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Reproductive Rights of Indigenous Women in Latin America

Freedoms and Entitlements under International Human Rights Law and Arising State Obligations

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Abstract

Although reproductive rights are an integral part of international as well as regional human rights law, indigenous women in Latin-America still face a variety of challenges concerning the enjoyment of their rights. Due to insufficient access to reproductive health care, fertility as well as maternal mortality rates among indigenous women are disproportionately high. In addition, discrimination in the health sector still is a prevailing issue. In order to determine what causes these inequalities, this master's thesis aims at establishing what reproductive rights indigenous women are entitled to and what obligations these rights entail for states parties. A special focus will lie on the right to contraception, information and education about reproductive health. Additionally, factors that impede effective access to reproductive health care are discussed. As such barriers are to a large extent of a cultural nature, the concept of intercultural health plays a major role. In order to show how state obligations under international human rights law can be implemented in practice, the legal framework of Bolivia concerning the protection of indigenous women as well as reproductive rights is analysed. Thus, the main challenges indigenous women face in the enjoyment of their reproductive rights are contextualised with the major shortcomings of international human rights law and potential deficiencies in national legislations are identified. The findings of this master's thesis can be used as groundwork for the development of intercultural reproductive health care programmes that take into account the specific needs of indigenous women and enable them to fully realise their reproductive rights.

List of Abbreviations

ACHR	American Convention on Human Rights
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CIDT	Cruel, inhuman and degrading treatment
CPR	Civil and Political Rights
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
ECLAC	Economic Commission for Latin America and the Carribean
ECtHR	European Court of Human Rights
ESCR	Economic, Social and Cultural Rights
FGM	Female Genital Mutilation
GBV	Gender based violence
GC	General Comment
IACHR	Inter-American Commission on Human Rights
IACtHR	Inter-American Court on Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
OAS	Organization of American States
PAHO	Pan American Health Organization
RTI	Reproductive tract infections
SAFCI	Programa de Salud Familiar Comunitaria e Intercultural
SUS	Sistema Único de Salud
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNDRIP	Declaration on the Rights of Indigenous Peoples
UNPF	United Nations Population Fund
WHO	World Health Organization

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1. Introduction

1.1. Background

In Latin America more than 45 million people belong to indigenous communities, making up 8.3% of the region's population.[1] After the colonisation of the Americas those communities had been oppressed and persecuted by colonial powers, leading to an extensive reduction of population numbers and partial extinction in some areas.[2] Although today certain communities are still declining in number due to contact with external diseases, loss of land and resources, ecological destruction or displacement, most indigenous communities in Latin America are rapidly growing.[3]

Although the situation of indigenous people has improved significantly, among others during the two Decades of the World's Indigenous People (1995-2004 and 2005-2014) that aimed at raising awareness and bringing advancement in such sectors as human rights, environment, development, education and health, indigenous people still suffer the consequences of centuries of subjugation.[4] Constituting one of the most marginalised and discriminated groups, indigenous peoples are still being widely left out in decision making processes on an international as well as national level. This not only affects their living standards and quality of life but also deprives them of many of their human rights. Obstacles they face in the enjoyment of their rights can be linked, among others, to cultural, geographical and economic factors as well as discriminatory social practices.

Some of the biggest issues indigenous communities struggle with are high poverty and fertility rates, and low levels of education. In Latin America, indigenous people are twice as likely to live below the poverty line as non-indigenous people, with 43% living in poverty and 24% in extreme poverty.[5] Additionally, although primary school in the region is free, indigenous children are less likely to complete primary education and receive secondary education than non-indigenous children. In addition, the gender gap in school attendance is much wider within indigenous communities, leaving indigenous girls in an even worse

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[1]Fabiana Del Popolo et al, *Summary: Guaranteeing indigenous people's rights in Latin America. Progress in the past decade and remaining challenges* (UN ECLAC 2014) <https://repositorio.cepal.org/handle/11362/37051> accessed 12 July 2019 6.

[2]E.g. discussed in Linda Newson, 'The Demographic Collapse of Native Peoples of the Americas' (1993) 81 Proceedings of the British Academy 247.

[3]UNFPA, 'Program of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994' (2004) UN Doc E/25,000/2004 para 6.21.

[4]Germán Freire et al, *Indigenous Latin America in the Twenty-First Century. The first Decade* (The World Bank Group Report No. 98544 2015) <http://documents.worldbank.org/curated/en/145891467991974540/Indigenous-Latin-America-in-the-twenty-first-century-the-first-decade> accessed 12 July 2019 15.

[5]Freire et al (n 4) 9.

position and further amplifying their marginalization.[6] Low levels of education decreases indigenous people's chance to find decent, fairly paid work and fuels the vicious cycle of poverty. This is further aggravated by high fertility rates. According to the Economic Commission for Latin America and the Carribean (ECLAC), in 2010, the fertility rate among indigenous women in Panama was 5,2 children per woman, compared to 2,3 for non-indigenous women, and 4 and 2,7 respectively in Ecuador, whereat numbers differ among the various indigenous communities.[7] These discrepancies are caused by a complex interplay of different factors, often of a structural nature, like socio-economic status, a lack of accessibility of reproductive health-care services, discriminatory practices or cultural factors such as patriarchal societal structures and distrust in modern medicine.[8] Nevertheless, in this context it has to be noted that indigenous women often prefer to have many children due to their societal beliefs and worldviews. This should however not be overrated, as statistics show that with increasing levels of education, even among indigenous women fertility rates decline.[9]

Another related, very preoccupying issue is the high number of adolescent pregnancies among indigenous girls. While the global adolescent birth rate is about 44 births per 1,000, girls aged 15 to 19 in low-income countries are five times more likely to get pregnant than same aged girls in high-income countries. In Latin America, the birth rate between 2015 and 2020 is as high as 61.3 births per 1,000 girls, and the number is only slowly decreasing.[10] Moreover, the birth rate is four times higher among girls from lower-income households than those with high-income.[11] In the Peruvian Amazon, numbers are even higher, with 34,6% of indigenous girls being mothers.[12] Teenage pregnancies affect adolescent girls in many ways,

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[6]UNICEF Regional Office for Latin America and the Caribbean (Panama), 'Finishing School. A Right for Children's Development: A Joint Effort. Executive Summary Latin America and the Caribbean' (All Children in School by 2015 Global Initiative on Out-of-School Children, UNICEF, 2012) <https://unesdoc.unesco.org/ark:/48223/pf0000217668> accessed 12 July 2019 22.

[7]Observatorio de de Igualdad de Género de América Latina y el Caribe, *Mujeres indígenas en América Latina. Dinámicas demográficas y sociales en el marco de los derechos humanos* (ECLAC 2013) <www.cepal.org/es/publicaciones/4100-mujeres-indigenas-america-latina-dinamicas-demograficas-sociales-marco-derechos> accessed 12 July 2019 59 f.

[8]E.g. in Daniela Ricco Quiroga, 'Salud materna y sus cambios generacionales en la provincia Velasco' in Manigeh Roostas, Salud materna en contextos de interculturalidad. Estudio de los pueblos Aymara, Ayoreode, Chiquitano, Guaraní, Quechua y Yuqui (CIDES-UMSA, OMS, OPS/OMS & UNFPA 2013) <www.clacso.org.ar/libreria-latinoamericana-cm/libro_detalle_resultado.php?id_libro=1227&campo=cm&texto=49> accessed 12 July 2019 151, 155 infusions for certain diseases regarded by indigenous people as being cold are believed to lead to death.

[9]Observatorio de de Igualdad de Género de América Latina y el Caribe (n 7) 59.

[10]UN Population Division, 'World Population Prospects 2017. Data Query' (UN DESA/Population Division) < https://population.un.org/wpp/DataQuery/> accessed 12 July 2019.

[11]World Health Organization (WHO), *World Health Statistics. Monitoring Health for the SDGs. Sustainable Development Goals* (WHO 2016) <www.who.int/gho/publications/world_health_statistics/2016/en/> accessed 12 July 2019 34.

[12]Instituto Nacional de Estadistica e Informatica (INEI), *Perú: Situación Social de las Madres Adolescentes, 2007. Dirección Técnica de Demografía e Indicadores Sociales* (INEI 2010)

jeopardizing not only their human right to health but also many other aspects of their lives such as their education or role in society. Early childbearing easily leads young girls into poverty, with little hope for breaking out.[13] One of the main causes for the high fertility rate among teenage girls is the lack of sexual education and the taboo that has been built around sexuality in many regions of the world. In Latin America, conservative policies rejecting scientific evidence and gender related contents have led to inadequate or non-existent sexual education in schools, leaving girls in an even more vulnerable position.[14] However, high fertility rates are by far not the only issues of reproductive health in Latin America. Forced sterilizations of indigenous women, for example, have been a recurring concern throughout the continent for decades.

Looking at the overall situation of indigenous women and girls in Latin America, reproductive rights are an extremely important to combat some of the most prevalent issues on the continent, like poverty and marginalization, and empower indigenous women and girls to make free and informed decisions about their reproductive health. Eventually, slower population growth benefits the whole population, as it helps to reduce poverty and increase economic progress in consequence of lower investments in the sectors of education, basic sanitation, infrastructure or food supply.[15]

1.2. Research Question and Limitations

Reproductive rights are universally acknowledged and addressed through a variety of international human rights instruments. Nevertheless, indigenous women still face considerable challenges in accessing and claiming their reproductive rights. Aim of this master's thesis is to determine the main obstacles that indigenous women face in the enjoyment of their rights and their causes. Therefore, it has to be established what reproductive rights indigenous women are entitled to under international and regional human rights law and what specific obligations arise from these rights for states home to indigenous peoples.

The geographical context of this paper is Latin America, with a special focus on Bolivia, one of the countries with the highest percentage of indigenous people in Latin America – over 40 percent of the population identifies as indigenous, belonging to more than

<www.inei.gob.pe/buscador/?tbusqueda=Situaci%C3%B3n+Social+de+las+Madres+Adolescentes> accessed 12 July 2019 7, 8, 25.

[13] WHO 2016 (n 11) 34.

[14] Camila Gianella et al, 'What causes Latin America's high incidence of adolescent pregnancy?' (2017) 16/9 CMI Brief <www.cmi.no/publications/6380-what-causes-latin-americas-high-incidence-of/> accessed 12 July 2019.

[15] UNFPA 2004 (n 3) para 3.14.

35 different indigenous communities.[16] Therefore, the Inter-American human rights system within the framework of the Organization of American States (OAS), alongside the international human rights system, the United Nations (UN), is used as the major source of reference. In addition, works of the World Health Organization (WHO), the Pan American Health Organization (PAHO) as well as the International Labour Organization (ILO) are referred to.

Concerning reproductive rights, focal points are the right to family planning and the right to information and education about family planning, some of the most effective tools for the reduction of fertility-rates and empowerment of women. Other elements of reproductive rights will be discussed as well, as they are necessary for a wider understanding of the topic in general. The main right holders in this context are women and girls, constituting the population most affected by reproductive health issues. Due to their 'double-vulnerability' resulting from marginalisation and discrimination on basis of their gender *and* ethnicity, main focus lies on women and girls of indigenous origin as rights holders.

As this master's thesis follows an interdisciplinary approach, it will not provide a full and detailed legal analysis of the issue but rather try to link the legal questions about reproductive rights and state responsibilities to underlying cultural and social determinants. The aim is to draw a broader picture of the issue in order to gain a wider understanding of the different factors impacting the enjoyment of reproductive rights of indigenous women and at the same time explore ways of improving the current situation.

1.3. Methods

This thesis is divided into four main parts. The first part elaborates on the term 'indigenous' and attempts to provide a definition, outlining the most important characteristics of indigenous peoples. Additionally, their protection under international as well as regional human rights law is analysed and discussed. The second part determines the scope of reproductive rights and examines if and how reproductive rights are protected in human rights law on an international as well as a regional level. Therefore, different human rights provisions are analysed on their content regarding reproductive rights, whereby focus lies on the right to health and its underlying determinants right to information and education as well as the principle of non-discrimination. In order to provide an overall picture of reproductive rights, other human rights that can be used to claim reproductive rights are reviewed briefly

[16]Instituto Nacional de Estadistica (INE) 'Resultados Censo Nacional de Población y Vivienda' (INEI Official Website 2012) <http://datos.ine.gob.bo/binbol/RpWebEngine.exe/Portal?BASE=CPV2012COM&lang=ESP> accessed 3 June 2019.

too. Those include the prohibition of cruel, inhumane and degrading treatment and the right to life. International treaties used are, most importantly, the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); the Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD). On the regional level, the American Convention on Human Rights (ACHR) and its Additional Protocol in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), as well as the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Convention of Belém do Pará) are used as references. In addition, General Comments (GC) of the treaty bodies as well as communications to the Inter-American Commission on Human Rights (IACHR) as well as case-law by the Inter-American Court of Human Rights (IACtHR) are consulted in order to facilitate the interpretation of the rights in question. Subsequently, specific obligations emerging from reproductive rights are analysed. To begin with, the concept of state obligations under ESCR in general are discussed. In this context, the enforceability and justiciability of ESCR on the international as well as the regional level are questioned in short. In this light, obligations under the right to health, and obligations under reproductive rights of states parties are examined. GCs as well as case-law and statements of Special Rapporteurs and other experts facilitate the understanding of the content of those rights, as they are often formulated in rather general terms.

In the third part, reproductive rights are put into context with indigenous peoples' rights. The main reference for this chapter is the Convention No. 169 of the International Labour Organization (ILO), known as the Indigenous and Tribal Peoples Convention. Next, special challenges arising for indigenous women in enjoying these rights are studied thoroughly. The analysis is based on the framework suggested by the CESCR Committee used for defining rights and their corresponding obligations, consisting of the dimensions of accessibility, availability, acceptability and quality. Naturally, the influence of cultural factors plays a major role in this chapter, wherefore it is backed by anthropological case-studies.

In order to see how reproductive rights can be implemented and state obligations can be fulfilled, the last part of this master's thesis consists of a small country-study. The country chosen for this chapter is Bolivia, as it has a unique constitution that is based on the premise that Bolivia is the entity of a variety of peoples and societies, offering broad protection to indigenous peoples. In order to determine how international and regional human rights laws in matters of reproductive health and indigenous people's rights are implemented in the country,

national legislation concerning family planning and information as well as education about the issue is analysed. As concluding whether Bolivia *de facto* fulfils all its obligations in the area of reproductive rights would require a more profound and field-based study, the aim is to establish whether the legal framework in Bolivia provides a good foundation for the implementation of reproductive rights and sets the necessary standards for states to comply with their obligations under reproductive rights, aiming at detecting potential weak spots in national legislation and policies.

2. Indigenous Peoples in Human Rights Law

2.1. Definition of the Term Indigenous

In order to talk about the special challenges indigenous people face in the enjoyment of their reproductive rights, first it has to be determined what 'indigenous' means. This is somewhat difficult, as the term, being an invention of colonial powers, has evolved in direct relation to colonisation and was for a long time used to contrast non-Europeans with Europeans. As a result, the denomination indigenous implicates asymmetric power relations and is therefore of a quite sensitive nature. Moreover, it is a highly politicised term whose interpretation to a large extent depends on the political system and policies of a country.[17] Under international human rights law, there is currently no official definition of the term 'indigenous'. Nevertheless, Special Rapporteur of the Sub-Commission on Prevention of Discrimination and Protection of Minorities Martínez-Cobo has attempted to define the term in his Study of the Problem of Discrimination against Indigenous Populations.

In this study, Martínez-Cobo uses the characteristics most commonly used by states to identify their indigenous populations and further elaborates on them. These characteristics are ancestry, culture, language, group consciousness, acceptance by the indigenous community and residence in a certain territory. Regarding ancestry, the Special Rapporteur stresses that being indigenous has nothing to do with the concept of race[18], but merely indicates that indigenous peoples are the descendants from the native inhabitants of a region that was later colonised.[19] The criterion of a shared, autochthonous culture includes both tangible and intangible elements such as scientific and philosophical knowledge, religious, moral and political beliefs, legends, traditions, symbols and ideals, legal, political and social organization, hygienic, agricultural, culinary and medical customs, arts, and clothing.[20] Nevertheless, the origin of a cultural element is not of great importance as societies are always dynamic and both borrow and adopt certain behaviour from other cultures. Consequently, boundaries between societies can become blurry over time. This is especially relevant in the light of colonisation, during which a lot of knowledge as well as customs were introduced to other continents and adopted by indigenous peoples and vice versa.[21] When

[17]Trevor W. Purcell, 'Indigenous Knowledge and Applied Antrhopology: Questions of Definition and Direction' (1998) 57/3 Human Organization 258 258.
[18]José Martínez Cobo *Study of the Problem of Discrimination against Indigenous Populations* (UN Indigenous Peoples Department of Economic and Social Affairs 8 September 2014) E/CN.4/Sub.2/1982/2/ para 17.
[19]Martínez Cobo (n 18) para 39.
[20]ibid (n 18) para 73.
[21]ibid (n 18) para 77f.

talking about cultural aspects, it has to be taken into account that indigenous societies are inherently distinct from Western ones, as they do not share the same history.[22] One of the most important cultural elements is the use of a vernacular language by a group as it is one of the main tools to transfer cultural knowledge from generation to generation. It teaches children the basic cultural legacy of their community and is an expression of the society's interpretation of the world. Moreover, it strengthens the social bond between group members and distinguishes them from other groups.[23]

The third main criterion, group consciousness, presupposes that groups and individuals have to consider themselves indigenous.[24] At the same time, acceptance by the indigenous community, the entity of all indigenous peoples, is crucial for the status of a group.[25] The last criterion is the residency of an individual within the territory of an indigenous group. In some countries like Australia, indigenous communities are bound to reserves in order to enjoy special protection. Usually, such territories have been inhabited by indigenous peoples since pre-colonial times and have substantially influenced their culture and way of living.[26] Nevertheless, this criterion has been contested, as due to migration of both the voluntary and involuntary sort, indigenous people have left their lands and settled down elsewhere, often in more urban areas.[27] In this context, however, it is interesting to mention that displacement from their ancient territories has in several cases led to the consolidation of societal characteristics. Indigenous peoples in diaspora, for example, tend to preserve a more hegemonic culture than more assimilated indigenous peoples still occupying their ancestor's territories, shared with non-indigenous societies.[28]

Although different countries have varying standards of classification of indigenous peoples, these criterions help to determine the status of a group. In Latin America, many indigenous communities resemble each other considerably. Hereby, societal and behavioural commonalities are especially predominant in geographically close populations, such as indigenous peoples of the Andean or selvatic communities. This can create a feeling of identity and belonging within a group and at the same time strengthen solidarity between different indigenous peoples. [29] Another very similar attempt to determine who falls under the

[22]Purcell (n 17) 259.
[23]Martínez Cobo (n 18) art 174-176.
[24]ibid (n 18) art 210.
[25]ibid (n 18) art 240.
[26]ibid (n 18) art 248, 249.
[27]ibid (n 18) 259; further discussed at the Sixth Session of the UN Permanent Forum on Indigenous Issues at the UN Headquarters in New York from 14 – 25 May.
[28]Purcell (n 17) 260.
[29]Raul A Montenegro, Carolyn Stephens, 'Indigenous Health in Latin America and the Caribbean' (2006) 367 The Lancet 1859 1859.

scope of indigenous peoples was made by the ILO in its Indigenous and Tribal Peoples Convention No. 169 which is based on the same principles.

Although definition may be complex sometimes, it is crucial in the light of indigenous peoples' rights under human rights law, which focuses on the rights and the protection of whole indigenous communities rather than the individual. How and where such rights are enshrined will be examined in the following subchapter.

2.2. Protection of Indigenous Peoples

One of the most important international treaties on the rights of indigenous people and peoples is the Indigenous and Tribal Peoples Convention No. 169 of the ILO. This convention was adopted in response to the inability of indigenous peoples all over the world to "enjoy their fundamental human rights to the same degree as the rest of the population" and the fact that "their laws, values, customs and perspectives have often been eroded".[30] The convention emphasises indigenous peoples' right to the full enjoyment of all human rights without discrimination[31] and poses several obligations on states parties, including the adoption of special measures.[32] Nevertheless, with only 23 ratifications since its entry into force in 1991 the recognition of the convention remains rather weak. However, in this context it has to be recognised that the convention is of minor relevance for countries that do not have indigenous populations.

Concerning the right to health, the convention emphasises that all health care systems must be elaborated in cooperation with the benefitting indigenous community, who must be included in the monitoring process. Moreover, health services must "take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines". Such services should focus on primary health care and employ and train health personnel from the community.[33] Article 30 moreover emphasises indigenous peoples' right to access information in indigenous languages, a passage especially relevant in the context of medical attention. [34] However, the convention does not include any particular provisions on reproductive rights nor women's rights, which could be considered a weak spot.[35]

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[30]*Convention (No 169) Indigenous and Tribal Peoples Convention* (adopted 27 June 1989, entered into force 05 September 1991) 1650 UNTS 383 preamble.
[31]*Indigenous and Tribal Peoples Convention* (n 30) art 3.
[32]Ibid (n 30) e.g. article 2,4.
[33]Ibid (n 30) art 25.
[34]Ibid (n 30) art 30.
[35]Despite article 20.3(d) on sexual harassment.

Other UN agencies do not count on the rights of indigenous peoples with a legally binding treaty. However, in 2007, the Declaration on the Rights of Indigenous Peoples (UNDRIP) was adopted. Although the Declaration is not legally binding, it contains and reinforces many rights enshrined in binding international human rights treaty law, of which some may be considered customary international law. Such rights are, among others, the freedom of discrimination, the right to equal treatment and economic, social and cultural rights.[36] Considering the high level of signatories, it can be argued that the UNDRIP reflects a global consensus on the rights of indigenous people.

In the UNDRIP, the right to health is enshrined in article 24, granting the "equal right to the enjoyment of the highest attainable standard of physical and mental health".[37] However, reproductive rights are not mentioned in the UNDRIP; a fact that has been heavily criticised, especially by feminist scholars. Kuokkanen for example argues that as the issue of reproduction is of such great significance for indigenous women, considering the status of family for the community, it is surprising that "rights associated with reproduction and childbirth" are not considered.[38] Overall she finds that women's rights are not sufficiently protected by the declaration and many prevalent issues for indigenous women are not discussed.[39] The underrepresentation of women in the UNDRIP has moreover been criticised by Special Rapporteur on violence against women Yakin Ertürk who demands contextualization of topics like GBV and reproductive health to indigenous women to ensure the effective implementation of the declaration.[40]

Another point of scholars' criticism is that women are only mentioned in context with children and persons with disabilities as similarly vulnerable groups. This suggests that women are inherently vulnerable and reinforces victimization. Iorn argues that women "only have 'special needs' because of oppression that they face" and that, in order to combat oppression and discrimination against women, the UNDRIP should rather focus on the

[36]Rauna Kuokkanen, 'Indigenous Women's Rights and International Law: Challenges of the UN Declaration on the Rights of Indigenous Peoples' in Corinne Lennox (eds) *Routledge Handbook of Indigenous Peoples' Rights* (Routledge International Handbooks 2015) 2.
[37]*United Nations Declaration on the Rights of Indigenous Peoples* (adopted 13 September 2007) UN Doc A/RES/61/295, 46 ILM 1013 (UNDRIP) art 24.
[38]Kuokkanen (n 36) 11, 15.
[39]Ibid (n 36) 3.
[40]The United Nations Special Rapporteur on Violence against Women, Its Causes and Consequences '15 Years of the UN Special Rapporteur on Violence against Women, its Causes and Consequences 1994-2009–A Critical Review <www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Publications.aspx> accessed 12 July 2019 49.

positive rights of women, for example participation in decision-making, and thus empower them.[41]

Although indigenous peoples' rights are of high significance in the region, the OAS does not count on the issue with any specific treaty. Indigenous people's rights consequently fall under other human rights conventions such as the ACHR, which however concentrates on the rights of the individual rather than of the community, or are claimed through instruments of international human rights law, like the ILO Convention 169.[42]

Despite the fact that the protection of indigenous peoples' rights under the Inter-American human rights system is rather weak, the OAS has recognised the significance of the issue, through its complaints mechanism as well as thematic and country reports. Likewise, the IACtHR has handled a variety of cases concerning indigenous peoples, notably concerning land rights and the environment.[43] In the context of reproductive health, cases brought before the IACHR have mostly concerned forced sterilizations.[44]

In the end, the rights of indigenous peoples can fall under any human rights treaty, depending on the right in question. Although collective rights might not be protected sufficiently by those, requiring additional protection through specialised instruments, this might not be of great importance in the context of reproductive rights. However, before delving deeper into the topic of indigenous women's reproductive rights, the next chapter will elaborate on the concept of reproductive rights and their protection under international as well as regional human rights law.

[41]Catherine J Iorns, 'The Draft Declaration of the Rights of Indigenous Peoples' (1993) Murdoch University Electronic Journal of Law 1/1 <http://classic.austlii.edu.au/au/journals/MurdochUeJlLaw/1993/2.html> accessed 07 July 2019.

[42]E.g. in *The Yakye Axa Indigenous Community v. Paraguay*, Judgement of 17 June 2005, Series C No. 125 para 52(a).

[43]E.g. The Mayagna (Sumo) Awas Tingni Community v. Nicaragua, Judgement of 31 August 2001, Series C No. 79; it has to be noted that many of those cases implicitly concern the right to health and may have effects on reproductive rights too.

[44]E.g. María Mamérita Mestanza Chávez vs Peru, No 12.191, 22 October 2003, Report No. 71/03.

3. Reproductive Rights

3.1. Sexual and Reproductive Health and Health Care

3.1.1. Sexual and Reproductive Health

In order to define what reproductive rights people are entitled to, firstly it has to be defined what reproductive health is and what services reproductive health care comprises. As sexual and reproductive health are two closely interlinked and partly overlapping concepts, they will be discussed together in this chapter.

For a long time, sexual health had been seen as merely a part of the concept of reproductive health, which itself has changed fundamentally over the past decades. When the topic gained popularity in the 1960's, it mainly covered family planning and methods of contraception and was directed towards women of childbearing age. Over the next years, the scope of reproductive health started to expand, integrating topics like infant and maternal health care and abortion. Subsequently, health care programmes started to include reproductive health care for adolescents too, and first educational programmes for young people were introduced. In the 1990's, a series of international events pushed for a more extensive definition and the recognition of the importance of reproductive health for the population as a whole and for development.[45] One of the most important happenings in this regard was the United Nations Population Fund's (UNPF) *International Conference on Population and Development in Cairo* 1994. In its *Programme of Action* the UNPF defined reproductive health as "a state of complete physical, mental and social well-being [...] in all matters relating to the reproductive system and to its functions and processes".[46] Accordingly, the precondition for achieving good reproductive health is the ability to have a safe and satisfying sex life and to reproduce when and how often one wishes to do so. Therefore, access to safe, effective, affordable and acceptable methods of family planning and fertility regulation in conformity with the law should be provided. Additionally, mothers-to-be need to have access to health care services that ensure a safe pregnancy and childbirth and enhance the chances of having a healthy infant. In order to fully enjoy those rights, women as well as men need to be informed and educated about their reproductive and sexual health and health care.[47]

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[45]PAHO, 'Population and Reproductive Health' (15 July 1998) Provisional Agenda Item 4.9. At the 25th Pan American Sanitary Conference 50th Session of the Regional Committees CSP25/15 5, 6.
[46]UNFPA 2004 (n 3) para 7.2.
[47]ibid (n 3) para 7.2.

According to this definition, the concept of reproductive health also includes sexual health. Sexual health is hereby seen as the part of reproductive health related to sex and sexuality, its purpose being the "enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases".[48] Nevertheless, as the following years were marked by the increase of public concern for sexually transmitted diseases (STDs), gender-based violence (GBV) and other sexual health related issues on the one hand, and advances in the development of new methods of family planning and medication for reproductive health problems on the other hand, it was found that defining sexual health as merely a subcategory of reproductive health was insufficient. Knowledge about sexual function, behaviour and health and public awareness in the field had improved significantly and sexual health became a precondition for reproductive health rather than a by-product.[49] Consequently, sexual health was defined as a "state of physical, mental and social well-being in relation to sexuality" and "not merely the absence of disease, dysfunction or infirmity". In order to achieve sexual health, a positive approach to sexuality and sex as well as the possibility of having safe sexual relations free of coercion, discrimination and violence, are crucial.[50]

Distinguishing between reproductive and sexual health is not an easy task and not always necessary either. Concerning this master thesis, sexual health will be referred to as an integral part of reproductive health, as most human rights instruments do not draw distinctions between those two fields. Moreover, as this master's thesis focuses on reproductive rights, especially on methods of family planning and contraception, the distinction between those two concepts is of minor importance.

3.1.2. Sexual and Reproductive Health-Care

Like reproductive and sexual health, reproductive and sexual health care are strongly interlinked and overlapping fields as well. Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. According to the definition of the UNFPA's *Programme of Action*, it also includes sexual health care.[51]

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[48]UNFPA 2004 (n 3) para 7.2.
[49]WHO, *Defining Sexual Health. Report of a Technical Consultation on Sexual Health 28–31 January 2002, Geneva* (WHO Sexual Health Document Series 2006).
<www.who.int/reproductivehealth/publications/sexual_health/defining_sh/en/> accessed 12 July 2019 4.
[50]ibid (n 49) 5.
[51]UNFPA 2004 (n 3) 45.

Reproductive health care should be an integral part of primary health care and include education and information about reproductive and sexual health as well as counselling and other medical services related to reproductive health issues. Such services must cover topics like family-planning and responsible parenthood, prevention and treatment of infertility, abortion, if provided by law, and post-abortion care, prenatal care, safe delivery and post-natal care, including breastfeeding, infant and women's health-care, treatment of reproductive tract infections (RTI), STDs and other reproductive health conditions like breast cancer or cancers of the reproductive system, and prevention of harmful cultural practices. In order to guarantee the success of such services, reproductive health-care programmes should always include women in planning as well as management. Additionally, special programmes for men and boys should educate them about related topics, especially men's role in preventing STDs and their responsibility in the upbringing of children.[52]

As shown above, sexual health care is an integral part of reproductive health care. It encompasses access to information and education about sex and sexuality that provides people with knowledge about risks and consequences of sexual activity as well as access to sexual health care that not only deals with STDs, but also issues like sexual and gender identity, sexual relationships and pleasure.[53] Sexual health care focuses on issues like STDs, RTIs, unintended pregnancy, safe abortion, sexual dysfunction, infertility, GBV, harmful practices, adolescent's sexual health and sexual education, sexual orientation and gender identity, mental health issues related to sexual health, the impact of physical disabilities and chronic illnesses on sexual well-being, and the promotion of safe and satisfying sex.[54] Many of those issues fall under the scope of reproductive health care too and again, drawing a line between those disciplines is difficult. Regardless, all reproductive health care programmes, including those related to sexual health, must be committed to promoting the responsible exercise of people's reproductive rights, namely to attain the highest standard of sexual and reproductive health. Such programmes should be gender-sensitive, non-discriminatory, age-appropriate and adapted to the cultural context.[55]

Having access to reproductive health care services is a human right enshrined in various human rights treaties and can be read into various human rights provisions. Although being a universal right, many people still do not have access to reproductive health care

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[52]UNFPA 2004 (n 3) 47-48.

[53]Peter Aggleton et al, *Developing sexual health programmes. A framework for action* (WHO WHO/RHR/HRP/10.22 2010) <https://www.who.int/reproductivehealth/publications/sexual_health/rhr_hrp_10_22/en/> accessed 12 July 2019 1.

[54]Aggleton (n 53) 6.

[55]UNFPA 2004 (n 3) principle 8, art 7.6

services. In order to evaluate why reproductive rights are not properly implemented on national level, and what states can and must do to combat this issue, it first has to be determined what explicit reproductive rights people have under human rights law. Generally, it can be said that reproductive rights consist of the right to reproductive health and health care and the right to information and education about reproductive rights, health and health care, which naturally is a precondition for the enjoyment of the former. Reproductive rights are enshrined in different provisions of international and regional human rights law, although they are not mentioned explicitly in either, but are rather read into different rights and further defined by the treaty bodies. The most important human right in the context of reproductive rights, especially when focusing on the right to contraception and the right to information about contraception, is the right to health. Nevertheless, before discussing the right to health in more detail, other human rights highly relevant for reproductive rights will be considered.

3.2. Reproductive Rights in Human Rights Law

3.2.1. The General Concept of ESCR

Reproductive rights predominantly fall under the scope of ESCR. Hereby they can be read into different human rights provisions, most importantly the right to health. ESCR brings along certain state obligations, as all human rights do. Nevertheless, as the concept of ESCR is somewhat different from CPR, it is important to understand the nature of obligations under ESCR in general in order to be able to determine what obligations state parties have under reproductive rights. Therefore, this chapter will briefly discuss the main issues surrounding state parties' duties under ESCR before delving into the analysis of reproductive rights and their corresponding obligations.

State obligations under ESCR are enshrined in the ICESCR and further defined by other conventions and their treaty bodies. However, what exactly those obligations comprise can be difficult to determine as the scope of ESCR itself is sometimes hard to confine due to imprecise language.[56] In order to help implement the ICESCR, a group of highly respected academics in the field has adopted a set of guidelines called the *Limburg Principles*.[57] Additionally, works of Special Rapporteurs and other experts as well as case law of the IACtHR and recommendations by the IACHR provide guidance on the realization of state

[56]Discussed e.g. in Mónica Feria Tinta, 'Justiciability of Economic, Social, and Cultural Rights in the Inter-American System of Protection of Human Rights: Beyond Traditional Paradigms and Notions' (2007) 29/2 Human Rights Quarterly 431 434.

[57]Economic and Social Council, 'The Limburg Principles on the Implementation of the ICESCR' (8 January 1987) in Forty-third Session E/CN.4/1987/17.

obligations.[58] To fully grasp the extent of state obligations, the justiciability of ESCR and subsequently rights holder's options to claim their rights and access legal remedies must be taken into account. Regarding ESCR, since the introduction of the Additional Protocol to the ICESCR in 2009 individuals under the jurisdiction of states parties to the protocol have been able to bring communications about violations of their ESCR to the ICESCR Committee. Nevertheless, up to date only 24 states have ratified the protocol.[59]

In the Inter-American human rights system, individuals can bring petitions about violations of rights protected by the ACHR to the IACHR.[60] The IACHR can further refer cases to the IACtHR, if the state in question recognises the contentious jurisdiction of the Court. The ACHR does include an article on ESCR, however, article 26 is of a rather general language and merely provides for the progressive realization of ESCR.[61] Although ESCR are not so well protected under the ACHR, article 29(b) recognises that other human rights mentioned in different conventions have to be taken into consideration too, which could favour ESCR. Referring to the jurisdiction of the IACHR and the IACtHR, the only ESCR that can be claimed through these mechanisms are the right to education and the right to organise and join unions.[62] The first time a violation of such a right has been found by the IACtHR was in the case of *Lagos del Campo v. Peru* in 2017, marking a shift towards the enforceability of ESCR under article 26 of the ACHR.[63] Despite their very limited justiciability, ESCR had been dealt with by the Court even before that case. In its ruling on *Acevedo Buendía et al. v Peru,* for example, the IACtHR acknowledged the justiciability of ESCR referring to the drafting history of article 26. Accordingly, the drafting states clearly had the full protection of ESCR in mind, and naturally their enforceability. In addition, the Court argued that the strategic positioning of article 26 within the ACHR, namely under the section of duties of states, supports the enforceability and justiciability of ESCR.[64]

Alternative ways of enforcing ESCR used by the Court, are the referral to other tools of protection of human rights, such as regional and international treaties. This strategy is

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[58]E.g. in Feria Tinta (n 56) 435.

[59]*Optional Protocol to the CRC on a communications procedure* (adopted 19 December 2011, entered into force 14April 2014) A/RES/66/138 art 1.1.

[60]*American Convention on Human Rights* (ACHR) (adopted 22 November 1969, entered into force 18 July 1978) 1144 UNTS 123 art 44.

[61]ACHR (n 60) art 26; however, this has been challenged by the IACtHR in its decision on the case Poblete Vilches v. Chile, Judgement of 8 March 2018, Series C No. 349 in which the Court acknowledged that article 26 also includes immediate obligations.

[62]Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) (adopted 17 November 1988, entered into force 16 November 1999) OAS Treaty Series No 69 (1988) art 19.6.

[63]Lagos del Campo v. Peru, Judgement of 31 August 2017, Series C No. 366 concerning, among others, the right to work.

[64]Acevedo Buendía et al. v Peru, Judgment of 1 July 2009, Series C No. 210.

particularly interesting as interpretation by different instruments has contributed significantly to the evolution and advancement of human rights law. Another method used by the Court is the enforcement of ESCR through CPR.[65] As it will be shown in more detail later, the IACtHR has been particularly creative when dealing with ESCR. Nevertheless, it has to be stressed that in its jurisdiction the IACtHR does not create any new rights and obligations out of external sources but rather uses them in support of its decisions, or to add "new dimensions to pre-existing rights".[66]

Returning to the issue of obligations under international human rights law, main duty bearers are states.[67] States parties to the ICESCR have the duty to enable the full exercise of all rights set out in the convention and are obliged to fulfil the obligations set out in article 2 of the ICESCR.[68] As defining the scope of these obligations can be challenging, it is useful to draw on the analytical framework for state obligations used by the CESCR Committee. Known as the tripartite typology of obligations, it divides obligations into three categories: the obligation to *respect*, *protect*, and *fulfil*. In addition, obligations can be divided into positive and negative obligations. While negative ones demand merely refraining from taking any action jeopardizing the right in question, positive duties require active measures in order to achieve the realization of a right. Consequently, the obligation to *fulfil*, under which states are obliged to "facilitate, provide and promote" human rights, as well as the obligation to *protect*, under which states are required to actively take measures in order to prevent interference with rights by third parties, are positive obligations. The obligation to *respect*, on the contrary, is of a negative nature. Nevertheless, rights never have a purely negative or positive character. Although both ESCR as well as CPR require positive action for their implementation, expenditures for ESCR are often believed to be higher, wherefore states can be reluctant to commit to the full realization of ESCR.[69]

Having established a theoretical framework for states obligations, it now can be analysed what obligations ESCR precisely encompass. According to article 2 of the ICESCR, each state party has to take steps to progressively achieve the full realization of the rights enshrined in the covenant. If a state, having exhausted all available resources, is unable to

[65] E.g. in Acevedo Buendía et al. v Peru (n 64); further discussed in Feria Tinta (n 56) 443.

[66] Lixinski, L., 'Treaty Interpretation by the Inter-American Court of Human Rights: Expansionism at the Service of the Unity of International Law' (2010) 21/3 European Journal of International Law 585 603.

[67] Asbjørn Eide, 'Economic, Social and Cultural Rights as Human Rights' in Asbjørn Eide, Catarina Krause and Allan Rosas (eds), *Economic Social and Cultural Rights. A Textbook. Second Revised Edition* (NIJHOFF 2001) 22.

[68] *International Covenant on Economic, Social and Cultural Rights* (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR) art 2.

[69] Further discussed and partly disproved in Eide 2001 (n 67) 10; Brigit Toebes, 'The Rights to Health' in Asbjørn Eide, Catarina Krause and Allan Rosas (eds), *Economic Social and Cultural Rights. A Textbook. Second Revised Edition* (NIJHOFF 2001) 179.

take such steps due to financial restraints or a lack of resources, international cooperation and assistance of economic as well as technical nature have to be sought. Naturally, developing countries cannot guarantee a level of implementation as high as wealthier countries. Therefore, the covenant allows for the limitation of certain positive obligations, according to resource availability.[70] This is reaffirmed by articles 1, 2 and 3 of the *San Salvador Protocol* which correspond to the content of article 2 of the ICESCR.[71]

Article 2 of the covenant is further interpreted by GC No. 3 of the CESCR on the Nature of States Parties' Obligations. The GC recognises that ESCR might have to be implemented progressively but stresses that regardless of any constraints, certain measures have to be taken immediately and that states still have to aim at the full realization of all rights.[72] Explicitly immediate measures are comparatively cost effective, allowing for their instant implementation, for example applying the principle of non-discrimination and adopting action plans or legislation. This means that although the realization of a right itself might take some time, steps initiating the realization have to be taken as soon as possible.[73] As the scope of 'appropriate means' might not always be easy to pinpoint, states are urged to justify their decisions in reports to the treaty body and prove that the rights in question are justiciable, also in practice. Subsequently, it is the Committees decision to determine if all appropriate means have been exhausted.[74] Lastly, the Committee urges states to not take any deliberately retrogressive measures that would jeopardise the realization of a right without a justified reason.[75] Again, the term 'justified reason' constitutes a grey area that is hard to grasp and has to be evaluated on a case by case basis.

Considering the quite vast scope of limitations supported by article 4 of the ICESCR, it might appear that the obligations posed on states by the covenant allow for restrictions of rights rather than enhancing their full realization. Narrowing down state obligations can make certain ESCR appear not as urgent and absolutely binding as for example CPR. Nevertheless, although the covenant allows limitations one must keep in mind that there are some non-negotiable core obligations ensuring a minimal threshold for ESCR. Such core obligations include, among others, primary health care and basic education and are, theoretically, not

[70]ICESCR (n 68) art 2.1.
[71]San Salvador Protocol (n 62) art 1,2,3.
[72]CESCR, 'General Comment No. 3: The Nature of States Parties' Obligations' (14 December 1990) E/1991/23. para 1.
[73]CESCR 1990 (n 72) para 1, 2, 3.
[74]ibid (n 72) para 4.
[75]ibid (n 72) para 9.

dependent on resource availability. Still, in practice, resource constraints and the economic situation of a country do determine the extent to which core obligations can be fulfilled.[76]

Having established what general obligations states have under ESCR, the next chapter will examine what reproductive rights are, under what human rights provisions they can fall and what particular obligations reproductive rights pose on states parties.

3.2.2. The Right to Health

Probably the most important provision in the context of reproductive rights is the right to health. The right to health is enshrined in most human rights treaties that deal with ESCR, some of them defining the right rather generally, others being more specific. In certain circumstances the right to health can be claimed through other provisions of human rights law too, for example the right to life. As all human rights are interlinked and interdependent, the right to health comprises a variety of determinants of health, like nutrition, access to information, participation in decision-making processes, gender equality and non-discrimination – all factors that have a direct impact on the accessibility of the right to health.[77] Simultaneously, the right to health functions as a determinant of other human rights, for example the right to an adequate standard of living.[78] At the same time, it also functions as a limitation – in the case of epidemics, for example, it can limit the freedom of movement.[79]

The right to health does not equal the right to be healthy, but is the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" as enshrined in article 12 of the ICESCR and replicated in article 10 of the San Salvador Protocol. What exactly the phrase "highest attainable standard" implies is difficult to assess, as the state of health of the individual is dependent on various interactive factors like geography, culture and socioeconomics.[80] As good reproductive health is a precondition to attain the highest possible standard of health reproductive rights are an integral part of the right to health. Guidance on how to define reproductive rights and determine their scope can be found in two GCs of the Committee on Social, Economic and Cultural Rights (CESCR); No. 14 on the right to the highest attainable standard of health and No. 22. on the right to sexual and reproductive health.

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[76]CESCR 1990 (n 72) para 10.

[77]UNGA, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (13 September 2006) Sixty-first Session A/61/338 art 18.

[78]ICESCR (n 68) art 11; *Convention on the Rights of the Child* (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3 (CRC) art 27.

[79] E.g. discussed in Ryan Rollinson, 'Public Health and Human Rights in an Era of Epidemics' (2015) Advocates' Forum 47.

[80]Toebes 2001 (n 69) 174.

GC No. 14 recognises that article 12, among others, protects reproductive rights. Thus, the provision provides for the freedom to control one's sexual and reproductive health and obliges states to provide access to affordable high quality sexual and reproductive health care services. According to the GC, article 12.2(a) requires states to take "measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care".[81] It further interprets that article 12.2(c) on the "prevention, treatment and control of epidemic, endemic, occupational and other diseases" covers also STDs.[82] In addition, GC No. 14 stresses the role of the right to health as a tool for eliminating all forms of discrimination against women and advocates for the removal of all barriers preventing women's access to health services, education and information, among others in the field of reproductive health. In this context, the GC establishes a link between domestic violence and reproductive rights and urges states to take all necessary measures to protect women from harmful traditional practices and other norms that jeopardise their reproductive rights.[83] Additionally, article 23 emphasises the importance of adequate reproductive health services for adolescents.[84]

As the CESCR found that the adoption of GC No. 14 was not followed by the expected progress and reproductive rights continued to suffer grave violations, it adopted a new GC, No. 22, in which it further develops reproductive rights.[85] GC No. 22 defines that reproductive rights consist of the freedom to "to make free and responsible decisions and choices, free of violence, coercion and discrimination, over matters concerning one's body and sexual and reproductive health" and the entitlement to access "health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health".[86] Building upon GC No. 14, it stresses the importance of the underlying determinants of sexual and reproductive health, such as access to sanitation, safe working conditions and health related education, as well as social determinants that influence people's ability to enjoy their reproductive rights.[87] In addition, GC No. 22 elaborates on the principles of availability, accessibility, acceptability and quality discussed in GC No. 14, contextualizing them with reproductive rights. Last, the GC examines states parties' obligations under the

[81]Committee on Economic, Social and Cultural Rights, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)' (11 August 2000) adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights E/C.12/2000/4 para 14.
[82]CESCR 2000 (n 81) para 16.
[83]ibid (n 81) para 21.
[84]ibid (n 81) para 23.
[85]Committee on Economic, Social and Cultural Rights 'General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)' (2 May 2016) E/C.12/GC/22 para 1.4.
[86]CESCR 2016 (n 85) para 2.1.
[87]CESCR 2016 (n 85) para 1, 2.

ICESCR, following the framework of state obligations set out by the CESCR discussed in the previous chapter. However, before focusing on state obligations, there are several other human rights treaties that have to be considered in the light of reproductive rights first.

Probably the most important and extensive human rights convention on reproductive health of women and the only one to explicitly mention family planning is the CEDAW. The convention "affirms women's right to reproductive choice" and their right to access adequate health care facilities, including information, counselling and services in family planning.[88] Special attention is paid to the needs of rural women and the challenges they face in accessing reproductive health services due to their geographical location.[89] General Recommendation No. 24 of the CEDAW Committee on Article 12 further elaborates on the right to health and addresses the issue of discrimination against women and its impact on reproductive rights. The Recommendation highlights the vulnerability of women belonging to disadvantaged groups such as refugees, women working in prostitution or indigenous women.[90] Other more specific recommendations of the CEDAW Committee discuss related issues like FGM, HIV and AIDS or violence against women.[91]

Reproductive rights of children, adolescents and mothers are further elaborated in Article 24 of the CRC on the right to health. The article urges states to take measures aimed at diminishing infant and child mortality and provide appropriate pre-natal, post-natal and preventive health care as well as family planning education and services. In addition, states have to push for the abolishment of traditional practices prejudicial to the health of children.[92] GC No. 15 of the Committee on the Rights of the Child specifies article 24 further and elaborates on the services that should be covered by health care. Pre-natal and post-natal health care, for example, should include, *inter alia*, prevention of neonatal tetanus, malaria and congenital syphilis, prevention of the transmission of HIV from mother to child and treatment of HIV- infected women and infants, nutritional care, prenatal classes, early recognition and management of complications, safe abortion and post-abortion care, even though abortion itself was illegal, essential care at delivery, and screening tests for birth

[88]*Convention on the Elimination of All Forms of Discrimination against Women* (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13 (CEDAW) preamble.
[89]CEDAW (n 88) art 14.
[90]CEDAW Committee 'General Recommendation No. 24: Article 12 of the Convention (Women and Health)' (1999) adopted at the Twentieth Session of the CEDAW Committee A/54/38/Rev.1 chap 1 para 6, 8.
[91]E.g. UN Committee for the Elimination of All Forms of Discrimination against Women, 'General Recommendation No 35 on gender-based violence against women, updating general recommendation No. 19' (14 July 2017) CEDAW/C/GC/35; or CEDAW General Recommendation No. 14 on Female Circumcision; CEDAW General Recommendation No. 15 on the prevention of AIDS.
[92]CRC (n 78) art 24.

defects.[93] Additionally, access to methods of family planning like condoms, hormonal methods and emergency contraception should be facilitated for sexually active adolescents.[94] Children and adolescents should moreover be allowed to receive certain medical treatments like HIV testing and reproductive health services without the consent of their parents, caregivers or guardians.[95]

In the context of persons with disabilities, reproductive rights are covered by the CRPD. Article 25 of the CRPD provides the right to free or affordable sexual and reproductive health care and related programmes for people with disabilities. Article 23.1 protects the right to decide "freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education" and emphasises that "persons with disabilities, including children, retain their fertility on an equal basis with others".[96] GC No. 3 of the CRPD Committee on article 6 on women and girls with disabilities highlights the importance of reproductive autonomy and the dangers of neglecting legal capacity and brings attention to the different obstacles impeding access to reproductive rights, like e.g. physical barriers.[97]

As we can see, reproductive rights cover a vast range of freedoms and entitlements belonging to the field of the right to health. Arising from those, states bear certain obligations toward right's holders. Regarding the right to health in general, under article 12 of the ICESCR states have to (a) ensure the healthy development of all children, reducing the stillbirth-rate and infant mortality, (b) improve environmental and industrial hygiene, (c) prevent and treat epidemic, endemic, occupational diseases and (d) ensure that all people can access medical services if they need to.[98] Those compose some of the most important obligations under the right to health and do, partly, also cover reproductive rights. Obligations under reproductive rights are further specified in article 12 of the CEDAW and in GC No. 14 of the CESCR. In addition, the CEDAW includes other provisions that could be interpreted in the light of reproductive rights. Some of those provisions will be discussed later, however, as this thesis focuses more on reproductive rights under the right to health, no complete analysis of the CEDAW in this context will be given.

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[93]Committee on the Rights of the Child (CRC), 'General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)' (17 April 2013) CRC/C/GC/15 art 54.
[94]Committee on CRC 2013 (n 93) para 70.
[95]ibid (n 93) para 31.
[96]*Convention on the Rights of Persons with Disabilities* (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3 (CRPD) art 23.1, 25.
[97]UN Committee on the Rights of Persons with Disabilities (CRPD), 'General Comment No. 3: Article 6: Women and girls with disabilities' (2 September 2016) CRPD/C/GC/3 art 44, 57.
[98]ICESCR (n 68) art 12.

For a more detailed identification of the obligations states bear under the right to health and consequently the right to reproductive health, the tripartite system discussed in the context of state obligations under ESCR proves to be a valuable tool of analysis. Broadly speaking, under the obligation to *respect* states have to refrain from impeding access to health services on an equal basis and taking actions that endanger the health of people. The obligation to *protect* demands the adoption of legislative or other measures that ensure equal access on the one hand, and protect people from health infringements of third parties on the other hand. Lastly, under the obligation to *fulfil* states have to adopt national health policies, allocate sufficient funds to the health sector and provide adequate health infrastructure and services to enable people to enjoy their right to health.[99] These rather generally formulated obligations are further elaborated in thematic reports of the IACHR[100] and specified in the second part of GC No. 14 on the right to health, as well as in GC 22 on reproductive health. Hereby, the CESCR distinguishes between specific legal obligations, international obligations, and core obligations.

Under specific legal obligations, the obligation to *respect* includes the obligation to abstain from carrying out discriminatory practices that have a negative impact on the health of the right holder. Such practices are, for example the criminalization of abortion. As abortion is a health service needed only by women and girls, its prohibition disproportionately affects them, limiting the enjoyment of their reproductive rights. Criminalization moreover fosters the rise of unsafe clandestine abortions which can cause several other reproductive health issues, like maternal deaths.[101] Furthermore, states have to refrain from prohibiting "traditional preventive care, healing practices and medicines", a clause of crucial importance for indigenous peoples, and "from marketing unsafe drugs and (...) applying coercive medical treatments", like forced sterilizations. In the context of reproductive rights, states have to "refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health".[102] Special Rapporteur Grover on the right to health notes that this is especially important in the light of unsafe abortions in countries where abortion is illegal or very restricted, as family-planning is a key element in the prevention of abortions and

[99]Toebes 2001 (n 69) 179, 180.
[100]e.g. IACHR *Access to Justice for Women Victims of Sexual Violence: Education and Health* (28 December 2011) OEA/Ser.L/V/II. Doc. 65.
[101]Center for Reproductive Rights, 'Inter-American Commission on Human Rights Calls for Better Access to Reproductive Health Services. Press Release' (24 October 2017) <https://reproductiverights.org/press-room/inter-american-commission-on-human-rights-calls-for-better-access-to-reproductive-health-> accessed 3 June 2019.
[102]CESCR 2000 (n 81) para 34.

unwanted pregnancies in general.[103] Additionally, states have to refrain from criminalizing sexual and reproductive health care services like the use of emergency contraception and ensure that laws and policies do not allow private actors to limit access to sexual and reproductive health services or health related information.[104] If such limitations are inevitable, they must be temporary and cannot disproportionately affect disadvantaged and marginalised individuals and groups.[105] As all those obligations are of a negative nature and are therefore not bound to resources, they have to be fulfilled immediately and do not allow for progressive realization.[106]

The obligation to *protect* covers the regulation and control of production and sale of medication as well as standards of education and training of medical personnel. States have to monitor privatization in the field in order to ensure availability, accessibility, acceptability and quality of health care facilities, goods and services. In addition, states have to hinder third parties from limiting access to health related information and services. Summarised, states have the obligations to take the appropriate measures to ensure that third parties do not interfere with the reproductive rights of others, for example through forcing women to undergo harmful social or traditional practices like FGM.[107] In connection, GC No. 19 of the CEDAW Committee emphasises states obligations to prevent forced medical procedures connected to fertility and reproduction.[108] Again, special protection should be given to vulnerable groups which often include women and children.[109] Special Rapporteur Hunt adds that states must adopt legislation prohibiting child marriage which is "linked to health risks including those arising from premature pregnancy" and set a legal minimum age for sexual consent and marriage to prevent sexual violence and other non-consensual acts like forced pregnancy or abortion.[110] Moreover, the state has to adopt legislative and other measures in order to ensure that medical personnel admits and assists all women without discrimination and maintains all patients' privacy and integrity as "a lack of confidentiality may deter

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[103]UNGA, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover. Mission to Guatemala' (16 March 2011) Seventeenth Session para 69.

[104]CESCR 2016 (n 85) 41, 57; In connection, the CEDAW Committee has repeatedly advocated for less strict abortion laws in the region and decriminalization of abortion, e.g. in CEDAW Committee 'Concluding observations on the combined seventh and eighth periodic reports of Honduras' (18 November 2016) CEDAW/C/HND/CO/7-8 para 36(a).

[105]CESCR 2016 (n 85) para 38.

[106]ibid (n 85) para 34.

[107]CESCR 2000 (n 81) para 35.

[108]CEDAW Committee 'General Recommendation No. 19: Violence against Women' (1992) adopted at llth session U.N. Doc. A/47/38 para 24(m).

[109]CESCR 2000 (n 81) para 35.

[110]Commission on Human Rights 'Economic Social and Cultural Rights. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health Report of the Special Rapporteur, Paul Hunt' (16 February 2004) Sixtieth session E/CN.4/2004/49 para 25, 26.

individuals from seeking advice and treatment, thereby jeopardizing their health and well-being".[111] This is especially urgent in the treatment of post-abortion patients who should not fear attending a health care facility because of possible legal consequences, e.g. if abortion is criminalised.[112] Therefore, the Special Rapporteur advocates for the removal of punitive measures against women who have illegally undergone abortions.[113]

The obligation to *fulfil* requires states to "take positive measures that enable and assist individuals and communities to enjoy the right to health" and enable persons who are not in a position to realise the right to health themselves in its enjoyment, e.g. through providing health related information for indigenous people in native languages. Additionally, states have to provide adequate health facilities, including for mental health, offer healthcare that covers at least the basic needs of people, e.g. through offering vaccinations against the most common diseases, and guarantee equal access to the underlying determinants of health. In order to promote health, states should conduct and fund research, provide information about health related issues like nutrition or harmful traditional practices as well as related health services, ensure health care services are culturally sensitive and support people in their decision-making about health related issues.[114]

Contextualised with reproductive rights, generally speaking under the obligation to facilitate, states have to include sexual and reproductive health services in their health infrastructure, particularly targeting rural areas with low accessibility. The focal point of such services should be maternal and child health care, including pre-natal and post-natal attention as well as the provision of education and information about the main health problems within a community and how to prevent and control them.[115] According to the PAHO, prevailing health issues in Peru are, among others, maternal mortality, adolescent pregnancy, the Zika virus and HIV/AIDS as well as other STDs. Thus, the state of Peru has the obligation to actively adopt measures to combat those health challenges, e.g. through information and educational programmes on the topic.[116] Concerning the payment of health care, states should develop a health insurance system that is affordable for everyone. Moreover, medical research, health education and information campaigns must be promoted and supported. These should, among others, target health issues like HIV/AIDS, sexual and reproductive

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[111]Commission on Human Rights 2004 (n 110) para 40.

[112]UNGA, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Paraguay' (2016) Human Rights Council Thirty-second Session A/HRC/32/32/Add.1. para 34.

[113]UNGA 2016 (n 112) para 38.

[114]CESCR 2000 (n 81) para 37.

[115]CESCR 2000 (n 81) para 37.

[116]PAHO, 'Leading Health Challenges' in Peru 2/5 Health in the Americas PAHO Official Website <https://www.paho.org/salud-en-las-americas-2017/?p=3232> accessed 12 July 2019.

health, harmful traditional practices and domestic violence.[117] Reproductive health services must also include "vital health services as voluntary testing, counselling and treatment for sexually transmitted infections, (...) and breast and reproductive system cancers, as well as infertility treatment."[118] Such services must be available for people of all sexual orientations and groups of people that tend to face discrimination in that area, like sex-workers, and eradicate all possible barriers of access.[119] Additionally, states have ensure women "appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".[120]

As demonstrated above, the right to health as well as to reproductive rights imposes all kinds of obligations on states, however, the full implementation of all those rights is rather expensive, especially for countries with weak health infrastructure, and can therefore often only be achieved progressively. Still, there are some obligations states have to fulfil regardless of resource constraints, the so-called core obligations. In the context of health, the core obligation of states is to guarantee a minimum essential level of health. This minimum level is covered by the provision of primary health care. Guidance on what primary health care should entail can be found in the Alma-Ata Declaration. Although not being a legally binding treaty, the declaration helps to interpret the minimum threshold of primary health care, which, *inter alia*, must include maternal and child health care and strategies of family planning.[121] The CESCR further elaborates on the issue, compelling states to enable access to healthcare without discrimination, safe and adequate minimum nutrition, basic shelter, housing, sanitation and safe and potable water, providing essential drugs, ensure equal availability of health facilities, goods and services and adopt national public health strategies and action plans that address the most urgent health issues of a country.[122] Moreover, states must provide "immunization against the major infectious diseases occurring in the community". Other core obligations under the right to health are educating and informing communities about the most prevalent health issues as well as their prevention, treatment and control, and educating and training health personnel on human rights.[123] Although those obligations undoubtedly include services of high importance, the whole concept of core obligations is disputed among

[117]CESCR 2000 (n 81) para 16, 17, 19, 36.
[118]Commission on Human Rights 2004 (n 110) para 29.
[119]Commission on Human Rights 2004 (n 110) para 39; among others discussed in *Toonen v. Australia* 5 November 1992 CCPR/C/46/D/488/1992.
[120]CEDAW (n 88) art 12.2.
[121]*Declaration of Alma-Ata* (6-12 September 1978) at the International Conference on Primary Health Care USSR VII 3.
[122]CESCR 2000 (n 81) para 43.
[123]ibid (n 81) para 44.

academics. Labelling some obligations *core* obligations might give the impression that they are superior to other obligations. This argument could be used by states as a loophole to delay the realization of all other obligations indefinitely. Therefore, it has to be emphasised that fulfilling core obligations is just one step towards the full implementation of the right to health, and that progressive realization of all other obligations is equally important.[124]

If states are not able to fulfil their obligations due to resource constraints, according to article 2 of the ICESCR they have to seek international assistance. Under international law, states are obliged to provide development assistance and cooperation to states which cannot guarantee the realization of human rights on their own.[125] Within international cooperation states should “facilitate access to essential health facilities, goods and services in other countries, wherever possible, and provide the necessary aid when required”. Moreover, the right to health must be taken into account when drafting international treaties and agreements which have to be compatible with the right to health. Likewise, members of international financial institutions like the International Monetary Fund or the World Bank must ensure their lending and credit policies are in accordance with the right to health.[126] Lastly, states have to refrain from interfering with other countries in a way that jeopardises the enjoyment of the right to health of the people residing in that country and prevents third parties from doing so, if lawful and within their power.[127] Special Rapporteur Hunt highlights that donor countries need to “adopt a rights-based approach to their policies” and support programmes that provide a variety of sexual and reproductive health services, including campaigns on unsafe abortions. Moreover, he claims that donor countries should rather support specific projects aimed at improving reproductive and sexual health than just providing funds for the sector health in general. This would prevent the marginalization of programmes targeting reproductive health and ensure sufficient funding. He argues that as issues of reproductive health are of such a sensitive nature, they are often disregarded when distributing.[128]

Although the framework for state obligations under reproductive rights is quite detailed, the implementation of those obligations is not as simple. In order to better understand the actual scope of those obligations, among others in regard to progressive realisation, it is helpful to take a look at what actually constitute violations of the right to health, and reproductive rights. Simplified it can be said that the obligation to *respect* is not fulfilled if individuals or groups are denied adequate access to health care services and

[124]Toebes 2001 (n 69) 176.
[125]ICESCR (n 68) art 2.
[126]CESCR 2000 (n 81) para 39, 45.
[127]ibid (n 81) para 39.
[128]Commission on Human Rights 2004 (n 110) para 46, 47.

underlying determinants of health.[129] Furthermore, the obligation to *protect* is not fulfilled if authorities do not take adequate measures to regulate the provision of health care services by third parties so equal access is guaranteed, or if the government fails to protect its citizens from environmental threats. While these two sets of obligations are rather easy to comply with and violations are easy to detect, the obligation to *fulfil* is more complex to define. Theoretically, the obligation to *fulfil* is not satisfied if a state does not do all within its power to provide adequate and good quality health services to the population, especially to the most underprivileged and vulnerable sections of society, such as prisoners or indigenous people, and if it does not allocate sufficient funds to the health sector.[130] As the threshold of this obligation is hard to pinpoint, the CESCR has implicated that one potential indicator of whether states comply with their obligations to use the maximum of available resources or not is the comparison of military expenditures with health expenditures. If the former are disproportionately higher, it can be assumed that the state does not fulfil its obligations.[131]

If a state does not comply with its obligations under the right to health, it would be assumed that the state can be held accountable for that. According to Special Rapporteur Hunt, this is a prerequisite for the full implementation of reproductive rights. Hunt therefore advocates for "effective, accessible and transparent mechanisms of accountability in relation to all duty-bearers".[132] Nevertheless, although violations of rights can be, more or less, easily determined, this does not automatically mean that all rights are also justiciable. Whereas the obligation to respect and the obligation to protect have a high probability of being justiciable, the obligation to *fulfil* is most likely not enforceable, as it is impossible to exactly define its scope.[133] Therefor, justiciability has to be determined by competent bodies such as human rights courts or committees on a case by case basis through their monitoring systems. One such body is the CESCR, which, through its relatively new communications system has already addressed the issue of the right to health. In the communication concerning the issue of in-vitro fertilization, the CESCR did find a direct violation of article 12 of the ICESCR, thus reaffirming the justiciability of the right to health.[134]

In the Inter-American human rights system, the IACHR and the IACtHR have dealt with the right to health repeatedly. For that matter, it must be commented that in their

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[129]Toebes 2001 (n 69) 180.

[130]ibid (n 69) 181.

[131]E.g. Committee on Economic, Social and Cultural Rights, 'Concluding observations on the second periodic report of the Sudan' (27 October 2015) E/C.12/SDN/CO/2 para 15, 16(c).

[132]Commission on Human Rights 2004 (n 110) para 49.

[133]Toebes 2001(n 69) 182.

[134]E.g. Committee on Economic, Social and Cultural Rights, 'Views adopted by the Committee under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, concerning communication No. 22/2017' (28 March 2019) E/C.12/65/D/22/2017.

decisions, the IACHR and the IACtHR quite commonly refer to international human rights law. This is especially interesting in the light of ESCR, which are mostly not justiciable within the Inter-American human rights system.[135] The first time a direct violation of the right to health was found by the IACHR was in the case of Poblete Vilches vs. Chile in 2018, concerning the death of Mr. Poblete Vilches due to medical negligence, marking a shift towards direct justiciability of ESCR enshrined in article 26 of the ACHR.[136] Prior to that the IACHR had already declared a case admissible based on a violation of article 26 in Jorge Odir Miranda Cortez et al v El Salvador. However, in the end no violation of the right to health was found as the IACHR recognised that some aspects of the right to health can only be implemented progressively.[137] Concerning reproductive rights, there are certain recurring issues that have been fought against by the Inter-American human rights system for years. One of them are wrongful convictions of women who, as a result of obstetric emergencies, suffer miscarriages. This has been worryingly common in San Salvador, where women can face murder charges for miscarriages. The IACHR has repeatedly voiced its concern about the issue, and dealt with it through its complaints procedure, e.g. in the case of Manuela and Family vs San Salvador.[138] Other cases concern medical negligence during childbirth, like in Aura de las Mercedes Pacheco Briceño and Balbina Francisca Rodríguez Pacheco vs Venezuela, where obstetric malpractice had severe consequences for the health of the alleged victim. The case was declared admissible, however, not based on the right to health itself but the right to humane treatment, the right to a fair trial and the right to judicial protection.[139] Another issue related to reproductive health brought before the IACtHR is the prohibition of in-vitro fertilization. In Artavia Murillo et al ("In-vitro fertilization") v Costa Rica the Court found a violation of the women's reproductive rights, nevertheless, in its judgement it did not invoke the right to health but rather relied on other CPR such as the right to personal integrity, rights of the family and the right to privacy.[140] Similarly, in its decision in Ana Victoria Sanchez Villalobos and others v Costa Rica on in-vitro fertilization the IACHR admitted that

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[135]E.g. in Jorge Odir Miranda Cortez et al v El Salvador, No 12.249, 20 March 2009, Report No 27/09 the IACHR relies on sources of international human rights law.

[136]Poblete Vilches v Chile (n 61).

[137]Jorge Odir Miranda Cortez et al v El *Salvador* (n 135)

[138]Manuela and Family v El Salvador, No 424.12, 18 March 2017, Report No 29/17 concerning the imprisonment oft the alleged victim due to a miscarriage caused by an obstetric emergency; further discussed in in Amnesty International 'El Salvador: Separated Families, broken ties: Women imprisoned for Obstetric Emergencies and the Impact on their Families' (2015) El Salvador: Women and Girls Official Website <www.amnesty.org/en/documents/amr29/2873/2015/en/> accessed 12 July 2019.

[139]Aura de las Mercedes Pacheco Briceño y Balbina Francisca Rodríguez Pacheco v Venezuela*,* No 1119-02, 20 March 2012, Report No. 20/12 (Report on Admissibility).

[140]Artavia Murillo et al ("In-vitro fertilization") v Costa Rica, Judgement of 28 November 2012, Series C No. 257.

it lacked jurisdiction to establish violations under the Protocol of San Salvador and instead used CPR in its decision.[141]

As shown by those cases, reproductive rights can not only be enforced through the right to health but can also fall under other provisions of human rights, some of which will be briefly mentioned later. In addition, within the right to health, reproductive rights are dependent on and interrelated with several determinants. Some of them, namely the principles of non-discrimination and equality, the right to education and the right to information, will be discussed in the following subchapters.

3.2.3. The Principles of Non-Discrimination and Equality

Besides constituting human rights on their own, non-discrimination and equality are principles that build the basis for the enjoyment of any fundamental right, *inter alia,* sexual and reproductive rights and are enshrined in every human rights treaty as well as several GCs. Most generally, article 3 of the ICESCR provides that all men and women are equal in the enjoyment of their human rights. In order to achieve this, article 2 obliges states parties to guarantee that all rights enshrined in the covenant can be exercised "without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".[142] Article 1 of the ACHR repeats this language.[143] More extensively, in the context of women's rights, the term discrimination is defined in the CEDAW as:

> any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women (...) on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.[144]

Due to their "sex/gender and reproductive function" the principles of non-discrimination and equality play a major role for women in the context of reproductive rights.[145] Inequality can be manifested in income, systematic discrimination and marginalization and fostered by laws and policies.[146] The most important treaty on the issue of equality between men and women is undoubtedly the CEDAW which was adopted in response to the extensive discrimination

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[141] Ana Victoria Sanchez Villalobos and others v Costa Rica, No 12.361, 11 March 2004, Report No 25/04 (Report on Admissibility).
[142] ICESCR (n 68) art 2.
[143] ACHR (n 60) art 1.
[144] CEDAW (n 88) art 1.
[145] IACHR, 'IACHR Urges All States to Adopt Comprehensive, Immediate Measures to Respect and Protect Women's Sexual and Reproductive Rights' (23 October 2017) Press Release No 165/17 <www.oas.org/en/iachr/media_center/PReleases/2017/165.asp> accessed 12 July 2019.
[146] CESCR 2016 (n 85) para 8.

women faced. In its preamble it states that discrimination "violates the principles of equality of rights and respect for human dignity" and that special measures must be taken in order to end discrimination against women.[147] Most relevantly for reproductive rights, the CEDAW prohibits discrimination in the field of education with the aim of eliminating stereotypes and gender roles and providing educational information on topics like family planning to enable girls and women to exercise their reproductive rights.[148] Moreover, the convention fights against discrimination based on marriage and maternity, especially when jeopardizing the right to work[149] and contextualises discrimination against women with the right to health.[150] As already mentioned, the CEDAW brings attention to the different forms of discrimination women living in rural areas face, a provision particularly relevant for indigenous women.[151] In addition, the CEDAW allows for special measures aimed at achieving "de facto equality between men and women", including measures aimed at protecting maternity, and affirms that such measures are not to be considered discriminatory.[152] All those articles premise that for the full enjoyment of reproductive rights all people have to be treated equally and granted access to education, information and health care services without discrimination on any basis.

Another convention specialising on women is the Convention of Belem do Para within the Inter-American human rights system. The convention examines the interplay of discrimination against women and gender based violence (GBV), and acknowedges that GBV and discrimination can affect the sexual and reproductive health of women. In article 6 it emphasises that in order to be able to live free from violence, women need to "be free from all forms of discrimination" and "be valued and educated free of stereotyped patterns of behaviour and social and cultural practices based on concepts of inferiority or subordination".[153] Although the convention does not explicitly mention reproductive rights, it is an important tool in the field.

Discrimination limiting reproductive rights is often manifested in stereotyping and can be based on other factors than gender, for example on age, ethnicity, disability or other social determinants like economic or social status as well as geographic location. One example is the discrimination of adolescent girls based on pregnancy manifested in the expulsion of pregnant students from school which violates not only the prohibition of discrimination, but also the

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[147]CEDAW (n 88) preamble.
[148]ibid (n 88) art 10.
[149]ibid (n 88) art 11.2.
[150]ibid (n 88) art 12.1.
[151]ibid (n 88) art 14.2.
[152]ibid (n 88) art 4.1.
[153]*Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para)* (adopted 9 June 1994, entered into force 5 March 1995) art 6(a).

right to education.[154] However, great efforts have been made by national courts to combat such discrimination with countries like Colombia or Venezuela adopting laws protecting pregnant students and prohibiting their exclusion from school.[155]

Another example is discrimination based on ethnicity, e.g. when information or services on reproductive health are not provided in the client's language, an issue that commonly affects indigenous or afro-descendant women.[156] How cultural factors can hinder women and girls from accessing reproductive health services has also been discussed by the Bolivian government in its plan on the prevention of pregnancies among adolescents. Accordingly, although adolescents in Bolivia do have knowledge about the use and access to contraceptives, stigma around the topic and cultural barriers, not only in indigenous communities but throughout the whole society, often deter them from accessing such services[157].

Regarding discrimination based on disability, harmful stereotypes about women with disabilities, including beliefs that they are "asexual, incapable, irrational lacking control or hypersexual" have a great impact on their reproductive rights. In consequence, women with disabilities are often not allowed to decide freely if and how often they want to reproduce and decide on matters related to their sexuality.[158] In the context of reproductive rights and discrimination based on disability, mention also has to be made of the controversial issue of the right to life of an unborn child with disability versus the reproductive rights of its mother. Whether abortion of unborn children based on disability is a discriminatory practice has been hotly debated on the international level. The IACHR has criticised states like El Salvador who do not allow for abortion in any circumstances, arguing that denying women the possibility to abortion, among others in the case of disability of the child, drives women to undergo unsafe abortions that jeopardise their right to physical integrity and their own right to life.[159] The UN Committee on the Rights of Persons with Disabilities on the contrary, has stated that abortion on ground of disability of the child violates the CRPD.[160] Nevertheless, recently it issued a

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[154]Committee on the Rights of the Child 2013 (n 93) para 56.

[155]Constitutional Court Colombia, Case C-355/06 [2006], Judgment of 10 May 2006; Resolution 1762 of the Ministry of Education [09 October 1996] art 2.

[156]IACHR, 'Access to Maternal Health Services from a Human Rights Perspective' (7 June 2010) OEA/Ser.L/V/II. Doc. 69 para 54.

[157]Ministerio de Justicia de Bolivia, *Plan Plurinacional de Prevención de Embarazos en Adolescentes y Jóvenes PPEAJ 2015 – 2020* (2015) 48.

[158]Committee on the Rights of Persons with Disabilities 2016 (n 97) para 38.

[159]E.g. in IACHR, 'Conclusions and Observations on the IACHR's Working Visit to El Salvador' (January 29, 2018) Press Release No. 011A/18 <www.oas.org/en/iachr/media_center/PReleases/2018/011A.asp> accessed 3 June 2019.

[160]E.g. in Committee on the Rights of Persons with Disabilities 'Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland' (3 October 2017) CRPD/C/GBR/CO/1 para 13.

joint statement with the CEDAW Committee advocating for more progressive abortion laws and negating that the CRPD restricts access to safe abortion.[161]

Regarding obligations under the principles of non-discrimination and equality, it is not enough to merely refrain from taking discriminatory measures. Instead, states have to actively take measures to eradicate discrimination on all levels. This includes addressing social determinants, reviewing existing "laws, regulations, practices, and public policies whose wording or implementation in practice could have discriminatory repercussions on women's access to all reproductive health services" as well as adopting new legislation on the issue.[162]

3.2.4. The Right to Information and Education

To make the full enjoyment of reproductive health and rights possible, all potential beneficiaries have to be informed and educated about the issue. As the right to information and the right to education are strongly intertwined and complement each other, they will be dealt with within the same chapter.

The right to seek, receive and impart information is granted by Article 19.2 of the ICCPR, and article 13 of the ACHR but only put into context with the right to health by GC No. 14 of the CESCR.[163] In the GC, the right to health is interpreted as an inclusive right that, *inter alia*, extends to "access to health-related education and information, including on sexual and reproductive health". Additionally, information accessibility constitutes part of one of the main pillars of the right to health, including the right to "seek, receive and impart information and ideas concerning health issues".[164] Article 10 (h) of the CEDAW reaffirms that educational information is crucial to ensure the enjoyment of the right to health and should include "information and advice on family planning".[165] The right to education for everybody is granted by Article 13 of the ICESCR and article 13 of the San Salvador Protocol. Moreover, it is incorporated into Article 26 of the ACHR on ESCR and is one of the two ESCR that can be enforced by the IACtHR.[166] In connection to the right to health, under article 10(e) of the San Salvador Protocol all people are entitled to health education on the

[161]OHCHR, 'Stop regression on sexual and reproductive rights of women and girls, UN experts urge' (5 September 2018) OHCHR Daily News <www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23503&LangID=E> accessed 07 July 2019.

[162]IACHR 23 October 2017 (n 145); for example, in the case of San Salvador IACHR 'IACHR Urges El Salvador to End the Total Criminalization of Abortion' (March 7 2018) Press Release No 042/18.

[163]*International Covenant on Civil and Political Rights* (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR); ACHR (n 60).

[164]CESCR 2000 (n 81) para 11.

[165]CEDAW (n 88) art 10(h).

[166]ACHR (n 60) art 26.

prevention and treatment of health problems.[167] Additionally, the Convention of Belém do Pará highlights the importance of educational programmes to tackle the issue of GBV. The treaty aims, *inter alia*, at modifying "social and cultural patterns of conduct of men and women" through educational programmes specially designed for different age groups. Such programmes should "counteract prejudices, customs and all other practices" based on gender roles and stereotypes that legitimise violence against women.[168]

According to the ICESCR, education in general should "be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms". The Committee claims that primary education should be free and accessible to anyone and further education equally accessible.[169] Additionally, article 24 of the CRC on the right to health includes the right to access to education and basic knowledge about children's health and "guidance for parents and family planning education and services". The right to education in general is further enshrined in article 28 of the convention.[170] About the role of education the CESCR has held that:

> Education is both a human right in itself and an indispensable means of realizing other human rights. As an empowerment right, education is the primary vehicle by which economically and socially marginalized adults and children can lift themselves out of poverty and obtain the means to participate fully in their communities. Education has a vital role in empowering women (...) Increasingly, education is recognized as one of the best financial investments States can make.[171]

GC No. 15 of the Committee to the CRC on the right of the child to health additionally stresses that children should be able to receive "education and guidance on sexual health, contraception and safe abortion" without the consent of a parent or legal guardian[172] reinforcing the Guiding Principle of the CRC on the right of the child to be heard which provides children the right to form their own opinion.[173] GC No. 15 further defines how sexual and reproductive health education should be designed. Accordingly, it should include "self-awareness and knowledge about the body, including anatomical, physiological and emotional aspects" as well as "content related to sexual health and well-being, such as information about body changes and maturation processes". Moreover, it should be "accessible to all children, girls and boys" and be "designed in a manner through which children are able to gain knowledge regarding reproductive health and the prevention of

[167] San Salvador Protocol (n 62) art 13, 16 and 10(e).
[168] *Convention of Belem do Para* (n 153) art 8(b).
[169] ICESCR (n 68) art 13.
[170] CRC (n 78) art 24 (e) (f), 28.
[171] Committee on Economic, Social and Cultural Rights 'Implementation of the ICESCR. General Comment No 13. The Right to Education' (08 December 1999) adopted at the Twenty-first Session E/C.12/1999/10 art 1.
[172] Committee on the CRC 2013 (n 93) para 31.
[173] CRC (n 78) art 12.1.

gender-based violence, and adopt responsible sexual behaviour".[174] The IACHR stresses that for girls and adolescents, access to information and education are important tools to "advance women's reproductive autonomy and prevent unwanted pregnancies".[175] Additionally, parents and caregivers should be provided information about children's health.

Educational and informative programmes can be achieved through campaigns in health institutions, parenting classes, community organisations, the media or public campaigns.[176] In GC No. 3, the Committee on the CRC further stresses the importance of sexual and family planning education for children for the effective prevention of HIV/AIDS.[177] GC No. 22 of the CESCR on the right to sexual and reproductive health claims that education and information on sexual and reproductive health must be "non-discriminatory, non-biased, evidence-based and taking into account the evolving capacities of children and adolescents".[178]

As we can see, information and education about sexual and reproductive health and rights are important on many different levels. First of all, programmes designed to eliminate discrimination in the health sector can be achieved through the dissemination of information.[179] Informative campaigns about STDs, harmful cultural practices, sexual and reproductive health or domestic violence can have a preventative effect and empower women to claim and defend their rights.[180] During the execution of such campaigns, it is crucial to focus on health problems prevailing in the targeted community and pay attention to the cultural appropriateness of the design.[181] Programmes should teach the population about methods of prevention as well as control.[182] All information services must be reliable, "sensitive and compassionate" and available for all people, including adolescents and homosexual people. As already mentioned, another important issue is the provision of information about legal ways of terminating a pregnancy to women in need.[183] Concerning marginalised people, article 14 of the CEDAW stresses the importance of providing women living in rural areas with the appropriate information and services in family planning.[184] Taking historically marginalised and disadvantaged groups of people into account is also

[174]Committee on the CRC 2013 (n 93) para 60.
[175]IACHR 23 October 2017 (n 145).
[176]Committee on the CRC 2013 (n 93) para 61.
[177]Committee on the Rights of the Child 'General Comment No 3 (2003) HIV/AIDS and the Rights of the Child' (17 March 2003) Thirty-second session CRC/GC/2003/3.
[178]CESCR 2016 (n 85) para 49(f).
[179]CESCR 2000 (n 81) para 18.
[180]CESCR 2016 (n 85) para 44.
[181]ibid (n 85) para 19.
[182]CESCR 2000 (n 81) para 22.
[183]Commission on Human Rights 2004 (n 110) para 39.
[184]CEDAW (n 88) art 14.

emphasised by the IACHR which claims that the sensitivity of the topic of reproductive rights can have an amplifying effect on marginalization.[185]

The right to sexual education is further interpreted and elaborated in the Report of the Special Rapporteur on the Right to Education. Accordingly, comprehensive sexual education is crucial for the well-being of a person as it enables people to keep healthy and "deal positively, responsibly and respectfully with our sexuality". Sexual education in schools should therefor "foster pupils' critical thinking about the various expressions of human sexuality and interpersonal relations, without reducing the topic to a biological approach". Moreover, sexual education has to be adapted to different age groups and societies as well as genders. Vulnerable groups like children who do not attend school, including young married girls or mothers, must be given special consideration.[186] A well-structured framework for how sexual education should be designed and implemented is offered by the UNESCO *International Guidelines on Sexuality Education.*[187]

Regarding state obligations, states have to refrain from "censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information".[188] This goes hand in hand with the positive obligation to provide "[a]ccess to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning".[189] Further, article 17 of the CRC obliges states to ensure that children can access "information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health". Additionally, all people, particularly parents and children, have the right to access information and education to gain basic knowledge in the fields of children's health and nutrition, including the advantages of breastfeeding, hygiene, environmental sanitation and accident prevention.[190] In its GC No. 15 the Committee on the CRC on the right to health stresses the importance of integrating educational programmes for boys and men into reproductive health services. This raises awareness of reproductive health issues for both men and women and at the same time gives

[185]IACHR *Access to Information on Reproductive Health from a Human Rights Perspective* (22 November 2011) OEA/Ser.L/V/II. Doc. 6 art 1.
[186]UNGA 'Report of the United Nations Special Rapporteur on the right to education' (23 July 2010) in Sixty-fifth session Item 69 (b) of the provisional agenda. Promotion and protection of human rights: human rights questions, including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms A/65/162 para 12, 13.
[187]UNESCO et al *International Technical Guidance on Sexuality Education. An Evidence-Informed Approach.* (UNESCO Revised edition 2018) <https://unesdoc.unesco.org/ark:/48223/pf0000260770> accessed 12 July 2019.
[188]CESCR 2000 (n 81) para 34.
[189]CEDAW (n 88) art 10(h).
[190]CRC (n 78) art 17, 24.2(e).

men and boys, who are after all important stakeholders in healthy pregnancies and deliveries, the opportunity to take part in dialogues about the topic. In this context, the committee also highlights the importance of providing child-friendly information and ensuring confidential and universal access to both male and female adolescents without discrimination based neither on gender nor age.[191] According to the IACHR, such information must be "timely, complete, accessible, reliable, and proactive".[192] Furthermore, the IACHR highlights the importance of informed consent, confidentiality, access to medical records and access to information about statistics.[193]

Under the CRC states have the duty to develop programmes of family planning education.[194] In addition, the CEDAW, highlighting the importance of education for modifying social and cultural patterns, imposes the obligation on states to "ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children".[195] The role of such education is also highlighted in the CEDAW Committees' latest country report on Kyrgyzstan which shows that "innovative forms and methods of informational and educational work" are a useful tool to raise public awareness and response on reproductive health issues and increase gender sensitivity. At the same time, education can be used to combat issues linked to reproductive health like bride kidnapping, early marriage, gender prejudices and stereotypes.[196] Educational programmes do not only constitute sexual education in schools but can also target an adult audience, for example through "paternity schools" that educate men about issues of maternity and child care.[197]

Obligations under the right to education and the right to information in regard to reproductive rights are abundant and cover services targeting a vast audience. Violations of those rights can be claimed by individuals through the complaints procedure of the CESCR as well as the CEDAW Committee and the IACHR. One recurring issue regarding the right to information is forced sterilizations performed without informed consent. In the case *A.S. v. Hungary,* for example, a woman of Roma origin was asked to sign a form of consent right before receiving an emergency Caesarean section. The form, written by hand by the doctor,

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[191]Committee on the CRC 2013 (n 93) para 57.
[192]IACHR 22 November 2011 (n 185) chap C.
[193]IACHR 22 November 2011 (n 185) art 42.
[194]CRC (n 78) art 24.2(f).
[195]CEDAW (n 88) art 5(b).
[196]CEDAW Committee 'Fifth periodic report submitted by Kyrgyzstan under article 18 of the Convention, due in 2019' (5 April 2019) in Human Rights Council Eleventh session CEDAW/C/KGZ/5 para 37.
[197]ibid (n 197) para 55.

stated that A.S. consented to being sterilised during the Caesarean section. A.S. later claimed that she did not understand what was written on the form.[198] Hungary was found to have violated A.S.' rights to informed consent to medical procedures, information on family planning, appropriate services in connection with pregnancy and the post-natal period and the right to determine the number and spacing of her children. It was the first time that an international human rights treaty body held a state responsible for failing to fulfil its obligation to provide appropriate information to women about reproductive health procedures. This reinforced state obligations under reproductive rights and was at the same time an important decision for the rights of Roma women.[199]

Similar cases have also been brought before the IACHR, for example in the case of *Paulina del Carmen Ramírez Jacinto v. Mexico*, where the applicant, 14 years old at the time, was denied timely information about legal abortion after a rape had resulted in her pregnancy. However, the case was closed by a friendly settlement before the Commission even considered the merits, wherefore it is hard to determine which provisions had actually been violated.[200] An interesting point in correspondent cases is the potential conflict between the reproductive rights of patients and the rights of health professionals to conscientious objection. The IACHR made it clear that if a health professional does not want to perform certain services due to their own conviction, they do have the obligation to refer patients to other professionals that are willing to provide the service in question.[201]

Another case, namely *F.S. v Chile*, concerned the sterilization without consent of a HIV positive women during a Caesarean section. The author claimed that during her pregnancy she did not receive any information about sterilization or other methods of family planning nor about the transmission of HIV to the child.[202] Therefore, even if she would have consented to the sterilization – which she did not – she would not have been able to make an informed decision about it.[203] The Commission declared the case admissible, *inter alia*, based on article 13 of the ACHR on the right to access to information. However, it did not consider article 26 and consequently the right to health.[204]

As indicated, sexual education is a powerful and relatively cheap tool for states to "achieve major improvements in (…) sexual and reproductive health" and one step towards

[198] A.S. v Hungary (2004) Communication No 4/CEDAW/C/36/D/4/2004 para 2.2.
[199] A.S. v Hungary (n 222) para 11.4, 11.5.
[200] Paulina del Carmen Ramírez Jacinto v Mexico, No 161-02, 9 March 2007, Report No 21/07; likewise, María Mamérita Mestanza Chávez v Perú (n 44) resulted in a friendly settlement before the IACHR could make any statement on violations.
[201] IACHR 22 November 2011 (n 185) para 95.; also discussed by the CEDAW Committee 1999 (n 106) para 11.
[202] F.S. v Chile, No 112-09, 21 July 2014, Report No. 52/14 (Report on Admissibility) para 12.
[203] ibid (n 203) para 15.
[204] ibid (n 203) para 41.

the full implementation of the right to reproductive health.[205] Nevertheless, although sexual education is declining in many Latin American countries and existing programmes are often inadequate, there have been no cases brought to the IACHR on the issue so far.[206]

Summarised, it seems that the right to information, especially in the form of free, prior and informed consent is a rather 'strong' right, comparatively easy to enforce, while the right to sexual education appears to be more difficult to claim, especially within the Inter-American human rights system. This is somehow surprising, as one the one hand, sexual education is such an important matter, especially in the Latin-American context, where issues like teenage pregnancies and GBV prevail, and on the other hand, education is one of the only two ESCR that are actually justiciable within the Inter-American system. One reason for that might be that the right to information could be considered more of an individual right, whereas the right to education is more of a collective nature. Moreover, while violations of the right to information in the field can have severe, immediate and direct consequences, the aftermath of the lack of sexual education is harder to pinpoint and does not necessarily have a direct effect.

3.2.5. Other Relevant Human Rights Provisions

As already suggested in the previous chapter, apart from the right to health and other ESCR, reproductive rights are "intimately linked to civil and political rights underpinning the physical and mental integrity of individuals and their autonomy" and can subsequently be claimed through other provisions of human rights law too, "such as the right to life; liberty and security of person; freedom from torture and other cruel, inhuman or degrading treatment; privacy and respect for family life; and non-discrimination and equality."[207] In the light of the enforceability of ESCR in particular, which in the Inter-American context is quite weak, claiming reproductive rights through CPR provisions is a useful tool. Therefore, this chapter will briefly examine two of the most important provisions, namely the prohibition of cruel, inhuman and degrading treatment (CIDT) together with the prohibition of violence, and the right to life.

The infringement of reproductive rights can, depending on the severity of the infringement, amount to cruel, inhuman or degrading treatment. In extreme cases, violations can also amount to torture. Nevertheless, as such cases do not fall under the scope of this

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[205]Commission on Human Rights 2004 (n 110) para 31.

[206]E.g. discussed by UNFPA director for Latin America, Esteban Caballero in
Agencia EFE, 'La ONU dice que el retroceso de la educación sexual en Latinoamérica aumentará las desigualdades' (17 October 2017) ONU Población <www.efe.com/efe/america/sociedad/la-onu-dice-que-el-retroceso-de-educacion-sexual-en-latinoamerica-aumentara-las-desigualdades/20000013-3410682> accessed 12 July 2019.

[207]CESCR 2016 (n 85) para 10.

thesis, this will not be discussed in more detail. The prohibition of subjecting people to CIDT is enshrined in Article 7 of the ICCPR and article 5 of the ACHR and further developed in the CAT and the Inter-American Convention to Prevent and Punish Torture.[208] While the act of torture is defined by the CAT, CIDT is further elaborated by the Special Rapporteur on torture. Accordingly, CIDT does not have to follow a specific objective, in contrast to torture, which is always inflicted with a special purpose, like extracting a confession. Furthermore, humiliating and degrading treatment does not necessarily need to involve any kind of pain.[209] In his Report, Special Rapporteur Nowak contextualises torture and CIDT with women and GBV.[210] Likewise, GCs No. 19 and 35. of the CEDAW Committee affirm that some forms of GBV may amount to cruel, inhuman or degrading treatment. Such can include violations of women's sexual and reproductive rights like:

> forced sterilizations, forced abortion, forced pregnancy, criminalisation of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services."[211]

This is reaffirmed by the Convention of Belem do Para which protects women against GBV, including physical, sexual and psychological violence. According to the convention, GBV can, among others, be expressed through rape, battery, sexual abuse or forced prostitution and under some circumstances even infringe the prohibition of torture.[212]

In the context of persons with disabilities, the ICRPD includes provisions on torture and CIDT, linking them, among others, to reproductive rights. Apart from article 15 on torture and CIDT, the convention provides for freedom from exploitation, violence and abuse highlighting gender-based aspects.[213] GC No. 3 of the Committee on the Rights of Persons with Disabilities on article 6 on women and girls with disabilities further develops the relation between article 15 and reproductive rights. It affirms that certain forms of violence, exploitation or abuse can amount to cruel, inhuman and degrading treatment or punishment.

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[208]ICCPR (n 163) art 7; ACHR (n 60) art 5.

[209]UNGA, 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak. Study on the phenomena of torture, cruel, inhuman or degrading treatment or punishment in the world, including an assessment of conditions of detention' 5 February 2010 Thirteenth Session Agenda item 3 A/HRC/13/39/Add.5 para 30, 36.

[210]UNGA 'Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak' (15 January 2008) Item 3 of the provisional agenda Seventh Session A/HRC/7/3.

[211]CEDAW Committee 2017 (n 91) para 18.

[212]*Convention of Belem do Para* (n 153); The first times the IACHR addressed the concept of sexual violence as torture was in its decisions in the cases of Raquel Martín de Mejía v Peru, No. 10.970, 1 March 1996, Report No. 5/96; and Ana, Beatriz, and Celia González Pérez v Mexico, No 11.565, 4 April 2001, Report No. 53/01. This was reaffirmed by a decision of the IACtHR in the case *Lopez Soto and Others v Venezuela*.

[213]CRPD (n 96) art 16.

Such include "invasive and irreversible surgical practises including psychosurgery, female genital mutilation or surgery or treatment performed on intersex children without their informed consent".[214]

Regarding children, the Committee on the Rights of the Child examines the issue of violence and its connection to reproductive rights in its GC No. 13 on the right of the child to freedom from all forms of violence. Respectively, withholding essential medical care, physical violence such as forced sterilization, sexual abuse, exploitation and harmful practices such as FGM, virginity testing or breast ironing all amount to violence against children and are infringements of their reproductive rights and, depending on the severity and circumstances, may amount to cruel, inhuman or degrading treatment.[215]

As mentioned previously, so far there has been one case of forced sterilization brought before the CEDAW Committee. Nevertheless, in the ruling of the communication of a Hungarian women of Roma origin, the committee did not base its decision on the prohibition of cruel, inhuman or degrading treatment.[216] On the regional level, the IACtHR has dealt with forced sterilizations exceptionally often concerning indigenous women, for example in the case of *María Mamérita Mestanza Chávez vs Peru,* which resulted in a friendly settlement before any decision on infringements could be made.[217] Forced sterilizations have also been dealt with by the European Court of Human Rights (ECtHR). Several cases like *V.C. v. Slovakia*, *N.B. vs Slovakia* or *I.G., M.K.* and *R.H. v. Slovakia* concerned women of Roma origin that were sterilised against their will immediately after giving birth.

Another example of reproductive rights violations under the prohibition of cruel, inhumane and degrading treatment is the denial of access to abortion. In the case of *R.R. v. Poland,* for example, a women pregnant with a child suffering from a severe genetic abnormality was denied timely access to genetic tests and was consequently not able to undergo abortion. Due to the psychological consequences for the women the European Court of Human Rights (ECtHR) ruled that this amounted to a violation of the prohibition of inhuman and degrading treatment.[218]

Another CPR reproductive rights are deeply interrelated and interlinked with is the right to life, enshrined in article 6 of the ICCPR as well as article 4 of the ACHR. Nevertheless, in connection to reproductive rights this right is somehow controversial,

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[214]Committee on the Rights of Persons with Disabilities 2016 (n 97) para 32.
[215]UN Committee on the Rights of the Child (CRC), 'General comment No. 13: The right of the child to freedom from all forms of violence' (18 April 2011), CRC/C/GC/13 para 20, 22, 29.
[216]Committee on the Elimination of Discrimination against Women, 'Views Communication No. 4/2004' (29 August 2006) Thirty-sixth session CEDAW/C/36/D/4/2004 para 11.5.
[217]María Mamérita Mestanza Chávez vs Peru (n 44).
[218]R.R. v. Poland, Application no. 27617/04, Judgment of 26 May 2011.

especially within the Inter-American human rights system which promotes a slightly more conservative approach on the topic. The ACHR protects the right to life from the moment of conception which has been interpreted as prohibition of abortion and could be seen as a restriction of reproductive rights.[219] This is reflected in national legislations in the region, where most states have very restricted abortion laws. In Latin America, only Cuba, Uruguay and French Guiana allow for abortions without restriction in the first 12 weeks of pregnancy. Other countries make exceptions in cases of rape, incest or if the life or health of the mother is in danger, and six countries, including San Salvador, do not allow for abortions in any case.[220] This is problematic in situations where the life of the mother is endangered by the pregnancy, creating a conflict between the right to life of the unborn child and its mother, like in the case with *Beatriz vs El Salvador*. In order to save the life of the women, the IACtHR required the state of El Salvador to take immediate measures, with the only possible solution being ending the pregnancy.[221] Other cases in which the right to life can be invoked in connection to reproductive rights is when the failure to provide access to reproductive health care endangers the life of a person. [222] This might be the case if an untreated infection with an STD, a lack of adequate medical attention during childbirth or obstetric emergencies evolve to be life-threatening. GBV, as under the Convention of Belem do Para*,* can, among others, also infringe the right to life. Nevertheless, in the case of GBV, a connection to reproductive rights is not always given.[223]

Now that it has been established what rights fall under the scope of reproductive rights, what obligations those rights pose on states parties and if and how those rights can be enforced, the following chapter will take a closer look at reproductive rights in the context of indigenous people.

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[219]ACHR (n 60) art 4.
[220]Center for Reproductive Rights, 'The World's Abortion Laws' (26 April 2019) Record of Legal Status of Abortion in Coutnries accross the World <https://reproductiverights.org/worldabortionlaws> accessed 12 July 2019.
[221]Beatriz vs El Salvador, No 2003-13, 7 September 2017, Report No. 120/17 (Report on Admissibility).
[222]CESCR 2016 (n 85) para 10.
[223]*Convention of Belem do Para* (n 153).

4. Indigenous People and their Reproductive Rights

4.1. Specific Challenges Indigenous People face

4.1.1. Availability

As already mentioned, the CESCR Committee suggests that the right to health is based on four interrelated pillars, namely availability, accessibility, acceptability and quality. This analytical framework can help to determine the main challenges indigenous women face in the enjoyment of their reproductive rights and indicate how states could minimise potential obstacles. Consequently, in order to fully implement reproductive rights, availability, accessibility, acceptability and quality of reproductive health services must be granted. As reproductive rights are individual rights, not collective, this chapter concerns indigenous people's rights rather than indigenous peoples' as a whole.

The first pillar, availability, demands that functioning public health care facilities, goods, services and programmes are available for everyone. This includes adequate sanitation facilities, such as hospitals, clinics and other health related buildings, trained medical and professional personnel and essential drugs, as defined by the WHO Action Programme on Essential Drugs.[224] Naturally, the lack of availability of such goods and services substantially jeopardises the right to health. Populations particularly affected by insufficient availability are indigenous people, as over half of the indigenous population in Latin America lives in rural areas with an inadequate infrastructure.[225] Although there has been an unquestionable improvement in the overall access to basic services in Latin America[226], the proportion of indigenous people that have access to sanitation is still considerably smaller than that of non-indigenous people.[227] The same applies to hospitals and health care centres: While urban populations usually have easy access to a full range of health services, in rural areas health care posts merely cover basic health care services, such as vaccinations or treatment of minor wounds and injuries. In Mexico, which has significantly improved access to health care over the past decade, many people living in small, scattered villages do not even have access to

[224]CESCR 2000 (n 81) 12(a).
[225]Freire 2015 (n 4) 30.
[226]Ibid (n 4) 58: access to sewerage for example has increased by more than 60 percent in Peru, Bolivia, and Costa Rica.
[227]ibid (n 4) 70.

mere primary health care services such as vaccination programmes.[228] In cases of emergency, this can pose serious threats to a person's health. In response to the inefficiency of the government to provide health care services, in Guatemala, NGOs run most health care institutions. The Special Rapporteur on the Right to Health criticises that claiming that "[a]lthough such efforts are admirable, this is not a sustainable substitute for State action".[229] Regarding reproductive health, availability is particularly essential in the field of obstetric care. Although the percentage of births attended by medical personnel in Bolivia has increased over ten percent from 2000 to 2006, differences between urban and rural populations as well as different ethnic and socio-economic groups are still highly visible.[230] In Bolivia, almost 70% of maternal deaths occur in the countryside and disproportionately affect indigenous women. Almost half of those deaths happen at home due to a lack of ambulances, hospitals, insufficient equipment of health care posts or a lack of water. Additionally, cultural barriers such as families opposing their daughters being attended in hospitals play a minor, but nevertheless important role too.[231] Another issue in the light of reproductive rights may be shortages of pharmacies as well as in supply, which can impede the purchase of contraceptives.

Similarly, a lack of human resources can negatively impact the enjoyment of reproductive rights. This is a prevalent issue in Peru as well as Bolivia.[232] Medical staff employed in rural areas mostly consists of nurses and promotional staff, while doctors and specialists are mainly employed in larger cities where the recommended number of doctors per hospital is often even exceeded.[233] This can result in restricted opening hours and consequently, long waiting periods and little time for paying attention to patients.

4.1.2. Accessibility

The principle of accessibility requires that health facilities, goods and services have to be accessible to everyone without discrimination. It consists of four overlapping dimensions: non-discrimination, physical, economic and information accessibility. Under the dimension of non-discrimination, all health facilities and services must be accessible to everybody, with a

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[228]Andrea Chipman, *Access to Healthcare in Latin America* (The Economist Intelligence Unit 2017) <http://accesstohealthcare.eiu.com/region/south-america/> accessed 12 July 2019 5.
[229]UNGA 2011 (n 103) para 49.
[230]Carmen Ledo, René Soria, 'Sistema de Salud de Bolivia' (2011) 53/2 Salud Pública de México 109 111.
[231]Angélica Michel, 'En el área rural, las mujeres mueren por falta de ambulancias, caminos y agua' (ANF 2016) ANF Online <www.noticiasfides.com/nacional/sociedad/en-el-area-rural-las-mujeres-mueren-por-falta-de-ambulancias-caminos-y-agua-373189> accessed 12 July 2019; Ricco Quiroga (n 8) 174.
[232]Chipman (n 228) 5.
[233]María Felipa Hernández, Eloina Meneses y Miguel Sánchez, 'Mujeres indígenas y su acceso a los derechos sexuales y reproductivos, 2009 y 2014' (CONAPO 2016) in La situación demográfica de México 2016 57 79, cited as in Szasz y Lerner, 2010 66.

special focus on the most vulnerable and marginalised people, like indigenous people. As already discussed in previous chapters, the prohibition of discrimination on any grounds must be enshrined in national legislation and be of a *de facto* nature.[234]

Physical accessibility means that all facilities, services and other infrastructure essential for the health and well-being of the population such as adequate sanitation and health facilities, must be within safe physical reach for everyone without discrimination. Physical accessibility can be challenging for various reasons and affect groups like indigenous people, women, children, adolescents, elderly people, persons with disabilities or persons with HIV/AIDS. Persons with disabilities as well as elderly people, for example, rely on barrier-free access to infrastructure.[235] Regarding indigenous people, the main issue of physical accessibility is geographical distance. In Guatemala, for instance, more than 70 percent of the most disadvantaged households has no access to paved roads and 13 percent has no access to roads that are drivable at all, putting health care services out of reach.[236]

The third dimension is economic accessibility. Health facilities, goods and services must be affordable for everyone, including socially disadvantaged groups. Payment has to be based on the principle of equity, demanding that poorer households are not burdened disproportionately.[237] Naturally, economic accessibility plays a major role for indigenous people, as they often depend on agriculture for subsistence and do not dispose of any other monetary income. Some indigenous communities still sustain themselves by countertrading products and are thus unable to pay for health care.[238] Nevertheless, studies suggest that in Latin America, the access to universal health care has improved significantly, with several countries providing free insurance and health care services. Still, it has to be taken into consideration that disparities exist between urban and rural areas as well as countries and ethnic groups. While Brazil, Colombia and Chile rank in the top 20 of the Global Access to Healthcare Index, countries such as Bolivia still continually face problems.[239] Chile's social health insurance system covers 97% of the population through both public and private insurers[240], Colombia's covers 96% – an increase of over 50% since the 1990s.[241] Despite these improvements, insufficient investment in health care services, particularly in preventive

[234]CESCR 2000 (n 81) 12(a).
[235]ibid (n 81) 12(b).
[236]World Bank, *Poverty in Guatemala* (The World Bank Report Number 27586 2004) 146.
[237]CESCR 2000 (n 81) 12(b).
[238]E.g.Claudia Valeggia, 'The Global and the Local: Health in Latin American Indigenous Women' (2016) 37/4 Health Care Women International 463 463.
[239]Chipman (n 228) 4.
[240]ibid (n 228) 7.
[241]ibid (n 228) 6f.

care, a lack of political will as well as corruption significantly slow down progress.[242] Consequently, people from poor socio-economic backgrounds are often not able to access health care services. This is reflected, for example, in the high prevalence of pregnancies among adolescent girls from low-income families[243] or the comparatively low rate of antenatal care among the poorest 20 percent of households. In this regard, it has to be taken into account that economic accessibility is not only impacted by the cost of health care but also by geographical distance: for people living in rural areas, e.g. indigenous people, long-distance travels to access health care services are linked to high expenditures, worsened through the absence at work for the duration of travel.[244]

The fourth dimension of accessibility is information accessibility. This includes the right to seek, receive and impart information and ideas concerning health related issues. In Mexico, the lack of information is the main reason among indigenous women not to use contraceptives. In comparison, the main reason for non-indigenous women to not use any methods of family planning is the wish to get pregnant, which ranks only second for indigenous women. Again, the lack of information can be linked to geographical location, socio-economic factors and a lack of skilled medical personnel providing indigenous people adequate and culturally sensitive information. One factor of great importance in this aspect is the language barrier, as many indigenous peoples primarily speak indigenous languages and do not understand information or campaign advertisements provided in other official languages.[245] Special Rapporteur Grover elaborated on this issue in his country report on Guatemala, criticising that in many health care institutions no interpretation services were available and patients had to rely on the interpretation of bilingual nursing staff rather than professionals. In many cases, people were denied attention because they were unable to explain their health problems due to language barriers.[246] Nevertheless, big efforts have been made in targeting this issue through national legislations in the past years, with many countries enshrining the right to medical attention in all official languages constitutionally. However, in many regions such laws remain merely theoretical.[247]

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[242]E.g. discussed in Thomas Fagan et al, 'Family Planning in the Context of Latin America's Universal Health Coverage Agenda' (2017) 5/3 Global Health: Science and Practice 382; Chipman (n 228) 9.

[243]ECLAC *Social Panorama of Latin America* (ECLAC 2014) LC/G.2635-P <www.cepal.org/en/publicaciones/ps> accessed 12 July 2019 152.

[244]UNFPA *The State of World Population 2017. Worlds Apart. Reproductive Health and Rights in an Age of Inequality* (UNFPA 2017) <www.unfpa.org/press/state-world-population-2017> accessed 12 July 2019 25.

[245]Hernández (n 233) 66.

[246]UNGA 2011 (n 103) para 45.

[247]E.g. Ley de Idiomas Nacionales Decreto No 19 [7 May 2003] Guatemala Guarantees Access to all Public Institutions, including Health-Care Facilities, in all Official Languages.

Another important issue related to access to information is sexual education. As indigenous people in general have lower levels of education, their knowledge about sexuality and reproduction is often limited too. In consequence, indigenous adolescents lack knowledge about topics like family planning, the reproductive system, the danger of STDs and other related issues, increasing the risk of unwanted pregnancies or reproductive health issues. Within the Chiquitano community in Bolivia for example, girls have very limited access to information about contraception as well as contraceptives themselves, as health personnel carrying out informative campaigns provides information mainly to mothers and mothers-to-be who are covered by the national insurance for mothers and children (SUMI).[248]

In order to guarantee accessibility of reproductive rights, all four dimensions, non-discrimination, physical, economic and information accessibility, have to be fulfilled. During the Zika epidemic in Colombia the opposite was the case. According to a report on the impact of the Zika virus on women's rights, the challenges in accessing contraceptives in order to prevent pregnancy during the outbreak were numerous. Regarding access to information, Colombian women were merely advised by the government to not get pregnant without being given any information on how and where to access contraceptives or other methods of family planning. Sometimes government information was contradictive and even medical personnel was reported of having difficulties in providing adequate information. Women who tried to access such services and receive information often faced discrimination, stigmatisation and violence. Accessing information about abortion, which is legal in Colombia under certain circumstances, was even more difficult. Moreover, the principle of non-discrimination was violated as women from higher socio-economic backgrounds as well as tourists received information of better quality. Physical access was an issue of special importance for women living in rural areas. In many regions, no health care facilities offered contraceptives and women had to travel long distances to purchase them.[249] If contraceptives were available, they were often unaffordable for women with less resources. Regarding abortion services, accessibility was even more limited.[250]

As demonstrated before, the lack of accessibility disproportionately affects indigenous women. However, in the case of the Zika virus, determining the impact on indigenous women

[248]Ricco Quiroga (n 8) 157.
[249]In consequence indigenous women were more vulnerable to infection, Sara Davies, Belinda Bennett, 'Zika and Ebola had a much worse effect on women: we need more research to address this in future' (19 October 2016) The Conversation Health and Medicine <https://theconversation.com/zika-and-ebola-had-a-much-worse-effect-on-women-we-need-more-research-to-address-this-in-future-64868> accessed 12 July 2019.
[250]Center for Reproductive Rights et al, *Voces Ignoradas. Experiencias de Mujeres con el Virus del Zika* (Center for Reproductive Rights 2018) <https://reproductiverights.org/document/voces-ignoradas-colombia> accessed 12 July 2019 15, 16.

can be somewhat challenging, as one consequence of the outbreak was the increase of clandestine abortions. Naturally, the number of illegal abortions as well as the place of their occurrence can only be estimated. However, it is suggested that the prevalence has been disproportionately high among indigenous women.[251] In addition, many studies affirm that the women most affected by the virus are poor, disadvantaged women belonging to vulnerable groups, among others, indigenous peoples.[252]

4.1.3. Acceptability

The third pillar, acceptability, demands that all health facilities, goods and services must be respectful of medical ethics and culturally appropriate. This means that they have to be respectful of the culture of individuals and communities, sensitive to gender and age and designed and adapted to specific target groups.[253] Cultural acceptability is crucial for health care services targeting indigenous people, as their customs and traditions may not match 'modern' health care systems. Many indigenous people mistrust modern medicine and prefer to rely on their traditional practices and methods. Additionally, indigenous people are often not familiar with modern health care and how it functions and are intimidated by doctors, all factors detaining them from accessing health care facilities.[254]

The consequences of culturally inappropriate health services are shown by case studies of different indigenous peoples throughout the continent. In Peru, 22.4% of indigenous people used traditional methods of family planning such as the use of calendars to determine fertile days, coitus interruptus or the use of herbs and plants with contraceptive or abortive properties in 2014.[255] In Bolivia, the subsector of traditional health care comprises 10% of the population, most of them living in rural areas.[256] Within the Bolivian Chiquitano community, for example, women are reluctant to use Intrauterine Devices as they are believed to turn up women's sex drive and incite infidelity.[257] Likewise, within the Toba community in

[251]David A. Schwartz, 'Pregnant and Out of Options: The Quest for Abortion in Latin America Due to the Zika Virus Pandemic' (2017) Family Planning, Zouhair O. Amarin, IntechOpen, DOI: 10.5772/intechopen.72377 <https://www.intechopen.com/books/family-planning/pregnant-and-out-of-options-the-quest-for-abortion-in-latin-america-due-to-the-zika-virus-pandemic> accessed 12 July 2019.

[252]E.g. discussed in Human Rights Watch, 'Neglected and Unprotected. The Impact of the Zika Outbreak on Women and Girls in Northeastern Brazil' (Human Rights Watch July 12 2017) <www.hrw.org/report/2017/07/12/neglected-and-unprotected/impact-zika-outbreak-women-and-girls-northeastern-brazil> accessed 12 July 2019.

[253]CESCR 2000 (n 81) art 12(c).

[254]Ricco Quiroga (n 8) 168.

[255]Myriam Escalante, 'El 24% de mujeres en el Perú no accede a métodos anticonceptivos (Ojo Público 19 March 2018) Ojo Público DD.HH. y género <https://ojo-publico.com/642/el-24-de-mujeres-en-el-peru-no-accede-metodos-anticonceptivos> accessed 12 July 2019.

[256]Ledo (n 230) 112.

[257]Ricco Quiroga (n 8) 159.

Argentina, it is commonly believed that married women use contraceptives to cover up adultery. Moreover, women refuse to use modern contraceptives as they do not trust the pill and are alienated by the idea of having foreign objects inserted in their bodies. This is amplified by discriminatory behaviour of medical staff, which detains Toba women from attending local health centres and discussing topics related to sex with health professionals. Additionally, as motherhood is still valued highly among indigenous communities, family planning programs are often criticised by indigenous leaders who claim they are a tool of 'white men' to control the indigenous population.[258]

Another example is the Tz'utujil Maya living in Atitlan in Guatemala. Their attitudes and beliefs towards reproduction and sex are shaped by the expression of machismo on the one hand and religion on the other. In Atitlan culture men are perceived to be responsible for the family's health. Consequently, it is their duty to decide whether sick family members should see a doctor or undergo a medical procedure in hospital. In cases of urgency, like childbirth, this can put the life of a woman or a child in great danger, for example if the husband is absent and the women can therefore not go to hospital.[259] Moreover, many indigenous men are reluctant to use condoms and prohibit their wives from using artificial contraception. In consequence, women conceal the use of contraceptives from their husbands or use clandestine methods, facing severe health risks as well as consequences upon discovery. The influence of religion is closely linked to machismo, as it plays an important role in the shaping of gender roles and gender power hierarchies. Machismo ideals originate from people's interpretation of the Bible and the official discourse by churches and clerics subordinating women.[260]

Another issue in this context is the sensitivity of the topic of sexuality and related matters like contraception, pregnancy, childbirth or abortion and the culturally fostered incapability of many women and girls to talk about the issue.[261] Medical personnel has to be aware of these obstacles and be trained accordingly. Likewise, cultural or societal peculiarities have to be considered in the planning of reproductive health care programs benefiting indigenous women. Additional attention should be paid to adolescents who abstain from using contraceptives out of fear of their parents.[262] In order to tackle such cultural barriers, it is essential to involve men in the decision-making process concerning reproductive

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[258]Valeggia (n 238) 467.
[259]See also UNGA 2011 (n 103) para 58: In Guatemala men are more likely to be considered primary decision-makers in emergency situations relating to pregnancy and birth.
[260]Valeggia (n 238) 469, 470.
[261]E.g. IACHR 22 November 2011 (n 185) para 1.
[262]Hernández (n 233) 79.

health and simultaneously empower women to exercise their reproductive rights without coercion.[263] Nevertheless, although traditions and customs of indigenous peoples need to be respected, as soon as such practices are harmful to or negatively impact the health of a person, medical personnel have to intervene. This is crucial if decisions are made on behalf of people who are not able to speak for themselves, such as children or people with disabilities, but also in other cases where a lack of knowledge threatens the health of the individual or the community. In Chiquitano culture, for example, people are known to treat minor diseases with antibiotics without completing treatment, which can, in the long run, jeopardise the health of the whole community.[264]

Advice on how to design culturally appropriate health care programs is provided, among others, by the PAHO, through its Action Plan for the Advancement of Indigenous People's Health[265] or Directive No. 47 on indigenous people and health. The PAHO stresses the role of intercultural education of medical professionals repeatedly, including capacitation in indigenous languages and deepening of the understanding of indigenous peoples' cosmovisions, as well as cooperation with indigenous communities and the capacitation of indigenous medical personnel. Moreover, it pledges for the mobilisation of national and international financial resources in order to support the advancement of indigenous people's health.[266] Regarding family planning, Special Rapporteur Grover suggests that related programs should rather aim at promoting postponing and spacing of children than preventing pregnancies. This approach might appeal more to indigenous women, who often consider having many children a blessing rather than a burden, and thus gain more acceptance among the whole community.[267]

An example of how intercultural health strategies can positively impact indigenous people's health is the intercultural health care system in Mapuche communities in southern Chile, where Mapuche organisations have been working towards improving the access to health care for rural Mapuche families since the late 1980's. In this system, strategies of management and biomedical care are complemented by traditional medical practices and knowledge. Hospitals and health care facilities are managed by both governmental bodies and Mapuche organisations and promote the concept of intercultural health based on the principle

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[263]ibid (n 233) 68.
[264]Ricco Quiroga (n 8) 150.
[265]PAHO, *Iniciativa Salud de los Pueblos Indígenas. Lineamientos Estratégicos y Plan de Acción 2003 – 2007* (2003) <http://iris.paho.org/xmlui/browse> accessed 12 July 2019.
[266]PAHO, 'Resolución CD47.R18. La Salud de los Pueblos Indígenas de las Américas' (25-29 September 2006) 47th Directing Council 58th Session of the Regional Committee <http://iris.paho.org/xmlui/handle/123456789/366?show=full> accessed 12 July 2019 para 2, 3; Rodrigo Cevallos, Alfredo Amores *Prestación de Servicios de Salud en Zonas con Pueblos Indígenas* (PAHO 2009) 15.
[267]UNGA 2011 (n 103) para 64.

of harmony with people's traditional beliefs and practices. In the space of 15 years, this project has significantly improved health care inclusion in rural areas, functioning as a model for other similar projects in the region and empowering communities culturally as well as politically.[268] Another successful example is the Churcampa community in Peru, where intercultural obstetric care has lowered maternal mortality significantly.[269]

4.1.4. Quality

The fourth pillar of health care is quality. It demands that all health care services are scientifically and medically appropriate and of high quality, as those are prerequisites for gaining patients' trust and convincing them to seek medical attention.[270] Quality requires, *inter alia*, skilled and culturally sensitive medical personnel that speaks the language of the target population and can not only attend to patients properly, but also inform them about reproductive health and family planning. At the same time, quality and safety of equipment, "scientifically approved and unexpired drugs", safe potable water, and good sanitation have to be guaranteed.[271] As can be deducted, the quality of medical attention depends to a large extent on the other three pillars of health care, availability, accessibility and acceptability. In addition, the principle of non-discrimination is to be respected on all levels. Concerning indigenous women, this is of special importance, as stigmatisation and prejudices by health personnel caused by indigenous women's traditional practices drastically decrease the quality of reproductive health services.[272]

As can be seen, indigenous women face a variety of challenges on all possible levels in the enjoyment of their reproductive rights, some caused by worldviews and beliefs distinct to the Western 'norm', others caused by their socio-economic situation or geographical location. In order to enable indigenous women to fully enjoy their reproductive rights, states have to actively take measures in consideration of the challenges discussed. What such measures entail is regulated through state obligations.

[268]Freire et al (n 4) 77.
[269]Melissa Silva Farnco, 'Churcampa, el pueblo donde no mueren las embarazadas' (26 November 2015) El País Online Mortalidad Materna <https://elpais.com/elpais/2015/11/06/planeta_futuro/1446805538_464080.html?rel=mas> accessed 12 July 2019.
[270]E.g. CESCR 2000 (n 81) para 12(d), 21.
[271]ibid (n 81) para 12(d).
[272]UNGA 2011 (n 103) para 56.

4.2. States' Obligations towards Indigenous People

State obligations under reproductive rights include certain special measures that benefit indigenous people in the enjoyment of their rights.[273] Such obligations are enshrined in GC 14 of the CESCR, which contextualises the right to health with indigenous people and provides guidance on how to implement the right to health for indigenous people in accordance with article 12 of the ICESC. Concerning the obligation to respect, the Committee recognises that in indigenous communities, the health of the individual often depends on the health of the whole community, wherefore states should refrain from displacing indigenous people from their communities. Besides, indigenous peoples' lands are often regarded as sacred places that play a vital role in traditional practices and rituals linked to health care and are often a source of food as well as medicinal plants. This gives rise to the positive obligation to protect natural resources. Under the obligation to protect, states must moreover ensure that health related services targeting indigenous people are "culturally appropriate, taking into account traditional preventive care, healing practices and medicines" and be designed, implemented and monitored in cooperation with representatives of indigenous communities.[274]

Apart from these, state obligations concerning the rights of indigenous people can be determined through other more general provisions of GC 14. Under the obligation to respect, most importantly the state has to refrain from undertaking any discriminatory practices that impede the access to health facilities, goods and services and hinder people from enjoying their reproductive rights. In this context states must refrain from "applying coercive medical treatments" harmful to reproductive health.[275] This is highly relevant in the light of institutionalised and systematic sterilisations of indigenous women, as they took place, for example, under the regime of Alberto Fujimori in Peru.[276] Furthermore, states must not prohibit "traditional preventive care, healing practices and medicines".[277] Nevertheless, as already mentioned, traditional practices should be restricted if they are harmful or if people under legal guardianship are denied access to effective methods of modern medicine and treated with scientifically unproven methods.

Positive obligations comprise the provision of culturally appropriate health care services, goods and facilities. In the context of indigenous people, this could be interpreted as the obligation to provide medical attention in native languages or arranging interpreting

[273] *Indigenous and Tribal Peoples Convention* (n 30) art 4.
[274] CESCR 2000 (n 81) para 27.
[275] CESCR 2000 (n 81) para 34.
[276] Discussed in Jelke Boesten 'Free Choice or Poverty Alleviation? Population Politics in Peru under Alberto Fujimori'(2007) 82 European Review of Latin American and Caribbean Studies 3.
[277] CESCR 2000 (n 81) para 34.

services. This is substantiated by Special Rapporteur Grover who pledges for medical professionals' capacitation in indigenous languages relevant in their operational catchment. He claims that "it is no longer acceptable to work within a community without having the ability to communicate with its indigenous members" and advocates for making language skills a requirement of recruitment. This, he argues, may also lead to a "cultural change in the profession" and wider acceptance of indigenous peoples' customs. As capacitation of health professionals in indigenous languages can only be achieved progressively, Grover suggests the use of telephone interpreting services in the interim period.[278]

In addition, states have to recognise the role of factors that positively impact health. For indigenous people, such factors can be practices of traditional medicine, which should be promoted and legally regulated by states. Therefore, medical personnel and health staff must be trained accordingly so as to respond appropriately to the specific needs of certain groups.[279] Moreover, medical staff should be recruited from the community, although the Special Rapporteur stresses that merely employing indigenous staff might not be sufficient, as it might not be fully accepted or taken seriously by non-indigenous co-workers. Indigenous staff, e.g. traditional midwives should be deployed to facilitate communication and information exchange between indigenous communities and the health care system and teach other personnel about intercultural interaction and communication. Through this process "cooperation and respect must be fostered" on both sides.[281]

The crucial role of cultural identity as well as language in the planning and implementation of any health strategies is also emphasised by the IACHR, which advocates for the participation of cultural experts in the process. Accordingly, it is important to "incorporate a holistic approach considering the sex, gender, and history of racism and discrimination faced by indigenous women and their worldview" and respect the relationship of indigenous people with their lands and culture. In addition, their conception of and approach towards human rights has to be taken into account. These principles have resulted from a fruitful cooperation between the IACHR and women belonging to indigenous communities.[282]

Special Rapporteur Grover further elaborates on the issue of cultural appropriateness in his country report on Guatemala, in which he adds that employing indigenous medical personnel not only improves the quality and acceptability of health care, but counteracts staff

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[278] UNGA 2011 (n 103) para 46.
[279] CESCR 2000 (n 81) para 37.
[281] UNGA 2011 (n 103) 48.
[282] IACHR, *Indigenous Women and Their Human Rights in the Americas (*17 April 2017) OEA/Ser.L/V/II. Doc. 44/17 para 31.

shortages in rural areas.[283] In addition to indigenous health staff, states have to involve the beneficiaries of health programs in related discussions. In the development of intercultural health care programs, for example, representatives of indigenous communities should be incorporated in the planning as well as the monitoring, which should be participatory, transparent and inclusive. Moreover, capacity building and assistance programmes should be carried out in the most marginalised areas and in cooperation with indigenous peoples' institutions.[284]

This goes hand in hand with the obligation to equally distribute health care facilities throughout the country. As already mentioned, this is especially important for indigenous communities situated in remote areas where access to certain health care services might be limited.[285] In connection, allocation of funds should be fair and appropriate and not discriminate against anybody. For example, funds should rather benefit primary and preventive health care than expensive services targeting more privileged parts of society. In relation to this, states must enable individuals that do not have sufficient means to access health care services to do so through affordable insurance to ensure equal access.[286] Again, this provision is essential for all underprivileged groups, including indigenous peoples. In order to fulfil all these obligations and enable indigenous women to fully enjoy their reproductive rights, states must adopt comprehensive health strategies and action plans that take all societal and cultural peculiarities and their impact on reproductive health into account.

Concerning the provision of information, states have the duty to disseminate appropriate health related information that informs people about the most significant issues as well as the availability of services. This provision is indispensable for indigenous people as they might not be able to access such information due to their geographical location, illiteracy or inappropriate channels of communication like social media or TV.[287] Apart from being accessible for everybody, information must be provided in the language predominantly spoken in the community. This goes hand in hand with the obligation to support people "in making informed choices about their health".[288] In addition, the guiding principle of non-discrimination has to be followed on all levels: under the obligation to respect, states must refrain from denying or limiting equal access to "preventive, curative and palliative health

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[283]UNGA 2011 (n 103) para 44.
[284]ibid 2011 (n 103) para 51.
[285]CESCR 2000 (n 81) para 36.
[286]Ibid (n 81) para 19.
[287]E.g. discussed in Redacción Tribuna, 'Maria Judite da Silva, la mujer que conciencia a las indígenas sobre el virus del Zika' (16 July 2016) Tribuna Feminista <https://tribunafeminista.elplural.com/2016/06/maria-judite-da-silva-la-mujer-que-conciencia-a-las-indigenas-sobre-el-virus-del-zika/> accessed 12 July 2019 in the context of the Zika virus.
[288]CESCR 2000 (n 81) para 37.

services", especially to women.[289] Regarding the obligation to protect, action plans and policies must "give particular attention to all vulnerable or marginalised groups". Finally, under the obligation to fulfil, all services must be provided on an equal basis without discrimination.[290]

The issue of reproductive rights of indigenous women has also been examined by the IACHR through its communication system, in the already mentioned case of *María Mamérita Mestanza Chávez vs Peru* for instance, which concerned the forceful sterilisation of an indigenous woman. The petitioner claimed that the sterilisation followed a wider government strategy that aimed at a demographic change by limiting the fertility rate of poor and indigenous women. Accordingly, 243 similar cases had been recorded in just one year by the Committee for Latin America and the Caribbean for the Defense of Women's Rights (CLADEM). Nevertheless, the case was resolved in a friendly settlement before the IACHR could further determine if and which rights were violated.[291]

In conclusion, in order to fulfil their obligations under reproductive rights contextualised with indigenous women, state parties have to facilitate access to relevant services on all levels and, if needed, take special measures that help indigenous women to overcome potential barriers they might meet. Such special measures could be the provision of health services in indigenous languages or specific campaigns aiming at eliminating certain prevalent health issues. In the light of the high fertility rates, especially among adolescent girls, and the incidence of issues like GBV, states must provide indigenous women and girls with education and information related to their reproductive health and rights. Naturally, all measures taken must be non-discriminatory and take the unique challenges indigenous girls and women in different contexts face into account.

In order to examine if and how states obligations can be fulfilled, the next chapter will take a closer look at one Latin American country, namely Bolivia, and analyse how reproductive rights have been implemented. The foundation for this analysis will be the legal framework of Bolivia concerning mainly the right to contraception, information and education about family planning, with a special focus on legislation benefiting indigenous people, and women in particular.

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[289] CESCR 2000 (n 81) para 34.
[290] ibid (n 81) para 43(f).
[291] María Mamérita Mestanza Chávez vs Peru (n 44).

5. Implementation of the Right to Reproductive Health Care in Bolivia

5.1. The Plurinational State of Bolivia

As mentioned earlier, an exceptionally high percentage of the population in Bolivia self-identifies as indigenous.[292] Consequently, the effective protection of indigenous peoples and peoples' rights is a crucial part of government work. This has been recognised, among others, by the newest constitution of Bolivia, which acknowledges the plurinational character of the state and the cultural and societal diversity within Bolivia. In order to assess the legal situation regarding the protection of indigenous women's reproductive rights, this chapter will first take a look at the unique Bolivian constitution and its impact on indigenous peoples. Furthermore, the national health policy and system as well as laws and policies relevant for reproductive rights in the context of indigenous women, including education and information on the issue, will be examined. Last, the concept of interculturality in the health sector will be discussed so as to provide an example of the practical implementation of the policies and laws outlined before.

In 2006 Evo Morales, the first president to self-identify as indigenous, was elected, seemingly marking a shift towards a more inclusive political system and societal change.[293] In 2009 this historical election was followed by the adoption of a new constitution based on the indigenous concept of *Vivir Bien,* which literally translates as *living well* and can be described as a "complex set of ideas, worldviews, and knowledge deriving from the diverse histories and experiences of indigenous movements, activist groups, and scholars of indigeneity".[294] *Vivir Bien* has since worked as the backbone to an alternative political system and has been used as a tool to fight poverty and empower indigenous people, pushing for the well-being of the individual as well as the community and decolonisation of the system. It is an approach based on human rights, community rights as well as environmental rights and meant to be an alternative to capitalist and imperialist structures.[295] One of the main stakeholders are

[292]Instituto Nacional de Estadistica (INE), 'Resultados Censo Nacional de Población y Vivienda' (INE Official Website 2012) <http://datos.ine.gob.bo/binbol/RpWebEngine.exe/Portal?BASE=CPV2012COM&lang=ESP> accessed 12 July 2019.
[293]E.g. discussed in Jeffery R. Webber, 'Burdens of a State Manager' (25 February 2015) Viewpoint Magazine Online <www.viewpointmag.com/2015/02/25/burdens-of-a-state-manager/> accessed 12 July 2019.
[294]Eija Maria Ranta, 'Vivir bien governance in Bolivia: chimera or attainable utopia?' (2017) 38/7 Third World Quarterly 1603 1603.
[295]Estado Plurinacional de Bolivia, *Plan de Desarrollo Económico y Social 2016-2020 en el Marco del Desarrollo Integral para Vivir Bien* (2015) <https://observatorioplanificacion.cepal.org/es/planes/plan-de-desarrollo-economico-y-social-en-el-marco-del-desarrollo-integral-para-vivir-bien-de> accessed 12 July 2019 8.

indigenous peoples and peasants, represented in decision-making processes through their own institutions and organisations.[296]

In this context, the constitution defines Bolivia as a *plurinational* state, which means it constitutes of the entity of all autonomous peoples and societies. The concept of plurinationality highlights the decentralised character of the country and supports economic, political, cultural and language pluralism.[297] Based on this premise, the constitution and consequently various other laws, grant extensive protection and privileges to indigenous peoples.[298] However, the effectiveness of these laws has been an issue of controversy, as many government decisions seem to oppose the values set out in the constitution. In 2011, for example, plans to build a highway through a protected national park in the Amazon home to indigenous peoples, sparked a lot of resistance among the population and was condemned a violation of indigenous peoples' as well as environmental rights.[299] Ironically, the government justified the project by referring to indigenous peoples' right to economic development, outlining the benefits improved traffic connections would entail for communities in remote areas. In addition, Morales' affinity towards indigenous peoples' rights and the use of indigenous symbols have been condemned tools of propaganda, misused to increase endorsement.[300] Nevertheless, the legal protection of indigenous peoples in Bolivia is unique – at least theoretically. This also applies to the health sector, as the following section will demonstrate.

5.2. The Bolivian Health Care System

Bolivia has ratified all major conventions of international human rights law discussed in the previous chapters, such as the ICESCR, the CEDAW, the CRC, the CRPD, the ACHR and the San Salvador Protocol as well as ILO Convention No. 169 and has consequently committed itself to comply with all state obligations imposed by those treaties, including obligations concerning the right to health and reproductive rights. This is reaffirmed by the Bolivian constitution which was drafted in accordance with international human rights law ratified by the state and comprises various provisions on human rights.[301]

[296]Estado Plurinacional de Bolivia 2015 (n 295) 7.
[297]Constitution of the Plurinational State of Bolivia [2009] art 1.
[298]E.g. the 4th chapter of the constitution is about indigenous peoples' rights.
[299]Mark Goodale, 'Human values and moral exclusion' (2016) 9/1 Ethics & Global Politics 1654 1659; discussed e.g. in Dan Collyns 'Bolivia approves highway through Amazon biodiversity hotspot' (15 August 2017) The Guardian Online <www.theguardian.com/environment/2017/aug/15/bolivia-approves-highway-in-amazon-biodiversity-hotspot-as-big-as-jamaica> accessed 12 July 2019.
[300]Goodale (n 299) 1659.
[301]Constitution of the Plurinational State of Bolivia (n 297) art 13.

The right to health is enshrined in the Bolivian constitution in article 18, which states that every person has the right to health without discrimination and commits to establish a universally free health system that covers the whole population.[302] In 2011, the government adopted a new health policy, the program for family and community health (Programa de Salud Familiar Comunitaria e Intercultural SAFCI) which aims at eliminating any social exclusion in the health sector and provides universal access to integral health services without discrimination on any ground, with a special focus on indigenous peoples and their needs.[303] The core principles of the health policy are community participation, intersectorality, interculturality and integrity.[304] In order to implement the SAFCI, in 2013 a free health insurance system, the Sistema Único de Salud (SUS), was introduced under law No. 475. The SUS covers health care services that fall under primary health care and cases of medical emergency.[305] It replaced and merged existing insurance systems, among others for mothers and children under 5 years[306] and for indigenous people.[307]

The beneficiaries of the SUS are inhabitants and residents of Bolivia that are not insured and that belong to one or more of the following groups: pregnant women, from the beginning of pregnancy until 6 months after childbirth, children under 5 years, men and women over the age of 60 and persons with disabilities. With special regard to reproductive and sexual health, all women in fertile age are entitled to free reproductive and sexual health care.[308] In February 2019 certain modifications were made to law No. 475, including an amplification of the list of beneficiaries.[309] Other modifications were the addition of core principles, e.g. equity, a more precise interpretation of existing principles and reaffirmation that all medical services covered by the SUS are free of charge at the time of access.[310] Nevertheless, probably the most important modification was the addition of a clause that states that the realization of free and universal health insurance is to be achieved "gradually and progressively".[311] While this new core principle does comply with the state obligations set out in the ICESCR, which allow for progressive implementation, it could be read as a step backwards, as it was not included in the original version of 2013. Moreover, the modified

[302]ibid (n 297) art 18.
[303]Decreto Supremo N° 29.601 Modelo de Salud Familiar Comunitario Intercultural [10 June 2012] preamble.
[304]ibid (n 303) para 3.
[305]Ley N° 475 de prestaciones de servicios de salud integral del Estado Plurinacional de Bolivia, DS Nº 1984 [30 April 2014] para 3.1.
[306]Had been modified by Ley Nº 3250 [06 December 2005] which amplified the scope the former to include additional sexual and reproductive health-care services.
[307]Decreto Supremo Nº 26330 [2001].
[308]Ley N° 475 (n 305) art 5.
[309]Ley N° 1152 Modificatoria a la Ley N° 475 [20 February 2019].
[310]ibid (n 309) art 2.
[311]ibid (n 309) art 2.10.

version of law No. 475 does not include any specific interpretation of the phrasing "gradually and progressively", leaving the Bolivian government plenty of leeway in its implementation.

Other criticism of the SUS concerns its practical implementation, as it does not fulfil the promise of universally free health coverage for everybody as enshrined in the constitution, but only covers limited groups of people that had already, to a large extent, been covered by different insurance systems. Furthermore, the impact of the SUS on the health of indigenous peoples is questionable. Especially in rural areas, attention of indigenous patients is frequently inappropriate and badly designed. In connection, medical personnel tend to lack proper cultural training and are therefore not capable of grasping the special needs and health challenges of the community. This is amplified by insufficient cooperation with local health structures and a lack of funding of health programs causing overstrained medical personnel and inadequate service. Another point of concern is that the role of environmental factors, which cause some of the leading health issues, are not considered and environmental policies are not incorporated into the health strategy. In addition, the SAFCI emphasises the population's responsibility of preserving their health through preventive health care and the importance of active participation in the health care system without taking into account that many indigenous people cannot access such services. Instead of promoting effective access to preventive health services, the government criticises people for their inability to maintain their health.[312]

As we can see, the Bolivian health care system seems to constitute a suitable framework for the implementation of the right to health in theory, especially when contextualised with indigenous people. However, research suggests that the practical implementation of universal health care is deficient and that the current health system neither adheres to the Bolivian health strategy nor the Bolivian constitution. In order to determine whether this also applies to reproductive rights, the next section will take a closer look at the implementation of reproductive health through the health care system in Bolivia.

5.3. Reproductive Rights within the SUS

Sexual and reproductive rights of men and women in Bolivia are granted by article 66 of the constitution.[313] This is reaffirmed by the SUS, which covers a variety of services in the field. Sexual and reproductive health care is defined by article 3.7 of Law No. 475 as all actions that

[312]e.g. discussed in Susana Ramírez Hita, 'Aspectos Interculturales de la Reforma del Sistema de Salud en Bolivia' (2014) 31/4 Revista Peruana de Medicina Experimental y Salud Publica 1726 <www.scielo.org.pe/scielo.php?script=sci_arttext&pid=S1726-46342014000400023> accessed 12 July 2019.
[313]Constitution of the Plurinational State of Bolivia (n 297) art 66.

relate to the prevention and treatment of cancerous premalignant lesions of the cervix, family planning counselling and provision of contraceptives in a consensual way, and treatment of STDs and other diseases prioritised by the Ministry of Health and Sports that are linked to a healthy motherhood.[314] Regarding contraception, the SUS guarantees the free provision of contraceptives, including masculine and feminine condoms, intrauterine devices (IUD), contraceptive implants, the pill and other hormonal contraceptive methods, and the emergency contraceptive pill.[315]

Guidance on how sexual and reproductive health care services granted by laws No. 475 and subsequently law No. 1152 should be implemented is given by the Ministry of Health and Sports. Regarding contraception, the National Norms on Contraception list authorised methods of contraception and ways of distribution and guides medical personnel concerning the provision of orientation, information and education on contraception. The ministry stresses that decisions about the use of contraceptives have to be made without coercion but with prior and informed consent, and that adequate information must be provided by qualified personnel. Regarding the legality of different methods of contraception, all common methods of contraception are legal in Bolivia, including emergency contraception, and can be attained without prescription.[316]

Information about the purchase and use of contraceptives can be provided both through sexual education in educational facilities and campaigns of health care institutions and other stakeholders such as NGOs. Sexual education is enshrined in national law as a right of every girl and boy attending school. Article 38 of the Law of the Young declares that sexual and reproductive education should be granted at all levels of education as well as in public and private health care centres. The main aim is the fulfilment of every adolescents' right to be informed and educated about sexual and reproductive health and to be able to enjoy a healthy and risk-free parenthood.[317] One focal point of sexual education is the prevention of adolescent pregnancies[318] as Bolivia has the highest fertility rate among adolescent girls between 15 and 19 years in Latin America, with 71 births per 1000 girls between 2006 and 2017.[319] In addition, article 40 of the Law of the Young provides the right to be given information about health services and programmes of both treatment and

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[314]Ley N° 475 (n 305) art 3.7.
[315]Ministerio de Salud y Deportes, *Norma Nacional, Reglas, Protocolos y Procedimientos en Anticoncepción* (2010) Documentos Técnico-Normativos Publication No. 169 Depósito Legal 4-1-104-10 P.O. chap 4.
[316]ibid (n 315) chap 4.
[317]Ley N° 342 de la Juventud [05 February 2013].
[318]Ministerio de Justicia de Bolivia (n 157) 81.
[319]UNFPA *The State of World Population 2019. Unfinished Business - The Pursuit of Rights and Choices for All.* (UNFPA April 2019) <https://asiapacific.unfpa.org/en/publications/state-world-population-report-2019-unfinished-business-pursuit-rights-and-choices-all> accessed 12 July 2019 158.

prevention of STDs and how to access them.[320] Whether sexual education fulfils all these criteria in practice is somewhat hard to assess, as Bolivia is not represented in major databases and indices of education like the World Bank's Human Capital Index due to a lack of data on education quality. This not only complicates the evaluation of educational achievements but also the development of educational programs and projects based on demand.[321]

Apart from sexual education, information about sexual and reproductive health is disseminated by professionals in the field of health care. The right to information is enshrined in Law No. 475, however only in connection to family planning counselling.[322] Although no other legal norms on the provision of information about reproductive and sexual health exist, technical documents of the Ministry of Health and Sports give guidance on the design and distribution of information. Concerning contraceptives, professionals must provide "truthful, complete and adequate information including benefits, limitations and health-risks, with the objective of guaranteeing an informed decision".[323] Channels of distribution can be individual counselling as well as larger-scale campaigns conveying basic knowledge about the different kinds of contraceptives, their functioning and purchase to those parts of the population most in need of respective information. According to the ministry, educative information must be culturally sensitive and adapted to its target audience.[324]

Apart from educational and informative campaigns the government has developed programmes to raise awareness about reproductive health and rights. One program worth mentioning is the Juana Azurduy bonus created in 2009, which aims at raising awareness about the importance of obstetric care. The economic incentive promotes prenatal health care and attended birth combating maternal and infant mortality. Participants receive monetary rewards for attending prenatal and postnatal controls and delivering in hospitals.[325]

Reviewing laws and policies, it can be concluded that the legal protection and promotion of reproductive rights in Bolivia does allow for the effective implementation of reproductive rights and fulfils state obligations under international human rights law to a large extent. Reproductive health care and a variety of contraceptives is available free of charge, obstetric care is heavily promoted and even rewarded and the right to sexual education provided by law. However, statistics suggest that those laws and policies remain theoretical to

[320]Ley N° 342 de la Juventud (n 317).
[321]Lykke E. Andersen 'Who is being left behind by the Education Revolution in Bolivia?' (13 March 2019) Southern Voice Online <http://southernvoice.org/who-is-being-left-behind-by-the-education-revolution-in-bolivia/> accessed 12 July 2019.
[322]Ley N° 475 (n 305) art 3.7.
[323]Ministerio de Salud y Deportes (n 315) 35.
[324]ibid (n 315) 43, 44.
[325]Established through Decreto Supremo Nº 066 [2009].

some extent–for example, only 49 percent of women aged 15 to 49 use modern contraceptives, compared to an average of 70 percent in Latin America and the Caribbean. Moreover, maternal mortality is three times higher than the average in the region and adolescent pregnancies are, as already mentioned, worryingly high.[326]

Now that it has been examined if and how reproductive rights in Bolivia are implemented, lastly, it will be shown how intercultural health care programmes can facilitate the enjoyment of indigenous women's reproductive rights.

5.4. Interculturality in the Health Care System

According to the Bolivian constitution, cultural specifics and customs of indigenous peoples have to be considered in the adoption of legislation and other policies, *inter alia,* in the health sector. In this context, health care must be free and accessible for everybody without discrimination and respect the cosmovisions and traditional practices of indigenous peoples.[327] This is reinforced by the core principles of the SAFCI, intraculturality, interculturality and equality.[328] The principle of intraculturality obliges the state to enable indigenous peoples to regain, strengthen and revitalise their cultural identity regarding the health of the community as well as the family and the individual. The concept of interculturality encompasses recognition, acceptance and respect for the knowledge and practices of indigenous people by the health care system. Accordingly, health care services must be inclusive, combining traditional with modern medicine.[329] Under those principles, the state of Bolivia pledges to promote, respect, investigate and apply traditional medical practices of indigenous peoples in the public health care system.[330] Such intercultural health care services are to be based on the indigenous philosophical concept of *Vivir Bien* discussed in the former section. In the context of health, *Vivir Bien* can be described as a model of living, which emphasises harmony and searches to balance all aspects of life including community, nature, spirituality, family, body, and mind.[331]

In order to strengthen the principle of interculturality of the Bolivian health care system, various agencies and institutions were founded. The Viceministry of Traditional

[326]UNFPA 2019 (n 319) 152.
[327]Constitution of the Plurinational State of Bolivia (n 297) art 13, 17.
[328]Ley N° 475 (n 305) art 2.
[329]ibid (n 305) art 2.2., 2.3.
[330]The use of traditional medicine is further regulated by Ley N° 459 de Medicina Tradicional Ancestral Boliviana [19 December 2013] art 35, 36, 42.
[331]Alison Ogawa, 'El Suma Qamaña: La convivencia en relación a la salud según la gente Aymara de Arica, Codpa, y Putre / El Suma Qamaña: Coexistence in relation to health according to the Aymara people of Arica, Codpa, and Putre' (2017) Independent Study Project (ISP) Collection 2548 2548f.

Medicine and Interculturality under the mandate of the Ministry of Health and Sports, for example, accredits traditional medics, organises courses and events and publicises material on the issue. Among others, the ministry has adopted a law on traditional medicine and developed a control mechanism for the practice of traditional medicine.[332] Regarding natural products, their authorization and control underlies the national control unit for drugs. [333]

Guidance on how inter- and intracultural health programmes should be designed is given by several publications issued by the Bolivian government as well as the PAHO. According to these guidelines, one essential component of intercultural health care services is the capacitation of medical personnel in the indigenous language spoken by the target community.[334] Nevertheless, Bolivia has not adopted any legislation concerning multilingual attention in health care institutions. Plurilingual attention as a constitutional right applies only to the governmental sector and educational institutions.[335] Consequently, indigenous people do not have the right to be attended to in their native language when seeking medical attention. Despite the lack of legislative backing, the Bolivian government has repeatedly stressed the importance of providing medical attention in indigenous languages, through guidebooks as well as through other measures, on intercultural communication that teach medical personnel basic language skills, for example in Aymara or Guaraní.[336]

Two practical examples of how the concept of interculturality in the health sector can be put into practice are the Villa Esteban Arce health-care centre and the Boliviano Español Patacamaya Hospital. Both facilities are supported by the Spanish Agency for International Development Cooperation (AECID), which has developed similar projects in Peru, and offer high-quality medical attention that combines modern and traditional medical practices to predominantly Aymara patients. A centrepiece of both facilities are culturally appropriate delivery rooms where women can give birth in line with their own cultural beliefs, supervised by medics who intervene in cases of emergency. Enabling indigenous women to deliver in a traditional way has led to an increase in births attended in health facilities and contributed to the reduction of maternal and infant mortality.[337]

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[332]Ley N° 459 (n 330) art 1.
[333]ibid (n 330) art 29.
[334]E.g. in Cevallos, Amores (n 266); PAHO, *Diálogo médico paciente en Aymara* (WHO 2013) <www.paho.org/bol/index.php?option=com_docman&view=document&layout=default&alias=35-dialogo-medico-paciente-en-aymara&category_slug=publications&Itemid=1094> accessed 12 July 2019.
[335]Constitution of the Plurinational State of Bolivia (n 297) art 12.
[336]E.g. PAHO 2013 (n 334).
[337]As already mentioned above, in Aymara culture it is believed that childbirth has to take place in a hot ambient whereby specific materials have to be used. Delivery rooms therefore have wooden beds, curtains and a small stove where traditional midwives prepare broths. Moreover, women can keep their own clothes on and can, if they wish to do so, give birth in a standing position, Spanish Agency for International Development Cooperation AECID, 'Centro de Salud Kallawaya Villa Esteban ' (n.d.) Aecid informe de transparencia 2016

However, it could be criticised that intercultural health care institutions focus strongly on the traditional practices and drugs of Aymara and Quechua people while other indigenous communities, especially selvatic ones, are underrepresented or not represented at all in the health care system. Moreover, intercultural health care programmes are often developed and promoted by NGOs or other international institutions, rather than by the Bolivian government itself.

<http://informetransparencia2016.aecid.es/proyectos/centro-de-salud-kallawaya-villa-esteban-arce-bolivia/> accessed 12 July 2019 and Amelia Castilla, 'Fusión de tradición y ciencia en la medicina boliviana' (8 July 2016) El País Online <https://elpais.com/elpais/2016/07/06/planeta_futuro/1467816048_811103.html> accessed 12 July 2019.

Conclusion

As the present thesis shows, reproductive rights are an integral part of international as well as regional human rights law and enshrined in the most important human rights treaties. They can fall under the scope of different human rights provisions, most importantly the right to health. Reproductive rights are crucial for all members of society, nevertheless, most of them apply to women and girls only due to their unique role in reproduction. Therefore, one of the most important conventions in the light of reproductive rights is the CEDAW. Through General Recommendations and other publications, the CEDAW committee has promoted and advocated reproductive rights of girls and women on many levels, highlighting the importance of non-discrimination in the enjoyment of reproductive rights. In addition, several other human rights treaty bodies such as the Committee on the Rights of the Child or the Committee on the Rights of Persons with Disability have dealt with the topic extensively. While the former has emphasised the role of sexual education in combating issues such as adolescent pregnancies or gender stereotyping, the latter has examined matters such as the abortion of children with disabilities or the forced sterilisation of women and girls with disabilities. Within the Inter-American human rights system, reproductive rights have been handled by the IACHR as well as the IACtHR through their complaint mechanisms.

Concerning their scope, reproductive rights nowadays encompass a vast range of both freedoms and entitlements, including, *inter alia,* services like family planning, obstetric care and artificial fertilisation as well as the prohibition of involuntary medical interventions, discrimination or harmful traditional practices. Two elements of special relevance for reproductive health that have been discussed extensively are the rights to information and education about related issues. As with all human rights, reproductive rights implicate certain obligations for state parties. This obligations guide the implementation of reproductive rights and sets a fairly well elaborated framework for the enjoyment of these rights. Thereby, it has to be taken into account that rights that fall under CPR entail different obligations than those which fall under ESCR. While reproductive rights under CPR, such as the prohibition of inhumane treatment, pose quite definite obligations on states, obligations under rights considered ESCR are generally harder to determine. The main reason for this is the rather vague formulation of many of these provisions. Most ESCR, for example, allow for progressive realisation and acknowledge that implementation can be limited by resource constraints. This phrasing can be interpreted quite freely and is consequently used by states to elude their obligations, postponing them indefinitely. Paired with political unwillingness to push for the implementation of ESCR and a lack of effective mechanisms of enforcement, this

makes ESCR, including a considerable part of reproductive rights, hard to enforce. This issue is also reflected in case-law. Although since 2009 the CESCR disposes of a complaints mechanism through which individuals can claim violations of their ESCR, many ESCR are still enforced through provisions of CPR, e.g. through the prohibition of inhuman treatment or the right to privacy. This is of special relevance in the Inter-American system, where only two ESCR, namely labour rights and the right to education, can actually be enforced through article 26 of the ACHR. Therefore, as on the international level, the IACHR as well as the IACtHR have used 'backdoors' to enforce ESCR, for example by invoking CPR or provisions of international treaty law. Such strategies have also been employed in the enforcement of the right to health, advantageous, among others, to petitioners in cases concerning reproductive rights. Nevertheless, one could criticise that while this promotes the enforceability of certain reproductive rights such as the prohibition of forced sterilization or obstetric violence, it disregards others, such as the right to sexual education or access to contraceptives that cannot be invoked through provisions of CPR and are therefore left unenforceable.

However, it has to be stressed that not all reproductive rights falling under ESCR allow for progressive realisation. Some rights, such as equal access to health care, health related education and information or access to primary reproductive health care, e.g. obstetric care, pose immediate obligations on states parties that cannot be limited by resource availability. However, these core obligations merely secure the minimum threshold of reproductive health and are only one step towards the full realisation of reproductive rights.

Although reproductive rights are quite well protected under international human rights law and state obligations in theory lay a good groundwork for their full enjoyment, in practice not all women are able to equally realise their reproductive rights and access services of reproductive health care. One of the most disadvantaged and marginalised groups in this regard, especially in the Latin American context, are indigenous women and girls. One reason for this might be the inadequate protection of indigenous peoples in human rights law in general: the only existing and legally binding convention on indigenous peoples on the international level is the ILO Convention No. 169 which has been ratified by only 23 states. Although the convention includes provisions on the right to health, no mention is made of reproductive rights. Furthermore, the convention has been criticised by feminist scholars for not contemplating the special vulnerability of indigenous women and challenges they face in the enjoyment of their human rights. This has major implications for indigenous women's reproductive rights, as cultural barriers arising from their origin are one of the main obstacles of access to respective health services. Culturally conditioned factors, including language,

customs and beliefs as well as patriarchal societal structures, not only negatively impact the accessibility of reproductive health care services, e.g. through language barriers, but also affect women's willingness to seek such services, due to fear of discrimination for example. Consequently, cultural factors that impede indigenous women's full enjoyment of their reproductive rights need to be addressed through and enshrined in legally binding human rights law in order to guarantee equal accessibility.

Concerning the specific obligations under reproductive rights states bear towards indigenous women, a lot of interpretative work has to be done. As stated in GC 14 of the CESCR on the right to health, states *do* have specific responsibilities towards indigenous peoples, although their formulation is rather half-hearted and most obligations must be deducted from other general provisions. After all, reproductive rights of indigenous women are a very specific issue which applies to a very restricted group of people and are consequently not as prominently represented as other more 'general' rights. However, treaty bodies as well as Special Rapporteurs and other experts should definitely put more pressure on states regarding this issue and push for more concrete obligations, especially concerning culturally appropriate reproductive health care.

How these obligations, being of a quite abstract character, can be implemented on the national level has been examined on the example of Bolivia. Fortunately, the legal framework in Bolivia is quite strong on the topic, especially since Evo Morales became president. In 2009, Bolivia adopted a new constitution, unique for the region and based on the indigenous philosophical concept of *Vivir Bien.* This moral guideline was supposed to constitute an alternative to the capitalist, imperialist system imposed on the country during the time of colonisation by promoting a pluralist society and the inclusion of indigenous peoples in policy and decision making on all levels. The constitution enshrines a vast range of freedoms and entitlements of indigenous peoples that have been, to some extent, translated into laws and policies. Naturally, the principle of non-discrimination is considered holy. This applies also to the health sector which has focused its work on the development of intercultural health strategies. The integration of traditional medical practices and drugs as well as the recruitment of indigenous health personnel and the capacitation of medical staff in intercultural communication are only some of the measures taken to improve access to health care for indigenous peoples. In the light of reproductive rights, one focal point is traditional delivery and culturally appropriate counselling on family planning, done through centralising the spacing of children rather than preventing pregnancies for example.

Although the legal framework for intercultural health care seems to be relatively strong, one weak point is the lack of legislation on the right to be attended and receive information in indigenous languages. Research suggests that this is a major problem, especially in rural areas, where a lack of communication seems to favour distrust and discrimination. Even though this thesis does not intend to assess how legislative measures are put into practice and what real-life effects for indigenous people they bring along, it can be assumed that intercultural health strategies to some degree rather serve the purpose of propaganda than actually improving the situation of the indigenous population. This is supported by the insertion of the phrasing *progressive realization* into the law regulating universal and free access to health care years after its adoption. Although this might have been a necessary and justifiable step, it is, after all, a step backwards.

Sexual education, another integral part of reproductive health, is fairly well protected under Bolivian law as well. To what extent this right is implemented in practice can be disputed. Due to a lack of data on education quality, it is hard to assess if and how extensively sexual education is taught in schools and what contents are imparted. However, in the light of recent developments in the region and statistics on adolescent pregnancy, it can be assumed that the realisation of the right to sexual education leaves a lot to be desired. Regarding information on reproductive health and rights, legislation only covers information on family planning. Again, no legislative norms on language of provision enable indigenous people to be attended to in their native language.

Considering the theoretical framework of reproductive rights and states obligations they entail as well as this practical example of implementation, in conclusion, it can be said that for their full realisation, reproductive rights of indigenous women require a stronger protection on the international as well as the regional level and a wider recognition in instruments developed especially for indigenous peoples. Simultaneously, states must recognise their responsibilities under international law and take active measures to fully implement those rights, focusing most importantly on cultural factors affecting the accessibility of reproductive health care. Despite budgetary limitations that must be taken into account, states should not postpone their obligations indefinitely due to resource constraints or referral to progressive realisation. Moreover, although international assistance is an important element of the realisation of the right to health, including reproductive rights, states must not rely on international organisations, NGOs and other external bodies for the realization of their obligations. In this regard, it again has to be emphasised that not all measures promoting reproductive rights are bound to high costs – sexual education, for example, is an easy, cost

efficient and long-term solution to improve the reproductive health of young people and should therefore be a key element of reproductive health strategies. Respective programs targeting indigenous adolescents must be designed accordingly, be culturally appropriate and provided, if necessary, in indigenous languages. Most importantly, sexual education programs as well as any other reproductive health initiatives have to be developed in cooperation with the community, including both men and women, and include representatives on all levels. The same applies to the provision of information on reproductive health to indigenous women, which should be another focal point of national health policies. In this context, it must be ensured that information reaches even the most remote areas and the most marginalised populations and is adapted to the particular needs of the target audience. These principles must also be employed in the development of other reproductive health care services, be it obstetric care or provision of contraceptives.

Applying the concept of interculturality to existing reproductive health care systems does not only benefit indigenous people, most importantly women and girls, but also fosters mutual understanding between the population and cultural exchange. Finally, political willingness to implement indigenous women's reproductive rights will benefit the country in many other aspects too, helping to combat high-fertility rates as well as adolescent pregnancies, and eventually contribute to a higher standard of living among indigenous peoples in general.

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