CENTER FOR REPRODUCTIVE RIGHTS

Independent Accountability Panel – 2018 Call for Submissions
Private Sector Accountability for Women's, Children's and Adolescents' Health
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The Center for Reproductive Rights (the Center)—an international non-profit legal advocacy organization headquartered in New York City, with regional offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington, D.C.—uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill. Since its inception twenty-five years ago, the Center has advocated for the realization of women and girls' human rights on a broad range of issues, including on the right to access sexual and reproductive health services; preventing and addressing sexual violence; and the eradication of harmful traditional practices. We are pleased to provide this submission to the Independent Accountability Panel.

This submission focuses on the role of the private sector in health care, and specifically effective accountability processes and mechanisms to monitor the private sector. It highlights two points on the role of the private sector in for women's health, briefly detailing key human rights decisions and standards relevant to the discussion. The first section focuses on a 2011 decision by the Committee on the Elimination of Discrimination Against Women (CEDAW Committee), which found that states have obligations to regulate private hospitals to ensure that they provide quality maternal health care. The second section discusses relevant legal standards and norms related to institutional conscientious objection and sexual and reproductive health and rights.

I. Governments have an obligation to regulate and monitor private hospitals.

In 2011, the CEDAW Committee issued its decision in *Alyne da Silva Pimentel Teixeira v. Brazil*.[1] The case centered on the death of a 28-year-old Afro-Brazilian woman, Alyne da Silva Pimentel Teixeira. In November 2002, Ms. da Silva Pimentel Teixeira was admitted to a private health center, complaining of nausea. At the time, she was six-months pregnant with her second child. Although she presented signs of a high-risk pregnancy, she was discharged without any medical treatment. Two days later, she returned to the private clinic in even worse condition. Her delivery was induced six hours later, producing a stillborn fetus, but Ms. da Silva Pimentel Teixeira's health continued to deteriorate. It took more than eight hours for her family to hire a private ambulance to take her to another hospital, after the receiving hospital refused to use its only ambulance to transport her so late in the afternoon. Once Ms. da Silva Pimentel Teixeira finally arrived, she then suffered through a delay of more than 21 hours before she was finally given medical treatment. She later slipped into a coma and died on November 16, 2002—five days after she initially asked for medical attention. In November 2007, the Center brought the case before CEDAW on behalf of Ms. da Silva Pimentel Teixeira's mother and her daughter.

The CEDAW Committee acknowledged that discrimination on the basis of sex, race, and income affected the lack of access to quality maternal health care services, concluding that "Ms. Da Silva Pimentel Teixeira was discriminated against, not only on the basis of her sex, but also on

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the basis of her status as a woman of African descent and her socio-economic background."[2] The Committee held that the Brazilian state was responsible for Ms. da Silva Pimentel Teixeira's death, noting that states are responsible for the provision of timely, non-discriminatory access to quality maternal health care for all women.[3] With regard to the actions of the private clinic, the CEDAW Committee found that whenever states are legally bound to provide universal access to health care,[4] they become directly responsible for monitoring and regulating private institutions that provide health services through outsourcing, thus making the state accountable for the actions of the institutions.[5] In addition, the Committee noted that the state "always maintains the duty to regulate and monitor private health-care institutions."[6] The Committee further explained that the state has a due diligence obligation to ensure that private parties rendering health services, such as private clinics, hospitals and health centers, perform medical activities with due diligence.[7]

II. Private health care institutions do not have a right to conscientious objection in the provision of sexual and reproductive health services.

Article 18 of the International Covenant on Civil and Political Rights (ICCPR) protects the right to freedom of thought, conscience and religion, which includes "freedom of thoughts on all matters, personal conviction and the commitment to religion or belief, whether manifested individually or in community with others."[8] Though international human rights law unconditionally protects the right to freedom of thought, conscience, religion or belief, the freedom to *manifest* religion or belief may be limited.[9] Specifically, limitations are valid when they "are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others."[10]

In terms of provision of health care services, the right to freedom of conscience has been interpreted to mean that health care professionals can legitimately refuse to provide certain services because they consider such services contrary to their personal moral convictions (i.e. conscientious objection).[11] This can be problematic in the context of ensuring women are able to access and exercise their sexual and reproductive health and rights. The medical provider's ability to conscientiously object must be limited, as the freedom to manifest the personal convictions of the health professional cannot supersede the autonomy and self-determination of the patient.[12] International human rights treaty monitoring bodies have noted the need for states to strike a balance between protecting the right to demonstrate one's freedom of conscience and the right of women to obtain safe and legal reproductive health services. For instance, the Human Rights Committee and the Committee on Economic, Social and Cultural Rights (CESCR Committee) have found that states must introduce regulations and implement appropriate referral mechanisms in cases of provider conscientious objection.[13] The CEDAW Committee has echoed the need for adequate referral mechanisms and has noted that "[i]t is discriminatory for a state party to refuse to provide legally for the performance of certain reproductive health services for women."[14] Referrals, however, are not permitted in urgent cases, such as where there is only one provider in the geographic region or when the life and health of the mother is at imminent risk.[15]

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With regard to the role of private legal entities, legal standards have noted that private institutions do not have a right to conscientious objection, and that only individuals are entitled to make such decisions.[16] As the CEDAW Committee established in its concluding observations to Hungary in 2013, the state must ensure that conscientious objection "remains a personal decision rather than an institutionalized practice."[17] Moreover, the report of the Inter-American Commission on Human Rights on *Access to Information on Reproductive Health from a Human Rights Perspective* notes the principles from the Constitutional Court of Colombia critical aspects on conscientious objection. Crucially, the Court found that "[c]onscientious objection is not a right to which juridical persons or the State are entitled; it can be recognized only for natural persons," and that conscientious objection is "is an individual, not an institutional or collective, decision."[18] Thus, in terms of the role of the private sector in the provision of sexual and reproductive health services, there is no right to institutional conscientious objection under international human rights law.

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[1] CEDAW Committee, Alyne da Silva Pimentel Teixeira v. Brazil: Commc'n No. 17/2008g U.N. Doc. CEDAW/C/49/D/17/2008 (2011).
[2] *Id*. at para. 7.7.
[3] *Id*.
[4] In this case, the Committee found that Brazil's responsibility to provide universal health care was strongly anchored in the Brazilian Constitution (articles 196-200), "which affirms the right to health as a general human right." *Id*., at para. 7.5.
[5] *Id*., at para. 7.5.
[6] *Id*., at para. 7.5.
[7] *Id*., at para. 7.5
[8] Human Rights Committee, *General Comment No. 22. (49) (art. 18)*, para. 1, U.N. Doc. CCPR/C/21/Rev.1/Add.4 (1993).
[9] *See id*., at paras. 3, 8.
[10] *Id*. at para. 8. *See also* International Covenant on Civil and Political Rights (ICCPR), *adopted* Dec. 16, 1966, art. 18(1), G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976); ORGANIZATION OF AMERICAN STATES, AMERICAN CONVENTION ON HUMAN RIGHTS (1978). Art. 12(3).
[11] ORGANIZATION OF AMERICAN STATES, AMERICAN CONVENTION ON HUMAN RIGHTS (1978). Art. 12; *see also* Inter-American Commission on Human Rights, *Access to Information on Reproductive Health from a Human Rights Perspective*, OEA/Ser.L/V/II., Doc. 61 (2011), paras. 93-99.
[12] *Cf*. Supreme Court of the United States, Roe v. Cf. Wade, 410 U.S. 113 (1973); I. Glenn Cohen, *Negotiating Death: ADR and End of Life Decision-Making*, 9 HARVARD NEGOTIATION L. REV. 253 (2004).
[13] *See* Human Rights Committee, *Concluding Observations: Poland*, paras. 23-24, U.N. Doc. CCPR/C/POL/CO/7 (2016); CESCR Committee, *Concluding Observations: Poland*, pars. 46-47, U.N. Doc. E/C.12/POL/CO/6 (2016). *See also* CEDAW Committee, *Concluding Observations: Hungary*, paras. 30-31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
[14] CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and Health)*, para. 11, U.N. Doc. A/54/38/Rev.1, chap. I (1999).
[15] *See* I / A Court HR, Case Cantos v. Argentina. Preliminary Objections., Ser. C No 85 (2001), paras. 22-23; Constitutional Court of Peru, Judgment EXP. No. 0905-2001-AA / TC, para. 5; Constitutional Court of Colombia, Judgment T-396, MP Vladimiro Naranjo Mesa, (1996); European Court of Human Rights, Stran Greek Refineries and Stratis Andreadis v. Greece, 13427/87 (1994); European Court of Human Rights, Tre Traktorer Aktiebolagv. Sweden, 10873/84 (1989).

[16] *See* Corte Inter-Americana de Derechos Humanos, Solicitada por law República de Panamá, Opinión Consultiva OC-22/16 (26 Febrero 2016). *See also* European Court of Human Rights, Case of Metropolitan Church of Bessarabia and Others v. Moldova, Application no. 45701/99.
[17] CEDAW Committee, *Concluding Observations: Hungary*, para. 31(d), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013). *See also* CEDAW Committee, Communication No.: 2/2003 (2005); European Court of Human Rights, Tysiac v. Poland, Application no. 5410/03 (2007).
[18] Constitutional Court, February 28, 2008, Judgment T209/08, Gaceta de la Corte Constitutional [G.C.C.], cited in IACHR, Access to Information on Reproductive Health, supra note 28, para. 97. See also Inter-American Commission on Human Rights, Access to Information on Reproductive Health from a Human Rights Perspective, OEA/Ser.L/V/II. Doc. 61 (2011).