
State Obligations to Protect the Lives and Health of Women After Abortion or Miscarriage

by Angie McCarthy*

“Carmen and Manuela, Salvadorian women, both suffered complications during labor leading to stillbirths. When the women sought follow-up medical care, doctors accused both women of having undergone abortions in violation of El Salvador’s restrictive abortion law. Police immediately arrested them for homicide — one of the women was shackled while she was still receiving critical medical care. Both were sentenced to more than [thirty] years in prison. In Carmen’s case, after more than eight years in prison, a judge ordered her release, acknowledging that a mistake had been made. Nevertheless, the government never compensated Carmen for the grievous rights violations. Manuela died in prison; she had suffered from Hodgkin’s lymphoma — a form of cancer — before she even became pregnant, but she received treatment only after it was too late to save her.”¹ She never had a chance to speak to a lawyer.²

INTRODUCTION

Annually, approximately five million women and girls suffer short and long-term injuries due to unsafe abortions.³ When these women and girls seek emergency obstetric treatment in health facilities, they are often met with hostility and judgment from health care providers and are subsequently denied access to basic medical care. In addition, many women who suffer miscarriages, stillbirths, or induced abortions are also mistreated and jailed.⁴ These women are punished simply because their bodies fail to sustain a pregnancy, not because they violated any law. In countries where there is a strict abortion ban, such as El Salvador, arriving at a public hospital seeking treatment for a miscarriage is a “risky business because instead of [receiving] medical care you might find yourself being cuffed to the bed and accused of ‘murder.’”⁵ For these women, their

quality of care depends on whether hospital staff label their abortion as spontaneous or induced — or, in other words, legitimate or illegitimate.⁶

In hospitals worldwide, medical workers subject women seeking post-abortion care to mistreatment, exploitation, and violations of confidentiality and privacy.⁷ Examples of mistreatment include: chastising women for procuring abortions, denying women care, reporting women who arrive with complications to the police, shackling hemorrhaging women to

hospital beds, intentionally withholding the use of proper pain control during procedures,⁸ and attempting to obtain confessions as a precondition for receiving potentially life-saving medical treatment.⁹ In addition, many hospitals require staff to report women suspected of having an abortion to the police, even though in most cases it is impossible to know if a pregnancy was terminated intentionally or if a woman has spontaneously mis-

carried. This uncertainty, coupled with a desire to punish women who have had abortions, creates problematic situations where women are charged, prosecuted, and imprisoned for the crime of obtaining an illegal abortion based on insufficient evidence, denying them both due process and liberty.

STATE OBLIGATIONS UNDER INTERNATIONAL LAW

Regardless of the legality of abortion, under international law, states have both a negative obligation to refrain from violating women’s rights and a positive obligation to promote and protect them. This includes protecting women from harmful acts by private persons or entities, including the public and private health sector. The abusive treatment patterns described above violate women’s rights, including the right to be free from violence and torture and other cruel, inhuman, and degrading treatment as well as the right to health and liberty and security of person.

TO PREVENT VIOLENCE AGAINST WOMEN

Human rights bodies have recognized that the abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering. There are several international instruments that prohibit such violence against women, including the Convention on the

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Elimination of All Forms of Discrimination Against Women (CEDAW)¹⁰ as well as regional treaties such as the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belém do Pará),¹¹ the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention),¹² and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol).¹³

These instruments take a broad view of violence. The Convention of Belém do Pará, for example, defines violence against women as “physical, sexual and psychological violence”¹⁴ that “occurs in the community and is perpetrated by any person,” which includes acts such as torture and sexual harassment in health facilities.¹⁵ It also states that every woman has the right to “have her physical, mental and moral integrity respected.”¹⁶ Moreover, the Istanbul Convention defines violence against women as “all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”¹⁷ The CEDAW Committee defines discrimination as acts (or threats of acts) that inflict “physical, mental or sexual harm or suffering and other deprivations of liberty” on women.¹⁸

Women suffer physical harm, and sometimes death, when medical care is delayed or they are treated inadequately and unsafely. Women also suffer psychological harm when they are threatened with physical harm, intimidated, insulted and humiliated, and denied even the most basic medical care.¹⁹ When governments tolerate abuse of women seeking post-abortion care at the hands of health care providers, and later fail to provide meaningful remedies, they effectively condone this violence.²⁰ To fulfill their obligations, states must prevent this violence against women by all means “of a legal, political, administrative and cultural nature that ensure the safeguard of human rights, and that any possible violation of these rights” is investigated, prosecuted, and punished.²¹

TO PREVENT TORTURE AND CRUEL, INHUMAN AND DEGRADING TREATMENT

Women seeking emergency post-abortion care may suffer cruel, inhuman and degrading treatment at the hands of medical professionals. Recently, the UN Committee against Torture (CAT Committee) recognized that women are particularly vulnerable to torture or ill-treatment in the context of medical treatment, especially when seeking reproductive health services. Women's rights are violated in several ways, including in the following circumstances: denying post-abortion care or providing



Women's Rights are Human Rights at the May Day Immigration Rights Rally- photo courtesy of takomabelot on Flickr Creative Commons

post-abortion care on conditional access, withholding care for the “impermissible purposes of punishment or to elicit confession,”²² arbitrarily refusing treatment for incomplete abortions or withholding available pain medication,²³ or shackling women suspected of illegal abortions to hospital beds.

According to Ipas, a non-governmental organization striving to end preventable deaths and injuries from unsafe abortions, some Peruvian medical professionals reportedly deny women anesthesia or pain medication to punish women for having abortions, believing that the denial of adequate anesthesia for post-abortion care is a type of mistreatment that women should “put up with.”²⁴ In Brazil, Ipas reported cases of women who were handcuffed to hospital beds while police investigated their allegations. In one reported instance, a woman remained handcuffed to the hospital bed for three months because she could not afford to post bail.²⁵ Although there is no explicit prohibition against

shackling women seeking post-abortion treatment, the international community condemns several similar practices, such as shackling female prisoners during labor or caesarian sections.²⁶

The UN Special Rapporteur on Torture, Juan E. Méndez, noted that some medical professionals condition life-saving treatment upon the extraction of confessions of women under duress, which he finds may, in certain circumstances, constitute cruel and inhuman treatment. The CAT Committee similarly views these practices as contrary to the UN Convention against Torture, and recently called on the Chilean government to eliminate any practices of extracting confessions for prosecution purposes when women seek emergency medical care. In addition, the CAT Committee urged the Chilean government to investigate and review convictions where statements obtained by such coercion were admitted into evidence, and to take appropriate remedial measures, such as nullifying the convictions.²⁷

State obligations to prohibit, prevent, and redress torture and ill-treatment extend to “all contexts of custody or control,” which includes hospitals and other settings where the “failure of the [s]tate to intervene encourages and enhances the danger of privately inflicted harm.”²⁸ Thus, even though the intentional denial of pain management and procurement of coerced confessions occur at the hands of private health practitioners rather than state actors, the state is not absolved from responsibility. Further, states have a positive obligation to investigate credible allegations of torture or ill treatment in all settings.²⁹ Public and private hospitals are no exception. Accordingly, states must investigate and punish acts by medical staff responsible for violating women's rights.

TO PROMOTE AND PROTECT THE RIGHT TO HEALTH FREE OF DISCRIMINATION

Women continue to suffer gender discrimination in the health system because of persistent gender stereotypes that imply that women “should prioritize childbearing over all other roles they might perform or choose,” and that “nothing should be more important for women than the bearing and rearing [of] children.”³⁰ The “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being,”³¹ and state obligations to realize the rights are enshrined in various international and regional instruments.³² Further, states are required to guarantee women access to quality health care free from discrimination.³³ Quality health services include those circumstances in which complications arise from unsafe abortions and miscarriages, regardless of the legal status of abortion.³⁴ As such, states are required to undertake measures to ensure access to post-abortion care for all women and girls, free from discrimination, violence, or coercion. This obligation includes the provision of “adequate training, support, and supplies to ensure that abortion-related complications can be treated, irrespective of the legality of abortion.”³⁵

To fulfill their obligations, states must address the systemic discrimination, stereotypes, and stigma that exist in medical communities surrounding abortion and invest in human rights-based training of health personnel and the judiciary to uphold the rights of women.³⁶ Further, states can no longer rely on NGOs to collect valuable data on the treatment (or mistreatment) of women in health care facilities; they must collect it themselves. The CEDAW Committee expressly stated that States Parties should report on how public and private healthcare providers meet their duties with respect to a woman’s right to access healthcare free from discrimination.³⁷ High quality data has the ability to spur positive interventions, and can be used as a tool to hold states accountable for looking the other way when these violations occur.

THE RIGHT TO LIFE

The right to life is a fundamental right enshrined in various international and regional treaties, and a peremptory norm binding all states to respect the right to life of all.³⁸ According to the UN Human Rights Committee, denying women access to “life-saving obstetric care, including post-abortion care, is a violation of their right to life.”³⁹ According to a Human Rights Watch study, some women seeking post-abortion care in Argentinian hospitals were simply denied treatment, or were left to wait for a very long time before receiving care, sometimes leading to death.⁴⁰ In other instances, healthcare workers have “refused to treat women suffering from complications resulting from a clandestine abortion performed elsewhere.”⁴¹ In Nicaragua, “there have been several documented cases in which the death of a pregnant woman has been associated with the lack of timely

medical intervention to save her life.”⁴² Unduly delaying or denying medical care to women and girls experiencing obstetric complications — even problems unrelated to abortion such as ectopic pregnancies, hypertension, or hemorrhages — “can only increase the risk that women and girls will die or suffer serious long-term health complications.”⁴³ Delaying life-saving treatment and letting women die or suffer from long-term adverse health effects is a clear violation of international law, raising serious concerns within the international community.

THE RIGHT TO DUE PROCESS

The Universal Declaration of Human Rights affirms that every person “is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.”⁴⁴ The fundamental right to due process and presumption of innocence are echoed by regional human rights treaties and are enshrined in constitutions worldwide. States that criminalize abortions nonetheless maintain an obligation to ensure the right to a fair trial and a presumption of innocence. Accordingly,

women seeking post-abortion care, even those in conflict with the law, should still benefit from all provisions associated with the right to a fair trial and equality before the courts without discrimination.⁴⁵

Though elements of the crime of abortion and severity of punishment vary from country to country, some countries impose lengthy prison sentences on women and girls who seek an abortion and on health professionals who provide abortion services and life-saving and health-preserving obstetric care.⁴⁶ However, because most abortions are clandestine, prosecutors rely heavily, and sometimes exclusively, on medical professionals to report women to the police. Reporting is conducted either by reporting women outright on the basis of suspicion of having an abortion, or by coercing confessions as a condition of life-saving care. This creates an atmosphere in health facilities where, in effect, every woman who arrives at a public hospital in the process of miscarrying is suspected of acting to terminate her pregnancy.⁴⁷ These denouncements are of particular concern because it is “often difficult and in some cases impossible to prove whether a woman suffered a miscarriage or had an abortion — leaving women and girls at risk for false accusations.”⁴⁸ For example, in 2009, in the southern state of Quintana Roo, Mexico, a Mayan woman was wrongfully jailed for what turned out to be a spontaneous miscarriage.⁴⁹ In Nepal, a woman took pain medication during her seventh month of pregnancy and subsequently miscarried — she was accused of inducing an abortion and thereafter was imprisoned.⁵⁰ In Brazil, between 2007 and 2011, there were 334 police reports involving women who allegedly had illegal abortions, and court records show that 128 of these women were prosecuted.⁵¹ These injustices are magnified when women facing false accusations have no assistance from or access to counsel.

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When doctors and hospital staff substitute their own moral judgment and preempt the legal system by reporting women to law enforcement prior to confirming that an abortion took place, they violate her presumption of innocence. Moreover, if law enforcement then fail to investigate, and prosecutors base charges on evidence that is insufficient to prove with certainty that an abortion took place, the justice system denies women due process of the law. In 2011, the UN Special Rapporteur on the Right to Health Anand Grover suggested that, as an interim measure, states should formulate “policies and protocols by responsible authorities imposing a moratorium on the application of criminal laws concerning abortion, including legal duties on medical professionals to report women to law enforcement authorities.”⁵²

PROPOSED ADVOCACY STRATEGIES

DEVELOPING GUIDELINES FOR HEALTH PROVIDERS MAY REDUCE INCIDENTS OF MISTREATMENT FOR WOMEN SEEKING EMERGENCY OBSTETRIC CARE

Sometimes health care practitioners delay or deny women life-saving treatment not solely as punishment, but also because of confusion or lack of clarity as to their responsibilities as well as fear they will be prosecuted. Ireland recently made headlines when a woman died of blood poisoning after being refused a procedure to terminate her pregnancy even though she suffered a miscarriage.⁵³ This tragic situation renewed concerns about the difficulties created by Irish laws that prohibit abortion except in cases where the mother’s life is at risk, without any real guidelines for doctors to follow to make that assessment.⁵⁴ In Nicaragua, where there is a total ban on abortion, doctors who follow obstetric protocols and intervene to save a woman from dying of obstetric complications “risk their professional career and, potentially, their liberty.”⁵⁵ One doctor in Nicaragua interviewed by Amnesty International stated that constraints on medical judgment and limits on treatment for pregnant women and girls make medical expert opinions worthless and potentially cause fatal delays in treatment or the denial of specific kinds of treatment.⁵⁶

Regardless of the legality of abortion, states have an obligation to both protect the life of the woman and ensure access to quality healthcare. In situations where it is legally permissible for doctors to intervene but they intentionally delay intervention to punish women for having abortions, the state has a duty to hold these doctors accountable. In situations where maternal death is caused by ambiguity in the law, such as the case in Ireland, states have an obligation to develop clear guidelines about the intersection between the law and obstetric protocols that inform medical staff of their obligations to treat women humanely and with dignity, and outline the consequences for failing to do so. These guidelines should begin with the premise that a woman’s life is of equal value to that of an unborn fetus. Finally, in countries where therapeutic abortion is permitted by

law, “health systems need to ensure that sufficient numbers of staff are trained and available to offer the procedure without the punitive attitudes and systematic actions that constitute institutional violence.”⁵⁷ For example, the International Conference on Population and Development (Cairo) Plan of Action urges governments at all levels to monitor and evaluate patient services with a view to “detecting, preventing and controlling abuses by family-planning managers and providers,”⁵⁸ and “to secure conformity to human rights, and to ethical and professional standards in the delivery of family planning and related reproductive health services.”⁵⁹ Developing clear guidelines has the potential to save women’s lives and encourage doctors willing to give life-saving treatment by providing cover from punitive prosecutions.

MEDICAL PERSONNEL MUST BE HELD ACCOUNTABLE BY STATES AND THE ADVOCACY COMMUNITY

While international law provides a useful framework for victim’s advocates, ultimately change must come at a local level. In addition to seeking to legalize or decriminalize abortion services in their countries, reproductive rights advocates should also pressure local justice systems to hold medical personnel accountable for the mistreatment of women seeking emergency obstetric care. These charges do not have to implicate women’s human rights but can be brought as claims for denial of due process guaranteed by the national constitution — particularly in situations where women are imprisoned on the basis of coerced confessions or insufficient evidence. In 2001, an Interim Report of the UN Special Rapporteur on the Independence of Judges and Lawyers noted that “judges must be in a position to challenge gender stereotyping and discrimination when they encounter it in the form of wrongful charging of suspects, charges being brought without any supporting evidence of wrongdoing and merely on the basis of hearsay, or mis-charging of a particular form of conduct (like charging abortion as infanticide).”⁶⁰ Alternatively, advocates could bring cases against healthcare professionals for malpractice or negligence under local laws for violations of patient confidentiality or the harm to or death of a female patient they treat. Putting pressure on domestic legal systems to release women who have been imprisoned for abortion-related crimes merely to make a statement may serve to alter the attitudes of some medical professionals who abuse the justice system and impose their own moral judgment on women.

CONCLUSION

The rights of women seeking care after an abortion should not depend on whether that abortion was spontaneous or induced — and a woman should never be harassed, denied pain relief and life-saving care, or imprisoned for failing to sustain a pregnancy. When ample evidence suggests that these abuses are happening, the failure of state action is a breach of international law. States must hold medical personnel responsible for violating women’s rights, and advocates must continue to pressure states to fulfill their obligations.

ENDNOTES

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- ³ See Special Rapporteur of the Human Rights Council, *Interim Report on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 25, U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover).
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- ⁵ Amanda Marcotte, *Women Jailed for Miscarriages in El Salvador*, SLATE (Oct. 18, 2013), http://www.slate.com/blogs/xx_factor/2013/10/18/el_salvador_abortion_ban_women_are_showing_up_at_public_hospitals_while.html.
- ⁶ See Joaquina Erviti et al., *Strategies Used by Low-Income Mexican Women to Deal With Miscarriage and "Spontaneous" Abortion*, 14 NO. 8 QUALITATIVE HEALTH RESEARCH 1058, 1060 (2004).
- ⁷ See CTR. FOR REPRO. RTS., SURVIVING PREGNANCY AND CHILDBIRTH: AN INTERNATIONAL HUMAN RIGHT 9 (2005), available at <http://reproductiverights.org/en/document/surviving-pregnancy-and-childbirth-an-international-human-right>.
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- ¹¹ Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women ("Convention of Belém do Pará"), June 9, 1994, 27 U.S.T. 3301, 1438 U.N.T.S. 63 [hereinafter Convention of Belém do Pará].
- ¹² Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention), Council of Europe, April 7, 2011 [hereinafter Istanbul Convention].
- ¹³ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, adopted July 11, 2003.
- ¹⁴ Convention of Belém do Pará, *supra* note 11, art. 2 (a).
- ¹⁵ *Id.* art. 2(b).
- ¹⁶ *Id.*
- ¹⁷ Istanbul Convention, *supra* note 12, art. 3.
- ¹⁸ See CEDAW Gen. Rec. No. 19, *supra* note 10, ¶ 16.
- ¹⁹ See MARIA DE BRUYN, IPAS, VIOLENCE, PREGNANCY AND ABORTION ISSUES OF WOMEN'S RIGHTS AND PUBLIC HEALTH 25 (2003), available at <http://www.ipas.org/~media/Files/Ipas%20Publications/VioPregAbortionEng2.ashx>.
- ²⁰ See *id.*
- ²¹ González et al. ("Cotton Field") v. Mexico. Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 205, ¶ 252 (Nov. 16, 2009).
- ²² SRT Méndez Report on Healthcare Abuses, *supra* note 9, ¶ 50.
- ²³ Human Rights Law and Access to Abortion, HUM. RTS. WATCH (June 15, 2005), <http://www.hrw.org/es/news/2005/06/15/qa-human-rights-law-and-access-abortion>.
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- ²⁵ See Ipas, Submission to U.N. Comm. on the Elimin. of Discrim. against Women, CEDAW Gen. Discussion on Access to Justice, Feb. 18, 2013 [hereinafter Ipas CEDAW Submission], available at <http://www2.ohchr.org/english/bodies/cedaw/docs/Discussion2013/Ipas.pdf>.
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- ³⁸ See Vickie Knox, *Abortion in the Americas: Non-discrimination and Equality as Tools for Advocacy and Litigation*, 9 EQUAL RTS. REVIEW 25 (2012).
- ³⁹ AMNESTY INT'L NICAR., *supra* note 32, at 30.
- ⁴⁰ See HUMAN RIGHTS WATCH, DECISIONS DENIED: WOMEN'S ACCESS TO CONTRACEPTIVES AND ABORTION IN ARGENTINA 2 (2005).
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- ⁴² U.N. Comm. against Torture, Concluding Observations: Nicaragua, ¶ 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).
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⁴⁷ *See* Erviti, *supra* note 6, at 1059–60.

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⁵⁰ *See* DE BRUYN, *supra* note 19, at 27.

⁵¹ *See* INT’L CAMPAIGN FOR WOMEN’S RIGHT TO SAFE ABORTION, ABORTION IN THE CRIMINAL LAW: EXPOSING THE ROLE OF HEALTH PROFESSIONALS, THE POLICE, THE COURTS AND IMPRISONMENT INTERNATIONALLY 7 (2013), *available at* [http://www.safeabortionwomensright.org/wp-content/uploads/2013/09/Abortion-in-the-criminal-law-](http://www.safeabortionwomensright.org/wp-content/uploads/2013/09/Abortion-in-the-criminal-law-exposing-the-role-of-health-professionals-the-police-the-courts-and-imprisonment-internationally-for-28-September-2013.pdf)

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⁵⁵ AMNESTY INT’L NICAR., *supra* note 32, at 9.

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⁵⁷ DE BRUYN, *supra* note 19, at 44.

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⁵⁹ *Id.*

⁶⁰ Ipas CEDAW Submission, *supra* note 25, at 2.

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