical cancer.¹²⁴

These facts evincing women's heightened need for reproductive health services all exist before obstetric, delivery, and post-natal care are even taken into consideration. When a woman has insurance, the burden of these health needs is not reduced, as insurers, under U.S. law, are allowed to practice discriminatory pricing policies and to exclude maternal and abortion care from coverage.

In the U.S., an insured woman will spend approximately \$91,000 more than a similarly-situated insured man on health care during her lifetime.¹²⁵ But the fact that spend more than men on basic health care¹²⁶ is not caused just by the fact that women visit the doctor more frequently for basic reproductive health needs; it is also due to the fact that insurers are allowed to employ a number of discriminatory practices which would be impermissible under a right-to-health analysis.

¹²² See 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 BRITISH MED. J. 809 (1992); J.A. Kulhanjian et al., *Identification of women at unsuspected risk of primary infection with herpes simplex virus type 2 during pregnancy* 326 N. ENGL. J. MED. 916 (1992) [A woman has an 8 – 10% of being infected versus a man's 4-5% likelihood].

¹²³ WORLD HEALTH ORGANIZATION, SEXUALLY TRANSMITTED INFECTIONS FACTSHEET, available at <http://www.who.int/mediacentre/factsheets/fs110/en/index.html>, See also Brenda Y. Hernandez et al., *Transmission of Human Papillomavirus in Heterosexual Couples* EMERG. INFECT. DIS. (2008) "Cervical cancer remains a major source of illness and death among women globally, and infection with oncogenic HPVs is its principal cause."

¹²⁴ See WORLD HEALTH ORGANIZATION, HUMAN PAPILLOMAVIRUS AND HPV VACCINES: TECHNICAL INFORMATION FOR POLICY-MAKERS AND HEALTH PROFESSIONALS (2007), available at http://www.who.int/reproductivehealth/publications/cancers/IVB_07.05/en/index.html

¹²⁵ During the 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 and Kenneth Warner, *The Lifetime Distribution of Health Care Costs*, 39 HEALTH SERV. RES. 3, 627 – 642 (2004).

¹²⁶ NARAL Pro-Choice America, *Birth Control*, http://www.prochoiceamerica.org/issues/birth_control/

Insurers are allowed to charge women higher premiums in the first place – a practice known as “gender rating” – for health care plans that, more often than not, do not even include maternity care. Gender rating is completely barred in only one U.S. state, Montana, and is prevalent everywhere¹²⁷ else notwithstanding the fact that women are charged co-pays for each visit, and notwithstanding the fact that women’s annual exams are *recommended* by doctors and health authorities, including insurers themselves.¹²⁸ Insurers defend gender rating with a profit rationale: “Women 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.”¹²⁹ This fact would be immaterial in a system designed to promote the right to health; in such a system, women’s health, and their ability to enjoy access to health free from discrimination, would be considered the ultimate policy goals.¹³⁰ When access to primary and preventive care is economically burdensome for a population based only on gender, the right to health is violated.¹³¹

¹²⁷ Under ‘gender rating’, insurers are allowed to charge women more than men for the same health care plans, which 87% of the time do not even include maternity care. 95% of the best-selling individual plans practice gender rating; women aged 25 are charged up to 84% more than men for plans that *exclude maternity coverage*. NATIONAL WOMEN’S LAW CENTER, STILL NOWHERE TO TURN: INSURANCE COMPANIES TREAT WOMEN LIKE A PRE-EXISTING CONDITION 3 (2009). Insurers practice gender rating on the individual market but also regarding group-employer plans; 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. This practice can inhibit companies from hiring more women workers. *Id.* at 9.

¹²⁸ SHEILA D. RUSTGI ET AL., WOMEN AT RISK: WHY MANY WOMEN ARE FORGOING NEEDED HEALTH CARE, COMMONWEALTH FUND ISSUE BRIEF 4 (2009). 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 50, women are recommended to get mammograms regularly. Yet, when women are required 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. NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, ISSUE BRIEF: HEALTH CARE REFORM: WHAT WOMEN NEED 4 (2009).

¹²⁹ Amy Gillentine, *Gender Bias: Should Women Pay More for Insurance?* COLORADO SPRINGS BUSINESS JOURNAL, Feb. 19, 2010, quoting Rebecca Weiss, government liaison for Anthem Blue Cross Blue Shield.

¹³⁰ CESCR, *General Comment 14*, *supra* note 2, at para 12, 14.

¹³¹ CESCR, *General Comment 14*, *supra* note 2, at para 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.”

Even more disturbing than the lack of universal, subsidized access to primary and preventative health services that only women need is the shocking lack of maternal health care coverage in the United States. The above-mentioned data relates only to women who are not pregnant and who are seeking not to become pregnant. If a woman does want to become a mother, her access to maternal and prenatal health care will depend almost entirely on her economic wealth, whether and how completely she is employed, or whether she is the dependant of someone with good health insurance. On the individual health-insurance market, only 13% of plans available to a 30-year woman include maternity coverage.¹³² The average cost of delivery in a hospital is \$7,000 to \$10,000, not including prenatal care,¹³³ and complications can make the cost skyrocket. While some plans offer supplemental “riders” for maternity care, they are often extremely expensive and thus do not allow women to make decisions about parenthood in a time frame that they choose.

Further, it is common for insurers to reject applicants for reasons including surviving domestic violence, having had a Cesarean, or being pregnant.¹³⁴ Federal law prohibits group insurance plans from refusing coverage to a pregnant person, but on the individual market, it is legal. A pregnant woman without any health insurance - and with no health insurers that will cover her - has a few unappealing options. She can seek to get a new job (not easy or likely when pregnant), or try to become poor enough to qualify for Medicaid, or resort to an abortion. But even Medicaid - in 20 states - is not required to provide coverage to pregnant women while they wait for the bureaucratic Medicaid process to approve their application.¹³⁵

¹³² NWLC, *supra* note 127, at 6.

¹³³ Sharon Lerner, *Why Women Need Healthcare Reform*, THE NATION (Aug. 21, 2009), available at <http://www.thenation.com/doc/20090831/lerner>

¹³⁴ NWLC, *supra* note 127.

¹³⁵ *Id.* See also Lerner, *supra* note 133.

3. *The U.S. system would have to change dramatically to comply with a right-to-health mandate; these changes would especially benefit women.*

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 U.S, therefore, could be seen as just another symptom of what MacKinnon – and Holmes, and other legal and philosophical historians - might call a legal system created by men, for men.¹³⁶ As such, to de-privatize the nation's health care system would have positive effects for women's financial parity with men at the very least. As Rebecca Cook notes: "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."¹³⁷ This logic works beautifully, if a government admits it has an "obligation to prevent death from disease" in the first place – that is, a 'right to the highest attainable standard of health.' As such, U.S. feminists and reproductive rights activists might focus on the health care debate from a right-to-health standpoint, in order to secure more state commitment to women-specific health needs.

¹³⁶ "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." Catherine MacKinnon, *Some Reflections on Sex Equality Under Law*, 100 YALE L. J. 1281 (1991). See also OLIVER WENDELL HOLMES, *THE COMMON LAW* 1 (1881). ("The life of the law has not been logic, it has been [men's] experience.").

¹³⁷ Rebecca Cook, *International Protection of Women's Reproductive Rights*, 24 N.Y.U.J. INT'L L. & POL. 689 (1992).

C. How does the U.S. situation compare to women's access to reproductive health care around the world?

Due to the extremely high costs of health care and relative inaccessibility of birth control for women in the U.S., unmet need for contraception in the U.S. has increased, not decreased, over the past 20 years.¹³⁸ Along with the U.S., only Haiti, Benin, and Liberia have also shown an increase in unmet need during this time period; the rest of the world has made striking improvements in access to contraception, demonstrating a powerful global trend to which the U.S. is the major exception.¹³⁹ For example, unmet need in Mexico and Colombia is now half what it was in 1988, and while Thailand's unmet need was much higher than that of the U.S. twenty years ago, it is now lower. The same is true of Mongolia, Turkey, Viet Nam, and Colombia.¹⁴⁰

In the U.S., the number of unwanted pregnancies has not decreased over the past twenty years; and for poor women, unwanted pregnancies have *increased* by 29%.¹⁴¹ This phenomenon is a predictable result of the economic hurdles faced by women in accessing contraceptives, as documented above. Further, after over ten years of decline, teen birth rates in the U.S. have been on the increase, a trend that might be linked not just to the burdens and expense of accessing

¹³⁸ United Nations, Department of Economic and Social Affairs, Population Division, World Contraceptive Use 2009 Database POP/DB/CP/Rev2009.

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ Lawrence Finer and Stanley Henshaw, The Guttmacher Institute, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSPECT. SEXUAL & REPROD. HEALTH 38(2)90 (2006). Unwanted pregnancies increased by 29% among poor women from 1994 to 2001, while the overall rate stagnated. "The rate among women whose income was below the federal poverty line was three times that of women whose income was at least double the poverty line...Such gaps have social justice implications, because they indicate that some groups of women have more difficulty than others in achieving their reproductive goals."

contraception and abortion, but to the biased and un-scientific sex education that children receive in schools under “abstinence-only” laws, as some have argued.¹⁴²

Ten years ago, the U.S. had the same maternal mortality ratio as many other wealthy, industrialized democracies, including Austria, Australia, Belgium, the Netherlands, Finland, and Italy, and even had a lower maternal mortality ratio than France.¹⁴³ However, by 2009, all of these countries had made major progress in eradicating maternal mortality, whereas the U.S. rate saw no change. Now, the U.S. has some of the worst maternal mortality ratios in the developed world. In 2009, there were more than twice as many maternal deaths per live birth in the U.S. as there were in Austria, Australia, and Italy.¹⁴⁴ Meanwhile, Mexico and Nepal, like many developing countries, continue to face high numbers of maternal deaths, but nonetheless reduced maternal mortality by almost half over the last ten years, while the U.S. experienced no change whatsoever.¹⁴⁵

III. CONCLUSION

Correlation does not imply causation, but the data cited above suggest that something the U.S. is doing that differs from global practices is having a visible, negative effect on women’s health and rights. It then stands to reason that the absence of a robust right to health in the United States could be responsible for our failure to prioritize access to health care; and that the enhanced health needs of women lead to especially detrimental results for women when health care in general is not available or accessible. Further, when policies that de-prioritize family planning and abortion access are allowed to persist, women’s health indicators decline notably. The

¹⁴² See Rob Stein, *Teen Birth Rate Rises in the U.S., Reversing a 14-Year Decline*, WASHINGTON POST, Dec. 6, 2007.

¹⁴³ UNITED NATIONS POPULATION FUND (UNFPA), STATE OF THE WORLD POPULATION 1999 (2000).

¹⁴⁴ UNFPA, STATE OF THE WORLD POPULATION 2009 (2010).

¹⁴⁵ UNFPA STATE OF THE WORLD POPULATION 1999 and UNFPA STATE OF THE WORLD POPULATION 2009.

absence of a right to health in the U.S has led to a jurisprudence that makes abortion and contraception 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 health in the manner they see fit.

Looking at the foreign jurisprudence and reforms discussed above provides compelling evidence that a right-to-health argument, in jurisdictions that recognize such a right, creates a strong platform for women's rights and access to reproductive health services. It seems that the opposite is also true – that the absence of a right to health allows a jurisprudence to continue to take backward strides with regard to access to reproductive health care, which, in turn, makes gender equality out of reach. This, I believe, is the U.S. 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-reform and universal-health-care activists.

Where could the right to health come from in the U.S.? As mentioned in Part I, the U.S. is not party to any of the treaties that explicitly create a right to health, but it is party to the ICCPR. As such, the decisions in *Tysiack* and *K.L.* are important, since they, along with Concluding Observations from the Human Rights Committee – the body that monitors compliance with the ICCPR – suggests that the treaty constructs a right to health at least for certain populations under certain circumstances, including around abortion.¹⁴⁶ While the U.S. has

¹⁴⁶ The Human Rights Committee has construed lack of access to safe abortion to implicate the right to life (Art. 6) under the ICCPR, as unsafe abortion is a major cause of maternal mortality. *See, e.g., Concluding Observations of the Human Rights Committee: Bolivia*, U.N. Doc. CCPR/C/79/Add.74 para. 22 (1997); *Colombia*, U.N. Doc. CCPR/C/79/Add.76 para. 24; *Mongolia* U.N. Doc. CCPR/C/79/Add.120, para. 8(b) (1997); *Peru*, U.N. Doc. CCPR/CO/70/PER, para. 20 (2000). In the *KL v. Peru* case, discussed *infra*, the HRC further articulated that lack of access to safe abortion implicated mental health and suffering, and therefore article 7 of the ICCPR on the right to be free from cruel, inhuman, and degrading treatment. For further discussion of a constructed right to reproductive

stated that the ICCPR is not self-executing, its civil and political rights concept of the right to health could be useful for advocacy in the U.S. even under domestic norms. The U.S. has not ratified CEDAW, but has, however, ratified CERD, which makes CERD binding as supreme law of the land under the U.S. Constitution.¹⁴⁷ This fact – and the case law around the ICCPR, such as *K.L.* – provides a glimmer of hope for human-rights advocates in the U.S., and could be one potential avenue towards right-to-health enforcement, if activists choose a different route than simply a movement to ratify CEDAW or ICESCR.

Alternatively, U.S. actors seeking to advocate for a right to health disaggregated from the broader, historically complex discussion of the U.S.’s ‘exceptionalism’ to international law might consider a comparative constitutional approach, looking at domestic contexts that give rise to the right to health (such as Mexico’s 1983 reform) as an alternative, or a defense, to the claim that the right to health comes inextricably bundled with an obligation to ratify ICESCR, or sign on to ‘international law’ entirely and/or the whole cohort of “economic, social, and cultural rights.”¹⁴⁸ A comparative constitutional approach need not entail the citing of foreign constitutional decisions in U.S. courts; instead, it could mean simply that U.S. advocates carefully analyze the strategies used by advocates around the world to construe their constitutions in ways giving rise to robust health protections,¹⁴⁹ and perhaps attempt to emulate

health under the ICCPR’s right to life provision, see Dina Bogecho, *Putting it to Good Use: The International Covenant on Civil and Political Rights and Women’s Right to Reproductive Health*, 13 S. CA. REV. L. & WOMEN’S STUD. 229 (2004).

¹⁴⁷ U.S. CONST., art. VI. “...all 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, anything in the Constitution or laws of any State to the contrary notwithstanding.”

¹⁴⁸ In fact, some scholars and commentators argue that the dichotomy between “civil and political rights” (CCPR) and “social, economic, and cultural rights” (ESCR) is outmoded and no longer useful; moving away from this dichotomy might provide new opportunities for U.S. advocacy and reform. See Alejandro Madrazo, CIDE, Mexico. Presentation at First Latin American Legal Conference on Reproductive Rights, Arequipa, Peru, Nov. 6, 2009; see also Cass Sunstein, *Why Does the American Constitution Lack Social and Economic Guarantees?* 56 SYR. L. R. 1 (2005), advocating for a move away from the negative/positive rights dichotomy.

¹⁴⁹ Justice Antonin Scalia and other vocal commentators believe that there is no place for comparative constitutional jurisprudence in the U.S. However, other Supreme Court justices have disagreed, showing that the ‘exceptionalist’

those strategies, even at the state or local level. For example, the city of San Francisco has adopted CEDAW; perhaps other local activists could convince state constitutions to adopt right-to-health language. This approach – both conceptually and strategically – seems especially relevant, and urgent, in light of the current health-reform debate in the U.S., where, even among the most radical universal-health-care proponents, “right to health” language is conspicuously absent.

Currently, an emphasis on the health implications of abortion and contraceptives is seen as a supplemental approach, or even an 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.¹⁵⁰ This may be our historical tradition,¹⁵¹ but why must it be accepted as destiny? Constitutions can be amended, local legislation can create a right to health, international treaties can be ratified and enforced, and popular consensus can change. Popular consensus, then, can change constitutional law – see, e.g., *Brown v. Board* and *Lawrence v. Texas*. What if we begin to describe the health argument not just as the ‘pragmatic’ sibling of the legal argument, but as a legal mandate itself? The examples of 191 other nation-states might be a reasonable place to start, and a defense to the claim that such an idea is unprecedented and impossible.

view is not as deeply entrenched in our judiciary as it might seem in popular idiom. In *Printz v. United States*, Justice Scalia declared that “comparative analysis [is] inappropriate to the task of interpreting a constitution.” *Printz v. United States*, 521 U.S. 898, 921 n.11 (1997) (Scalia’s use of the article ‘a’ here might reveal a logical fallacy and paradox: does he want his words to be interpreted by other constitutional courts?) Justice Breyer’s dissent in the same case argued for the use of comparative constitutional analysis. See also Justice John Paul Stevens (*Thompson v. Oklahoma*, 487 U.S. 815 839 (1988)), on comparative approaches to the death penalty, Justice David Souter (*Washington v. Gluckberg*, 521 U.S. 702, 785-86 (1997) on the Dutch approach to assisted suicide). See also Vicki C. Jackson, *Ambivalent Resistance and Comparative Constitutionalism: Opening up Conversation on Proportionality*, 1. U. PA. J. CONST. L. 583, 638-39 (1999), and Mark Tushnet: “the Constitution might sometimes license comparative inquiry when other sources of constitutional interpretation run out.” Mark Tushnet, *The Possibilities of Comparative Constitutional Law*, 108 YALE L.J. 1225, 1235 (1999).

¹⁵⁰ See Robin West, *supra* note 82.

¹⁵¹ See *DeShaney v. Winnebago County Dep’t of Soc. Servs.*, 489 U.S. 189, 195-97 (1989), which held that due process did not impose a state’s duty to provide adequate protective services to members of the general public, and *Harris v. McRae*, 448 U.S. 297 (1980).

But we should not blindly follow the rest of the world for its own sake. However, nor should we blindly follow our own tradition for its own sake. We should forge a path that makes sense; that leads us where we want to go, even if tradition does not get us there, and even if tradition presents a daunting obstacle. U.S. activists should critically assess what they are demanding, what values give rise to those needs, and act in furtherance of those values. If women in the U.S. feel that gender equality is an important value, then the purpose of this essay is to attempt to marshal those activists in the service of the right to health.