Report on International Human Rights Obligations regarding Sexual and Reproductive Health during the Emergency of the Zika Epidemic
for
The Federal Supreme Court of Brazil

by
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Introduction

This report explains the obligations of states under international and regional human rights treaties to address the particular aspects of sexual and reproductive health that have been starkly illuminated by the emergency of the Zika epidemic. It is filed pursuant to a case before the Federal Supreme Court of Brazil claiming individuals' rights of access to a) information on how best to protect one's sexual and reproductive health, particularly given the harms, risks and uncertainties of the Zika virus infection; b) comprehensive sexual and reproductive health services, especially those that are relevant to the prevention and treatment of the Zika virus infection; c) legal abortion for pregnant women diagnosed with Zika virus infection and suffering from mental stress caused by the awareness of the harms, risks and uncertainties of the infection; d) health care to children affected by the Zika syndrome; and e) for families affected by the Zika syndrome access to social assistance.

1. Does the Zika epidemic constitute a public health emergency of international concern?

The World Health Organization (WHO) defines health emergencies as "sudden-onset events from naturally occurring or man-made hazards, or gradually deteriorating situations through which the risk to public health steadily increases over time."[1] On February 1, 2016, WHO declared that the clusters of microcephaly and other neurological disorders associated with the Zika virus are a Public Health Emergency of International Concern (PHEIC).[2] The WHO International Health Regulations Emergency Committee recommends PHEIC declarations when health situations constitute a health risk to other countries through international spread, require a coordinated response, and have implications beyond the affected country that require immediate action.[3] Pursuant to this PHEIC designation, only the fourth of such WHO designations ever made, WHO has issued Interim guidance for pregnancy management during Zika.[4]

It is recognized that the Zika virus infects through mosquito-borne transmission and non-mosquito born transmission, including from mother-to-fetus transmission during pregnancy and around the time of birth, and through sexual transmission via the semen, possibly through blood transfusion[5] and breast milk.[6] Findings have now established that "a causal relationship exists between Zika virus infection and microcephaly and other serious brain anomalies" in fetuses and newborns.[7] These same findings stressed that "many questions that are critical to our prevention efforts remain, including the spectrum of defects caused by prenatal Zika virus infection, the degree of relative and absolute risks of adverse outcomes among fetuses whose mothers were infected at different times during pregnancy, and factors that might affect a woman's risk of adverse pregnancy and birth outcomes."[8]

2. What are a state's obligations under international human rights law in the event of a public health emergency of international concern?

The United Nations (UN) and regional human rights bodies that monitor state compliance with international and regional human rights treaties recognize that states have obligations to mitigate the impact of public health emergencies in their countries, and to reduce the risk and harmful effects of its spread. For example, under the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Committee on Economic, Social and Cultural Rights (CESCR) explains that the right to health "includes the creation of a system of urgent medical care in cases of …epidemics…."[9] The Inter-American Commission on Human Rights requires states to act expeditiously in emergencies to avoid possible irreparable harm of alleged violations when it grants precautionary measures,[10] as does the Inter-American Court of Human Rights when it grants provisional measures.[11] States also have obligations not to take regressive measures during public health emergencies. If they do, the burden is on them to prove their necessity.[12] During times of public

emergency "which threatens the life of the nations and the existence of which needs to be officially proclaimed" states are permitted to derogate from their obligations to protect certain limited rights.[13] However in the absence of official state proclamations during the Zika emergency, derogation from obligations is not permitted.

3. How are obligations under international and regional human rights law determined?

Obligations under international and regional human rights law are determined by the work of human rights bodies established under international treaties, including the Committee on Economic, Social and Cultural Rights (CESCR),[14] the Human Rights Committee (HRC),[15] the Committee against Torture (CAT),[16] the Committee on the Elimination of Discrimination against Women (CEDAW),[17] the Committee on the Rights of the Child (CRC),[18] the Committee on the Elimination of Racial Discrimination (CERD),[19] and the Committee on the Rights of Persons with Disabilities (CRPD).[20] They are also determined by the work of the UN Special Rapporteurs, the UN Human Rights Council, the jurisprudence of the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights[21] and, for example, the European Court of Human Rights (ECHR).[22] Throughout this report, the term "human rights bodies" refers as appropriate to all of these committees, courts, councils and rapporteurships.

The normative work of these bodies includes: their decisions in individual complaints and inquiry procedures, their relevant General Comments, their Concluding Observations on states' reports, and the reports of the special rapporteurs. All of this work constitutes sources of international human rights law, some of which is firmer and more developed than other sources. The evolving nature of these norms is often referred to as the hardening of human rights norms. These bodies often draw on important international consensus documents, such as the *Report of the International Conference on Population and Development* (known as the ICPD Programme of Action)[23] and the *2030 Agenda for Sustainable Development*.[24]

Human rights bodies recognize the subsidiary nature of international human rights law and the fact that states have the particular knowledge necessary to determine what is most effective in their own countries. As a result, they defer to states to determine what measures are most effective, and only review whether the measures chosen are reasonable[25] or appropriate.[26] Decisions of national courts interpreting international and regional human rights treaties and similar provisions of their own constitutions often have persuasive authority before human rights bodies.

4. What is sexual and reproductive health, and what rights are relevant to its protection?

4.1. What is sexual and reproductive health?

Definitions of sexual and reproductive health have been crafted through WHO and international consensus documents, as understandings have evolved over the past quarter of the century. They are restated in the CESCR General Comment 22: "Sexual health, as defined by WHO, is a state of physical, emotional, mental and social well-being in relation to sexuality."[27]

Reproductive health was first described in the 1994 ICPD Programme of Action.[28] It "concerns the capability to reproduce and the freedom to make informed, free and responsible decisions. It also includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behaviour."[29] Significantly for states facing the Zika epidemic, the definition of reproductive health includes "appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[30]

The right to sexual and reproductive health is "an integral part of the right to health enshrined in Article 12" of the ICESCR.[31] As the General Comment 22 explains,[32] sexual and reproductive health is also protected by other international human rights conventions, including the Convention on the Elimination of All Forms of Discrimination against Women (the Women's Convention),[33] the Convention on the Rights of the Child (The

Children's Convention),[34] and the Convention on the Rights of Persons with Disabilities (the Disabilities Convention).[35]

Despite these protections, CESCR noted that grave violations of the right to reproductive health persist, due to "numerous legal, procedural, practical and social barriers, people's access to the full range of sexual and reproductive health facilities, services, goods and information [is denied]…. In fact, the full enjoyment of the right to sexual and reproductive health remains a distant goal for millions of people, especially for women and girls…."[36]

This goal is even more distant for poor women and girls because epidemics "primarily affect the poor and the disempowered…. Malnutrition, dirty water, crowded living conditions, poor education, lack of sanitation and hygiene, and lack of decent health-care provisions all increase chances that those who suffer from poverty will also suffer from infectious disease…. Crowded living and working conditions facilitate the spread of disease from person to person. Those who are poorly educated fail to take sufficient disease-avoidance measures. And poor communities often lack adequate resources to improve sanitation."[37] While the gender dimensions of the Zika epidemic are emerging, it can be said that poor women, particularly those in rural areas, will suffer worse consequences than would otherwise occur. For example, they live in crowded living conditions and often lack the power to negotiate for safe sex, and they often lack the resources to take preventative measures and access health care systems and essential medicines.

4.2. What rights are relevant to the protection of sexual and reproductive health?

While human rights bodies have yet to directly address compliance with human rights obligations during the Zika emergency, this report focuses on the following categories of rights as particularly important to protect sexual and reproductive health during the epidemic:

- rights regarding special protection and assistance for: pregnant women before, during and after childbirth, their children with disabilities, and their families;
- the right to health, the right to equal access to health care;
- the right to equal application of the law;
- the right of women to be free from torture and other cruel, inhuman or degrading treatment or punishment; and
- rights relating to women's access to justice for infringement of their rights.

These are not the only relevant rights, because the enjoyment of sexual and reproductive health is interdependent with other rights, such as the rights to education, the right to non-discrimination and equality between men and women and the right to private and family life.[38]

CESCR explains that, like the right to health more generally, the "right to sexual and reproductive health entails a set of freedoms and entitlements. The freedoms include the right 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. The entitlements include unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health under article 12 of the Covenant."[39] That is, "entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[40]

5. What measures of protection might be deemed reasonable or appropriate to protect sexual and reproductive health during the emergency of the Zika epidemic?

Based on the work of human rights bodies to date, these bodies would consider the following five categories of measures reasonable or appropriate to protect sexual and reproductive health during the public health emergency of the Zika epidemic:

Measure No. 5.1: Provide special protection to infected women before, during and after childbirth

International human rights law requires states to provide special protection "to mothers during a reasonable period before and after childbirth."[41] Human rights bodies have repeatedly recognized that women who are pregnant or have recently given birth are often in situations of heightened vulnerability and therefore require greater protections. In assessing alleged human rights violations, the ECHR has routinely acknowledged pregnancy and childbirth as conditions of vulnerability.[42] In finding a violation of a pregnant minor's right "to such measures of protection as are required by [her] status as a child," the HRC recognized the vulnerability of a pregnant adolescent girl because "she did not receive during and after her pregnancy, the medical and psychological support necessary in the specific circumstances of her case."[43] The CAT has called on states to take specific, targeted measures to protect the rights of women during pregnancy.[44]

The *WHO interim guidance on pregnancy management in the context of Zika virus* acknowledges that "women who want to carry their pregnancy to term must receive appropriate care and support to manage anxiety, stress and the birth environment … [and that] all women, whatever their individual choices with respect to their pregnancies, must be treated with respect and dignity."[45]

Based on the foregoing, human rights committees might reasonably conclude that states should provide such measures of special protection for pregnant women who are exposed to, or infected with, the Zika virus as accurate, comprehensive, and unbiased information regarding the effect of the congenital syndrome associated with the Zika virus on:

i. their pregnancies, such as the possible heightened risk of miscarriage, and the kind of care and support to manage anxiety, stress and the birth environment;

ii. the risks on fetal development and birth outcomes, such as possible disabilities, including microcephaly, health-endangering outcomes and possible stillbirths;

iii. what raising an affected child might entail and the availability of educational, health, financial, social and other support necessary for raising a child with disabilities;

iv. social services for pregnant women infected by the Zika virus and for women who have given birth to children with disabilities as a result of the Zika infection.

In addition, human rights committees would also conclude that states should provide good quality maternal health care, including early diagnosis, and pre- and post-natal care, that is responsive to the specific health risks and needs associated with the Zika virus, with the understanding that prenatal screening, ultrasound examination, and other diagnostic testing must be with the informed consent of the pregnant woman.

Measure No. 5.2: Provide assistance to and accommodate the special needs of children, including children with disabilities, and their families

Human rights bodies have repeatedly recognized that children, especially those with disabilities, are vulnerable, and therefore require greater protections.[46] Regarding the greater protection for children with disabilities, the CRC recommends that states "ensure access to medical care and to support measures for all children with disabilities,"[47] but recognizes the "difficulties in obtaining medical examinations for children with disabilities, which are often a prerequisite for access to medical care or support measures."[48] As a result, the CRC recommends that "facilitate the obtaining of medical examinations" for children with disabilities.[49]

In order to combat the isolation of children with disabilities, particularly in rural areas, the CRC obligates states to combat the stigmatization of such children, and prejudice against them and their families.[50] The CRC recommends more comprehensive social support systems to complement financial assistance for families of children with disabilities, to prevent or reduce the placement of children in institutions.[51] The CRC urges states to develop "a specific Plan of Action to provide health care, comprehensive education and protection to children and adolescents with disabilities."[52] The CRC further urges states to make available "reliable and quality disaggregated data on the extent and causes of disability."[53]

The CRPD has made similar recommendations for children with disabilities, recommending that states "allocate sufficient resources" to develop "community-based rehabilitation programmes for children with disabilities" to maximize their capacities to lead fulfilling lives.[54] The CRPD stresses the need for professional and financial resources to be made available and geographically accessible, particularly at the local level to support children with disabilities, and their families.[55] It urges states to "elaborate comprehensive health programmes in order to ensure that persons with disabilities are specifically targeted and have access to rehabilitation and health services…."[56] The CRPD recommends states allocate resources to ensure that mainstream health services are accessible to persons with disabilities.[57]

In light of the above, human rights bodies would conclude that the rights of children with disabilities associated with the Zika syndrome, including microcephaly, require states to provide them with appropriate measures of protection, including immediate access to health care and social assistance.[58] Under state duties to protect the family,[59] human rights bodies might also conclude that social assistance to all families with children affected by the Zika syndrome is necessary.

Measure No. 5.3: Create an Enabling Legal Environment for the Delivery of Sexual and Reproductive Health Services

Health professionals' paramount objective is the provision of health services to ensure patients' healthy outcomes. They can advance their objective through better understanding how human rights principles can assist in the delivery of sexual and reproductive health services, especially how such principles can be used to redress the chilling effect of prohibitive criminal law. The CESCR recognized this chilling effect by requiring states to address the social determinants of sexual and reproductive health, "as manifested in laws, institutional arrangements and social practices that prevent individuals from effectively enjoying in practice their sexual and reproductive health."[60] This Court can assist health professionals in more effectively advancing their objectives by articulating how human rights principles are relevant in the provision of sexual and reproductive health services, and explain how such principles might be applied in specified circumstances of the Zika epidemic. Recognizing the evolving nature of this epidemic, the following is only suggestive of what measures might be reasonable under international human rights standards.

5.3.1. Explain how human rights are relevant to the Zika epidemic

Explaining how human rights are relevant to sexual and reproductive health during the Zika epidemic is important because in emergency situations respect for human rights tends to be overlooked. Moreover, it is useful to remind health professionals how human rights can be interpreted to facilitate availability of and access to services. Drawing on the list of human rights outlined in 4.2 above, this section focuses on rights to equal access to services, the right to health and the equal application of the law.

The obligation to guarantee equal access to sexual and reproductive health services is based on the right to be free from all forms of discrimination, which is fundamental in international human rights law, and in most national constitutions. The CEDAW has noted that where states overlook, neglect or fail to provide health care that only women need, such as emergency obstetric care,[61] and lawful abortion,[62] this failure constitutes discrimination against women, because only women require such health services. The CEDAW continually calls on states to "repeal all national penal provisions which constitute discrimination against women."[63]

Failure to provide contraception is also a form of discrimination against women because its denial disproportionately impacts women and their health,[64] which is especially the case during the Zika epidemic. In Chile, the Constitutional Court referenced the Women's Convention to find that health insurance policies imposing higher fees on women than on men disproportionately burden women, and thus violate their equal access to health services.[65] This decision is consistent with the Inter-American Court of Human Rights' finding that the denial of in vitro fertilization is sex discrimination because infertility disproportionately burdens women.[66]

Where a state systematically denied the public availability of a full range of modern methods of contraception and information, the CEDAW held it accountable for grave and systematic violations of reproductive rights.[67] Substantive equality requires that states address the actual needs of women who are exposed to Zika virus infection while liable to become or actually pregnant, and how preexisting laws and policies hinder their actual access to sexual and reproductive health care during the emergency of the epidemic.[68] Similarly, substantive equality requires examining how preexisting neglect of condom distribution inhibits the ability of men to play their part in stemming the spread of the Zika virus, given the potential spread of the virus through semen of infected men.[69]

Numerous UN and regional human rights bodies have noted the enhanced risk of human rights abuses in the context of reproductive health care, based on sex and gender intersecting and compounding with other factors, including women's pregnant status.[70] The Inter-American Commission on Human Rights noted that "Women who have historically been marginalized based on their race, ethnicity, economic status, or age are those who face the most barriers in access to information on health, and these barriers become even greater when the information has to do with matters related to sexual and reproductive health."[71] Reading the right to health consistently with states' obligations to guarantee Covenant rights "without discrimination of any kind", the CESCR requires the equitable provision of sexual and reproductive health services to both men and women, lawful abortion services for women who choose them, irrespective of their age, socio-economic, racialized and, for example, geographic (including rural) status.[72] During the Zika epidemic, it would be especially important to emphasize pregnant status as a prohibited ground of discrimination. Such a requirement builds on the CESCR's Concluding Observations on the periodic reports of states explaining what they have done, or not yet done, to bring their laws, policies and practices into compliance with the ICESCR.[73]

To ensure the full exercise of the right to sexual and reproductive health, CESCR requires states to ensure the availability, accessibility, acceptability and quality of sexual and reproductive health services and information,[74] which are often referred to as the AAAQ standards. States are thus required to make available an "adequate number of functioning health care facilities, services, goods and programs"[75] including skilled health personnel, a wide range of contraceptive methods, including long-acting and emergency contraception, and the most modern methods of medical and surgical abortion.[76] Given the Zika epidemic, a plentiful supplies of insect repellents, particularly repellents that are safe for pregnant women to use, is especially necessary. Such products need to be accessible to all individuals without discrimination, and free of barriers including ideological, gender and legal barriers.[77] Accessibility includes physical, including geographic (rural) accessibility, affordability and accessibility of information consistent with the needs of the individual and the community.[78] Acceptability requires services to be respectful of cultures of individuals and, for example, life cycle requirements.[79] Quality requires goods and services to be "evidence-based and scientifically and medically appropriate and up-to-date."[80]

Equal application of the law is a foundational principle in international human rights law.[81] The obligation to guarantee equal application of the law applies to all laws, including those regulating availability of and access to sexual and reproductive health services. However, such laws tend to be applied unequally, according to the subjective interpretations of laws by hospital administrators, clinic directors and/or doctors, for which states have been held accountable under international[82] and regional[83] human rights law. Moreover, subjective interpretations are often reflected in informal rules that may undermine the formal law.[84] In Canada where the exceptions to the criminal prohibition of abortion had been applied inequitably due to numerous bureaucratic hurdles, its Supreme Court held the inequity a violation of women's rights to security of the person.[85]

5.3.2. Apply human rights principles to facilitate provision of information and services

In addressing how this Court might apply human rights principles to facilitate the lawful provision of health-related information and services on abortion, it is important to understand the public health context of abortion laws. The WHO's *Safe Abortion: Technical and Policy Guidance for Health Systems* explains that:

> Legal restrictions on abortion do not result in fewer abortions nor do they result in significant increases in birth rates. Conversely, laws and policies that facilitate access to safe abortion do not increase the rate or number of abortions. The principle shift of [reforming and clarifying laws] is to shift previously clandestine, unsafe procedures to legal and safe ones. Restricting legal access to abortion does not decrease the need for abortion, but it is likely to increase the number of women seeking illegal and unsafe abortions, leading to increased morbidity and mortality. Legal restrictions also lead many women to seek services in other countries/states, which is costly, delays access and creates social inequities.[86]

Given this public health context, this section addresses how states have been obligated by human rights bodies or have voluntarily chosen to mitigate the harmful effects of restrictive criminal abortion laws. These examples include, but are not limited to:

1. Legal direction on danger to women's lives
2. Legal and policy guidance, and
3. Harm reduction programs.

5.3.2.1. Legal direction on danger to women's lives: In order for this Court to determine how best to provide legal direction on what specified exceptions from criminal prohibition of abortion mean in actual practice, it is helpful to understand the preventable causes of maternal mortality and morbidity. Maternal death is defined as the "death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."[87]

Globally, direct causes of maternal mortality, including hemorrhage, hypertension, infection, unsafe abortion and embolism, cumulatively account for about 73% of maternal deaths (listed in priority order).[88] Globally, indirect causes of death, including HIV/AIDS,[89] pre-existing medical conditions (such as malaria[90]) which complicate or are aggravated by pregnancy, contribute the remaining 27%.[91] In Brazil in 2010, the percentage breakdown of direct and indirect causes differs somewhat from the global estimates, with hypertension, infection, hemorrhage, and unsafe abortion listed in decreasing order as the leading causes.[92] The estimated maternal mortality ratio (the number of maternal deaths per 100,000 live births) in Brazil in 2010 fell to 56, from 120 deaths per 100,000 live births in 1990.[93] Nonetheless, health inequalities exist: Afro-Brazilian women are seven times more likely to die in childbirth than white Brazilian women.[94]

In order to decrease maternal death even further, especially during the public health emergency of the Zika epidemic, this Court can assist by clarifying the meaning of preservation of a pregnant woman's life as an indication for lawful abortion. Where states fail to clarify the meaning of pregnancy-related danger to life, they have been held accountable. Because Ireland failed to clarify the meaning of a "real and substantial" risk to life of a woman,[95] it was held in violation of the European Convention on Human Rights in *A, B and C v. Ireland*.[96] C claimed that the criteria for a woman to qualify under a "real and substantial risk" to life lacked precision under Irish law, which "contributed to the lack of certainty for a woman seeking a lawful abortion."[97] The ECHR condemned Ireland, and was emphatic that any rights afforded must be more than theoretical. Rights must be given practical effect by force of law, which the Court ruled was defective because:

> There is no framework whereby any difference of opinion between the woman and her doctor or between different doctors consulted, or whereby an understandable hesitancy on the part of the woman or doctor, could be examined and resolved through a decision which would establish as a matter of law whether a particular case presented a qualifying risk to a woman's life such that a lawful abortion might be performed.[98]

The Court condemned the Irish government's failure to give direction on what is meant by the phrase "real and substantial", which has "resulted in a striking discordance between the theoretical right to lawful abortion in Ireland on grounds of relevant risk to a woman's life and the reality of its practical implementation."[99] The ECHR thus held that the state violated C's right to private life. Pursuant to this decision, Ireland enacted the Protection of Life During Pregnancy Act 2013, followed by guidelines for health care professionals.[100] The Act and its accompanying guidelines have been criticized as setting onerous procedures that do little to allow doctors to exercise their best clinical judgment to save women's lives consistently with human rights standards.[101]

In order to comply with human rights standards, legal direction is needed about how various risk factors, including clinical, public health and social risks, are considered in the overall assessment of protection of a woman's life.

Regarding clinical risks to life**,** states have produced important guidance for management of high risk pregnancies to assist health care providers in ensuring healthy pregnancies and birth outcomes.[102] Such

guidance addresses the best standards of medical care when pregnant women suffer with such conditions as hypertension, or might be at risk of hemorrhage, and address, for example, how best to treat co-infections in pregnant women, such as malaria and HIV/AIDS, that often put their pregnancies at even higher risk. It is unclear whether and how this guidance can be used as an authoritative source for determining threats to a woman's life that justify an abortion. It would be valuable if this Court could clarify criteria that satisfy the life indication for lawful abortion.

The *WHO Safe Abortion Guidance* explains that "some countries provide detailed lists of what they consider life-threatening medical conditions."[103] Such lists are generally meant to be illustrative of the kinds of conditions that are considered life threatening. However, they are often interpreted to exhaust life threatening conditions, thus precluding a doctor's clinical assessment of risk factors that may be life-threatening for a particular woman. There are debates regarding how imminent the risk has to be, with some explaining that waiting for the risk to be imminent or immediate prevents women from accessing termination earlier in pregnancy which is in their best health interests.[104] For usual medical conditions presenting long-term risks of patients' serious injury, prompt treatment is considered preferable to delayed care.

Tragic cases persist: a woman in Brazil who was refused judicial authorization when she asked for an abortion for a life threatening pregnancy died in childbirth.[105] A report into another case, where a woman in Ireland died of a life-threatening pregnancy, made clear that standard clinical practice would have led to an early termination of pregnancy, had local law on the exemption from criminal liability to save life been clearer.[106] The same report underscored the challenges in clinical practice of distinguishing between risk to life and to health.[107] Some situations that are considered threatening only to health result in death.

Beyond the clinical risks to life, there is widespread consensus that there are significant public health risks to life where safe abortion is not widely available.[108] States know that at least 10% of abortions will result in maternal death in states with highly restrictive abortion laws.[109] States also know that the public health risk of unsafe abortion is greater in subgroups of women who are poor and otherwise marginalized.[110]

Social risks to life have to be determined according to the actual social and family circumstances of an individual woman, implicating both underlying and social determinants of health.[111] The *WHO Safe Abortion Guidance* explains that social risks to life include a pregnancy that implicates family "honour," where a pregnancy out of wedlock may result in a woman being subject to physical violence, or even to being killed.[112] Social risks may be greater when a child is liable to be born or become seriously disabled, exposing a family to social disgrace and ridicule in those communities that do not value all human beings equally.

5.3.2.2. Legal and policy guidance: In addition to clinical guidance, legal and policy guidance is necessary. The WHO interim guidance on *Pregnancy management in the context of Zika virus* explains that "women who choose to discontinue their pregnancies should receive accurate information about their options to the full extent of the law, including where the care desired is not readily available."[113] Without clarity on what is meant by the phrase "to the full extent of the law," there is real reluctance among health care providers to supply the necessary services, and women to seek them, because they fear criminal prosecution and penalties including prolonged imprisonment. Moreover, there is a strong risk of unequal application of the law where law enforcement is uneven or arbitrary.

States have produced important clinical guidelines to inform clinicians about appropriate clinical care for those who are or might be infected with the Zika virus.[114] These guidelines are an important step toward ensuring that clinicians treat their patients according to the most current scientific information. They acknowledge, as WHO guidelines do, that the guidance is continually updated as information becomes progressively available.

These guidelines are necessary, but they are not necessarily sufficient, especially in the context of the hazards of the Zika virus to pregnant women and their newborns. Such guidelines are not sufficient where they fail to address how services can be provided "to the full extent of the law," and what needs to be done to guarantee the equal application of the abortion law, particularly to poor women who are liable to be most affected by the Zika virus.[115] The WHO *Safe Abortion Guidance* states that "the respect, protection and fulfillment of human rights require that comprehensive regulations and policies be put in place … to ensure that abortion is safe and accessible."[116] To guarantee accessibility, national protocols will need to show how states can maximize physical accessibility, affordability and information accessibility as required by the AAAQ standards.[117]

The 2016 Colombian Zika guidelines come closest to satisfying the test of sufficiency where they explain what is meant by the phrase "to the full extent of the law."[118] They explain what is permitted and required under Colombian Constitutional Court decisions on abortion.[119] Consistently with the WHO definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,"[120] the Colombian guidelines clarify that Colombian law[121] requires that health be protected holistically according to its physical, mental and social dimensions.[122] The Guidelines require that threats to mental health be understood to include mental suffering caused to a pregnant woman and her family members by a diagnosis of Zika virus infection and the accompanying uncertainties about fetal health, or by a diagnosis of serious fetal impairment. These guidelines require that all women considering abortion and those eligible to provide it are informed about what the law permits, thus maximizing the chances of equal application of the law.

Legal direction is needed to make sure that the law allows doctors to exercise their clinical judgement in their patients' best interests, free of conflict of interest due to fear of being prosecuted or professionally disciplined. Deference to doctors' clinical judgment is particularly important where medical knowledge is uncertain and evolving, such as with the Zika virus.[123] States often afford doctors security against the fear of prosecution when they authorize them to terminate pregnancies on their prognoses of risks to women's lives from continuing pregnancy that are independently confirmed by a second medical opinion. Official law-enforcement guidelines can discourage prosecutors from proceeding against doctors on abortion charges when the doctors' diagnoses of danger to life are previously confirmed by independent peers. Such guidelines, perhaps issued by ministries of justice, can liberate doctors to act in what they believe in good faith to be in the best interests of their consenting patients. Such guidelines can also avoid the need for women to request judges' authorization when doctors are unwilling to provide services because they fear criminal prosecution.[124] Such requests by women, who have the means to avail themselves of them, require judges to make medical assessments when such assessments should be made by doctors.

5.3.2.3. Harm Reduction programs: It is likely in states with restrictive law that unsafe abortion will rise during the Zika epidemic. Pregnant women infected with Zika who face the possibility of giving birth to a child with disabilities and who have decided they cannot provide the care necessary for such child are likely to terminate their pregnancies. Those who do not have access to safe services will resort to unsafe practices, contributing to an increase in abortion-related maternal mortality and morbidity. To address such harmful health outcomes associated with restrictive abortion laws, some states have instituted "Harm Reduction" programs that seek to ensure that women have access to scientifically-based information about how to avoid unsafe means to terminate their pregnancies, and neutral counseling.[125] Neutral counseling includes information on the risks associated with different means to induce abortion and signs of complications that require immediate attention. The health care professional is not involved in inducing an unlawful abortion, but only in providing information to help women reduce avoidable harm such as death or long-term disability, infection and trauma. Clarifying that such neutral counselling is not against the law would be an important step forward in creating an enabling environment.

Creating an enabling legal environment for harm reduction programs also requires the state to clarify that doctors, when exercising their professional duty to first act in the best interests of their patients, are not obligated to report suspected criminal activity. The Inter-American Court recognized that confidentiality is privileged over any duty to report. In a case finding a violation of the American Convention and ordering the state to pay reparations, the Court stated that:

> the State violated the principle of legality … for penalizing a medical activity, which is not only an essential lawful act, but which it is also the physician's obligation to provide; and for imposing on physicians the obligation to report the possible criminal behavior of their patients, based on information obtained in the exercise of their profession.[126]

The above discussion explain ways in which this Court might consider mitigating the effects of the Zika epidemic, by clarifying the meaning of preservation of a pregnant woman's life as an indication for lawful abortion. The Court could explain how equality principles and the AAAQ standard are applicable to the delivery of necessary services, and could provide a legal foundation for harm reduction programs.

Measure No. 5.4: Guarantee that infected women are free from torture and other cruel, inhuman or degrading treatment or punishment

The right to be free from torture and other cruel, inhuman or degrading treatment or punishment is protected in many international and regional human rights treaties.[127] Women receiving reproductive health services are at particular risk of being subjected to torture or cruel, inhuman or degrading punishment. Recently, the Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan Méndez, explained that:

> Unsafe abortion is the third leading cause of maternal death globally. Where access to abortion is restricted by law, maternal mortality increases as women are forced to undergo clandestine abortions in unsafe and unhygienic conditions. Short- and long-term physical and psychological consequences also arise due to unsafe abortions and when women are forced to carry pregnancies to term against their will. Such restrictive policies disproportionately impact marginalized and disadvantaged women and girls. Highly restrictive abortion laws that prohibit abortions even in cases of incest, rape or fetal impairment or to safeguard the life or health of the woman violate women's right to be free from torture and ill-treatment. Nevertheless, some States continue to restrict women's right to safe and legal abortion services with absolute bans on abortions. Restrictive access to voluntary abortion results in the unnecessary deaths of women.[128]

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health explained the negative effects of criminalization of abortion: "The marginalization and vulnerability of women as a result of abortion-related stigma and discrimination perpetuate and intensify violations of the right to health."[129] The Rapporteur on Health recommended legalization of abortion for mental health indications, among others, pointing to the mental health harms of denial:

> The criminalization of abortion also has a severe impact on mental health. The need to seek illegal health services and the intense stigmatization of both the abortion procedure and women who seek such procedures can have deleterious effects on women's mental health. In some cases, women have committed suicide because of accumulated pressures and stigma related to abortion. In jurisdictions where rape is not a ground for termination of pregnancy, women and girls who are pregnant as a result of rape but who do not wish to continue their pregnancy are either forced to carry the

> pregnancy to term or seek an illegal abortion. Both options can cause enormous anguish. In electing to pursue either option, the overarching threat of being investigated, prosecuted and punished within the criminal justice system has significant negative impacts on the emotional health and well-being of both those who seek abortions and those who do not.[130]

Short- and long-term physical and mental health consequences arise due to unsafe abortions, or when women are forced to carry pregnancies against their will. The vulnerability of pregnant women infected with the Zika virus is exacerbated by the psychological stress caused by the uncertainties, risks and harms associated with the infection. With regard to a state forcing an adolescent girl to carry a pregnancy to term knowing that she would give birth to an infant with a fatal anomaly, a psychiatrist informed the HRC that forcing an adolescent to carry a pregnancy to term whose fatal outcome was known in advance "substantially contributed to triggering the symptoms of depression, with its severe impact on the development of the adolescent and the patient's future mental health."[131] Similar symptoms of depression might arise in pregnant women knowing that there is a possibility of giving birth to a child with severe anomalies.

The CAT has repeatedly urged states to stop punishing abortion providers and women seeking abortions.[132] The CAT and other human rights bodies could reasonably conclude that investigating, prosecuting and punishing women who, while pregnant, were infected with Zika and likely to give birth to Zika infected children is a form of torture or cruel, inhuman or degrading treatment.[133] Moreover, human rights bodies could conclude that an appropriate step for a court to take, under international human rights law, would be to accept a defense of necessity, and acquit women and their doctors accordingly. That is, an abortion could be found necessary to preserve the life or health of the woman and to prevent her from becoming "a mental wreck," as an English court decided in the widely followed historic 1938 *Bourne* case.[134] A variant of the defense of necessity would be a self-defense argument, based on self-defense of the woman against the harmful effects on her physical and/or mental health of knowingly bearing, delivering and caring for a severely impaired child.

Another approach could be for the state to exercise discretion to suspend the enforcement of the criminal prohibition of abortion for Zika infected pregnant women who are in severe states of mental distress, so that they can live free of the psychological trauma of imposed pregnancies of severely damaged fetuses, or the mental stress associated with seeking and having unsafe abortions, and risking prosecution and imprisonment.[135]

Ministries of Justice or for instance Attorneys General or Directors of Public Prosecutions could issue guidelines for prosecutors advising them of the suspension of the enforcement of the criminal prohibition of abortion during the Zika emergency. Such guidelines would compromise the administrative or legal basis on which prosecutors can proceed against doctors or infected women. Guidelines might prevent the occurrence of punitive and malicious prosecutions,[136] at least for the duration of the Zika emergency. Alternatively, prosecutorial guidelines might explain that doctors will not be prosecuted for performing abortions, provided that in advance they secured second medical opinions concurring in good faith that abortion was necessary to save the women's lives or prevent them suffering long-term mental harm.

Whatever approach this Court decides to take to deter prosecutions and punishment of pregnant women infected with the Zika virus who terminate their pregnancies, any one approach would obviate the need for women to go to courts of law to find judges who are willing to certify that pregnancy is a threat to their lives. This is an immense burden for women to shoulder, and is very difficult, if not impossible, for poor women to

bear. Setting unjust conditions for the application of the law is a denial of its equal application, and denial of the human right to be free from torture and other cruel, inhuman or degrading treatment or punishment.

Any of the above approaches would be a step toward complying with international human rights standards during the Zika emergency. In the longer term, this Court should be aware that international human rights bodies consistently call on states to reform their restrictive criminal abortion laws to enable availability of and access to safe and legal abortion services, at least in circumstances of rape, incest, severe fetal impairment and when the woman's life, or physical or mental health, are at risk, in order to ensure that women are free from torture and other cruel, inhuman or degrading treatment or punishment.[137]

Measure No. 5.5: Guarantee Infected Women's Access to Justice

States are obligated to guarantee as a general matter that their justice systems are available and accessible, and contain the quality necessary to secure effective remedies.[138] It is a specific matter that their justice systems effectively address alleged infringements of the right to sexual and reproductive health.[139] In order for remedies to be effective, especially for women exposed to or infected by Zika, justice systems have to be timely, to be adequate and ensure that they respond to the particular types of violations experienced by women,[140] or subgroups of women such as adolescent girls.[141] That is, they need to be gender sensitive.[142] The CEDAW has held states accountable where women's rights to emergency obstetric care have been violated,[143] and where women have been denied access to lawful abortion.[144]

The HRC has twice held states accountable for failure to provide effective remedies when women's access to lawful abortion was denied,[145] or delayed,[146] with severe consequences for the women's physical and mental health. In addressing the need to reduce preventable maternal mortality, the United Nations Human Rights Council obligates states to ensure women's access to mechanisms of accountability at various levels, such as professional, institutional (hospital and clinic), and the health system levels, when they claim that their rights have been violated.[147]

Based on the foregoing analysis of the work of the human rights bodies and the UN Human Rights Council, states would be held accountable when they fail to ensure access to justice for alleged violations of women's rights to sexual and reproductive health, especially during the Zika emergency.

Conclusion

This report has explained the obligations of states under international and regional human rights law to address the public health emergency of the Zika epidemic. International law recognizes that states have heightened responsibilities to mitigate the impact of public health emergencies, and defers to states to determine which means might be most effective. However, human rights bodies will review those determinations to assess whether they are reasonable in the particular contexts. What would not be reasonable is for states to permit regression from the protection of rights during the Zika emergency.

Building on the distinction between freedoms and entitlements (see 4.2), human rights bodies might consider it reasonable for a state to first focus on freedoms from interventions with rights, such as the right to be free from torture, and then moving to securing entitlements, such as services. Every society benefits when states comply with their enhanced duties of protection for those most vulnerable, especially women affected by the Zika epidemic and children with disabilities.

This Court has an opportunity to create an enabling legal environment that positively assists health professionals to deliver sexual and reproductive health services, thus mitigating the especially harmful effects of criminality that often impair such delivery. This Court can clarify when preservation of a pregnant

woman's life serves as an indication for lawful abortion, explain how the equality principles and the AAAQ standard are applicable to the delivery of essential services, and provide a legal foundation for harm reduction programs.

This Court can also address the inhuman and degrading nature of the treatment of pregnant women by elaborating how the right to be free from torture and other cruel, inhuman and degrading treatment or punishment should be applied during this public health emergency. The Court can similarly identify how women who have been subjected to dignity-denying treatment can be facilitated to achieve access to justice, and ensure necessary remediation of such treatment. It can mitigate the short and long-term health consequences of unsafe abortion for Zika infected pregnant women, especially the mental health consequences, by

- clarifying judicial acceptance of a defense of necessity raised by providers of abortion and women seeking it,
- recognizing prosecutorial discretion to suspend the enforcement of the criminal law,
- acknowledging that restraining guidelines for prosecutors might be appropriate, or
- explaining whether the right to be free from inhuman and degrading treatment requires the state to suspend prosecution and punishment of pregnant women infected with the Zika virus and at high risk of mental depression.

In so doing, this Court can contribute to prevention of another epidemic of preventable maternal mortality and morbidity due to unsafe abortion and dignity-denying treatment of women.

Epidemics transform understandings of disease from pathologies of human bodies to pathologies of the environment.[148] This Court has an opportunity to ensure that the Zika epidemic does not become a pathology of the state, by ensuring that every citizen affected by Zika, without regard to their circumstances, has access to the essential sexual and reproductive health services necessary to ensure their right to health.

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