

**Consultation with CESC and CEDAW: Women and Economic, Social and Cultural Rights –  
Current Challenges and Opportunities for Advancement**

**Novotel Hotel, Geneva, 7 November 2015**

**[DRAFT] Briefing on the intersection between  
substantive equality and health**

**Introduction**

Interpreting the right to health through a substantive equality lens is critical for addressing the unique barriers women face in realizing their right to health, including states' differential treatment of women's health needs, formal and informal obstacles women face in making autonomous decisions about their health, and the barriers women face in accessing health services. Women's health needs differ from men's both as a result of their biological differences, such as women's reproductive capacities, and as a result of gender roles and stereotypes that impact the risks to their health with which women must contend. In regards to their reproductive capacities, women are often forced to contend with discriminatory laws that outright deny or inhibit access to essential reproductive health services, such as restrictive abortion laws, bans on certain forms of contraception, and targeted funding restrictions for specific health services. Procedural barriers, such as mandatory waiting periods and biased counselling, often also inhibit women's access to health services. Furthermore, pervasive stigma around women's sexuality also acts as a barrier to their access to sexual and reproductive health information and services.

Legal and cultural norms about women's ability to make autonomous decisions also undermines their right to health. For example, women may be required to receive authorization from a male family member or spouse before accessing any health services. Discriminatory gender roles and stereotypes also undermine the realization of women's right to health, as women may have less control over household's financial resources, which may mean that they are denied the ability to allocate money for their health needs, particularly in light of gender norms or stereotypes that place men and boys' needs above those of women and girls. For single mothers or families living in poverty, women's socialized role as the primary caregiver may make them unwilling to sacrifice spending money on their children's needs in order to attend to their own health care.

Where health systems are inadequately functioning – either throughout a state or in a certain region or area – women are often disproportionately impacted both as a result of their greater health needs and their lower social status. For example, where health resources are scarce, hospitals and clinics may prioritize what they view as “general” health needs while neglecting the unique risks women face to

their health, such as the need to stock essential medicines related to pregnancy and childbirth. Further, in developing countries, poor health outcomes such as maternal mortality and morbidity are often seen as fatalistic outcomes rather than conditions that are preventable. Women from marginalized groups are doubly impacted by this, for example, women from dalit or indigenous backgrounds, as they both must contend with the neglect of their health needs and often face other forms of discrimination in healthcare settings that undermine their right to quality care. In many countries, women often face serious human rights abuses when seeking reproductive health services in public and private healthcare facilities. These abuses include neglect and mistreatment during and after delivery, physical and verbal abuse, detention in health facilities for inability to pay for services, and female genital mutilation.

The social determinants of health are “conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.” Gender itself is a critical aspect of the social determinants of health, as it affects access to information and education, the way individuals experience poverty, and the quality of and access to nutrition, housing, water, and sanitation, among a range of other factors that affect individuals’ health. Addressing the social determinants of health, and also recognising and addressing intersectional discrimination that may also be present, is essential for improving health outcomes and realizing the right to health.

Finally, power dynamics, both within and outside of healthcare settings, strongly influence women’s right to health. Where women are not empowered to assert their rights, they are unable to seek remedies for human rights violations perpetrated against them, such as maltreatment or abuse in healthcare settings or violations of their right to informed consent. Furthermore, where women fear experiencing abuse in healthcare settings, it deters them from accessing health services. The way these power dynamics permeate societies also influences patterns of gender-based violence which, in addition to directly undermining women’s health, requires that health services be equipped to respond appropriately and effectively.

## Positive developments

Over the past several years, the CEDAW Committee has integrated a strong intersectional approach into women’s right to health. For example, in the case of *Alyne v. Brazil*,<sup>1</sup> in addressing a preventable maternal death of a poor, AfroBrazilian woman, the CEDAW Committee recognized that the state discriminated against her both on the basis of her sex and based on her socioeconomic status. This recognition that states are not in compliance with their human rights obligations where health measures neglect or fail to reach all sectors of society, including the most marginalized, is an essential component of substantive equality. The CEDAW Committee further utilized this approach in its Philippines inquiry, which was released this year, wherein the committee recognized that Manila City’s effective ban on modern contraceptives violated the convention and had a disproportionate effect on women from disadvantaged groups, including poor women, adolescents and women in abusive relationships.

The ground-breaking precedent in *Alyne v. Brazil* was recently built upon in a domestic case in Kenya surrounding the detention of poor women in hospitals after delivery for failing to pay their medical bills.

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<sup>1</sup> Communication No. 17/2008; Views adopted by the Committee at its Forty-ninth session, CEDAW/C/49/D/17/2008; Further information on the case and its impacts is available at: <https://www.escri-net.org/docs/i/1623066>

Relying on the standards set forth by the ESCR Committee in its general comment 14, and by the CEDAW Committee in *Alyne v. Brazil*, the judge found that the state violated the rights to health and non-discrimination, among other rights, by failing to provide affordable reproductive health care and discriminated against women on the basis of their sex and economic status.<sup>2</sup> Similarly, the case of *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors*,<sup>3</sup> explored how socioeconomic status and gender adversely affected access to the right to health in practice.

The 2012 decision by the Inter-American Court of Human Rights in the case of *Artavia Murillo et al. v. Costa Rica*,<sup>4</sup> which overturned Costa Rica's ban on in vitro fertilization (IVF), also adopted a substantive equality approach in examining the disproportionate impact the ban had on the basis of gender, disability and economic status. The Court ordered Costa Rica to make IVF available within its health care system as a treatment for infertility, in accordance with the principle of nondiscrimination.

OHCHR's Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity provides states with the concrete measures for realizing human rights on the ground. Although targeted towards maternal mortality and morbidity, the technical guidance's utility spans across the health sector as it provides critical guidance on creating accountability, including through monitoring, reviews and oversight and remedies. Furthermore, it provides guidance on a gendered and human right-based approach to planning and budgeting in the health sector.

Each committee has issued significant guidance to states regarding health, including CEDAW's general recommendation No. 24 on women and health, and the ESCR Committee's general comment no. 14 on the right to the highest attainable standard of health. More recently, the ESCR Committee's adoption of its optional protocol is a significant development for women's rights to health, as the committee has been a leader in advancing the human rights standards on health and gender equality. The optional protocol represents a significant opportunity for greater access to justice for violations of women's rights in the health sector and further elaboration on gender and the right to health.

## Issues to consider

- Many states have put in place strong laws or policies around women's health but have failed to allocate adequate financial resources to fully implement them. To comply with their human rights obligations, these programs must be fully funded and be implemented equitably, which requires disaggregated monitoring of their outcomes on the basis of sex, race, age, geography, and disability. There is also a need for increased transparency in accessing budgets to determine allocations, utilisations and expenditures, including robust right to information laws to empower communities and civil society to access budgetary information.
- As several regional and international human rights cases have recognized, states must put in place mechanisms for women to challenge denials of their right to access health services,

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<sup>2</sup> Ibid

<sup>3</sup> W.P. (C) Nos. 8853/2008 High Court of Delhi. Further information on the case and its impacts is available at: <https://www.escr-net.org/docs/i/1370523>

<sup>4</sup> Inter-American Court of Human Rights Case of Artavia Murillo Et Al. ("in vitro fertilization") v. Costa Rica Judgment of November 28, 2012. [http://www.corteidh.or.cr/docs/casos/articulos/seriec\\_257\\_ing.pdf](http://www.corteidh.or.cr/docs/casos/articulos/seriec_257_ing.pdf)

whether in public or private settings, in a timely manner. Such mechanisms must enable the woman's opinion to be heard, issue a decision within a timeframe that would still enable her to access the services and be subject to appeal if she is denied services. States should also be responsive to community-based monitoring programs, especially as they feed into citizen grievance forums and other mechanisms.

- Laws and policies criminalizing women on the basis of their immigration status, area of work, HIV status, or sexual orientation or gender identity, among other factors, undermines their right to health by deterring or preventing them from accessing essential care. Furthermore, despite the recognition that laws restricting access to health services only women need is a form of discrimination, restrictive laws and policies continue to undermine women's access to health services and perpetuate stigma and gender-based stereotypes.
- To enable women to make meaningful decisions about their health, it is essential that states take positive measures to elevate the status of women, including eradicating harmful gender norms and stereotypes and guaranteeing women access to the information and resources to act on these decisions.
- Inadequately functioning health systems disproportionately impact women, particularly women from marginalized groups. It is critical that state ensure *all* individuals have access to health facilities with the properly trained staff and adequate resources to provide quality care.

## Useful resources

Center for Reproductive Rights. [Substantive Equality and Reproductive Rights : a briefing paper on aligning development goals with human rights obligations.](#) 2014.

Health and Human Rights Journal. Audrey R. Chapman. [The social determinants of health, health equity, and human rights.](#) Volume 12, Number 2. 2013

\_\_\_ Alicia Ely Yamin. [Shades of dignity: Exploring the demands of equality in applying human rights frameworks to health.](#) Volume 11, Number 2. 2013 (Published December 2009)

\_\_\_ Gillian MacNaughton. [Untangling equality and non-discrimination to promote the right to health care for all.](#) Volume 11, Number 2. 2013 (Published December 2009)

Office of the High Commissioner for Human Rights. [Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality.](#) 2012.

\_\_\_ [Report of the Special Rapporteur on the Right to Health, on criminalisation of sexual and reproductive health.](#) 2011.

\_\_\_ [Report of the Special Rapporteur on the Right to Health; communication report.](#) 2010.

World Health Organization. [Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health,](#) Chapter 13: Gender Equity. 2008.