

IN THE EUROPEAN COURT OF HUMAN RIGHTS

APPLICATION NO. 27617/04

BETWEEN

R.R.

APPLICANT

AND

POLAND

RESPONDENT

WRITTEN COMMENTS

BY

**THE INTERNATIONAL REPRODUCTIVE AND SEXUAL HEALTH LAW
PROGRAMME, UNIVERSITY OF TORONTO, FACULTY OF LAW
PURSUANT TO RULE 44, § 2 AND § 4 OF THE RULES OF THE COURT**

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I. Introduction

1. The International Reproductive and Sexual Health Law Programme at the University of Toronto, Faculty of Law (“the Programme”) respectfully submits written comments by permission of the President of the Chamber of the European Court of Human Rights (“the Court”) pursuant to Article 36 § 2 of the *European Convention on Human Rights* (“the Convention”) and Rule 44, § 2 and § 4 of the Rules of Court.

II. Interest of the Programme

2. The Programme is an academic programme dedicated to improving the legal protection and promotion of reproductive and sexual health (“RSH”). The Programme has particular expertise in the application of equality and non-discrimination rights in the regulation of RSH care and has collaborated with government and international agencies, non-government organizations, and academic institutions to develop policies and scholarship on this subject. The Programme most recently filed *amicus curiae* briefs in constitutional challenges in Colombia and Nicaragua.

III. The Legal Issue

3. This case presents the question of whether a Contracting Party of the Convention is obligated under Articles 3, 8, 13, and 14 of the Convention to ensure a woman’s timely access to prenatal genetic diagnosis so that the woman, and not her doctor, can direct her consequent treatment.

IV. Discussion

4. The following discussion is divided into four Parts. Part A addresses the reasons why a finding of a violation of the right to sexual non-discrimination (Article 14) in relation to the right to private life (Article 8), freedom from inhuman or degrading treatment (Article 3), and the right to an effective remedy (Article 13) is necessary. Part B argues that Contracting Parties’ denial of women’s autonomy and moral agency in the delivery of reproductive health services violates Article 14 in relation to Article 8. Part C explains the reasons why Contracting Parties’ subjection of women to humiliating or otherwise dignity-denying treatment in the delivery of timely diagnostic services, and consequent medically-indicated lawful treatment, violates Article 14 in relation to Article 3. Finally, Part D explores the reasons why Contracting Parties violate Article 14 in relation to Article 13 when they fail to provide effective means of legal redress when women are denied sex-specific diagnostic and related services.

A. In order to address the historical patterns of paternalism and sexism in the delivery of women’s reproductive health services, a finding of a violation of the right to sexual non-discrimination (Article 14) in relation to the right to private life (Article 8), freedom from inhuman or degrading treatment (Article 3), and the right to an effective remedy (Article 13) is necessary.

5. This Court has addressed some of the more explicit forms of sex discrimination.¹ The Court now has an important opportunity to address implicit and systemic forms of sex discrimination underlying medical practices, in particular the delivery of women’s reproductive health services. These forms of discrimination deny women, because they are women, the information necessary to make free and informed decisions about medical care.
6. As is well recognised in the jurisprudence of this Court, “[w]here a substantive Article of the Convention has been invoked both on its own and together with Article 14 and a separate breach has been found of the substantive Article, it is not generally necessary for the Court to consider the case under Article 14 also, though the position is otherwise if a clear inequality

of treatment in the enjoyment of the right in question is a fundamental aspect of the case ..."² Under the Convention, Contracting Parties are responsible for health-care systems,³ like other organs of state,⁴ and therefore are obligated to ensure that all patients, irrespective of their sex, can make free and informed decisions about their reproductive health. The Court is faced with a clear inequality of treatment in women's enjoyment of their rights in health-care systems. Women, on the basis of their sex, are denied access to diagnostic and related services, and thus the opportunity to make free and informed decisions about their reproductive health.

7. Even if a separate breach has been found of one of the substantive Articles, it is still necessary for the Court to consider the case under Article 14 in order to issue a remedy that specifically addresses sex discrimination, or the denial of women's equal exercise of Convention rights. Moreover, the Courts' explicit recognition of the sex-discriminatory dimensions of Convention violations provides notice to Contracting Parties more generally that they must attend to and remedy persistent sex and gender discrimination in all aspects of state affairs, including the administration and design of health-care systems.⁵
8. This Court has reconfirmed that Article 14 of the Convention, "does not forbid every difference in treatment in the exercise of the rights and freedoms recognised by the Convention."⁶ Rather, this Court explains that Article 14:
 - requires "safeguards [of] persons ... who are 'placed in analogous situations' against discriminatory differences of treatment,"
 - defines discrimination as "a difference of treatment ... [that] has no objective and reasonable justification," and
 - justifies a difference in treatment only if it pursues a "legitimate aim" and exhibits a "reasonable relationship of proportionality between the means employed and the aim sought to be realized."⁷

The Court also recognizes that Contracting Parties enjoy a certain margin of appreciation in assessing whether and to what extent differences of treatment are legally justified.⁸

i. Contracting Parties, in regulating health-care systems, should not treat men and women differently in the delivery of medically-indicated diagnostic and related services.

9. As this Court has explained, Article 14 "safeguards persons ... who are 'placed in analogous situations' against discriminatory differences of treatment."⁹ Men and women are equally entitled to due respect and consideration for their health needs, and thus are similarly situated or placed in analogous situations in this regard. Yet, when women, and not men, are subjected to deliberately obstructed or circuitous pathways when they seek information, such as through diagnostic tests, to make informed medical choices about treatment to which they are legally entitled, there is a difference in treatment. Moreover, when women, and not men, experience such denials of their autonomy in decision-making with regard to their sex-specific medical needs, there is a difference in treatment.
10. This Court has recognized that women are often unjustly disadvantaged in making free and informed decisions,¹⁰ or accessing care to which they are legally entitled.¹¹ As recognised by the Court of Appeal in Northern Ireland, Departments of Health are obligated to discharge their general duty to provide integrated health services. Since integration "includes services to women who seek a lawful termination of a pregnancy the Department has the same duty to provide this service as any other however controversial the subject matter may be."¹²

11. International legal norms, especially those elaborated under the Convention on the Elimination of All Forms of Discrimination against Women,¹³ explain that the neglect of health needs specific to women constitutes a form of discrimination against women that states are obligated to remedy.¹⁴ National courts are also increasingly finding that the singling out of women's health services from other medically-indicated procedures may constitute "an unconstitutional form of discrimination on the basis of gender."¹⁵

ii. Contracting Parties, in regulating health-care systems, might afford different treatments between men and women, but those differences in treatment must be reasonably justified as necessary to achieve a legitimate objective.

12. Differences in the treatment of women seeking medically-indicated diagnostic and related services as compared to men or the singling out of women's health services from other medically-indicated procedures require objective and reasonable justification. The mere fact that the services relate to health needs specific to women is insufficient to justify differences in treatment. The different treatment of women, or health services specific to women's health needs, must pursue a legitimate aim.

13. The different treatment of women seeking diagnostic tests related to reproductive health may be justified as pursuing the following legitimate aims: (a) protection of prenatal life, (b) pursuit of benevolent paternalism, or (c) protection of conscience. The protection of prenatal life is an important social and moral value in all Contracting Parties. However, it must be asked whether protecting this value is a legitimate reason to deny women access to prenatal tests that will assist them, rather than their doctors, to make informed decisions whether to pursue consequent treatment.

14. Benevolent paternalism respecting women's reproductive health services is predicated on stereotypes of women as incapable of independently making health-care decisions in their own best interests. Women's decision-making was and continues to be subject to third party authorization by doctors, hospital directors,¹⁶ and partners,¹⁷ on this basis. While historically the practice of third party authorization was justified as a form of benevolent paternalism, this Court has stood firmly against this form as interfering with a woman's right to private life,¹⁸ as have courts of Contracting Parties,¹⁹ and courts beyond Europe.²⁰

15. The Convention protects freedom of thought, conscience and religion, but it also recognizes that the manifestation of one's conscience is subject to such limitations "as are prescribed by law and are necessary in a democratic society ... for the protection of ... health or morals, or for the protection and freedoms of others."²¹ The freedom of conscience of health care providers must be balanced against the rights of women to their physical and mental health, and their right to exercise moral agency in matters of personal conscience, such as the decision to lawfully terminate pregnancy.

16. There is an unfortunate history of abuse of conscientious objection to deny women, and not men, a range of reproductive health services.²² Such denial fits into an overall pattern of discriminatory attempts to reduce women's moral agency.²³ Significantly, this Court has resisted this pattern,²⁴ by denying admissibility in a case where joint owners of a dispensary tried to justify their refusal to sell contraceptive pills by invoking the freedom of conscience. This Court explained that "as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they can manifest those beliefs in many ways outside the professional sphere."²⁵ This observation is equally applicable to physicians' refusal to undertake sex-specific diagnostic services, or to refer their patients to appropriate colleagues for legally permitted termination of pregnancy.

17. The Committee on the Elimination of Discrimination against Women explains that “[i]t is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.”²⁶
18. While the aims of health-care systems to protect prenatal life, pursue benevolent paternalism and protect conscience have legitimacy, it is questionable whether the difference in treatment between men and women that results from the promotion of such aims is reasonably justified. Any means employed to pursue these aims must not be excessive; the means proposed must be proportionate to their legitimate aims.

iii. Contracting Parties, in regulating health-care systems, must employ means that are proportionate to their legitimate aims.

19. Although the protection of prenatal life is a legitimate objective, when the means employed to pursue this objective are excessively burdensome, the differential treatment is unjustified. The difference in treatment is discriminatory because “there is not a ‘reasonable relationship of proportionality between the means employed and the aim sought to be realised’ ...”²⁷ There are many effective means to protect prenatal life that are compatible with women’s right to be free from inhuman and degrading treatment, and their right to respect for private and family life. They include the provision of prenatal care and nutrition, the reduction of spontaneous miscarriages, including recurrent miscarriages, and, for example, welfare measures to ease the social and economic vulnerabilities of pregnant women.²⁸

iv. Contracting Parties, in regulating health-care systems, should not exceed their margin of appreciation in differentiating on grounds of sex in the delivery of diagnostic and related services.

20. Contracting Parties enjoy a narrow margin of appreciation in cases involving a difference in treatment on the basis of sex.²⁹ States’ margin of appreciation is also narrow where standards of treatment are unified throughout Europe.³⁰ Since “the advancement of the equality of the sexes is today a major goal in the Member States of the Council of Europe” this Court has indicated that “very weighty reasons would have to be advanced before a difference of treatment on the ground of sex could be regarded as compatible with the Convention.”³¹
21. There is widespread regional and international recognition of the importance of ensuring women’s right to equal access to health care systems generally,³² and access to timely diagnostic treatment³³ and lawful abortion.³⁴ The Committee of Ministers of the Council of Europe has, for example, adopted standards regarding prenatal genetic diagnosis and associated genetic counseling.³⁵ Principle 10 of those standards explains that: “No discriminatory conditions should be applied to women who seek prenatal screening or diagnostic testing or to those who do not seek such tests, where these are appropriate.” Where uniform European standards exist regarding women’s timely access to medically-indicated diagnostic tests and consequent lawful treatment, Contracting Parties’ margin of appreciation is greatly diminished, and should therefore not be relied upon to justify a difference in treatment on the basis of sex.

B. Contracting Parties' denial of women's autonomy and moral agency in the delivery of reproductive health services violates Article 14 in relation to Article 8.

i. Contracting Parties, in regulating health-care systems, are obligated to ensure that health providers and institutions provide care in the best health interests of their patients, and not on the basis of their own self-interest or sex-based stereotypes.

22. The application of Article 14 together with Article 8 is necessary to address the sex-specific ways in which women's decisional autonomy is compromised by Contracting Parties in regulating health-care systems. A sex equality analysis is concerned that the gender norms governing the delivery of health-care services values men's decisional autonomy more than women's, compromising women's capacity to make free and informed decisions.³⁶ It has been explained that "... legal challenges to undue restrictions on abortion procedures do not seek to vindicate some generalized notion of privacy; rather, they center on a woman's autonomy to determine her life's course, and thus to enjoy equal citizenship stature."³⁷
23. Women are often treated differently than men in the delivery of health-care services because of historical and continuing prejudices against women, including discriminatory stereotypes of women. Stereotypes generalize certain attributes to an entire class of persons and preclude assessment of individuals in the particular circumstances of their private and family lives. All societies create and perpetuate stereotypes. Sometimes stereotypes are common among societies, and sometimes they differ.
24. Article 5(a) of the Convention on the Elimination of All Forms of Discrimination against Women requires states parties to eliminate prejudices and practices that are "based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women."³⁸ The Committee on the Elimination of Discrimination against Women recently urged Poland to "... intensify its efforts to overcome persistent and deep-rooted stereotypes that are discriminatory against women, and to galvanize action by all parts of society ... in order to counteract stereotypical attitudes and portrayals of women and to bring about cultural change whereby women's equal rights and dignity are fully respected."³⁹
25. The stereotype that motherhood is women's natural role and destiny is discriminatory when it implies that all women should be treated only as mothers or potential mothers, and not according to their individual needs not to become mothers at certain points in their lives. When Contracting Parties incorporate such a stereotype into the delivery of health-care services, it disadvantages women. Discriminatory stereotypes limit the ability of individual women to make autonomous decisions about their health, and their private and family lives that may conflict with their role as mothers or future mothers. Women's voluntary role as mothers should always be taken into serious account, but women should not be condemned by stereotyping when they make the private choice to forgo motherhood in particular circumstances. Women should be as free as men to select parenthood.
26. A state policy, or passive acceptance of institutional norms, that rely on a stereotypical view of women as only mothers restricts women's private and family choices in a discriminatory manner. It has been explained that: "the notion ... that women are to be regarded as the primary care givers of young children, is a root cause of women's inequality in our society. It is both a result and a cause of prejudice; a societal attitude which relegates women to a subservient, occupationally inferior yet unceasingly onerous role. It is a relic and a feature of patriarchy which the Constitution so vehemently condemns."⁴⁰ It has been further explained that: "[o]ne of the ways in which one accords equal dignity and respect to persons is by seeking to protect the basic choices they make about their own identities. Reliance on the

generalisation that women are the primary care givers is harmful in its tendency to cramp and stunt the efforts of both men and women to form their identities freely.”

ii. Contracting Parties, in regulating health-care systems, are obligated to ensure that health-care providers and institutions make diagnostic services equally available to all patients, regardless of sex, to enable them to make informed decisions about medically-indicated care.

27. This Court confirmed that effective access to lawful abortion is a matter of private life.⁴¹ Women should not be conditioned by state agents’ withholding of available medical services that would diagnose severe fetal abnormalities when the law allows them the private choice to terminate such pregnancies. It is not just the uncertainty in delivery of services, but, as this Court has explained, it is also the anguish and distress it causes.⁴² Accordingly, unjust denial or obstruction of diagnostic services on the basis of a woman’s express intention to terminate a pregnancy is an interference with private life.
28. Contracting Parties, in regulating health-care systems, often use laws, policies and practices that entrench and aggravate discriminatory stereotypical views of women as incapable of making autonomous medical decisions. The longstanding tradition of imposing such stereotypical burdens on women does not strengthen a Contracting Party’s claim to legitimacy, and may indeed weaken it.⁴³ A pregnant woman’s “suffering is too intimate and personal for the State to insist, without more, upon its own vision of the women’s role, however dominant that vision has been in the course of our history and culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.”⁴⁴ A sex equality approach to Article 8 enables courts to identify and condemn the predisposed sexist stereotypes embedded in health-care systems that enable the denial of equal access to diagnostic treatment in ways that violate women’s rights to make private autonomous decisions.
29. Women’s private choices of the design and composition of their families should not be at the disposal of health-care professionals or institutions that determine the allocation of available health care resources, or that seek to advance sex-specific norms based on religious or cultural ideologies through the denial of available diagnostic services in order to prevent outcomes they disapprove. Women are usually the primary care-givers within their families. Women’s human right to control their own bodies affects their capacity to serve their families, including dependent children and often dependent elderly family members. The design and composition of women’s family life, including how they proportion resources of time and energy among healthy and disabled children, and among children and elderly family members, is a matter of deep personal and emotional significance.
30. This Court has observed that: “there may ... be positive obligations [on states] inherent in an effective “respect” for private life. These obligations may involve the adoption of measures designed to secure respect for private life even in the sphere of relations between individuals, including both the provision of a regulatory framework of adjudicatory and enforcement machinery protecting individuals’ rights and implementation, where appropriate, of specific measures.”⁴⁵ There is a wide consensus that in the administration of health-care systems, Contracting Parties are obligated positively to ensure reasonable availability of diagnostic services to enable patients to have the information necessary to make medical decisions significant to their health and family well-being.⁴⁶ This principle of free and informed decision making is found in codes of medical ethics and reflected in national laws,⁴⁷ court decisions of Contracting Parties,⁴⁸ international legal norms⁴⁹ and their application,⁵⁰ and international guidelines for medical practice.⁵¹ The rights of women, as well as men, to make

autonomous medical decisions cannot be compromised by stereotypical views of women as incapable of making such decisions.

C. Contracting Parties' subjection of women to humiliating or otherwise dignity-denying treatment in the delivery of timely diagnostic services, and consequent medically-indicated lawful treatment, violates Article 14 in relation to Article 3.

31. In considering whether there is a violation of Article 3, this Court has said that regard must be had to all the circumstances of the case.⁵² Doctors are in positions of authority and power over their dependent patients. This innate power imbalance is often greater when male doctors are treating female patients. Doctors can exploit their professional authority to treat female patients according to their own beliefs and sex-based stereotypes, rather than according to the actual needs of such patients. When patients are treated in ways unrelated to their own medical needs, and to their own priorities and aspirations, but rather as means to advance doctors' own ends, there is a form of degrading treatment.
32. Significantly, this Court has held that the failure to take positive steps to undertake adequate investigations of allegations of rape violated Article 3 of the Convention.⁵³ Denying women the exercise of reproductive autonomy through obstructing timely access to prenatal diagnostic tests may comparably violate Article 3. Any resulting involuntary continuation of legally terminable pregnancy, and the birth of a child with severe abnormalities, would constitute a form of inhuman and degrading treatment.⁵⁴
33. In considering whether there is a violation of Article 14 in conjunction with Article 3, it is necessary to consider the sex-specific elements of particular cases. Doctors find it far more difficult to relegate the medical needs of male patients than female patients to their own personal beliefs. Male patients do not experience the same vulnerabilities as women with respect to self-determination in reproduction and family formation, pregnancy, childbirth and responsibility for childrearing. Men do not have to cope with health-care systems that stigmatize their choice of lawful health-care, and are not subjected to the vulnerabilities caused by health-care systems that fail to clarify vague indications for lawful services, or to disclose how patients who fit within these indications may obtain them.⁵⁵
34. Contracting Parties must account for the particular sex-specific vulnerabilities of women seeking prenatal genetic diagnosis. Such women often have existing dependent children for whom they have to care. They face a very stressful decision, perhaps one of the most difficult decisions in their lives. As a result, they require non-judgmental counseling that enables them to think through their particular life circumstances, personal values and priorities, usually under severe time constraints. When Contracting Parties, in regulating health-care systems, subject pregnant women, faced with the possibility of births of children with severe abnormalities, to circuitous or obstructed means to obtain information or treatment, with the effect that they are denied opportunities to make timely decisions about legal abortion services, there is a violation of Article 14 in relation to Article 3.

D. Contracting Parties violate Article 14 in relation to Article 13 when they fail to provide effective means of legal redress when women are denied sex-specific diagnostic and related services.

35. This Court has recognized that Article 14 covers situations in which persons in different situations have been treated properly according to those differences: "The right not to be discriminated against in the enjoyment of the rights guaranteed under the Convention is also violated when States without an objective and reasonable justification fail to treat differently persons whose situations are significantly different."⁵⁶ This ruling is applicable to the gender-differentiated ways in which Contracting Parties disregard women's needs for diagnosis of

severe fetal abnormalities, and thus requires remedial treatment that addresses those sex-specific needs. The Committee on the Elimination of Discrimination against Women has observed that “[i]t is not enough to guarantee women treatment that is identical to that of men. Rather, biological as well as socially and culturally constructed differences between women and men must be taken into account. Under certain circumstances, non-identical treatment of women and men will be required in order to address such differences.”⁵⁷ Women, therefore, require sex-specific reproductive health care services, such as diagnoses of severe fetal abnormalities.

36. In considering whether there is a violation of Article 13, this Court has observed that this provision “must be interpreted as guaranteeing an ‘effective remedy before a national authority’ for everyone who claims that his rights and freedoms under the Convention have been violated.”⁵⁸ In order to comply with Article 13, a remedy must be “effective” both in law and in practice.⁵⁹ It is not sufficient to meet their Convention obligations for Contracting Parties to enact legislation ostensibly guaranteeing equality in the delivery of health-care services. States have a positive obligation to implement measures designed to ensure women’s *de facto*, as well as their *de jure*, equality with men in the health-care context.⁶⁰ The need for concrete measures is made all the more urgent in light of historical patterns of paternalism and sexism in the delivery of reproductive health services to women, which have denied women effective remedies at the national level.
37. States are obligated to ensure that women are able to exercise their rights in the health-care context and to have effective access to all lawful services. Contracting Parties are thus required to accommodate and redress the sex-specific vulnerabilities of women seeking access to medically necessary services – including prenatal genetic diagnosis and lawful abortion. States are obligated, for example, to address existing power imbalances between doctors and female patients, as well as the paternalistic tradition in the delivery of reproductive health services to women, such as in cases of abuse of conscientious objection.⁶¹
38. Remedies need to target the ways in which discriminatory stereotypes, including stereotypes of women as only mothers and as incapable of making health-care decisions, impede women’s access to essential health-care, and contribute to women’s inequality more generally. Sex inequality is aggravated when those who deny or obstruct abortion services are protected by governmental inaction and indifference to the needs of women for whose care abortion is medically indicated and legally permitted. Remedies that fail to address the vulnerabilities of women, arising specifically because they seek care that only women need, will be limited in their effect.
39. While Contracting Parties have instituted a number of measures designed to ensure women effective remedies in the health-care context,⁶² United Nations treaty monitoring bodies frequently express concern regarding the inadequacy of measures intended to ensure women’s effective access to reproductive health-care, specifically addressing obstacles faced by women in accessing lawful abortion services.⁶³ In 2007, for example, the Committee on the Elimination of Discrimination against Women urged Poland to “take concrete measures to enhance women’s access to health care, in particular to sexual and reproductive health services, in accordance with article 12 of the Convention and the Committee’s general recommendation 24 on women and health.”⁶⁴ It further urged Poland to “ensure that women seeking legal abortion have access to it, and that their access is not limited by use of the conscientious objection clause.”⁶⁵
40. In 2004, the Human Rights Committee noted its concern at “the unavailability [in Poland] of abortion in practice even when the law permits it, for example in cases of rape, and ... the lack of information on the use of the conscientious objection clause by medical practitioners

who refuse to carry out legal abortions.”⁶⁶ The Committee subsequently recommended that Poland “should provide further information on the use of the conscientious objection clause by doctors ...”⁶⁷ This Court also criticized Poland for its failure to implement an adequate legal framework allowing for the determination of disputes between patients and health-care providers in cases relating to lawful abortion.⁶⁸

41. When Contracting Parties, in regulating health-care systems, fail to provide women, in contrast to men, with an effective means of redress, both in law and in practice, they unjustifiably discriminate on the basis of sex. It is essential, therefore, that Contracting Parties put in place ethical and legal frameworks sufficient to enable women to overcome sex-specific obstacles to the *de facto* and *de jure* enjoyment of their rights in the health-care context:

i. Adoption and observance of medical guidelines that address the discriminatory stereotypical attitudes about women is necessary for the ethical provision of prenatal genetic diagnosis and related services.

42. It is a discriminatory difference in treatment for Contracting Parties to fail to observe guidelines for the ethical provision of prenatal diagnosis, a form of treatment required only by women, when guidance has been issued in relation to the provision of other health services that affect both men and women.⁶⁹ Contracting Parties should be required to observe guidelines on the provision of prenatal genetic diagnosis.⁷⁰ Such guidelines should include elaboration of the ethical principle to consider first the well-being of the patient, to ensure that this principle is implemented, irrespective of the sex of the patient. Such guidelines should also explain that reliance on stereotypical attitudes about women’s decision-making capacity and sole roles as mothers, and not on women’s needs for medically-indicated treatment, offends that ethical principle of justice of treating different cases according to their differences.

43. This Court has affirmed governmental use of its professional licensing authority to require provision of professional services to underserved populations.⁷¹ A requirement for ethical training as a condition of licensure might similarly be considered. Such training would need to explicitly include case studies that explore the ethical duties of fairness and justice, to ensure that all patients, irrespective of sex, are treated fairly and equally. The use of case studies is required that enable the clarification of values regarding sexist stereotypes of women as incapable of making their own medical decisions, and as incapable of exercising their moral agency.

ii. Adoption and implementation of sex-sensitive procedures is necessary to enable women on the basis of equality with men to appeal medical decisions denying requests for medically-indicated services.

44. The absence of appeal procedures in circumstances where women are denied access to services necessary for health-care that only women require poses a major obstacle to women’s equal enjoyment of the rights and freedoms guaranteed under the Convention. Contracting Parties should be encouraged to develop procedures to enable women to appeal, in a manner that takes account of rising dangers to health from delay in delivery of health-care services, against decisions of the health-care system itself. Such procedures might include instituting a medical ombudsperson, as has been adopted in Hungary.⁷²

V. Conclusion

45. Contracting Parties, in regulating health-care systems, should not allow difference in treatment between men and women in their access to medically-indicated services, when the difference in treatment is based on gender-differentiated stereotypical perceptions that

degrade women. When Contracting Parties deny women the information necessary for them to make informed decisions about whether to undergo sex-specific medical treatment, because of discriminatory stereotypical attitudes, and not medical assessments, they discriminate on the basis of sex. When Contracting Parties neglect health needs specific to women, or single out health services for women from other medically-indicated procedures for reasons unrelated to health, they fail to treat all patients equally according to their medical needs. Health-care systems are obligated to respect and protect women's autonomy and moral agency as that of men, and to act in the best interests of their patients.

46. When Contracting Parties rely on discriminatory stereotypical beliefs regarding women's decision-making capacities or gender-roles, and not on medical assessments, they make sex-based distinctions that discriminate on grounds of sex in relation to the right to private life. Moreover, when Contracting Parties subject pregnant patients, faced with the possibility of births of children with severe abnormalities, to circuitous or obstructed means to obtain information or treatment, with the effect that they are denied opportunities to make timely decisions about legal abortion services, there is sex discrimination in relation to the right to be free from inhuman and degrading treatment of women.
47. When Contracting Parties fail to address the historical patterns of paternalism and sexism in the delivery of health services to women, they have prevented women from enjoying equality in access to lawful health services and from making private decisions. It is therefore important that the Court takes this opportunity to address the implicit forms of sex discrimination that are hidden in medical practices and traditions of stereotypical thinking about women. In finding a violation of Article 14 in conjunction with Articles 3, 8 and 13, the Court can make explicit the discrimination that is implicit in the ways in which Contracting Parties, through their health-care systems, discriminate against women on the basis of their sex.

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- 1 See e.g. *Abdulaziz, Cabales and Balkandali v. United Kingdom*, (1985) 7 EHRR 471 [“Abdulaziz”]; *Burghartz v. Switzerland*, (1994) 18 EHRR 101 [“Burghartz”]; *Schuler-Zraggen v. Switzerland*, (1993) 16 EHRR 405 [“Schuler-Zraggen”]; *Van Raalte v. The Netherlands*, (1997) 24 EHRR 503 [“Van Raalte”]; *Karlheinz Schmidt v. Germany*, (1994) 18 EHRR 513 [“Karlheinz Schmidt”].
- 2 *Chassagnou and Others v. France*, (2000) 29 EHRR 615, at para. 89. See also *Airey v. Ireland*, (1979-1980) 2 EHRR 305, at para. 30 [“Airey”]; *Dudgeon v. United Kingdom*, (1982) 4 EHRR 149, at para. 67.
- 3 See *Feldbrugge v. Netherlands*, (1986) 8 EHRR 425.
- 4 See e.g. *Belgian Linguistics Case*, (1979-1980) 1 EHRR 252; *A. v. United Kingdom*, (1997) 27 EHRR 611.
- 5 See Aalt Willem Heringa & Fried van Hoof (revised by), “Prohibition of Discrimination” in Pieter Van Dijk et al., *Theory and Practice of the European Convention on Human Rights*, (4th ed.), (Antwerp; Oxford: Intersentia, 2006), 1027 (arguing that “decisions of the Court, as the highest organ competent to interpret the Convention, have an effect far exceeding the concrete aspects of the case submitted to it, and that these decisions may therefore also have implications of a more general character” at 1032-1033 [citation omitted]).
- 6 *Lithgow v. United Kingdom*, (1986) 8 EHRR 329 [“Lithgow”].
- 7 *Ibid* at para. 177 (citations omitted). This same test was affirmed in *Koua Poirrez v. France*, (2005) 40 EHRR 34, at para. 46.
- 8 *Lithgow*, *ibid*.
- 9 *Ibid*.
- 10 *Open Door Counselling Ltd and Dublin Well Woman Centre Ltd v. Ireland*, (1993) 15 EHRR 244.
- 11 *Tysiac v. Poland*, App. No. 5410/03 (Eur. Ct. H.R. Sept. 21, 2005) [“Tysiac”].
- 12 *Family Planning Ass’n of N. Ir. v. Minister for Health, Soc. Services & Public Safety*, [2004] NICA 37-39 (Civ), [2005] N. Ir. L.R. 188 (Civ), *Campbell LJ*, at para. 41 [“Family Planning Ass’n”]. See also Judgment of the Bavarian Higher Administrative Court of 03/07/1990, *BayVGH DVb1*. 1990, 880-82 (F.R.G.); Judgment of the Federal Administrative Court of 12/13/1991, *BVerwGE* 89, 260-70 (F.R.G.) (upholding decision of Bavarian Higher Administrative Court).
- 13 *Convention on the Elimination of All Forms of Discrimination against Women*, 1 March 1980, 1249 U.N.T.S. 13, Can. T.S. 1982 No. 31 (entered into force 3 September 1981) [“CEDAW”].
- 14 See *Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Women and Health*, UN Doc. A/54/38 at 5 (1999) [“CEDAW General Recommendation No. 24”].
- 15 *Tucson Women’s Clinic v. Eden*, 379 F.3d 531 (9th Cir. 2004) at 548. See also *New Mexico Right to Choose/NARAL v. William Johnson, Secretary of the New Mexico Human Services Department*, 126 N.M. 788 (1999) (holding that “New Mexico’s Equal Rights Amendment requires a searching judicial inquiry to determine whether the [Human Services] Department’s rule prohibiting state funding for certain medically necessary abortions denies Medicaid-eligible women equality under law. We conclude from this inquiry that the Department’s rule violates New Mexico’s Equal Rights Amendment because it results in a program that does not apply the same standard of medical necessity to both men and women, and there is no compelling justification for treating men and women differently with respect to their medical needs in this instance:” 792); *Jane Doe I v. Manitoba*, [2004] 248 D.L.R. (4th) 547 (Can.). See generally *Joanna N. Erdman*, “In the Back Alleys of Health Care: Abortion, Equality, and Community in Canada” (2007) 56(4) *Emory L.J.* 1093.
- 16 *Karen Noelia Llantoy Huamán v. Peru*, HRC, Communication. No. 1153/2003 (2005) [“K.L. v. Peru”]; *Friendly Settlement, Paulina del Carmen Ramirez Jacinto*, *Petition 161-02, Inter-Am. C.H.R.* (Mar. 9, 2007) (Mex.)
- 17 See e.g. *Paton v. United Kingdom*, 3 EHRR 408 (1980) (Eur. Comm’n H.R.) [“Paton”]; *R.H. v. Norway* [“H”], 73 Eur. Comm’n H.R. Dec. & Rep. 155 (1992) 1; *Boso v. Italy*, 7 Eur. Ct. H.R. 451 (2002) [“Boso”].
- 18 See *Paton*, *ibid*; *R.H.*, *ibid*; *Boso*, *ibid*.
- 19 *C. v. S.*, (1987) 2 W.L.R. 1108 (Court of Appeal, Eng.); Judgment of Oct. 31, 1980, *Conseil d’Etat*, D.S. Jur. 19,732 (Council of State of France, 1980); Judgment of Mar. 31, 1988, *Gazz. Ufficiale*, 1 série spéciale, Apr. 13, 1988, n.15, *Giur. Cost. e Civ.* 2110, (Constitutional Court of Italy, 1988); *Kelly v. Kelly*, (1997) S.C. 285 (Court of Session, Scotland); Judgment of Feb. 15, 1978, Dec. No. 157/77, 3 *Yugoslav Law* 65 (Constitutional Court of Yugoslavia, 1979).
- 20 *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 69 (1976); *Tremblay v. Daigle*, [1989] 2 S.C.R. 530 (Can.); *A v. B.*, [1981] *IsrSC* 35(3) 57; *Attorney-General (QLD) ex rel. Kerr v. T* (1983) 46 A.L.R. 275 (Austl.) .
- 21 *European Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950, 213 U.N.T.S. 221 at 223, Eur. T.S. 5, Article 9(2).
- 22 See *R. Alta Charo*, “The Celestial Fire of Conscience – Refusing to Deliver Medical Care” (2005) 352 *New Eng. J. Med.* 2471; *Bernard M. Dickens*, “Conscientious Objection: A Shield or a Sword” in *Sheila A.M. McLean ed.*, *First Do No Harm: Law, Ethics and Healthcare* (Aldershot, Hants, England; Burlington, VT: Ashgate, 2006) 337; *Charles Ngwenya*, “Access to Legal Abortion: Developments in Africa from a Reproductive and Sexual Health Rights Perspective” (2004) 19 *S. Afr. Pub. L.* 328.
- 23 *Rebecca J. Cook & Susannah Howard*, “Accommodating Women’s Differences under the Women’s Anti-Discrimination Convention” (2007) 56(4) *Emory L.J.* 1039, at 1082-1087.
- 24 *Pichon and Sajous v. France*, App. No. 49853/99, Eur. Ct. H.R. (2001).
- 25 *Ibid* at p. 4.
- 26 *CEDAW General Recommendation No. 24*, *supra* note 14, at para. 11. See also *Concluding Observations of the Human Rights Committee: Poland*, HRC, UN Doc. CCPR/CO/82/POL (2004), at para. 8.
- 27 *Lithgow*, *supra* note 6, at para. 177.

28 See Cook & Howard, *supra* note 23; Reva B. Siegel, “Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression” (2007) 56(4) *Emory L.J.* 815 [Siegel, “Sex Equality”].

29 Abdulaziz, *supra* note 1, at para. 78; Van Raalte, *supra* note 1, at para. 39; Burghartz, *supra* note 1, at para. 27; Schuler-Zgraggen, *supra* note 1, at para. 67; Karlheinz Schmidt, *supra* note 1, at para. 24.

30 Compare *Petrovic v. Austria* (1998) 33 EHRR 307 (granting Austria a significant margin of appreciation on the basis of “a very great disparity between the legal systems of the Contracting States in this field. While measures to give fathers an entitlement to parental leave have now been taken by a large number of States, the same is not true of the parental leave allowance, which only a very few States grant to fathers:” at para. 42. “The Austrian authorities’ refusal to grant the applicant a parental leave allowance has not, therefore, exceeded the margin of appreciation allowed to them. Consequently, the difference in treatment complained of was not discriminatory within the meaning of Article 14:” at para. 43.). See also Aalt Willem Heringa & Fried van Hoof, *supra* note 5, at 1045.

31 Abdulaziz, *supra* note 1, at para. 78. See also Schuler-Zgraggen, *supra* note 1, at para. 67; Burghartz, *supra* note 1, at para. 27; Karlheinz Schmidt, *supra* note 1, at para. 24; Van Raalte, *supra* note 1, at para. 39.

32 See e.g. CEDAW, *supra* note 13, Article 12; CEDAW General Recommendation No. 24, *supra* note 14.

33 See e.g. Committee of Ministers of the Council of Europe, Recommendation No.R(90)13, 21 June 1990.

34 Regarding women’s transparent access to abortion, see e.g. Tysiac, *supra* note 11; K.L. v. Peru, *supra* note 16; Family Planning Ass’n, *supra* note 12.

35 Committee of Ministers of the Council of Europe, *supra* note 33.

36 Siegel, “Sex Equality,” *supra* note 28, at 817.

37 Justice Ruth Bader Ginsburg dissenting in *Gonzales v. Carhart*, 127 S. Ct. 1610 (2007), at 1641, and specifically referencing Reva B. Siegel, “Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection” (1992) 44(2) *Stan L. Rev.* 261; Sylvia A. Law, *Rethinking Sex and the Constitution*, (1984) 132 *U. Pa. L. Rev.* 955, at 1002–1028.

38 CEDAW, *supra* note 13, art. 5(a). See also Rikki Holtmaat, *Towards Different Law and Public Policy: The Significance of Article 5a CEDAW for the Elimination of Structural Gender Discrimination* 31–45 (2004), http://www.emancipatieweb.nl/uploads/947/Towards_Different_Law_and_Public_Policy.pdf (reviewing the Committee’s work on Article 5(a)).

39 Concluding Observations of the Committee on the Elimination of Discrimination against Women: Poland, UN Doc. CEDAW/C/POL/CO/6 (2007), at para. 17.

40 *President of the Republic of South Africa v. Hugo*, 1997 (4) SA 1 (S. Afr. C. C.), 1997 6 B.C.L.R. 708, at para. 80. Kriegler J (agreeing that the stereotypical perception of women as primary care givers of young children was a form of sex and gender discrimination but dissenting on the finding that reliance upon the stereotype was justified). For a finding of stereotyping of men as discriminatory, see *Mississippi University for Women v. Hogan*, 458 U.S. 718 (1982).

41 Tysiac, *supra* note 11, at para 109, referencing the European Commission decision in *Brüggemann and Scheuten v. Federal Republic of Germany* (1977). The right to private life was one of the rights on which the Human Rights Committee found an unlawful interference with privacy rights when a young woman was prevented in lawfully terminating a pregnancy of an anencephalic fetus. The Committee found a state in breach of the prohibition of arbitrary or unlawful interference with privacy rights when the director of a state hospital denied a young woman a medical procedure to which she was legally entitled, *K.L. v. Peru*, *supra* note 16–42 *Ibid.* at para. 65.

43 Siegel, “Sex Equality,” *supra* note 28, at 816.

44 *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, at 852 (1992), per Justices O’Connor, Kennedy and Souter JJ.

45 Tysiac, *supra* note 11, at para. 110.

46 See e.g. Committee of Ministers of the Council of Europe, *supra* note 33.

47 Rebecca J. Cook et al., *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law* (Oxford: Clarendon Press; New York: Oxford University Press, 2003), at 109-113.

48 Family Planning Ass’n, *supra* note 12, per Nicholson LJ (arguing that “[t]he mother who gives her consent to the abortion must give an informed consent” at para. 76).

49 See e.g. CEDAW General Recommendation No. 24, *supra* note 14.

50 Ms. A.S. v. Hungary, CEDAW, Communication No. 4/2004, UN Doc. CEDAW/C/36/D/4/2004 (2006), at paras. 11.2-11.5.

51 World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems*, (Geneva: WHO, 2003) online: www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf.

52 *Ireland v. UK*, (1979-1980) 2 EHRR 25, at para. 162.

53 *M.C. v Bulgaria*, 646 Eur. Ct. H.R. 150 (2003), at paras. 182-187.

54 *K.L. v. Peru*, *supra* note 16.

55 Tysiac, *supra* note 11; Eileen V. Fegan & Rachel Rebouche, “Northern Ireland’s Abortion Law: The Morality of Silence and the Censure of Agency” (2003) 11(3) *Fem. Legal Stud.* 221, 250.

56 *Thlimmenos v. Greece*, (2001) 31 EHRR 411, at para. 44. Confirmed in *Nachova and Others v. Bulgaria*, App. Nos. 43577/98 and 43579/98 (Eur. Ct. H.R., July 6, 2005), at para. 145; *Jane Smith v. the United Kingdom*, (2001) 33 EHRR 712, at para. 138; *Case of Beard v. the United Kingdom*, (2001) 33 EHRR 442, at para. 132; *Case of Chapman v. the United Kingdom*, (2001) 33 EHRR 399, at para. 129.

57 CEDAW General Recommendation No. 24, *supra* note 14, at para. 8.

58 *Klass and Others v. Germany*, (1979-1980) 2 EHRR 214, at para. 64.

59 *Aksoy v. Turkey*, (1997) 23 EHRR 553, at para. 95.

60 In *Tysiác*, this Court reiterated that “the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective (see *Airey v. Ireland*, judgment of 9 October 1979, Series A no. 32, p. 12-13, § 24);” *supra* note 11, at para. 113.

61 *Supra* note 22.

62 See e.g. Law No. 239 of 24 March 1970 on the interruption of pregnancy, as amended through Law No. 572 of 24 July 1998 (Fin.); Law No. 50 of 13 June 1975 concerning Termination of Pregnancy, as amended 16 June 1978 no. 5 (Nor.); Decree No. 2 of 1 February 1990 on the conditions and procedures for the artificial termination of pregnancy (Bulg); Law No. 1252-1978 of 21 April 1978, Act concerning the medical measures for materialization of the right to freely decide on the birth of children, Art. 24 (Croat.); Law of 30 June 1977, the Act concerning the conditions of and procedures for the termination of pregnancy, Art. 25 (Serb.); Law of 20 April 1977 on medical measures to implement the right to a free decision regarding the birth of children, Art. 25 (Slovn); Law No. 350 of 13 June 1973 on the interruption of pregnancy, as amended through Law No. 389 of 14 June 1995, ch. 2; Law No. 66 of 20 October 1986 of the Czech People’s Council concerning the artificial termination of pregnancy, Art. 8 (Czech Rep.).

63 See e.g. Concluding Observations of the Committee on the Elimination of Discrimination against Women: Croatia, CEDAW, UN Doc. A/53/38 (1998), at para. 109; Hungary, UN Doc. A/52/38 (1996), at para. 254; Lithuania, UN Doc. A/55/38 (2000), at paras. 158-159; Romania, UN Doc. A/55/38 (2000), at paras. 314-315; Concluding Observations of the Committee on Economic, Social and Cultural Rights: Poland, UN Doc. E/C.12/1/Add.26 (1998), at para. 12; Armenia, UN Doc. E/C.12/1/Add.39 (1999), at para. 15; Georgia, UN Doc. E/C.12/1/Add.42 (2000), at para. 18; Concluding Observations of the Human Rights Committee: Argentina, UN Doc. ICCPR, A/56/40 vol. 1 (2000).

64 Concluding Observations of the Committee on the Elimination of Discrimination against Women: Poland, *supra* note 39, at para. 25.

65 *Ibid.*

66 Concluding Observations of the Human Rights Committee: Poland, *supra* note 26, at para. 8.

67 *Ibid.*

68 *Tysiác*, *supra* note 11.

69 See generally Family Planning Ass’n, *supra* note 12.

70 See e.g. Committee of Ministers of the Council of Europe, *supra* note 33.

71 *Van der Musselle v. Belgium* (1984) 6 EHRR 163.

72 Act XX of 1949 Constitution of the Hungarian Republic (1949. Évi XX. Törvény a Magyar Köztársaság Alkotmányá), Article 32/B.