

## Abstract

*Human rights and public health advocates working to compel states to guarantee access to legal abortion services face obstacles. We describe the challenges faced by "Rosa," a nine-year old Nicaraguan girl, whose pregnancy following rape sparked international controversy. The health and human rights arguments utilized either to support or undermine her family's petition for access to legal abortion are explored. Rosa's case highlights how laws that narrowly restrict abortion and make access contingent upon health care providers' approval undermine human rights principles. The article analyzes the strengths, limitations, and complementarity of health and human rights approaches for achieving access to safe, legal services in restrictive contexts. The importance of strategic alliances and implications for future cases are considered.*

---

*Les défenseurs des droits de l'homme et de la santé publique qui exigent des états qu'ils garantissent l'accès à l'avortement légal rencontrent de nombreux obstacles. Nous décrivons les problèmes rencontrés par "Rosa," une fillette du Nicaragua âgée de neuf ans, dont la grossesse suite à un viol a suscité une polémique internationale. Nous explorons les arguments relatifs à la santé et aux droits de l'homme utilisés pour défendre ou attaquer la pétition de sa famille pour obtenir qu'il y ait un avortement légal. Le cas de Rosa montre comment les lois qui restreignent l'avortement et soumettent son accès à l'autorisation du personnel médical minent les principes de droits de l'homme. L'article analyse les forces, les limites et la complémentarité des approches médicales et des droits de l'homme pour garantir l'accès à des services légaux et sûrs dans des contextes restrictifs. L'importance d'alliances stratégiques et les conséquences pour les cas futurs sont prises en considération.*

---

*Los defensores de los derechos humanos y de la salud pública que trabajan para obligar a los estados a garantizar el acceso a servicios de aborto legales encaran unos obstáculos. Describimos los desafíos enfrentados por "Rosa", una niña nicaragüense de nueve años de edad, cuyo embarazo después de una violación desencadenó una controversia internacional. Los argumentos en cuanto a derechos de salud y humanos utilizados para apoyar ya sea la petición de su familia de acceso a aborto legal, o para oponerse a la misma se exploran. El caso de Rosa pone de relieve la manera en que las leyes que restringen estrechamente el aborto y hacen que el acceso dependa de la aprobación de proveedores de cuidado de la salud, socavan los principios de los derechos humanos. En el artículo se analizan los puntos fuertes, las limitaciones y la complementariedad de los enfoques de derechos humanos y el derecho a la salud para alcanzar el acceso a servicios legales y seguros en contextos restrictivos. Se considera la importancia de alianzas estratégicas y las inferencias para casos futuros.*

# INVOKING HEALTH AND HUMAN RIGHTS TO ENSURE ACCESS TO LEGAL ABORTION: The Case of a Nine-Year-Old Girl from Nicaragua

*Heathe Luz McNaughton Reyes, Charlotte E. Hord,  
Ellen M. H. Mitchell, and Marta Maria Blandon*

Where the legal status of abortion is unclear, human rights and national laws are invoked both to support and to challenge the provision of abortion services.<sup>1</sup> In such situations, ideological political forces and subjective understandings of law—rather than concern for human rights or health—may determine access to legal abortion services.<sup>2</sup> We analyze how political actors and health and human rights standards influenced the fate of “Rosa,” a nine-year-old Nicaraguan girl, who in 2003 was raped in Costa Rica, became pregnant, and sought a legal abortion. Laws in both Costa Rica and Nicaragua can be interpreted to allow abortion to preserve a person’s health.<sup>3–6</sup> Their interpretation and application in Rosa’s case, however, were contested by individual health care providers, government representatives, and institutions, ranging from hospitals to national ministries, who obstructed her family’s quest for information and abortion services.

Rosa’s parents petitioned the government of Nicaragua to satisfy the *positive* duty of providing a legal abortion and,

---

*Heathe Luz McNaughton Reyes, MPH, is a research and policy consultant for Ipas Central America, Managua, Nicaragua and a doctoral student in the Department of Health Behavior and Health Education at the University of North Carolina at Chapel Hill, NC, USA; Charlotte E. Hord is Director of Policy for Ipas in Chapel Hill; Ellen M.H. Mitchell, PhD, is Research Associate for Ipas in Chapel Hill; and Marta Maria Blandon, MsC, is Director of Ipas Central America in Managua, Nicaragua. Please address correspondence to the authors at [mcnaught@email.unc.edu](mailto:mcnaught@email.unc.edu).*

Copyright © 2006 by Ipas and the President and Fellows of Harvard College.

in doing so, became the subject of a political and ideological maelstrom that eclipsed her rights and health care needs. The right to access health care, including legal abortion services, is a *positive* right in the sense that an individual's ability to access care depends on "governmental or other accommodation beyond [their] own resources."<sup>7</sup> Positive rights imply a positive duty on the part of the state to provide active assistance to individuals who otherwise would be unable to exercise their rights.<sup>8</sup>

The challenges that Rosa's family faced in seeking legal abortion services from the state have far-reaching implications because, like Rosa, a significant proportion of the world's population lives in countries where national laws permit abortion only if the pregnancy poses a risk to the individual's health or life and/or if pregnancy is the consequence of rape.<sup>9</sup> However, women and girls eligible for legal abortions in these countries are often unable to obtain services.<sup>10</sup> This is particularly the case for petitioners who, like Rosa's family, do not have the means to obtain a safe abortion from a private health care provider.

The relationship between access to safe abortion care and the protection of health and human rights has been acknowledged by expert scholars and authorities from both fields. The World Health Organization (WHO) has declared that providing ready access to safe legal abortion services can prevent needless death and disability.<sup>11</sup> Human rights treaty monitoring bodies have recommended that States parties consider decriminalizing abortion, ensure that women are not forced to seek unsafe abortions, and provide services where not prohibited by law.<sup>12-15</sup> Moreover, the Committee on Economic, Social, and Cultural Rights (CESCR) states that health services should be "accessible to all, especially to the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds."<sup>16</sup>

Despite these seemingly clear and compelling health and human rights arguments for providing access to abortion where not prohibited by law, advocates for rights and health face a complex and controversial task when they work to ensure that states guarantee non-discriminatory access to legal abortion care.<sup>17</sup> In this article we document the challenges

faced by Rosa's family and discuss the potential for and limitations of human rights and public health approaches to overcoming them. Challenges include: 1) addressing competing claims that human rights standards and national laws uphold both fetal and pregnant girls' rights; 2) clarifying the legal status of abortion where laws are vague and no health system guidelines exist to help interpret them; and 3) ensuring that rights to privacy, health, and non-discrimination are protected where health care providers are the gatekeepers of access to legal abortion.

### **Rosa's Story**<sup>18</sup>

Rosa is the only child of illiterate migrant workers who moved from Nicaragua to Costa Rica in the early 1990s in search of work. When Rosa was eight years old, she was raped by a neighbor; ten weeks later, she was diagnosed with a sexually transmitted infection and discovered to be pregnant. Costa Rican doctors regarded her pregnancy as "extremely risky" and kept her hospitalized and primarily confined to bed for over three weeks to protect her health and the developing pregnancy.<sup>19</sup> Costa Rican law permits abortion when pregnancy poses a risk to the woman's life or health.<sup>20</sup> During the time she was kept in the hospital, however, health care providers did not inform Rosa's family about the possibility of a legal abortion because, in their seemingly contradictory estimation, both Rosa and the fetus were in "good health" at the time and therefore ineligible for the procedure.<sup>21</sup>

While Rosa was in the hospital, health care personnel leaked news of her condition to the press, resulting in daily media coverage and alerting health and human rights groups in Nicaragua to her situation. These groups asked the Nicaraguan Human Rights Ombudsman's Office (PPDH) to provide legal support to Rosa and her family.<sup>22</sup> In response, the PPDH sent a Commission to Costa Rica, comprising one State attorney and three experts in child sexual abuse from nongovernmental agencies.

Rosa's parents requested the Commission's assistance in returning to Nicaragua, complaining of discrimination and mistreatment by Costa Rican health and legal authorities, conflicting medical evaluations of Rosa's health condition,

and distress due to constant harassment by the media.<sup>23,24</sup> With the Commission's help, Rosa and her family returned to Nicaragua and, after careful consideration, decided to request a legal abortion. Abortion is legal in Nicaragua when it is deemed "therapeutic" and has the authorization of a committee of at least three physicians and the permission of the woman's spouse or closest relative.<sup>25</sup>

As Rosa was then a child of nine, the law provides that her parents be the primary decision-makers regarding her care.<sup>26</sup> Rosa's parents, however, ran into numerous official roadblocks in obtaining an objective committee of health care providers to authorize the procedure, as required by law. The Nicaraguan Ministers of Health and Family publicly opposed Rosa's parents' request, arguing that national laws protect life from the moment of conception and calling all abortion "a crime."<sup>27,28</sup> Although the Ministers' statements had no legal bearing on her case, Rosa's advocates feared their statements would influence the authorization decision of the physicians who would consider her request. In addition, the Minister of the Family considered ways of suspending parental rights to allegedly "ensure that Rosa was properly cared for."<sup>29,30</sup> The PPDH denounced the move as outside of the Ministry of Family's legal jurisdiction and as a violation of Rosa's parents' right to make decisions on their daughter's behalf.<sup>31</sup>

The PPDH further demanded that the Ministry of Health (MINSAs) form a commission to evaluate Rosa's request for a legal therapeutic abortion.<sup>32</sup> After failed attempts by the Ministry of Family to have a well-known anti-abortion activist appointed to head the commission, a committee of four health care providers, acceptable to Rosa's family and advisors, was convened to evaluate whether Rosa qualified for a therapeutic abortion under the law.<sup>33,34</sup> The committee concluded that Rosa's health and life would be at equal risk whether she continued or terminated the pregnancy, then at 16 weeks gestation.<sup>35</sup>

Rosa ultimately obtained an abortion without complications. A subsequent criminal investigation of the legality of the abortion found that Rosa, her parents, and her clinicians were innocent of any wrongdoing, based on the committee's declaration that the pregnancy endangered her health and life.<sup>36</sup>

## Health and Human Rights Approaches to Legal Abortion Access

Several health and human rights issues underlie Rosa's story, including child welfare policies, immigrants' rights, restitution, sexual violence, and the role of nongovernmental organizations (NGOs) in human rights protection and their relation to the state. Yet Rosa's case is fundamentally about states' obligation to provide access to a legal health service, thereby fulfilling her right to health. Limited access to legal abortion services disproportionately affects the well-being of vulnerable individuals who, like Rosa, depend on the state to ensure they have access to needed health care.<sup>37</sup> Thus, we focus on articulating health perspectives and human rights perspectives on legal abortion and use Rosa's case to analyze the strengths, limitations, and complementarity of both approaches as tools for achieving access to safe legal abortion services in restrictive legal contexts.

Health and human rights rationales for ensuring access to legal abortion services can be articulated at two levels—the population and the individual. At the individual level, the *health*-related rationale for providing access to abortion is based on the specific therapeutic benefit of having an abortion for the physical, psychological, and social well-being of the individual pregnant woman or girl and her family. The *human rights* argument for access to legal abortion care is based on consideration of the individual pregnant woman's or girl's rights to life, privacy, health, and equality.

At the population level, the *health*-related motivation for ensuring access to legal abortion care is based on the utilitarian goal of reducing death and disability due to pregnancy-related complications. Articulating a *human rights* rationale for legal abortion access at the population level is challenging due to the field's traditionally individualistic premises. Yamin argues, however, that the exercise of individual human rights engenders social participation and that social participation benefits society as a whole because it promotes equity.<sup>38</sup> Thus, access to legal abortion may be justified from a rights perspective at the population level on the grounds that greater social equity is achieved "through the participation of people in the decisions that affect their own bodies and lives."<sup>39</sup>

### ***Human Rights Standards Regarding Abortion Services***

Human rights treaties were designed to give legal force to the Universal Declaration of Human Rights. Treaty monitoring bodies have developed General Comments or General Recommendations to clarify the meaning of specific treaty articles for States parties.<sup>40</sup> States that ratify these treaties legally bind themselves to progressive implementation of the treaty commitments through adaptation of their domestic laws.

Both Costa Rica and Nicaragua have ratified international treaties that obligate them to protect interests related to reproductive health. These treaties include the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social, and Cultural Rights (ICESCR), and the Convention on the Rights of the Child (CRC).<sup>41-44</sup>

General Comments issued by treaty monitoring bodies clarify that access to reproductive health services is essential to the achievement of equality between men and women and fulfillment of the rights to life and health.<sup>45-48</sup> In particular, states are obliged to pay special attention to the sexual and reproductive health needs of socially disadvantaged groups, including migrant women and the girl child.<sup>49</sup> Furthermore, CEDAW explicitly obliges States parties to “take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services.”<sup>50</sup>

Human rights standards (treaty provisions and treaty monitoring body recommendations) do not explicitly mandate that states provide legal abortion services. Treaty monitoring bodies, however, have made several General Recommendations regarding abortion. These recommendations declare that states should take measures to:

- 1) prevent unsafe abortion by ensuring access to contraceptive methods;
- 2) consider the decriminalization of abortion;
- 3) ensure patients’ privacy during post-abortion care;

- 4) report to treaty monitoring bodies as to whether access to safe abortion is provided to women who have become pregnant as the result of rape; and
- 5) provide access to abortion where not against the law.

The treaty monitoring bodies' recommendations are based on consideration for women's right to be free from inhuman and degrading treatment, and their rights to life, health, and equality.<sup>51-54</sup> In the case of rape, providing access to a safe abortion may fulfill a state's obligation to provide restitution to victims by returning the victims to their original (non-pregnant) state and restoring their liberty to pursue a range of goals that may have been compromised by pregnancy and/or motherhood.<sup>55-57</sup>

### ***Health Perspectives on Legal Abortion***

There are two lines of reasoning justifying access to legal abortion based on health-related concerns. The first is the *public* health contention that safe legal abortion care is necessary because it reduces morbidity and mortality due to unsafe abortion. The second is the *individual* health contention that abortion is sometimes necessary to protect the health of a specific pregnant girl or woman. The public health grounds for providing safe abortion care are upheld by epidemiological data. For example, a recent World Bank report found that 90% of abortion-related maternal mortality could be prevented by providing access to safe legal abortion care.<sup>58</sup> Expert health bodies like the WHO acknowledge that "ready access to safe abortion significantly reduces high rates of mortality and morbidity...[and] provides care for women [and girls] who clearly are not yet well enough served by family planning programmes or for whom contraception has failed."<sup>59</sup>

Although advocates may use the public health argument that safe legal abortion will reduce death and disability to push for liberalization of abortion laws, health professionals and state services can legally provide abortion only for the reasons permitted by national law—not to all women or girls who seek or need them. Often, laws that generally prohibit abortion do permit therapeutic terminations to be performed if the health or life of the patient is endangered by pregnancy. These laws are motivated by a second line of reasoning that finds access to legal abortion warranted where the health or



life of the *individual* pregnant woman or girl is at risk.<sup>60</sup> Just as the public health argument was based on aggregate social benefit, however, claiming access to legal abortion based on specific health risk requires an objective assessment of morbidity risk for the unique clinical characteristics of each pregnant woman or girl.

Clearly, pregnancy carries many risks to the physical, psychological, and social well-being of pregnant women and girls. According to the WHO, “. . . all pregnant women, by virtue of their pregnant status, face some level of maternal risk.”<sup>61</sup> Adolescents are at even greater risk due to their physical and emotional immaturity.<sup>62</sup> Pre-teens are at heightened risk for prolonged and obstructed labor, pre-eclampsia, fistulae, postpartum hemorrhage, and endometriosis.<sup>63,64</sup>

A recent cross-sectional study of pregnancy outcomes in Latin America found that girls under 15 are at five times greater risk of maternal death than adolescents 15 to 19.<sup>65</sup> In the long term, the competition for nutrients between a still-growing child and the fetus during pregnancy may cause growth stunting as well as contributing to obesity and cardiovascular risk.<sup>66</sup> Moreover, girls who experience pregnancy following sexual abuse have been shown to experience significantly higher rates of stress, depression, and social isolation than non-abused peers.<sup>67</sup> Long-term social consequences related to precocious pregnancy are also a concern. They include unemployment, poverty, and school abandonment.<sup>68</sup> While epidemiological data point to general risk factors for pregnancy-related morbidity, however, according to the WHO, “it is almost impossible to predict, on an individual basis, who will develop a life-threatening complication.”<sup>69</sup>

### **Challenges and Contradictions: Invoking Human Rights, National Law, and Public Health Principles to Secure Access to Legal Abortion**

Advocates who advance human rights, national laws, and public health principles to obtain access to legal abortion services from the state face both challenges and contradictions. Several of the key issues are discussed below.

### ***Lack of Explicit Language and Mechanisms for Enforcing Human Rights Standards***

With the exception of the recent optional protocol on women's rights now in force as part of the African Charter on Human and People's Rights, no human rights treaty explicitly mentions the right to legal abortion.<sup>70</sup> "Soft law," developed through progressive interpretation by treaty monitoring bodies of the application of the major treaties, has created a body of support for such a right.<sup>71,72</sup>

At the time of Rosa's case, however, there was also no explicit reference in a General Recommendation or Comment issued by a treaty monitoring committee regarding a state's duty to render abortion services.<sup>73</sup> In fact, some countries are parties to these treaties despite having laws that do not permit abortion for any indication (for example, El Salvador).<sup>74</sup> This reality reflects the following challenge: Although treaty bodies' recommendations and concluding comments to country reports are *intended* to guide states in the implementation of treaty provisions, there is no enforcement mechanism to ensure that states comply with them. Implementation of recommendations depends on political will and, because abortion sparks polarizing debate, it is an area that states may prefer not to address. Consequently, states may take no steps to follow General Recommendations or address Comments, delay implementation of recommended actions, or invoke their sovereign right to determine national laws on abortion in response to any criticism of conduct.<sup>75</sup>

### ***Conflicting Claims that Laws and Human Rights Principles Protect Fetal Rights***

In general, treaty bodies and human rights scholars have recognized that human rights treaty provisions are only applicable after birth.<sup>76</sup> Drafters may have generally avoided inclusion of specific language on this issue in order to permit states with both permissive and restrictive abortion laws to ratify treaty provisions. The CRC and the American Convention on Human Rights do, however, include mention of legal protections that apply "before birth" and from the "moment of conception."<sup>77,78</sup> While it has been clarified that these protections are not incompatible with national laws

that permit abortion and thus do not necessarily privilege the rights of the fetus over those of the pregnant woman, neither do they clearly privilege women's rights.<sup>79</sup>

Advocates are not likely to have access to this type of information about drafters' intentions regarding the application of human rights treaties to fetal rights. When state authorities or healthcare providers use national abortion laws to underscore that fetal rights take precedence over those of a living pregnant woman or girl, the lack of clarity and even contradictory language in human rights treaties make it difficult to use them to justify women's requests for legal abortion services.

Rosa's rights were protected by both Costa Rican and Nicaraguan laws that recognize the special vulnerability of children and require state agencies to consider the best interests of the child above all other considerations. The Costa Rican Code of Childhood and Adolescence, however, states that the right to life applies to all children from "conception" through age 12.<sup>80</sup> This law led authorities to believe they had an equal obligation to protect both Rosa and the developing fetus. For example, authorities from the Costa Rican Ministry of Children and Adolescents argued that their duties regarding Rosa were equally to protect "two persons from conception as mandated by the Code of Childhood and Adolescence."<sup>81</sup> The Director of the Children's Rights Division of the Office of the Human Rights Ombudsman (*Defensoria de los Habitantes*) in Costa Rica stated that he believed that health care providers and state authorities were obliged by human rights and national laws to protect the health of both Rosa and her fetus.<sup>82</sup>

The situation in Nicaragua was similar. The legal advisor to MINSA claimed that Rosa's fetus should be protected, based on Article 12 of the Code of Children and Adolescence, which grants all children and adolescents the right to life from "conception."<sup>83</sup> On the other hand, the Special Ombudsman for Children's Rights (the lead lawyer from the PPDH assigned to Rosa's case) demanded that her request for a therapeutic abortion be considered. As an official representative of a state institution, he had the political power to negotiate with authorities from MINSA and insist

that Rosa be evaluated by a committee of providers acceptable to Rosa's family. In his view, Nicaragua's laws and the Children's Convention clearly oblige state institutions to respect Rosa's family's wishes and prioritize her interests above all other considerations.<sup>84</sup> Such conflicting interpretations of existing law and human rights language make it challenging for advocates, and virtually impossible for the average citizen, to understand where their protections lie.

In some countries the question of whose rights should prevail will be resolved by the criminal codes, which permit legal abortion in certain situations and thus seem clearly to privilege the rights of the women who meet the eligibility criteria circumscribed by law. These codes, however, can be vaguely or ambiguously worded and thus open to contest by groups alleging fetal rights.<sup>85</sup> While Nicaragua's law, for example, allows for therapeutic abortion, health care providers have long expressed uncertainty as to whether "therapeutic" abortion may be performed only in cases where the woman's life is in danger or whether it extends to other indications, including rape.<sup>86</sup> Costa Rica's law does not explicitly allow for abortion in the case of rape but does provide that abortion may be performed to preserve a woman's health or life.<sup>87</sup>

### ***Lack of Health Systems Guidelines for Determining Eligibility***

Neither Costa Rica nor Nicaragua has published health system guidance on legal abortion clarifying the law. As a result, providers face a complex task in determining the specific circumstances under which abortions can be performed legally. The odds that a specific pregnancy will result in a health problem are hard to quantify with precision. Without guidance, providers must subjectively choose the level of risk that they think is acceptable for their patients to bear. Providers may also consider only immediate risks to health, ignoring future risks to physical or mental health caused by advanced pregnancy, childbirth, and parenthood. As a result, different patients may be subjected to different standards for authorizing legal abortion, depending on their particular health care providers, who may allow moral or religious views to influence their decisions.<sup>88</sup> Furthermore,

the lack of guidelines means that there is no transparent, evidentiary criteria against which to compare providers' decisions. This was the situation for Rosa.

Without clear guidance for how to interpret the vague law, Rosa's Costa Rican health care providers decided that their obligation was to protect the growing pregnancy and to consider abortion only if the pregnancy posed a demonstrable and imminent risk to her life. While they informed Rosa's parents that the pregnancy was "high risk," they did not inform them of the possibility of future obstetric complications or discuss the merits of therapeutic abortion. The testimony of the president of the Costa Rican Health System, who spoke on behalf of Rosa's health care providers at a congressional inquiry into the actions of state officials in Rosa's case, highlights the vulnerability of marginalized populations needing unbiased information and life saving services:

*Legislative Commission:* We would like to understand what you mean by "very high risk pregnancy." When I hear that term, it makes me think that the life or health of the woman is at risk. Could you please explain the term to us?

*President of the Costa Rican Health System:* Logically, when a nine-year old girl is pregnant it is of the highest risk.... It is abnormal for a nine-year old girl to be pregnant, thus it is high risk. She does not have the anatomical configuration necessary to give birth. Thus we classify her as high risk.

*Legislative Commission:* Then [Rosa's] pregnancy did endanger her health and life?

*President of the Costa Rican Health System:* No, the classification was to call attention to the diagnosis...but later...we did an ultrasound and had various specialists look at her. We found that [she] had absolutely no symptoms at the time that indicated the pregnancy was going to affect her life or health...and the fetus was in good condition. Thus, there was no reason to talk about any other type of procedure because...the pregnancy was developing normally and the fetus was in good condition.<sup>89</sup>

### ***Conditioning Access to Legal Abortion on Proof of Health Risk***

While guidance from health systems may help to standardize decision-making, it will likely not eliminate subjectivity from provider decision-making regarding the level of risk that a woman should face in bringing a pregnancy to term. In Rosa's case, invoking a health argument for safe abortion was problematic because there are limited morbidity or mortality data on *child* (as vs. adolescent) pregnancy outcomes to buttress it. Although her obvious immaturity would be a risk factor, the limited incidence of child pregnancy meant that there were no contemporary population-based studies from which to draw.

The report of the Nicaraguan Committee, which evaluated Rosa's health status, highlights the ambiguity involved in predicting health outcomes. The Committee stated that:

Continuing the pregnancy carries the risk of severe health complications and we cannot be sure that the pregnancy will come to a satisfactory end. On the other hand, the interruption of pregnancy may present severe complications given the girl's age and the gestational age.... After an exhaustive evaluation we conclude that both alternatives, continuing with and interrupting the pregnancy, carry the potential risk of severe complications and even death. This information should be given to her parents (as legal guardians of the minor) so that they may make an informed decision.<sup>90</sup>

As a result, while health systems may outline the general procedures and guiding principles for deciding whether a woman is eligible for a legal abortion, providers may still come to contradictory conclusions about the eligibility of a particular woman, possibly leading to discrimination and violations of human rights. Studies documented such racial and class discrimination in the implementation of the US abortion policy before *Roe v. Wade*, and more recently in South Africa, prior to the 1996 Choice of Termination of Pregnancy Act, when physicians were granted the right to make decisions for women on access to therapeutic abortion.<sup>91,92</sup> White women and women with the financial means to obtain private health care in both countries were

more likely to be granted access to therapeutic abortion for mental health reasons.

The South Africa Country Study in *Advocating Access to Abortion* maintains that “most white women, having greater access to money, could either use their personal contact with sympathetic gynecologists, or pay the costs to go to Europe to secure an abortion.”<sup>93</sup> Thus, it may be that the only way to protect women’s rights and ensure social justice is by reforming laws to grant women (or parents, in cases such as Rosa’s) control over the decision to have an abortion.

### **The Potential and Limitations of Health and Human Rights Approaches for Ensuring Access to Legal Abortion**

At the policy level, treaty monitoring bodies can increase the power of human rights standards as tools for promoting access to legal abortion by providing guidance regarding how treaty obligations relate to states’ duty to provide legal abortion services. These bodies can also clarify whether and in what ways provisions apply to developing fetuses.

Evidence-based public health arguments for increasing safe abortion access clearly exist, suggesting the need to liberalize restrictive laws and improve access to services. At the individual level, however, health care professionals’ ability to accurately predict health risk in pregnancy is limited. Providers have an ethical obligation to acknowledge this and, abiding by the medical ethical principle of respect for autonomy, should promote the development of laws and policies that make the patient the ultimate arbiter in health care decisions. Furthermore, it is clear from health care providers’ testimony in Rosa’s case that health-related arguments for interrupting the pregnancy were primarily limited to consideration of severe imminent risks to her physical health. Stronger health-based arguments for therapeutic abortion access could have been invoked based on threats to Rosa’s social and psychological well-being.

Finally, efforts to change laws and policies must be accompanied by a national dialogue on abortion and human rights. As Larry Cox notes, “human rights argumentation cannot exist in an ivory tower but must also resonate in the court of public opinion.”<sup>94</sup> Connecting human rights and

abortion in a way that is meaningful in the social context of Latin America is an ongoing challenge. A “human rights box” has been identified, wherein “the work of human rights practiced by the international community continues to have limited popular legitimacy.”<sup>95</sup> Thus, where the connection between human rights and abortion is made by treaty monitoring bodies and international NGOs, but not at the local level, we fail to break out of this box. Policy reforms made in the absence of strong grassroots support are unlikely to survive political turnovers.

Rosa’s case, however, suggests that it is possible to make the connection. Although health care providers narrowly defined her entitlement in terms of mere survival, the larger Nicaraguan society openly debated a broader, more universal human rights approach.<sup>96</sup>

### **The Rosas of the Future**

Since Rosa’s situation was resolved, new human rights and public health tools have become available that can assist advocates working to increase access to legal abortion services. The WHO has issued landmark technical and policy guidelines that can be used to develop health system protocols.<sup>97</sup> Both the 2003 CRC recommendation on adolescent health and development and the African Charter of Human and Peoples’ Rights make explicit reference to states’ duty to provide abortion services in certain circumstances.<sup>98,99</sup> In 2005 the UN Human Rights Committee also ruled on the issue for the first time, finding that denying access to legal abortion is a violation of women’s rights to protection from cruel, inhuman, and degrading treatment; to privacy; and to special protection for the rights of minors. The decision orders the Peruvian government to pay reparations to the woman in question and to produce guidelines to clearly interpret the existing law.<sup>100</sup> Future advocates will be able to anchor their arguments in specific provisions and legal precedents of international human rights norms such as these.

Locally, Rosa’s safe abortion established a legal precedent within Nicaragua that advocates may invoke. The case generated worldwide attention and discussion about sexual violence, child rape, and the denial of rights. This family’s struggle, while tragic, may move the world forward toward recognizing and eliminating such injustices.



On the other hand, taking a visible position on a polemical issue like abortion can be risky, especially to those in elected positions. In 2004, the Nicaraguan Children's Ombudsman who defended Rosa was voted out of office by legislators who disagreed with his position on that case. Furthermore, although Rosa and her family were ultimately successful in their use of the human rights system to exercise her legal right to an abortion, the Ombudsman's support for Rosa's case may be unique for a Latin American human rights institution addressing children's rights and abortion. While the Children's Ombudsman pressed the PPDH to take on Rosa's case because of his conviction that human rights standards and national laws protected her right to health above all other considerations, he found that the most persuasive argument for convincing his office to take a public stance upholding Rosa's rights was not based on human rights considerations at all, but rather on the fact that the case offered an important political opportunity to establish the recently-created PPDH as an independent human rights body.<sup>101</sup>

Thus, tangential motives rather than true commitment to the issue may have played a role even in the support that Rosa received from the PPDH. Rosa's success in obtaining a legal abortion may have been somewhat serendipitous, attributable to the political acumen and ideology of a coordinated group of well-connected and passionate advocates who were able to navigate the system, together with the family. Without continued vigilance by the human rights movement in the region, girls in Rosa's situation are certain to face enormous difficulty in exercising their rights in the future.\*

## Conclusions

The contradictory conclusions and diagnoses of Rosa's providers in Costa Rica and Nicaragua illustrate the injustice of national laws that permit abortion only to preserve

---

\* In October 2006 Nicaragua's legislature voted to ban abortion, removing the exception which had formerly permitted therapeutic abortion with physician approval (see note 6) and which had allowed Rosa to obtain a legal abortion. The vote came only a few weeks before a fiercely contested presidential election and is largely seen as politically motivated. Current President Enrique Bolaños signed the measure into law in November 2006.

women's health or life. These laws invariably condition access to legal abortion on the subjective assessment of health care providers, who may lack scientific evidence or choose to ignore it. Human rights principles affirming human dignity and autonomy preclude the notion that providers can determine the level of risk that another individual must assume. Laws that disenfranchise women of their right to participate in decisions about their own well-being undermine their capacity as citizens and work against the goal of promoting human dignity in health care.<sup>102</sup>

Countries with restrictive laws can take measures to guarantee equal access to legal abortion services by 1) ensuring that women are aware of their right to request abortion care; 2) developing health system protocols for legal abortion services; 3) educating and training public health care providers; 4) monitoring health system compliance with the duty to inform women of their eligibility for and provide them with legal abortion services; and 5) ensuring that providers and government authorities do not impose their personal ideologies on women and girls, especially those who have been taken into the state's care.

It is precisely in situations such as Rosa's, in which one individual or a group of individuals are empowered to make decisions about the health risks that another must assume, that health and human rights advocates must intervene to ensure that dignity and autonomy are protected. The numerous barriers placed before Rosa's family in both Costa Rica and Nicaragua demonstrate the challenges faced in using health and human rights arguments and tools to obtain access to legal abortion.

Ideally, human rights and public health approaches to the issue of safe abortion should work in tandem to ensure that women's access to safe abortion transcends politics and rhetoric. Indeed, the role of the state, NGOs, and health care providers in deciding Rosa's fate is at the heart of the notion of reproductive rights, which ought to privilege women's autonomy and liberty to make informed decisions about their own reproductive health care above all other considerations. The experience of this nine-year-old girl demonstrates how far we still have to go to achieve this goal.

## References

1. R.J. Cook and B.M. Dickens, "Human Rights and Abortion Laws," *International Journal of Gynecology and Obstetrics* 65/1 (1999): pp. 81–7.
2. H.L. McNaughton, E.M. Mitchell, and M.M. Blandon, "Should Doctors Be the Judges? Ambiguous Policies On Legal Abortion in Nicaragua," *Reproductive Health Matters* 12/24 (supplement) (2004): pp. 18–26.
3. For example, H.L. McNaughton, et al. (see note 2): pp. 18–26.
4. Asamblea Legislativa de la Republica de Costa Rica, Departamento de Comisiones, Comisión Especial de la Mujer, Acta de la Sesión Ordinaria No 20 (March 20, 2003): p. 11.
5. Republica de Costa Rica, Código Penal Sección II, Aborto, Artículo 121 (Republic of Costa Rica, Penal Code, Section II, Abortion, Article 121): "No es punible el aborto practicado con consentimiento de la mujer por un medico o una obstétrica autorizada, cuando no hubiere sido posible la intervención del primero, si se ha hecho con el fin de evitar un peligro para la vida o la salud de la madre y este no ha podido ser evitado por otros medios." (Abortion is not punishable when practiced by a physician or, if a physician is unavailable, a licensed obstetric nurse with the consent of the woman and when the procedure is performed to avert risk to the life or health of the mother and said risk cannot be averted by other means). Available at <http://cyber.law.harvard.edu/population/abortion/CostaRica.abo.htm>.
6. Republica de Nicaragua, Código Penal, Libro II, Título I, Delitos Contra las Personas y su Integridad Física, Psíquica, Moral y Social, Capítulo V, Del Aborto, Article 165 (Republic of Nicaragua, Penal Code, Book II, Title I, Crimes Against Persons and their Physical, Moral and Social Integrity, Chapter V, On Abortion, Article 165): "El aborto terapéutico será determinado científicamente con la intervención de tres facultativos por lo menos, y el consentimiento del cónyuge o pariente más cercano a la mujer para los fines legales." (Legal therapeutic abortion must be determined scientifically by at least three physicians and performed with the consent of the spouse or closest relative to the woman). Available at <http://cyber.law.harvard.edu/population/abortion/Nicaragua.abo.htm>.
7. R.J. Cook, B.M. Dickens, and M.F. Fathalla, *Reproductive Health and Human rights* (Oxford: Clarendon Press, 2003): p. 152.
8. Ibid.
9. Center for Reproductive Rights (CRR), *The World's Abortion Laws* (April 2005). Available at [http://www.reproductiverights.org/pub\\_fac\\_abortion\\_laws.html](http://www.reproductiverights.org/pub_fac_abortion_laws.html)
10. World Health Organization (WHO), *Safe Abortion: Technical and Policy Guidance for Health Systems* (Geneva: 2003): p.15. Available at [http://www.who.int/reproductive-health/publications/safe\\_abortion/](http://www.who.int/reproductive-health/publications/safe_abortion/)
11. Ibid.: p.14.
12. Human Rights Committee (HRC), General Comment No. 28, Equality of rights between men and women (article 3), CCPR/C/21/Rev/1/Add.10 (2000), para.10: State parties should give information on any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening

clandestine abortions; para.11: The Committee...also needs to know whether the State party gives access to safe abortion to women who have become pregnant as a result of rape; para. 20:... States may fail to respect women's privacy [where] States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion.

13. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), G.A. Res. 34/180, UN GAOR, 34th Sess., Supp. No. 46, at 193, UN Doc. A/34/46 (1979), para. 24(m): State parties should ensure that measures are taken to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe medical procedures such as illegal abortion because of lack of appropriate services in regard to fertility control.

14. Committee on the Elimination of Discrimination Against Women (CEDAW Committee), General Recommendation No. 24, Women and Health, UN Doc. No. A/54/38/Rev.1 (1999), para. 31(c): States should also...when possible, [amend] legislation criminalizing abortion to remove punitive provisions imposed on women who undergo abortion.

15. Committee on the Rights of the Child (CRC Committee), General Comment No. 4, Adolescent Health and Development in the Context of the Convention on the Rights of the Child, UN Doc. No. CRC/GC/2003/4 (2003), para. 31: Adolescent girls should have access to information on the harm that ...early pregnancy can cause and those who become pregnant should have access to health services that are sensitive to their rights and particular needs. State parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy...[and] develop and implement programmes that provide access to sexual and reproductive health services, including...safe abortion services where abortion is not against the law.

16. Committee on Economic, Social and Cultural Rights (CESCR), General Comment No.14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000), para. 5(b).

17. WHO (see note 10): p.14.

18. Information about Rosa's case was gathered from 187 newspaper articles, government documents (memorandums and directives issued by the Ministries of Health, Family and the Public), written correspondence between Rosa's family and government authorities, and transcripts of interviews with Rosa's family, providers, and state authorities involved in her case that were conducted in 2003 by the Commission on Women's Affairs of the Costa Rican Legislature and by the authors of this article (transcripts on file with authors). Rosa and her family's direct testimony was also documented in a book titled *Historia de una Rosa* by Maria Lopez Vigil, published by the Nicaraguan Network of Women against Violence in 2003.

19. Asamblea Legislativa de la Republica de Costa Rica. Departamento de Comisiones, Comisión Especial de la Mujer, Acta de la Sesión Ordinaria No. 29 (March 27, 2003). Testimony of Dr. Eliseo Vargas García, President of the Costa Rican Health System: p. 7.

20. Republica de Costa Rica (see note 5).

21. Asamblea Legislativa de la Republica de Costa Rica (see note 19): p. 9.

22. The Nicaraguan Human Rights Ombudsman's Office (Procurador Público de Derechos Humanos) is an autonomous government-funded institution. The Ombudsman is voted into power by the National Assembly and, in collaboration with Special Ombudsmen for Children's Issues, Women's Issues and Indigenous Affairs, is responsible for ensuring that laws and policies of the state conform to human rights standards and for prosecuting human rights violations perpetrated against Nicaraguan citizens. A 1995 law created the office, and active investigations into human rights violations began in 2000. See *Country Reports on Human Rights Practices*. Released by the Bureau of Democracy, Human Rights, and Labor (March 31, 2003). Available at <http://www.state.gov/g/drl/rls/hrrpt/2002/18339.htm>.
23. M. Fletes and F. Fletes (Rosa's parents), Letter requesting support from authorities of the Nicaraguan Government sent to the President of Nicaragua and the Human Rights Ombudsman's Office, February 13, 2003. On file in the Ipas Central America office.
24. E. Romero, "Padres piden interrumpir el embarazo," *La Prensa* (February 14, 2003).
25. Nicaraguan law does not define "therapeutic abortion," and the Ministry of Health has published no official policies on legal abortion procedures since 1989, when the outgoing Sandinista government published norms for abortion procedures. These norms are no longer in effect, and providers and policy-makers disagree as to whether "therapeutic abortion" may be performed only to save the woman's life or whether it also may be performed to protect the physical and mental health of the woman and in cases of fetal malformation and pregnancy due to rape. Public health facilities have approved therapeutic abortions for all of these indications—to preserve health/life and in instances of fetal malformation and pregnancy resulting from rape. For more information on abortion law and services in Nicaragua, see H.L. McNaughton, E.M. Mitchell, and M.M. Blandon (note 2).
26. Had Rosa been an adolescent capable of making her own decisions, or had the family not been united in seeking an abortion, the issues would have been significantly more complex, involving questions of adolescent rights to decision-making in health care.
27. N. Miles, "Abortion Ruling Splits Nicaragua," BBC News (March 4, 2003). Available at <http://news.bbc.co.uk/1/hi/world/americas/2817051.stm>.
28. "Lucia Salvo irresponsable," *El Nuevo Diario* (February 23, 2003).
29. "Raped Nicaraguan girl aborts baby," BBC News (February 21, 2003). Available at <http://news.bbc.co.uk/1/hi/world/americas/2789279.stm>
30. E. Romero, "Disputa institucional por niña embarazada," *La Prensa* (February 15, 2003).
31. *Ibid.*
32. E. Romero (see note 24).
33. Ministry of the Family, *Memorandum regarding the medical care for "Rosa" sent to the Ministry of Health* (2003). (Copy in Ipas Central America files).
34. E. Romero, "Niña violada en peligro," *La Prensa* (February 19, 2003).
35. Ministerio de Salud, Hospital Vélez País, *Informe Científico Técnico*

(Caso “Rosa”), (February 18, 2003).

36. Ministerio Público de Nicaragua, Departamento de Managua, *Resolución sobre el caso de la menor “Rosa,”* (March 3, 2003).

37. The Alan Guttmacher Institute, *Sharing Responsibility: Women, Society and Abortion Worldwide*. available at <http://www.guttmacher.org/pubs/sharing.pdf>.

38. A.E. Yamin, *Learning to Dance: Advancing Women’s Reproductive Health and Well-Being from the Perspectives of Public Health and Human Rights* (Cambridge, MA: Francois-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, 2005): p. 7.

39. *Ibid.*: p. 7.

40. R.J. Cook, et al. (see note 5): p. 153.

41. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), G.A. Res. 34/180, UN GAOR, 34th Sess., Supp. No. 46, at 193, UN Doc. A/34/46 (1979). Ratified by Costa Rica, April 4, 1986. Ratified by Nicaragua, October 27, 1981.

42. International Covenant on Civil and Political Rights (ICCPR), G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966). Ratified by Costa Rica, November 29, 1968. Ratified by Nicaragua, March 12, 1980.

43. International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966). Ratified by Costa Rica, November 29, 1968. Ratified by Nicaragua, March 12, 1980.

44. Convention on the Rights of the Child (CRC), G.A. Res. 44/25, UN GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/25 (1989). Ratified by Costa Rica, August 21, 1990. Ratified by Nicaragua, October 5, 1990.

45. Committee on Economic, Social and Cultural Rights (CESCR; see note 13), paras. 34, 36.

46. Committee on the Elimination of Discrimination Against Women (CEDAW Committee), General Recommendation No. 24, Women and Health, UN Doc. No. A/54/38/Rev.1(1999), para. 31(c).

47. Human Rights Committee (HRC), General Comment No. 28, Equality of Rights Between Men and Women (art. 3), UN Doc. No. CCPR/C/21/Rev.1/Add.10 (2000), para. 10.

48. Committee on the Rights of the Child (CRC Committee), General Comment No. 4, Adolescent Health and Development in the Context of the Convention on the Rights of the Child, UN Doc. No. CRC/GC/2003/4 (2003), para. 31.

49. CEDAW Committee (see note 46), para. 6.

50. CEDAW (see note 41): art. 12 (1).

51. HRC (see note 47), para. 11.

52. *Ibid.*, para. 10.

53. CRC (see note 44), para. 31.

54. CEDAW Committee (see note 46), para. 13.

55. R.J. Cook and B.M. Dickens, “The Human Rights Dynamics of Abortion Law Reform,” *Human Rights Quarterly* 25 (2003): p. 11.

56. Rome Statute on the International Criminal Court, U.N. Doc. A/Conf. 183/9 (1998), reprinted in 37 I.L.M. 999 (1998): art. 7(1) (g).

57. Commission on Human Rights, Draft Resolution, Basic principles and guidelines on the right to a remedy and reparation for victims of gross violations of international human rights law and serious violations of international humanitarian law (Part IX. Reparation for Harm Suffered), UN Doc. No. E/CN.4/2005/L.58 (2005), para. 19.
58. A. Wagstaff and M. Claeson, *The Millennium Development Goals for Health: Rising to the Challenges* (Washington, DC: The World Bank, 2004).
59. WHO (see note 10): p. 15.
60. Ibid.
61. WHO, "Every Pregnancy Faces Risk," (WHD 98.5). Available at [http://www.who.int/docstore/world-health-day/en/pages1998/whd98\\_05.html](http://www.who.int/docstore/world-health-day/en/pages1998/whd98_05.html).
62. A.M. Fraser, J.E. Brockert, and R.H. Ward, "Association of Young Maternal Age with Adverse Reproductive Outcomes," *New England Journal of Medicine* 332 (1995): pp. 113–17.
63. Ibid.
64. C. Schauburger, "Adolescent obstetrics," *Seminars in Adolescent Medicine* 2/3 (1986): pp.197–205.
65. A. Conde-Agudelo, J.M. Balizan, and C. Lammers, "Maternal-Perinatal Morbidity and Mortality Associated with Adolescent Pregnancy in Latin America: Cross-Sectional Study," *American Journal of Obstetrics and Gynecology* 192 (2005): pp. 342–9.
66. M.L. Hediger, T.O. Scholl, and J.I. Schall, "Implications of the Camden Study of Adolescent Pregnancy: Interactions among Maternal Growth, Nutritional Status, and Body Composition," *Annals of the New York Academy of Sciences* 28/817 (1997): pp. 281–91.
67. C. Stevens-Simon and E.R. McAnarney, "Childhood Victimization: Relationship to Adolescent Pregnancy Outcome," *Child Abuse & Neglect* 18/7 (1994): pp. 569–75.
68. C.D. Hayes, *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing* (Washington, DC: National Academy Press, 1987).
69. WHO, (see note 61).
70. African Commission on Human and People's Rights, *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (2003). Available at [http://www.achpr.org/english/\\_info/women\\_en.html](http://www.achpr.org/english/_info/women_en.html). The Protocol states, "protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."
71. CRR (see note 9).
72. For more information about human rights and abortion law on a global scale, see R.J. Cook and B.M. Dickens (note 1) and R.J. Cook and B.M. Dickens (note 52): pp.1–59.
73. In 2003 the Committee on the Rights of the Child (CRC) put forth a general comment that does make explicit reference to the right to access abortion where not prohibited by law. See General Comment No. 4, Adolescent Health and Development in the Context of the Convention on the Rights of the Child, UN Doc. No. CRC/GC/2003/4(2003), para 31.
74. Center for Reproductive Law and Policy, *Political Process and*

*Abortion Legislation in El Salvador: a Human Rights Analysis* (New York: Center for Reproductive Rights, 2000).

75. R.J. Cook and B.M. Dickens (note 72).

76. For example, R.J. Cook and B.M. Dickens (see note 55): p. 24.

77. CRC (see note 44): preamble.

78. American Convention on Human Rights, signed November 22, 1969, entered into force July 18, 1978, O.A.S.T.S. No. 36, p.1, O.A.S. Off. Rec OEA/Sr.L/V/II.23, doc. 21 rev. 6 at 25: art. 4.

79. For example, R.J. Cook and B.M. Dickens (see note 48): pp 24–5 and R.J. Cook, B.M. Dickens, and M.F. Fathalla (see note 5): p. 352.

80. Republica de Nicaragua, Ley No. 287, Código de la Niñez y la Adolescencia. Libro Primero. Derechos, Libertades, Garantías y Deberes. Capitulo I. Derechos Civiles y Políticos. Arto. 12. *“Las niñas, niños y adolescentes tienen derecho intrínscico a la vida desde su concepción...”*

81. Asamblea Legislativa de la Republica de Costa Rica, Departamento de Comisiones, Comisión Especial de la Mujer, Testimony of Lic. Rodolfo Vicente, Chief Legal Representative for Child’s Rights, Ministry of Children and Adolescents (Acta de la Sesión Ordinaria No. 20, March 20, 2003): p. 14.

82. This information comes from notes taken during a personal interview between two of the authors and the Director of the Children’s Rights division of the Office of the Human Rights Ombudsman (Defensoria de los Habitantes) in Costa Rica (April 30 2003).

83. E. Romero, “Red de Mujeres y Minsa en sordida discusion por menor embarazada,” *La Prensa* (February 18, 2003).

84. This information comes from notes taken during personal interviews that two of the authors conducted with lawyers from the Human Rights Ombudsman’s office, members of the Network of Women against Violence, and the Commission that was sent to provide support to Rosa while she was in Costa Rica.

85. For example, H. L. McNaughton, E. M. Mitchell, and M. M. Blandon (see note 2): pp. 18–26.

86. H.L. McNaughton, M.M. Blandon, and L. Altamirano, “Should Therapeutic Abortion Be Legal in Nicaragua? The Response of Nicaraguan Obstetrician-Gynecologists,” *Reproductive Health Matters* 10/19 (2002): pp. 111–9.

87. Republica de Costa Rica (see note 5).

88. For more information about contradictory decision-making by providers with regard to access to legal abortion, see note 2 and N. Aries, “The American College of Obstetricians and Gynecologists and the Evolution of Abortion Policy: 1951–1973: The Politics of Science,” *American Journal of Public Health*, 93/11 (2003): pp. 1810–9.

89. Asamblea Legislativa de la Republica de Costa Rica, Departamento de Comisiones, Comisión Especial de la Mujer, Acta de la Sesión Ordinaria No. 29 (27 de marzo de 2003). Testimony of Dr. Eliseo Vargas García, President of the Costa Rican Health System (testifying on behalf of Rosa’s health care providers): p. 7

90. Ministerio de Salud (see note 35): p. 2. *“Ante todo consideramos que de continuar el embarazo corre el riesgo de sufrir danos severos, por lo*



que no tenemos la seguridad de que el embarazo termine de una forma satisfactoria. Por otro lado de realizarse la interrupción del embarazo, corre el riesgo potencial por la edad de la niña y por la edad gestacional, de sufrir danos severos.... Sin embargo aunque estos problemas pueden ser intervenido no se garantiza de forma absoluta que no puedan ocurrir danos. Luego de la evaluación exhaustiva concluimos que la niña corre riesgo potencial de sufrir daño severo e incluso la muerte en cualquiera de las dos alternativas, esto debe ser dado a conocer a los padres (tutores legales de la menor) para la toma de una decisión informada.”

91. B. Klugman and D. Budlender, “South Africa Country Study,” in B. Klugman and D. Budlender (ed), *Advocating for Abortion Access* (South Africa: Women’s Health Project, 2001): pp. 252–82.

92. For example, N. Aries (see note 88): p. 1813.

93. For example, B. Klugman and D. Budlender (see note 91): p. 260.

94. L. Cox, “Reflections on Human Rights at Century’s End,” *Human Rights Dialogue* 2/1 (2000).

95. For example, see *ibid.*, p. 1.

96. M.L.Vigil, *Historia de una Rosa* (Managua, Nicaragua: Red de Mujeres contra la Violencia, 2003): pp. 132–6.

97. WHO (see note 10).

98. CRC (see note 73).

99. *Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa* (see note 70).

100. For example, Center for Reproductive Rights, “Woman Forced to Carry Fatally Impaired Fetus to Term Wins Case.” Available at <http://www.planetwire.org/details/5599>.

101. C.E. Lopez (Children’s Ombudsman in 2003), Personal Communication (March 29, 2003).

102. A.E. Yamin (see note 35): p. 7.