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Multiple Discrimination In Access To Sexual And Reproductive Health: Experiences From Latin America And The Caribbean

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I. OVERVIEW

The historical disparity and inequality between men and women in Latin America and the Caribbean is reflected in the limited access women in the region have to sexual and reproductive health services. Through different examples, I will try to demonstrate how gender-based discrimination in particular—and discrimination based on race/ethnicity, location, financial status, and age, among other factors—affects women's access to sexual and reproductive health services and restricts the exercise of their sexual and reproductive rights. Similarly, I will describe how Planned Parenthood Federation of America's (PPFA) international advocacy and service delivery program contributes to the promotion and defense of sexual and reproductive rights, as a key part of women's rights in the region.

II. THE RIGHT TO PRIVACY IN SEXUAL AND REPRODUCTIVE HEALTH

During her thirteenth week of pregnancy, A.N., a 26-year-old Costa Rican woman, received a diagnosis of occipital encephalocele that was incompatible with extrauterine life[1] and decided to have a legal abortion;[2] yet despite several psychological and psychiatric diagnoses determining that the pregnancy posed severe risks to her life due to the serious depression she was suffering, the abortion was denied by the

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1. This consists of a severe deformation of the neural tube that is characterized by protuberances, with or without skin, in the brain.

2. In Costa Rica abortion is legal when the life or health of the woman is threatened. CÓDIGO PENAL [C. PEN] art. 121 (Costa Rica).

public hospital. A.N. desperately sought help from the Supreme Court of Justice of Costa Rica, which denied the protection of her fundamental rights, deeming that they were not threatened. On June 30, 2007, A.N. gave birth to a stillborn.[3]

Unfortunately, A.N.'s story is common throughout Latin America and the Caribbean. The generalized stigmatization of abortion and other sexual and reproductive health services contributes to a climate in which both administrators of justice and health-care providers believe they have been authorized to mistreat the very women they should be assisting. In the case of *A.N. v. Costa Rica*[4] as well as in the case of *K.L v. Peru*[5] and *Paulina del Carmen Ramírez Jacinto v. Mexico,*[6] public officials used different forms of deceit to dissuade women from their decisions to legally terminate their pregnancies, and in cases in which dissuasion failed, forced women to carry their pregnancies to term; the outcome in the cases of both K.L. and A.N. was the death of the fetus.

A.N. was abused by the doctors at the hospital, thus suffering the violation of her right to dignity, liberty, and privacy. According to A.N.'s testimony

> While she [the doctor] was reading my file she asked me if my pregnancy was planned. As soon as I said no, she asked why I didn't use protection. Surprised by the tone of her voice, I told her that although my baby was not planned she was not unwanted and that I had been using Mesigyna [injectible] protection for two years. The doctor replied with a "cruel smile" and a bitter remark, saying, "You should play the lottery to see if you can actually get something right." I was speechless, which I think gave way for her to continue to judge and

3. *Se Presenta Petición ante Comisión Interamericana de Derechos Humanos Reclamando el Derecho Fundamental al Acceso al Aborto Legal en Costa Rica*, CENTER FOR REPROD. RIGHTS (Oct. 3, 2008), http://reproductiverights.org/es/centro-de-prensa/se-presenta-petici%C3%B3n-ante-comisi%C3%B3n-interamericana-de-derechos-humanos-reclamando-el.

4. *See id.*

5. United Nations, Human Rights Comm., Int'l Covenant on Civil & Political Rights, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (Nov. 22, 2005). K.L. was a 17-year-old Peruvian woman with fourteen weeks of gestation who received a diagnosis of anencephalic fetus. *Id.* ¶ 2.1. When she heard this, she decided to terminate her pregnancy, but the abortion was denied by the director of the public hospital. *Id.* ¶¶ 2.2–.3. On January 13, 2002, K.L. gave birth to an anancephalic baby who died four days after birth. *Id.* ¶ 2.6. In Peru, therapeutic abortion is legal. In this case, even though medical standards demonstrated that the pregnancy posed risks to the young woman, the director of the hospital deemed that the law did not contemplate cases such as K.L.'s and therefore denied her the abortion. *Id.* ¶ 2.3.

6. Paulina del Carmen Ramírez Jacinto v. Mexico, Petition 161-02, Inter-Am. Comm'n H.R., Report No. 21/07 (2007), http://www.cidh.oas.org/annualrep/2007eng/Mexico161.02eng.htm. In 1999, Paulina became pregnant at the age of fourteen after being raped, and despite having filed the corresponding police report, she was never offered emergency contraception. *Id.* ¶ 9. After finding out that she was pregnant, Paulina decided to terminate the pregnancy. The laws of Baja California, Mexico, authorize abortion in the case of rape, but by resorting to deceit, public officials managed to convince Paulina to desist from getting the abortion. *Id.* ¶¶ 10–13.

> attack me, adding that "[you] should assume the risk of pregnancy. Although the baby will die, [you] should carry it to term for the full nine months." Then I said, "That is what I am trying to avoid." She continued, "And not try to terminate the pregnancy because it is something you did to yourself, and you have to accept God's will."[7]

The unfortunate events experienced by Paulina, K.L., and A.N. reflect the discrimination that many women suffer when they are unable to freely make choices, within their private sphere, regarding their bodies, particularly when it comes to reproduction. Although these types of decisions should only be made by the woman, other people participating in the decision-making process (e.g., health-care professionals and justice officials, among others) take over the woman's power to decide and then make decisions based on their broad knowledge and personal, moral, and religious conceptions. When such decisions made for women are commonplace and take place on a regional level, the results are consistent, region-wide violations of the rights of women. Women in Latin America often face a series of obstacles that hinder the right to adequate access to justice, to being treated with dignity and impartiality, and, above all, to exercising their sexual and reproductive rights—a cornerstone of their fundamental human rights.

The Inter-American Commission on Human Rights established that adequate access to justice is not limited only to the formal existence of legal remedies, but also involves the appropriateness of investigation, sanction, and reparation of reported violations.[8] According to a 2007 report, the Commission found that structural problems typical in justice-administration systems in the region more critically affect women as a result of the discrimination they have historically suffered.[9]

III. THE INTERNATIONAL HUMAN RIGHTS FRAMEWORK: PENDING IMPLEMENTATION

Discriminatory treatment is also visible in the fact that Latin America is one of the most dangerous places in the world to be a woman; according to the World Health Organization, seventeen percent of all maternal mortality in Latin America is attributable to unsafe abortion.[10] Both the Cairo Program of Action in 1994 and the Beijing Plat-

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7. A.N.'s testimony provided to PPFA, Colectiva por el Derecho a Decidir and the Center for Reproductive Rights during the fact finding mission in 2008.

8. Inter-Am. Comm'n H. R., Org. of Am. States, *Access to Justice for Women Victims of Violence in the Americas*, at 2–3, OEA/Ser.L/V/II, doc. 68 (Jan. 20, 2007).

9. *Id.* at 3–4.

10. ELISABETH AHMAN & IQBAL SHAH, WORLD HEALTH ORG., UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2000, at 13 tbl.3 (4th ed. 2004), *available at* http://whqlibdoc.who.int/publications/2004/

form for Action in 1995 established that health and—even further—that sexual and reproductive rights are cornerstones for human rights and development.[11] At these United Nations world conferences,[12] the international community recognized the need to address the issue of women's reproductive rights, including unsafe abortion. On the one hand, the Cairo Program of Action serves as a milestone, establishing that "reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents."[13] But it also urges states to ensure universal access to basic reproductive health services by, for example, taking specific measures to ensure social and economic development.[14] It also includes the right of all people to make decisions regarding their reproduction without being submitted to discrimination, coercion, or violence.[15] In fact, the Cairo Program of Action observed the true concept of reproductive rights for the first time, not only reiterating the right to determine the number and spacing of children, but also acknowledging that reproductive rights involve the "right to attain the highest attainable standard of sexual and reproductive health."[16] At the same time, the Beijing Platform for Action established that women's human rights include the right to have control over issues related to their sexuality,

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9241591803.pdf. Similarly, different human rights protection organs have voiced concern over the fact that unsafe abortion continues to be one of the main causes of maternal mortality in the region and over the restricted interpretations of legal abortion, recommending that the law be revised to establish exceptions to the prohibition and sanction of abortions. *See* Fourth World Conference on Women, Beijing, China, Sept. 4–15, 1995, *Beijing Declaration and Platform for Action*, ¶¶ 97, 106(j)–(k), U.N. Doc. A/CONF.177/20/Rev.1 (1996) [hereinafter Beijing Platform for Action]; *see also* International Conference on Population and Development, Cairo, Egypt, Sept. 5–13, 1994, *Report of the International Conference on Population and Development*, ¶ 8.19, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter Cairo Program of Action]. The Beijing Platform for Action recommended states to consider the possibility of reviewing laws that establish punitive measures against women who have had illegal abortions. Beijing Platform for Action, *supra*, ¶ 106(k). More specifically, both the Beijing Platform for Action and the Cairo Program of Action urged

> [a]ll Governments and relevant intergovernmental and non-governmental organizations . . . to strengthen their commitment to women's health [and] to deal with the health impact of unsafe abortion as a major public health concern . . . . [W]omen should have access to quality services for the management of complications arising from abortion.

Id.; Cairo Program of Action, *supra*, ¶ 8.25.

11. Beijing Platform for Action, *supra* note 10, ¶¶ 89, 92–96; Cairo Program of Action, *supra* note 10, ¶ 7.3.

12. Although the declarations made in United Nations conferences are not legally binding, they document pledges, and their importance is reflected in the fact that they establish concepts and instruments of political action that define the direction toward which human rights are headed.

13. Cairo Program of Action, *supra* note 10, ¶ 7.3.

14. *See id.* ¶ 7.6.

15. *Id.* ¶ 7.2–.3.

16. *Id.* ¶ 7.3.

including sexual and reproductive health, and to freely decide on those matters without being subjected to coercion, discrimination, and violence.[17]

This juncture between existing human rights treaties and sexual and reproductive rights has been reiterated throughout the years. For example, in 2003, the Commission on Human Rights confirmed that "sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[18] In addition, Mr. Paul Hunt, the former U.N. Rapporteur on the Right of Everyone to Enjoy the Highest Attainable Standard of Physical and Mental Health, stated at the tenth anniversary of Cairo, 1994, that "the rights to sexual and reproductive health have an indispensable role to play in the struggle against intolerance, gender inequality, HIV/AIDS and poverty . . . and that increased attention [should] be devoted to a proper understanding of reproductive health, reproductive rights, sexual health and sexual rights."[19] Although the Millennium Development Goals do not explicitly mention sexual and reproductive health, "at least three of the eight Goals—on maternal health, child health and HIV/AIDS—are directly related to sexual and reproductive health."[20]

Despite the fact that the states in this region have embraced these international principles, the gap between paper and practice is still profound, taking the lives and health of hundreds of Latin American women. Unfortunately, women in the region face several physical, cultural, economic, and gender-related barriers. For example, according to a recent study in Guatemala, the incidence of maternal mortality in the municipality of Senahu, Alta Verapaz during 2007 was just as high among women living a great distance from healthcare facilities as it was among women living near them. Some women traveled 45 kilometers to the nearest health-care center, while others were one kilometer away. Some had to walk for eight hours to get transportation to a healthcare center; by the time they were referred to a hospital, some women had traveled 75 kilometers while others over 185 kilometers, of which approximately 170 were on unpaved roads. In addition to these physical barriers are economic barriers; only one woman was transported by ambulance while the rest had to pay for private transportation, which in some cases had a cost of 500 quetzals for families that earn an average

17. Bejing Platform for Action, *supra* note 10, ¶¶ 92, 95.

18. Comm'n on Human Rights Res. 2003/28, Office of the High Comm'r for Human Rights, 56th meeting, Apr. 22, 2003, U.N. Doc. E/CN.4/RES/2003/28., pmbl. & ¶ 6 (Apr. 22, 2003).

19. Special Rapporteur on the Right to Health, *Economic, Social, and Cultural Rights: The Right of Everyone to Enjoy the Highest Attainable Standard of Physical and Mental Health*, Comm'n on Human Rights, 2, U.N. Doc. E/CN.4/2004/49 (Feb. 16, 2004) (by Paul Hunt).

20. *Id.* ¶ 8.

of 25 quetzals per day in agricultural labor.[21]

The same study noted that many women from indigenous populations lack qualified health-care services during labor as a result of not only shortages of available qualified personnel but also as a result of discriminatory and degrading treatment to which these women are subjected. A great insufficiency in terms of cultural belonging was described for health-care services, including maternal–infant health; it was often reported that the health-care system did not respect the desire of many indigenous women to give birth in a vertical position, which is their cultural tradition.[22] These situations clearly show the discrimination and gender-based inequality that persists in the region. They also capture the lack of adequate services because of not only personnel shortage but also insufficient knowledge and respect toward different cultures and languages. Because of the cultural diversity that is found in Latin America, medical personnel within health-care systems must be aware of local culture or, at least, speak the local language.

IV. LEGAL PROTECTIONS OF THE RIGHT TO HEALTH AND NONDISCRIMINATION

The enjoyment of the right to health, which includes the right to reproductive health,[23] depends, in great part, on the enjoyment of the right to be free from discrimination. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) explicitly calls for states to adopt "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."[24] However, the discriminatory framework faced in reproductive health in the region is visible in

21. CTR. FOR ECON. & SOC. RIGHTS & INSTITUTO CENTROAMERICANO DE ESTUDIOS FISCALES, ¿DERECHOS O PRIVILEGIOS?: EL COMPROMISO FISCAL CON LA SALUD, LA EDUCACIÓN Y LA ALIMENTACIÓN EN GUATEMALA 44–45 (2009), *available at* http://www.cesr.org/downloads/Derechos%20o%20Privilegios%20Final.pdf.

22. This is exemplified by some of the testimonies provided during the study: "I have given birth to all my children at home with the help of my mother-in-law and my husband. He sits on the chair and holds me while I push; but at the health-care center, they don't let anyone in; not even the midwife." *Id.* at 55. "We go by foot, and by the time we get there in the middle of the afternoon, the health-care center is already closed. The few times we manage to get there before it closes, they are rude to us because we can't speak Spanish." *Id.* at 54.

23. As a human right, the right to reproductive health is contained in, inter alia, the Beijing Platform for Action, *supra* note 10, at ¶ 94; General Comment No. 14, Comm. on Econ., Soc. & Cultural Rights, Rep. on its 22d Sess., Apr. 25–May 12, 2000, ¶ 8, U.N. Doc. E/C.12/2000/4 (July 4, 2000) [hereinafter CESCR]; Convention on the Elimination of All Forms of Discrimination Against Women, art. 12, ¶ 1, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 13 [hereinafter CEDAW].

24. CEDAW, *supra* note 23, art. 12, ¶ 1.

the limited access to family-planning methods,[25] including oral emergency contraceptive pills (EC).[26] The decision to ban the sale of or free access to EC—as in Chile,[27] Ecuador,[28] Peru,[29] and Honduras[30]—violates women's rights to make free and responsible decisions regarding the number and spacing of their children.

The International Covenant on Economic, Social and Cultural Rights, which has been ratified by most countries in the region, established the right to reproductive health care, recognizing in Article 12.1 "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[31] From another point of view, the right to determine the number and spacing of children is a human right that stems from civil rights that are as deeply rooted as the rights to autonomy or personal liberty[32] and intimacy.[33] Therefore, the rights to

25. The right to family planning is defined in the CEDAW as the right of women to "decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights." *Id.* art. 16, ¶ 1(e).

26. Oral emergency contraception is a hormonal contraceptive. Its main specificity lies in the fact that it is the only method that can prevent pregnancy after unprotected sex and therefore is especially necessary where sexual violence against women persists because it can prevent pregnancies resulting from rape. Today, most emergency oral contraceptive products are levonorgestrel based (a synthetic progestogen component).

27. In 2007, the Constitutional Tribunal of Chile declared the sale, marketing, and distribution of EC in the public-health sector to be unconstitutional, thus denying access to EC to women of limited financial resources.

28. The Third Circuit Civil Judge (*Juez Tercero de lo Civil*) of Guayaquil, Ecuador, permanently prohibited the granting of sanitary licenses for marketing and commercially expending the EC "Postinor 2"; this judicial order was confirmed by the Constitutional Tribunal in 2006, when selling and marketing the drug was completely banned.

29. On October 22, 2009, the Constitutional Tribunal of Peru prohibited the free distribution of emergency contraception.

30. Through Ministerial Decree 2744 of 2009, signed by de facto President Roberto Micheletti and published in the Official Bulletin of Honduras on October 24, 2010, the use and marketing of oral emergency contraception was banned.

31. International Covenant on Economic, Social and Cultural Rights, art. 12, ¶ 1, *opened for signature*, Dec. 16, 1966, 993 U.N.T.S. 3. This guarantee is reiterated in the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social, and Cultural Rights. *See* Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, art. 10, *adopted* Nov. 17, 1988, 9 I.L.M. 673, *available at* http://www.oas.org/juridico/english/treaties/a-52.html.

32. The right to personal liberty and safety is contained in Article 4 of the Inter-American Convention to Prevent, Punish and Erradicate Violence Against Women, known as the "Convention of Belém do Pará." Inter-Amercian Convention on the Prevention, Punishment and Eradication of Violence Against Women, art. 4, *adopted* June 9, 1994, 33 I.L.M. 1534, *available at* http://www.oas.org/juridico/english/treaties/a-61.html ; *see also* International Covenant on Civil and Political Rights, art. 9, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess. Supp. No. 16 (Vol. 52), U.N. Doc. A/6316 (Mar. 23, 1976); Universal Declaration of Human Rights, art. 3, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948); Organization of American States, American Convention on Human Rights, art. 7, Nov. 22, 1969, 1144 U.N.T.S. 123 [hereinafter American Convention], *available at* www.oas.org/juridico/English/treaties/b-32.html.

33. This right has been recognized in Article 17 of the ICCPR, G.A. Res. 2200A (XXI), *supra*

personal liberty and privacy are also violated when a state impedes women's access to fertility control methods.

States must also ensure that women are aware of technological and scientific advancements in contraception in order to make informed decisions regarding control of their own bodies. Therefore, decisions made by the governments of Chile, Ecuador, Peru, and Honduras to prohibit the promotion, use, sale, purchase, or creation of policies or programs related to EC—as well as paid or free distribution or marketing of emergency contraceptive drugs—are discriminatory. They exclude women from the protection the state is obliged to ensure to them as well as from unwanted pregnancies, subjecting them to unsafe services that further threaten their health and lives. These restrictions also further increase violations against women with limited financial resources and against teenage women, especially those who have overcome sexual violence.

In terms of sexual and reproductive health, the liberties involved in the right to health include the right of individuals to control and make decisions regarding sexuality and reproduction, without any kind of interference or coercion. In addition, the right to health includes the prerogative of an adequate health-care system which, in terms of sexual and reproductive health, ensures all the services, goods, and conditions that are necessary for enjoying the highest attainable standard of health. According to the U.N. Committee on Economic, Social and Cultural Rights (CESCR), states have the obligation to ensure the availability,[34] accessibility,[35] acceptability, and quality[36] of a variety of sexual and reproductive health services, including access to pre- and post-natal care; emergency obstetric services; safe and legal abortion; family-planning services; and access to information and education.

Despite the above, Latin American women are subjected to discrimination, which only increases danger and violations of the human rights of women. Paradoxically, even though it has been argued that

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note 32, art. 17; Article 12 of the Universal Declaration, G.A. Res. 217 (III), *supra* note 32, art. 12; and Article 11 of the American Convention on Human Rights, American Convention, *supra* note 32, art. 11.

34. *Availability* implies that each member state must have a sufficient number of public health-care establishments, goods, and services. CESCR, *supra* note 23, ¶ 12.

35. *Accessibility* means that establishments, goods, and services must be obtainable in fact and in law to marginalized groups within the population, without discrimination and taking into account the geographical and economic scope of each sector of the population. *Id.*

36. As far as *acceptability* and *quality*, the Committee established that the aforementioned must be "respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, [and] sensitive to gender and life-cycle requirements . . . ." *Id.* Similarly, "skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation" are needed. *Id.*

women live longer than men, local statistics have shown that in the region there is a high incidence of women dying from preventable, maternity-related diseases.[37] Why? As has been explained by Professor Lidia Casas,[38] it is partially due to a series of stereotype-based notions about women, where gender roles and cultural and social attributes have a direct impact on reproductive health and capacity.[39] Similarly, maternity involves costs that are paid solely by women. For example, health insurance can be more expensive for women, potential employment is more unstable and discriminatory, and inequality in salaries is often based on maternity-related criteria.[40] An example of this generalized sexual discrimination based on a person's reproductive situation is latent in the working class, particularly for female factory workers, who are forced to reveal as a condition for employment, either through questions in their job applications, at interviews, or in medical exams, whether or not they are pregnant.[41]

According to CEDAW, "discrimination against women" includes laws that have the "purpose of" or "result in" preventing women from exercising any of their human rights or fundamental liberties on the basis of equality with men. Nevertheless, the restrictions on sexual and reproductive rights often found in Latin America are a clear example in which the very spirit of the law is discriminatory. Examples include the prohibition of access to abortion, even when the life and health of the woman is at risk, which was the case in Nicaragua; the prohibition of

37. Mirta Roses, *Desigualdades Ocultas*, *in* LA AGENDA ÉTICA PENDIENTE DE AMÉRICA LATINA 149, 150 (Bernanrdo Kliksberg ed., 2005). Haiti, for example, has the most alarming maternal mortality rates in the region, with 520 maternal deaths for every 100,000 births. See *UN Agency Calls for Steps to Improve Healthcare in Latin America and Caribbean,* UN NEWS SERVICE (Aug. 22, 2005), http://www.un.org/apps/news/printnewsAr.asp?nid=15511. In Guatemala, in fact while indigenous women have a maternal mortality rate of 211, non-indigenous women have a maternal mortality rate of 70, which exhibits the double discrimination that indigenous women, who represent twenty-one to twenty-nine percent of the Guatemalan population, have to face. *See* CTR. FOR ECON. & SOC. RIGHTS, *supra* note 21, at 211.

38. Lidia Casas is a professor at the Law School of the Diego Portales University in Chile. Since 1994, she has worked as an assistant and then as a consultant in different studies related to justice-system reforms. Professor Casas has published diverse studies on legislation and jurisprudence on sexual and reproductive rights. In 2001, Professor Casas was awarded with the Medal of Honor for Outstanding Individual Contribution to the Family Planning of the International Planned Parenthood Federation, Western Hemisphere Region.

39. Lidia Casas, *Derecho a la Vida y Derecho a la Salud*, *in* LA MIRADA DE LOS JUECES: GÉNERO EN LA JURISPRUDENCIA LATINOAMERICANA 367, 368–69 (Cristina Motta & Macarena Sáez eds., 2008).

40. *Id.*; *see also* Joan Williams, *Igualdad sin Discriminación*, *in* GÉNERO Y DERECHO (Alda Facio & Lorena Fries eds., 1999).

41. *See* HUMAN RIGHTS WATCH, FROM THE HOUSEHOLD TO THE FACTORY: SEX DISCRIMINATION IN THE GUATEMALA LABOR FORCE 88 (2002); RUDOLF VAN DER HAAR, ORGANIZACION PANAMERICANA DE LA SALUD, LA SITUACION ACTUAL DE SALUD DE LOS TRABAJADORES EN LOS PAISES DE CENTROAMERICA Y PANAMA (1989).

free access to oral emergency contraception (contradicting scientific evidence provided by the World Health Organization and the Pan American Health Organization), which occurred in Chile and Peru; and imposing restrictions on assisted reproduction, as was the case in Costa Rica.

Article 12 of CEDAW specifically prohibits any form of discrimination against women in the field of health care.[42] In addition, the CEDAW committee, which oversees compliance with the convention, confirmed that denying certain female-specific health services to women constitutes discrimination.[43] In General Recommendation No. 24, the CESCR Committee established the prohibition on gender-based discrimination in accessing health-care services and highlighted the need to incorporate a gender-based perspective in national health-care strategies and plans.[44]

V. Civil Society Advocacy for Sexual and Reproductive Rights

PPFA's international program responds to women's critical health and rights needs through innovative projects involving technical training and financial assistance to partners in Latin America and the Caribbean, in order to provide sexual and reproductive health services and ensure sexual and reproductive rights. The courage, commitment, and creativity of our partners in the region helps to promote and protect sexual and reproductive rights, increase access to sexual and reproductive health services, and advance PPFA's overarching goal to create the healthiest generation ever. For example, PPFA's Youth Peer Provider Model[45] is empowering young people and women, particularly in rural areas, to take control of their sexuality and reproduction. During the implementation of the model in Nicaragua, Guatemala, Peru, and Ecuador, young people were trained to provide contraceptive services and comprehensive education in sexual and reproductive health to members of the community. Ten years of evaluation of the model revealed an increase in the use of contraception, empowering young people to make informed decisions and strengthening bonds with friends and family members in the communities in which the model was implemented. For its part, Ceiba, an organization that functions in Retalhuleu on the southern Pacific

42. CEDAW, *supra* note 23, art. 12, ¶ 1.

43. United Nations, Comm. on the Elimination of Discrimination Against Women, General Recommendation No. 24, Article 12: Women and Health, ¶ 11 (Feb. 5, 1999), http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm.

44. *Id.* ¶ 20.

45. Claire Tebbets et al., *Teens as Health Care Providers: Experiences of Sexual and Reproductive Health Programs in Ecuador, Guatemala, and Peru*, 34 J. Ambulatory Care Mgmt. (forthcoming 2011).

coast of Guatemala, joined forces with PPFA to offer sexual and reproductive health services to internally displaced women and men from the armed conflict in Guatemala. Thanks to this project and its high level of organization, the community has managed to establish a community clinic, medicinal plant garden, and the formation of a health-care team consisting of a dozen community promoters and over fourteen midwives and nurse–midwives, reaching a population of over 11,000 people. In the words of one midwife, "My job is to assist women who are about to give birth, and to teach others by showing them how to care for women who are about to give birth. Promoters and other midwives receive training to evaluate whether or not they are learning. Communities are happier now . . . since government services don't reach the communities."[46]

The Women in Solidarity Association (*Asociación de Mujeres en Solidaridad*, or AMES) is an organization that provides sexual and reproductive health services to female factory workers and people with limited financial resources through community clinics in Guatemala City, Chimaltenango, and the department of San Marcos. AMES also offers training for the defense and promotion of labor rights, urging the participation and protection of female factory workers. These trainings are complemented with the opportunity to pursue studies in nursing, which has allowed many female factory workers to grow professionally and move into the medical field. Meanwhile, Promsex[47] is working on different strategies to ensure access to therapeutic abortion, which has been legal in Peru since 1924. Its strategies include working with members of the Peruvian medical community to establish protocols for legal abortion care, which ensure safe practices for women whose pregnancies must be terminated due to medical reasons, thus protecting their life and health. In collaboration with the Center for Reproductive Rights,[48] Promsex submitted a petition before the CEDAW Committee reporting the lack of measures to ensure access to legal abortion services.[49]

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46. Testimony gathers by Carolina Delgado, PPFA Program Officer for the Latin America Regional Office, during her visit to Guatemala in 2010.

47. Promsex, or *Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos*, is an organization in Peru whose mission is to eliminate all forms of discrimination that hinder human development and the full enjoyment of sexual and reproductive rights. *Acerca de Promsex*, PROMSEX, http://www.promsex.org/acerca-de-promsex/mision-vision (last visited Apr. 11, 2011).

48. "For more than 15 years, the Center for Reproductive Rights has used the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill." *About Us*, CENTER FOR REPROD. RIGHTS, http://reproductiverights.org/en/about-us (last visited Apr. 11, 2011).

49. *L.C. v. Peru (UN Committee on the Elimination of Discrimination Against Women)*, CENTER FOR REPROD. RIGHTS (July 8, 2009, 4:57 PM), http://reproductiverights.org/en/case/lc-v-peru-un-committee-on-the-elimination-of-discrimination-against-women. In a moment of desperation, L.C., a 13-year-old Peruvian girl who was impregnated after repeatedly being raped by a 34-year-old man who lived in her neighborhood, tried to commit suicide by jumping off the

Finally, using international human rights protection mechanisms, the partners are working to develop shadow reports for the CEDAW Committee, the Committee on Human Rights, and the U.N. Committee on the Rights of the Child to highlight the dramatic situation experienced by women in the region in the exercise of their sexual and reproductive rights. Meanwhile, PPFA is generating forums where civil-society groups have the opportunity to discuss issues relating to health, particularly sexual and reproductive health, such as the consultation with the civil society by the Special Rapporteur of the United Nations on the Right of Everyone to Enjoy the Highest Attainable Standard of Physical and Mental Health, Mr. Anand Grover. This consultation was held in March 2010 in Guatemala with the participation of nearly forty people from organizations in Mexico, the Dominican Republic, and Central America. We are also working to build awareness and training members of the legal community in the region on the issue of discrimination and jurisprudence related to reproductive health for the purpose of promoting a debate and exchange within the legal community in the region, from a comparative law point of view and gender and international perspective. An example of this effort was the First Latin American Legal Congress on Reproductive Rights, held in November 2009 in Arequipa, Peru. This Congress brought 450 leaders from the region and forty-three legal experts together for the first time[50] to discuss emerging issues in the region pertaining to the reproductive rights of women.[51]

VI. CONCLUSION

It is not enough to simply approve laws that allow access to different sexual and reproductive health services. It is also necessary for states to establish and comply with regulations that guarantee that women can access these services without incurring risks. This means ensuring that both legal and health professionals are duly sensitized and trained to provide and guarantee these services, including safe and legal abortion.

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roof of a building next to her house. L.C. was taken to a hospital where, after examining her and concluding that her spine needed to be straightened immediately, doctors refused to provide emergency service to her because she was pregnant, despite the fact that abortion is legal in Peru in cases in which the woman's life is in danger. Several weeks later, L.C. had a miscarriage, and nearly three and a half months after she was told that she needed surgery, L.C. had spinal cord surgery. However, surgery had little or no effect and L.C. was paralyzed. *Id.*

50. Attendants included members of the European Court on Human Rights, the Pan American Health Organization, the World Health Organization, former justices of the Supreme Court of Colombia, and legal scholars from universities in Canada, the United States, and the region, among others.

51. *Post Congreso*, PRIMER CONGRESO LATINOAMERICANO JURÍDICO SOBRE DERECHOS REPRODUCTIVOS, http://congresoderechosreproductivos2009.com/index.php?option=com_content&view=article&id=118&Itemid=128 (last visited Mar. 27, 2009).

People should not have to suffer unjust disadvantages in the enjoyment of their right to the highest attainable level of health on the basis of gender, age, religion, disability, financial status, or any other characteristic. The right to live free from discrimination is crucial for the protection of women's health, particularly the health of women suffering marginalization. As stated by Professor Joan Williams,[52] a distinguished Professor of Law who has received the Margaret Brent Award for Women Lawyers of Achievement, "the only thing that women need is what men have: equal opportunity in a world built against them. Equality without discrimination only requires that masculine norms are replaced by new ones that reflect the bodies and life experiences of women as well as men. That is the promise of equality without discrimination."[53]

52. *See Joan C. Williams, Distinguished Professor of Law, 1066 Foundation Chair, Director of the Center for WorkLife Law, University of California, Hastings College of the Law*, U. CAL. HASTINGS C. L., http://www.uchastings.edu/faculty-administration/faculty/williams/ (last visited Apr. 11, 2011).

53. Williams, *supra* note 40, page 283.