

**IN THE EUROPEAN COURT OF HUMAN RIGHTS**

**(APPLICATION NO. 46132/08)**

**Z. APPLICANT**

**AGAINST**

**POLAND RESPONDENT**

**WRITTEN COMMENTS BY**

**INTERNATIONAL REPRODUCTIVE AND SEXUAL HEALTH LAW PROGRAMME**

**FACULTY OF LAW, UNIVERSITY OF TORONTO**

**28 OCTOBER 2009**

**Joanna N. Erdman**

Adjunct Professor  
Faculty of Law, University of Toronto  
joanna.erdman@utoronto.ca

**Rebecca J. Cook**

Professor and Faculty Chair in International  
Human Rights  
Faculty of Law, University of Toronto  
rebecca.cook@utoronto.ca

**Bernard M. Dickens**

Professor Emeritus of Health Law and Policy  
Faculty of Law, University of Toronto  
bernard.dickens@utoronto.ca

**International Reproductive and Sexual Health Law Programme**

Faculty of Law, University of Toronto  
84 Queen's Park Crescent  
Toronto, Ontario Canada M5S 2C5  
Tel: 416-978-1751, Fax: 416-978-7899  
<http://www.law.utoronto.ca/programs/reprohealth.html>

## Table of Contents

	Paragraphs
I. <b>Introduction</b>	1 - 4
II. <b>Interest of the International Reproductive and Sexual Health Law Programme</b>	5
III. <b>The Legal Issues</b>	6 - 7
IV. <b>The Rights of Pregnant Women to Access Comprehensive Health Care</b>	8 - 18
A. Access to Comprehensive Health Care and the Interpretation of Articles 2, 8 and 14	11 - 15
B. Access to Comprehensive Health Care and the Interpretation of Articles 3 and 14	16 - 18
V. <b>The Management of Maternal and Fetal Health Interests</b>	19 - 27
A. Maternal and Fetal Health Interests and the Interpretation of Articles 8 and 14	22 - 25
B. Maternal and Fetal Health Interests and Criminal Abortion Laws	26 - 27
VI. <b>Rights and Obligations of Conscience Objection</b>	28 - 38
A. Conscientious Objection and Access to Care	31 - 35
B. Conscientious Objection and Informed Decision-Making	36 - 38
VII. <b>Conclusion: Maternal Mortality and Positive State Obligations</b>	39 - 43
A. Positive State Obligations: Investigations of Causes of Maternal Death	40 - 41
B. Positive State Obligations: Policies and Guidelines on the Care of Pregnant Women and Conflicts of Interest	42 - 43

## I. Introduction

1. The International Reproductive and Sexual Health Law Programme, Faculty of Law, University of Toronto (“the Programme”) submits these written comments as a third-party intervener in *Z. v. Poland* (46132/08) pursuant to leave granted by the European Court of Human Rights (the “Court”) in accordance with Rule 44 § 2 of the *Rules of Court*.
2. These comments address standards in international human rights law respecting the rights of pregnant women to access health care without discrimination. These standards are derived from international human rights jurisprudence relevant to Poland and Europe generally, with attention to the following authoritative interpretive guidance.

- *CEDAW General Recommendation No. 24: Women and Health (Article 12)*<sup>1</sup>

Article 12 of the *Convention on the Elimination of All Forms of Discrimination against Women* (the “CEDAW”) requires States parties to “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.”<sup>2</sup>

- *CESCR General Comment No. 14: The Right to Health (Article 12)*<sup>3</sup>
- *CESCR General Comment No. 16: The equal right of men and women (Article 3)*<sup>4</sup>
- *CESCR General Comment No. 20: Non-discrimination (Article 2.2)*<sup>5</sup>

Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (the “CESCR”) requires that States parties “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”<sup>6</sup> Pursuant to Articles 2.2 and 3, States parties undertake to guarantee that the right to health will be exercised without discrimination of any kind, and in particular, on the basis of sex.<sup>7</sup>

3. These comments further address the reflection and application of international human rights law standards in the law and policy of member states of the Council of Europe.
4. We respectfully request that the Court take notice of these standards in its interpretation of Articles 2, 3, 8 and 14 of the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (the “Convention”)<sup>8</sup> in *Z v. Poland* (46132/08).<sup>9</sup>

## II. Interest of the International Reproductive and Sexual Health Law Programme

5. The *Programme* is an academic programme dedicated to improving the legal protection and promotion of reproductive and sexual health. The *Programme* has particular expertise in the application of human rights in the regulation of reproductive health care. It has collaborated with government and international agencies, non-governmental organizations, and academic institutions to develop policies and scholarship on this subject. The *Programme* has acted as a third-party intervener in constitutional and human rights cases respecting the regulation of reproductive health care before domestic, regional and international tribunals.

### III. The Legal Issues

6. *Z. v. Poland* (46132/08) raises issues respecting the interpretation of Articles 2, 3, 8 and 14 of the *Convention* regarding the rights of pregnant women to access health care without discrimination. These comments address standards in international human rights law and their application in the laws and policies of member states of the Council of Europe, respecting:
  - The rights of pregnant women to access comprehensive health care (Section IV);
  - The management of maternal and fetal health interests (Section V);
  - Rights and obligations of conscientious objection (Section VI).
7. The interpretation of Articles 2, 3, 8 and 14 of the *Convention*, as informed by these standards, support positive state obligations to ensure the rights of pregnant women to access comprehensive maternal care (Section VII).

### IV. The Rights of Pregnant Women to Access Comprehensive Health Care

8. Maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy for any cause related to or aggravated by the pregnancy or its management.<sup>10</sup> Maternal death may result from conditions directly related or unique to pregnancy (direct maternal deaths) and conditions that occur in the general population that may pre-exist or develop during pregnancy and may require different management during pregnancy (indirect maternal deaths).<sup>11</sup>
9. *CEDAW Recommendation No. 24* identifies maternal death as an “important indication for States parties of possible breaches of their duties to ensure women’s access to health care.”<sup>12</sup> Maternal death in Europe is also treated as an indicator of health system performance.<sup>13</sup> “While the maternal mortality ratios ... in European countries are low compared with those in developing countries, many are preventable deaths, and thus provide a key indicator of the quality of health services.”<sup>14</sup> The majority of maternal deaths result from substandard care,<sup>15</sup> such as failure to diagnose and delayed treatment.
10. International human rights law moreover addresses comprehensive maternal care, that is, care for health needs both directly and indirectly related to pregnancy. The right to health, as interpreted in *CESCR General Comment No. 14*, encompasses “the right of access to appropriate health-care services that will ... enable women to go safely through pregnancy and childbirth.”<sup>16</sup> *CEDAW General Recommendation No. 24* calls on States parties to report on “measures ... taken to ensure women appropriate services in connection with pregnancy.”<sup>17</sup>

#### A. Access to Comprehensive Health Care and the Interpretation of Articles 2, 8 and 14

11. Denied access to health care contributing to death or harm to health implicates the human rights to life, health and non-discrimination. The right to life, protected under Article 6 of the *International Covenant on Civil and Political Rights* (the “ICCPR”) requires States parties to adopt positive measures to protect life, such as measures to ensure access to health care to reduce maternal death.<sup>18</sup> The interpretation of Article 2(1) of the *Convention* reflects this standard. States are required to take steps to safeguard the lives of pregnant women, including from wrongful maternal death.<sup>19</sup> Access to reproductive health care, including comprehensive maternal care, is an essential component of women’s right to health.<sup>20</sup> Although the *Convention* does not guarantee a right to

health per se, the right to respect for private life under Article 8(1) encompasses physical and psychological integrity, which states are under a positive obligation to secure.<sup>21</sup>

12. Denied access to comprehensive maternal care further implicates the human rights prohibition against discrimination on the ground of sex. International human rights law recognizes as sex discrimination any distinction, exclusion or restriction on the basis of pregnancy status which impairs women's enjoyment or exercise of their rights.<sup>22</sup> The definition of maternal death isolates pregnancy as a contributing cause of death (*see* paragraph 8). If the woman had not been pregnant, she would not have died at that time. Denied access to health care contributing to maternal death, for this reason, raises concerns of sex discrimination. These international standards on sex discrimination inform the interpretation of Article 14 of the *Convention*.<sup>23</sup>
13. Sex discrimination, as defined in *CESCR General Comment No. 16* and *CESCR General Comment No. 20*, derives from the different treatment of women because of physiological characteristics, such as pregnancy, and the social construction of gender.<sup>24</sup> "Gender refers to cultural expectations and assumptions about the behaviour ... [and] capacities of men and women, based solely on their identity as men or women."<sup>25</sup> Discrimination against women may be pervasive and persistent because it is premised on deeply entrenched and often unchallenged cultural role expectations of women.<sup>26</sup> The *CEDAW*, for this reason, requires States parties to eliminate all practices "which are based ... on stereotyped roles for men and women."<sup>27</sup>
14. In maternal care, women are too often reduced to their physical state of pregnancy, a practice informed by stereotyped roles for women, and in particular pregnant women, as mothers. This stereotype prescribes motherhood as women's primary role, and as a result confines the medical needs of pregnant women to their gestating function in pregnancy. Access to care rests on an implicit assumption that women will and should act only in service of their pregnancy even to the detriment of their lives and health.<sup>28</sup> Such practices violate the prohibition against sex discrimination as interpreted in *CEDAW General Recommendation No. 24*, which requires that pregnant women be treated as individuals with needs and interests, and that maternal care be delivered from this perspective.<sup>29</sup>
15. Stereotyped prescription is evident in health service organization. Health systems have historically isolated reproductive health services from other health services, and by consequence, reproductive health needs from other health needs. Specialized programs for pregnant women in drug treatment, for example, may focus disproportionately on pregnancy and neglect other needs.<sup>30</sup> Segregated organization may also weaken multi-disciplinary collaboration. Collaboration among obstetricians and other specialists is recognized as the standard of care.<sup>31</sup> Provider failure to identify and manage common medical conditions outside their immediate area of expertise are often attributable to lack of multidisciplinary care, including poor and non-existent team work and failure to share information.<sup>32</sup> Caring for pregnant women with medical conditions that pre-exist or develop during pregnancy is challenging.<sup>33</sup> Multi-disciplinary care can improve diagnosis and the differentiation of medical illness from the common physiological changes of healthy pregnancy.

#### B. Access to Comprehensive Health Care and the Interpretation of Articles 3 and 14

16. Denied access to comprehensive maternal care based on stereotypes implicates the human rights prohibition against cruel, inhuman and degrading treatment. Article 3 of the *Convention* prohibits inhuman or degrading treatment. The Human Rights Committee recently held that denied access to health care in pregnancy constituted cruel, inhuman and degrading treatment in violation of Article

7 of the *ICCPR*.<sup>34</sup> The violation resulted from the knowing or wilful causing of harm. Health care was withheld contrary to medical indication and despite the known risk to maternal health and life.

17. Disregard for the welfare of pregnant women apart from their gestating function degrades women, arousing feelings of inferiority, humiliation and debasement. Expressed needs and interests indirectly related to pregnancy are assessed against gender stereotyped roles. Women are humiliated, judged as selfish, uncaring and acting against the best interests of their future child in seeking comprehensive care. *CEDAW General Recommendation No. 24* recognizes that women's access to health care depends on the manner in which they are treated in the clinical context. To ensure access to health care, services must be acceptable to women, respectful of a woman's dignity and sensitive to her needs and perspectives.<sup>35</sup>
18. *CESCR General Comment No. 16* recognizes that "[w]omen are often denied equal enjoyment of their human rights, in particular by virtue of the lesser status ascribed to them."<sup>36</sup> States parties are obligated to take steps to eliminate all practices that perpetuate the notion of women's inferiority.<sup>37</sup> Where the health and lives of pregnant women are treated as at best secondary interests, the inferior if not instrumental status of women is confirmed. Women are treated as means to an end, the delivery of a child. Many women desire this end, but have equal interests in the means necessary to achieve it. The physiological condition of pregnancy cannot justify women's degradation or inferior status. Once pregnant, women are not disentitled of their rights to be treated as equal in dignity and human worth.

## **V. The Management of Maternal and Fetal Health Interests**

19. Excessive concern for fetal health can contribute to substandard care in maternal health. "The most frequent cause of asthma exacerbations and uncontrolled seizures during pregnancy is discontinuation of required medications because of concerns about fetal effects."<sup>38</sup> Failure to diagnose is often attributed to the mistaken belief that diagnostic interventions are contraindicated in pregnancy.<sup>39</sup>
20. Recognition that fetal health is dependent on maternal health lessens perceived conflict between these interests. *CESCR General Comment No. 14* interprets measures to ensure the right to maternal and child health as consistent rather than conflicting.<sup>40</sup> Aggressive treatment for acute conditions indicated in non-pregnant persons is clinically advised as the most effective treatment from the perspectives of both maternal and fetal health.<sup>41</sup> With less acute conditions, modification of diagnostic and treatment methods according to gestational age of the fetus can achieve satisfactory maternal and fetal health outcomes.
21. Maternal and fetal health interests can but do not necessarily coincide. Care indicated for maternal health can pose risks to fetal health or cause fetal death, such that a conflict of interest may arise. Failure to ensure that pregnant women can seek and receive health care because of concern for or risk to fetal health implicates Article 8 and 14 of the *Convention*.

### **A. Maternal and Fetal Health Interests and the Interpretation of Articles 8 and 14**

22. The right to health, as interpreted in *CESCR General Comment No. 14*, includes the right to control one's health and body, and the right to be free from interference, such as non-consensual care.<sup>42</sup> The right to respect for private life under Article 8(1) of the *Convention* includes a similar right to personal autonomy.<sup>43</sup> These rights are implicated where maternal care is dictated by a primary duty

to preserve fetal interests. Protection of fetal health cannot be achieved without direct effect on the physical integrity of the pregnant woman.<sup>44</sup> She is the person primarily concerned by pregnancy and its management. Article 14 of the *Convention* is implicated by any restriction on the right to personal autonomy based on pregnancy status (*see* paragraph 12).

23. Fetal health nevertheless remains relevant to maternal care. It is a legitimate interest in the patient-provider relationship and from the perspective of law and policy. Protection of fetal health is often a shared interest between health providers and pregnant women. To identify the benefits and risks for maternal and fetal health of proposed care can support women in the exercise of their right to personal autonomy, as both interests may be material to an informed decision on maternal care.<sup>45</sup> The right to non-discrimination, as interpreted in *CEDAW General Recommendation No. 24*, entitles women to be fully informed of the likely benefits and potential adverse effects of proposed care, which may include fetal health effects.<sup>46</sup>
24. Protection of fetal health is a legitimate interest in law and policy. There is considerable variance in international human rights law, and among constitutions of the member states of the Council of Europe, on the temporal limitations of the right to life. There is broad agreement that if applicable to the protection of prenatal interests, the right to life is limited and not absolute.<sup>47</sup> This standard is reflected in the interpretation of the right to life under Article 2(1) of the *Convention*.<sup>48</sup> The protection of prenatal interests may also constitute a legitimate state interest, i.e. protection of public morals, sufficient to justify limitation of a *Convention* right.<sup>49</sup> Fetal health interests may thus be relevant to an interpretation of Article 8(2) and limitations on the right of pregnant women to personal autonomy in decision-making about maternal care.
25. Standards in international human rights law resolve the conflict between maternal and fetal health interests through the principle of proportionality. The rights of pregnant women in protection of life and physical integrity (health), and personal autonomy are recognized to prevail over fetal interests. National courts in Europe reflect this standard by respecting the right of women to refuse medical interventions, such as caesarean sections, with potential adverse fetal health effects.<sup>50</sup> International consensus guidelines, such as those issued by the *International Federation of Gynecology and Obstetrics (“FIGO”)*, provide that “no woman should be forced to undergo an unwished-for medical or surgical procedure in order to preserve the life or health of her fetus, as this would be a violation of her autonomy and fundamental human rights.”<sup>51</sup> This standard is consistent with the interpretation of *Convention* rights involving the protection of prenatal interests.<sup>52</sup>

#### B. Maternal and Fetal Health Interests and Criminal Abortion Laws

26. The proportionality principle in the management of conflicts of interest in maternal and fetal health is best reflected in criminal abortion laws and their treatment under international human rights law. The human rights to life and health require that States parties amend criminal laws to permit legal termination of pregnancy in cases of risk to life and health.<sup>53</sup> Criminal laws in the vast majority of member states in the Council of Europe reflect this standard, allowing women to request pregnancy termination in cases of risk to maternal life or health.<sup>54</sup>
27. It is recognized, however, that articulation in criminal law of the proportionality principle creates a “chilling effect.” Health providers may not be confident to act in the absence of adequate guidance on the management of conflicts of interest between maternal health and protection of fetal interests. Fearful of criminal liability, health providers may delay or deny care that may affect continuation

of pregnancy. Health providers and legal actors often mistakenly interpret criminal laws as requiring evidence of an immediate life endangering emergency for permissible action.<sup>55</sup> The positive obligations of states under Article 8(1) are implicated by the chilling effect of criminal abortion laws on women's access to therapeutic care, and the need to ensure clarity of a pregnant woman's legal position with respect to proposed care.<sup>56</sup>

## **VI. Rights and Obligations of Conscience Objection**

28. Concern for fetal health interests can intersect with moral obligations. When indicated maternal care conflicts with fetal health interests, health providers may consider themselves obligated to refuse care on grounds of conscience.<sup>57</sup>
29. International human rights law recognizes the right of conscientious objection pursuant to freedom of conscience and religion and to its manifestation in practice.<sup>58</sup> Health providers are entitled to refuse to participate in health care contrary to their conscience. This right, however, is subject to limitations. Based on the proportionality principle, the right to conscientious objection is subject to limitations where necessary to protect health and the rights of others.<sup>59</sup> This standard is reflected in the interpretation of Article 9 of the *Convention*.<sup>60</sup>
30. International human rights law not only permits but requires States parties to regulate conscientious objection in the health sector to ensure that its exercise does not function as a barrier to care, interfering with the rights of women to access care and to free and informed decision-making.<sup>61</sup> Effective regulation includes not only the enactment of laws and policies, but their enforcement.<sup>62</sup>

### **A. Conscientious Objection and Access to Care**

31. Denied access to comprehensive maternal care for reason of conscientious objection or otherwise implicates Articles 2, 8 and 14 of the *Convention* (see paragraphs 11-12).
32. The right to conscientious objection is limited with respect to emergency maternal care. The right to non-discrimination, as interpreted in *CEDAW General Recommendation No. 24*, imposes an obligation on "States parties to ensure women's right to safe motherhood and emergency obstetric services."<sup>63</sup> This obligation may require enactment of laws or policies restricting the exercise of conscientious objection in life- or health- endangering emergencies. International consensus guidelines reflect this standard. Guidelines issued by *FIGO* require that "[i]n emergency situations, to preserve life or physical or mental health, practitioners must provide the medically indicated care of their patients' choice regardless of the practitioners' personal objections."<sup>64</sup>
33. Among member states of the Council of Europe, including Austria, Croatia, Germany, and Italy, health providers are restricted by law from refusing emergency care, which often expressly includes termination of pregnancy services, on grounds of conscience.<sup>65</sup>
34. To ensure continuity in access to health care, international human rights law requires States parties to ensure that health providers exercising conscientious objection legally provide good faith referrals to health providers or institutions that do not object to providing care. The right to non-discrimination, as interpreted in *CEDAW General Recommendation No. 24*, requires States parties to ensure that comprehensive maternal health services are available in the health system. "If health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."<sup>66</sup>



International consensus guidelines reflect this standard. Guidelines issued by *FIGO* provide that “[p]atients are entitled to be referred in good faith, for procedures medically indicated for their care that their practitioners object to undertaking, to practitioners who do not object.”<sup>67</sup>

35. Among member states of the Council of Europe, including Croatia, France, Moldova, and Portugal, good faith referral to a non-objecting provider is required by law.<sup>68</sup>

### B. Conscientious Objection and Informed Decision-Making

36. Access to information is essential to informed decision-making, an aspect of the human right to health<sup>69</sup> and of the equal right of women to personal autonomy under Articles 8 and 14 of the *Convention* (see paragraph 22). Patients are entitled to receive information material to their health care decision-making. The right of non-discrimination, as interpreted in *CEDAW General Recommendation No. 24*, includes the right of women to be fully informed, by properly trained personnel, of their health care options and available alternatives.<sup>70</sup>

37. The right of conscientious objection thus cannot be exercised in a manner that impairs the right of women to seek and receive information about their health status and available health care options. As interpreted in *CESCR General Comment No. 14*, this prohibition against impairment of information extends to “the deliberate withholding or misrepresentation of information vital to health protection or treatment.”<sup>71</sup> Health providers cannot give information instrumentally to ensure that health care options accord with the dictates of their conscience.<sup>72</sup> International consensus guidelines reflect this standard. Guidelines issued by *FIGO* require that practitioners “giv[e] [patients] information about the medically indicated options of procedures for their care and of any such procedures in which their practitioners object to participate on grounds of conscience ... Practitioners have a professional duty to abide by scientifically and professionally determined definitions of reproductive health services, and to exercise care and integrity not to misrepresent or mischaracterise them on the basis of personal beliefs.”<sup>73</sup>

38. Among member states of the Council of Europe, including Belgium and Norway, health providers are required by law to disclose material health information on health care options.<sup>74</sup> A High Court of Justice in England held a health provider negligent for refusing to inform a pregnant woman of prenatal diagnostic options for reason of conscientious objection.<sup>75</sup>

## **VII. Conclusion: Maternal Mortality and Positive State Obligations**

39. The interpretation of Articles 2, 3, 8 and 14 of the *Convention*, as informed by standards in international human rights law, support positive state obligations to ensure women’s access to comprehensive maternal care.<sup>76</sup> These obligations may include the following measures to ensure timely access to health care:

- investigations of causes of maternal death; and
- policies or guidelines on the care of pregnant women and conflicts of interest.

### A. Positive State Obligations: Investigations of Causes of Maternal Death

40. Confidentiality inquiries into maternal deaths are conducted in many European countries, including France, the Netherlands and the United Kingdom.<sup>77</sup> These investigations are powerful measures to

understand the health system and how it serves the health needs and interests of pregnant women, to identify dysfunctions in comprehensive maternal care and to provide an evidence-base for recommendations to improve care and prevent maternal deaths.

41. Monitoring is an integral feature of accountability under international human rights law. *CEDAW General Recommendation No. 24* advises States parties to monitor the provision of health services to women to ensure equal access and quality of care.<sup>78</sup> The Northern Ireland Court of Appeal recently affirmed state obligations to investigate whether women are receiving satisfactory health services relating to legal terminations of pregnancy.<sup>79</sup> The Court found widespread uncertainty among health providers on the criteria for legal termination. Although based on statutory obligations, it was suggested that Article 8 of the *Convention* provided for similar duties to investigate as part of broader positive state obligations to secure the provision of integrated health and personal social services to pregnant women.<sup>80</sup>

#### B. Positive State Obligations: Policies and Guidelines on the Care of Pregnant Women and Conflicts of Interest

42. International human rights law requires States parties to adopt legislative and other measures, including sanctions where appropriate, to safeguard against violation of women's rights in access to health care, including discrimination by health providers.<sup>81</sup>

43. As interpreted in *CESCR General Comment No. 14* and *CEDAW General Recommendation No. 24*, this obligation extends to States parties' effective regulation of health care practice and health providers, and supports the enactment of policies and guidelines on the following subjects:

- rights of pregnant women to access comprehensive health care, including training on the identification, management and timely referral for maternal health conditions unrelated to pregnancy.<sup>82</sup>
- management of maternal and fetal health interests, including guidance that sets out in a positive frame legally permissible care in the event of conflicts between maternal health and protection of fetal interests.
- limitations on the exercise of health providers' rights of conscientious objection with respect to emergency maternal care, good faith referrals and the provision of health information, including an effective enforcement mechanism to hear complaints and impose appropriate sanctions.<sup>83</sup>

## References

- <sup>1</sup> U.N. Comm. on the Elimination of all Forms of Discrimination against Women, *General Recommendation No. 24: Women and Health*, U.N. Doc. A/54/38/Rev.1 (1999) [hereinafter *CEDAW General Recommendation No. 24*].
- <sup>2</sup> *Convention on the Elimination of All Forms of Discrimination against Women*, art. 12, Dec. 18, 1979, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981) [hereinafter *CEDAW*].
- <sup>3</sup> U.N. Comm. on Econ., Soc. and Cultural Rights. *General Comment No. 14. The Right to the Highest Attainable Standard of Health (art. 12)*, U.N. Doc. E/C.12/2000/4 (11 August 2000) [hereinafter *CESCR General Comment No. 14*].
- <sup>4</sup> U.N. Comm. on Econ., Soc. and Cultural Rights. *General Comment No. 16. The equal right of men and women to the enjoyment of all economic, social and cultural rights (art. 3)*, U.N. Doc. E/C.12/2005/4 (11 August 2005) [hereinafter *CESCR General Comment No. 16*].
- <sup>5</sup> U.N. Comm. on Econ., Soc. and Cultural Rights. *General Comment No. 20. Non-discrimination in economic, social and cultural rights (art. 2.2)*, U.N. Doc. E/C.12/GC/20 (2 July 2009) [hereinafter *CESCR General Comment No. 20*].
- <sup>6</sup> *International Covenant on Economic, Social and Cultural Rights*, art. 12, Dec. 16, 1966, 993 U.N.T.S. 3, (entered into force Jan. 3, 1976) [hereinafter *CESCR*].
- <sup>7</sup> *Ibid.*, at arts. 2.2, 3.
- <sup>8</sup> *European Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950, 213 U.N.T.S. 222 (entered into force 3 September 1953).
- <sup>9</sup> *Opuz v. Turkey*, App. No. 33401/02 (2009) (European Court H.R.). “[T]he common international or domestic law standards of European States reflect a reality that the Court cannot disregard when it is called upon to clarify the scope of a Convention provision.” *Ibid.* at para 184.
- <sup>10</sup> World Health Organization (WHO). *International Statistical Classification of Diseases and Related Health Problems*. 10th rev., vol. 2. WHO: Geneva, 1992.
- <sup>11</sup> Confidential Enquiry into Maternal and Child Health (CEMACH). *Saving Mothers’ Lives: reviewing maternal deaths to make motherhood safer, 2003-2005*, G. Lewis (ed.), The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. CEMACH: London, 2007, at p. xxiv [hereinafter *UK Confidential Enquiry*].
- <sup>12</sup> *CEDAW General Recommendation No. 24*, *supra* note 1 at para. 17.
- <sup>13</sup> EURO-PERISTAT. *European Perinatal Health Report*. 2008, at p. 95 (available online: <http://www.europeristat.com/bm.doc/european-perinatal-health-report.pdf>) [hereinafter *European Perinatal Health Report*].
- <sup>14</sup> K. Wildman & MH. Bouvier-Colle. “Maternal mortality as an indicator of obstetric care in Europe” (2004) 111 *Br. J. Obstet. Gynecol.* 164-169, at p. 164.
- <sup>15</sup> *Ibid.*, at pp. 164, 168; *European Perinatal Health Report*, *supra* note 13 at p. 10.
- <sup>16</sup> *CESCR General Comment No. 14*, *supra* note 3 at para. 14, fn. 12.
- <sup>17</sup> *CEDAW General Recommendation No. 24*, *supra* note 1 at para. 26.
- <sup>18</sup> *International Covenant on Civil and Political Rights*, art. 6, Dec. 16, 1966, 999 U.N.T.S. 171, (entered into force Mar. 23, 1976) [hereinafter *CCPR*]; U.N. Human Rights Comm. *General Comment No. 6. The right to life (art.6)*, U.N. Doc. A/37/40 (30 April 1982), at para. 5.
- <sup>19</sup> *Tavares v. France*, App. No. 16593/90 (1991) (European Commission H.R.).
- <sup>20</sup> *CESCR General Comment No. 14*, *supra* note 3 at paras. 14 and 21; *CEDAW General Recommendation No. 24*, *supra* note 1 at paras. 1, 23, 29 and 31(b).
- <sup>21</sup> *Tysiac v. Poland*, App. No. 5410/03 (2007) (European Court H.R.) at para. 107.
- <sup>22</sup> *CEDAW*, *supra* note 2 at Art. 1; *CESCR*, *supra* note 6 at Art. 2.2.
- <sup>23</sup> *Opuz v. Turkey*, App. No. 33401/02 (2009) (European Court H.R.). “[W]hen considering the definition and scope of discrimination against women, in addition to the more general meaning of discrimination as determined in its case-law, the Court has to have regard to the provisions of more specialised legal instruments and the decisions of international legal bodies ...” *Ibid.* at para. 185.
- <sup>24</sup> *CESCR General Comment No. 16*, *supra* note 4 at para. 11; *CESCR General Comment No. 20*, *supra* note 5 at para. 20.
- <sup>25</sup> *CESCR General Comment No. 16*, *ibid* at para. 14.
- <sup>26</sup> *CESCR General Comment No. 20*, *supra* note 5 at para. 12.
- <sup>27</sup> *CEDAW*, *supra* note 2 at art. 5(a).
- <sup>28</sup> BM. Dickens & RJ Cook. “Dimensions of informed consent to treatment” (2004) 85 *Int. J. Gynecol. Obstet.* 309-314. “Physicians should not trust to implicit agreements on patients’ treatment goals, but should explicitly inform patients of different goals that care may serve, and obtain consent on their choice.” *Ibid.* at p. 312.
- <sup>29</sup> *CEDAW General Recommendation No. 24*, *supra* note 1 at para. 12.
- <sup>30</sup> See N. Uziel-Miller & J. Lyons. “Specialized substance abuse treatment for women and their children: An analysis of program design” (2000) 19 *J. Sub. Abuse. Treat.* 355-367; EL. Wolfe et al. “Drug treatment utilization before, during and after pregnancy” (2007) 12 *J. Sub. Use* 27-38.

- 
- <sup>31</sup> *UK Confidential Enquiry*, *supra* note 11; E. Keely & K. Rosene-Montella. “An Approach to Medical Disorders in Pregnancy” in *Medical Care of the Pregnant Patient*. 2nd ed. K. Rosene-Montella, E. Keely, LA. Barbour & RV. Lee, (eds.) American College of Physicians: Philadelphia, 2008. “Health care providers must work collaboratively with each other and the patient for the best outcome.” *Ibid.* at p. 7.
- <sup>32</sup> *UK Confidential Enquiry*, *ibid.* at pp. 1-2.
- <sup>33</sup> E. Keely & K. Rosene-Montella, *supra* note 31 at p. 3.
- <sup>34</sup> *CCPR*, *supra* note 18 at art.7; *K.L. v. Peru*, Comm. (2005) CCPR/C/85/D/1153/2003 (Human Rights Committee).
- <sup>35</sup> *CEDAW General Recommendation No. 24*, *supra* note 1 at paras. 12 and 22.
- <sup>36</sup> *CESCR General Comment No. 16*, *supra* note 4 at para. 5.
- <sup>37</sup> *Ibid.* at para. 19.
- <sup>38</sup> E. Keely & K. Rosene-Montella, *supra* note 31 at p. 7.
- <sup>39</sup> *Ibid.* at p. 3.
- <sup>40</sup> *CESCR General Comment No. 14*, *supra* note 3 at para. 14.
- <sup>41</sup> E. Keely & K. Rosene-Montella, *supra* note 31 at p. 3.
- <sup>42</sup> *CESCR General Comment No. 14*, *supra* note 3 at para. 8.
- <sup>43</sup> *Tysiac v. Poland*, App. No. 5410/03 (2007) (European Court H.R.) at para. 107.
- <sup>44</sup> *Ibid.* at para. 106
- <sup>45</sup> *CESCR General Comment No. 14*, *supra* note 3 at para. 37.
- <sup>46</sup> *CEDAW General Recommendation No. 24*, *supra* note 1 at para. 20.
- <sup>47</sup> See e.g. *American Convention on Human Rights*, 22 November 1969, 1144 U.N.T.S. 123 (entered into force 19 July 1978). “Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception.” *Ibid.* at art. 4(1); The Constitution of Ireland guarantees legal protection for the right to life of the unborn, but with due regard to the equal right to life of the mother. *Constitution of Ireland*, at art. 40.3.3.
- <sup>48</sup> *Vo v. France*, App. No. 53924/00 (2004) (European Court H.R.) at para. 80.
- <sup>49</sup> *Open Door Counselling and Dublin Well Woman v. Ireland*, 15 EHRR 244 (1992) (European Court H.R.). “The restriction thus pursued the legitimate aim of the protection of morals of which the protection in Ireland of the right to life of the unborn is one aspect.” *Ibid.* at para. 63.
- <sup>50</sup> See e.g. *Re MB (Medical treatment)* 8 Med LR 217 (1997 CA).
- <sup>51</sup> International Federation of Gynecology and Obstetrics (FIGO). *Ethical issues in obstetrics and gynecology: ethical guidelines regarding interventions for fetal well-being*. London: FIGO, 1998 at para. 6.
- <sup>52</sup> “[I]f the unborn do have a ‘right’ to ‘life’, it is implicitly limited by the mother’s rights and interests.” *Vo v. France*, App. No. 53924/00 (2004) (European Court H.R.) at para. 80; an injunction enacted to protect prenatal interests as public morals could not justify the risk to women’s health it created, *Open Door Counselling and Dublin Well Woman v. Ireland*, 15 EHRR 244 (1992) (European Court H.R.) at para. 77.
- <sup>53</sup> See e.g. *HRC Concluding Observations: Chile*, 18 May 2007, CCPR/C/CHL/CO/5, para 8; *HRC Concluding Observations: Colombia*, 26 May 2004, CCPR/CO/80/COL, at para. 13; *HRC Concluding Observations: Mauritius*, 27 April 2005, CCPR/CO/83/MUS, at para. 9; *CESCR Concluding Observations: Nepal*, 24 September 2001, E/C.12/1/Add.66., at paras. 33 and 55; *CESCR Concluding Observations: Malta*, 4 December 2004, E/C.12/1/Add.101, at para. 41; *CESCR Concluding Observations: Monaco*, 13 June 2006, E/C.12/MCO/CO/1, at para. 23; *CEDAW Concluding Observations: Dominican Republic*, 18 August 2004, A/59/38(SUPP)paras.275-315, at para. 309 .
- <sup>54</sup> United Nations. (2001a) *Abortion policies: a global review. Volume I Afghanistan to France*. New York, United Nations. (ST/ESA/SER.A/187) United Nations. (2001b) *Abortion policies: a global review. Volume II Gabon to Norway*. New York, United Nations. (ST/ESA/SER.A/191) United Nations. (2002) *Abortion policies: a global review. Volume III Oman to Zimbabwe*. New York, United Nations. (ST/ESA/SER.A/196).
- <sup>55</sup> See *K.L. v. Peru*, Comm. (2005) CCPR/C/85/D/1153/2003 (Human Rights Committee).
- <sup>56</sup> *Tysiac v. Poland*, App. No. 5410/03 (2007) (European Court H.R.) at para. 116.
- <sup>57</sup> BM. Dickens & RJ. Cook. “The scope and limits of conscientious objection” (2000) 71 *Int. J. Gynec. Obstet.* 71-77 at p. 72.
- <sup>58</sup> *CCPR*, *supra* note 18 at art. 18(1).
- <sup>59</sup> *Ibid.* at art. 18(3).
- <sup>60</sup> *Pichon and Sajous v. France*, App. No. 49853/99 (2001) (European Court H.R.).
- <sup>61</sup> *CESCR General Comment No. 14*, *supra* note 3 at para. 21.
- <sup>62</sup> *Ibid.* at para. 49.
- <sup>63</sup> *CEDAW General Recommendation No. 24*, *supra* note 1 at para. 27.
- <sup>64</sup> FIGO. *Ethical Issues in Obstetrics and Gynecology: Ethical Guidelines on Conscientious Objection*. London: FIGO, 2005 at Guideline 8 [hereinafter *FIGO Conscientious Objection Guidelines*].

- 
- <sup>65</sup> See Austria: Strafgesetzbuch [StGB] [Penal Code] Bundesgesetzblatt [BGB1] No. 60/1974, as amended at s. 97(2); Croatia: Zakon o liječništvu (Zl) [Law of Doctoring] 2003 01-081-03-2663/2, at art. 20; Germany: Gesetz zur Vermeidung und Bewältigung von Schwangerschaftskonflikten [SchKG], July 27, 1992, as amended, [Law on Abortion and Conflicts] at art. 12(2); Italy: Legge 22 Maggio 1978, n. 194, art. 9, Gazzeta Ufficiale 22 Maggio 1978, n. 140 (*Norme per la Tutela Sociale Sella Maternità e sull'Interruzione Volontaria Della Gravidanza*) at art. 9.
- <sup>66</sup> CEDAW General Recommendation No. 24, *supra* note 1 at para 11.
- <sup>67</sup> FIGO Conscientious Objection Guidelines, *supra* note 64 at Guideline 6.
- <sup>68</sup> See Croatia: Zakon o liječništvu (Zl) [Law of Doctoring] 2003 01-081-03-2663/2, at art. 20; France: Code de la Sante Publique [Public Health Code], at arts. L2212-8 and R4127-18; Moldova: Rifat Atun et al., *Moldova: Health System Review*, 10 *Health Systems in Transition* 1, 32 (2008) (describing Law on Practicing the Medical Profession No. 264-XVI of 27 October 2005; Portugal: Regulation No. 189/98, *Interrupcao voluntaria da gravidez/ Servicos obstetrician* [Voluntary Termination of Pregnancy and Obstetric Services] at art. 5.
- <sup>69</sup> CESCR General Comment No. 14, *supra* note 3 at para. 12(b).
- <sup>70</sup> CEDAW General Recommendation No. 24, *supra* note 1 at para 20.
- <sup>71</sup> CESCR General Comment No. 14, *supra* note 3 at para. 50.
- <sup>72</sup> *BM. Dickens & RJ. Cook*, *supra* note 28 at p. 310.
- <sup>73</sup> FIGO Conscientious Objection Guidelines, *supra* note 64 at Guidelines 2 and 3.
- <sup>74</sup> See Belgium: *Loi relative aux droits du patient* (Belgian Code of Patients' Rights), *Moniteur belge* 26.09.2002 at art. 7, al. 1; Norway: *Lov om pasientrettigheter* 2 juli 1999 nr. 63 ch. III, § 3.2, [*Patients' Rights Act*].
- <sup>75</sup> *Enright and another v. Kwun and another*, [2003] E.W.H.C. 1000 (Q.B.).
- <sup>76</sup> CEDAW General Recommendation No. 24, *supra* note 1 at paras. 17, 21, 29 and 31; CESCR General Comment No. 14, *supra* note 3 at paras. 35-37.
- <sup>77</sup> *European Perinatal Health Report*, *supra* note 13 at p. 95, citing: CNEMM. Rapport du Comité national d'experts sur la mortalité maternelle, Paris: INSERM-InVS, 2006; *UK Confidential Enquiry*, *supra* note 11.
- <sup>78</sup> CEDAW General Recommendation No. 24, *supra* note 1 at para. 31(a)(d).
- <sup>79</sup> *Family Planning Association of Northern Ireland v Minister for Health Social Services and Public Safety*, [2004] NICA 39 (N.I. Court of Appeal).
- <sup>80</sup> *Ibid.* at para. 99.
- <sup>81</sup> CEDAW General Recommendation No. 24, *supra* note 1 at para. 17; CESCR General Comment No. 14, *supra* note 3 at para. 51.
- <sup>82</sup> CEDAW, *ibid.* at para 31(a)(d)(e); CESCR, *ibid.* at para 37.
- <sup>83</sup> CEDAW, *ibid.* at para. 14.