SHADOW REPORT

on the

THE THIRD PERIODIC REPORT OF

CHILE

COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

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Presented by

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SHADOW REPORT
SECOND PERIODIC REPORT OF
THE GOVERNMENT OF CHILE

Introduction

1. This report is submitted by the La Morada Women's Development Corporation, Santiago, Chile, the International Women's Human Rights Law Clinic (IWHR) of the City University of New York School of Law, and the Center for Reproductive Rights (CRR), New York City. La Morada is a renowned non-profit organization with vast experience in the promotion and defense of women's human rights. In 2002, La Morada obtained consultative status with the ECOSOC of the United Nations and is currently registering before the Organization of American States. IWHR is widely recognized for its expertise in international law and women's human rights and, particularly, in reproductive and sexual health rights. CRR is a renowned international non-profit legal advocacy organization dedicated to promoting and defending women's reproductive rights worldwide.

2. The purpose of this report is to address pressing concerns with regard to Chile's systematic violations of article 12 of this Convention with regard to women's health, and, particularly, women's sexual and reproductive health rights. Specifically, this Report will focus on policies and violations affecting access to safe, legal abortion and to emergency treatment of abortion complications.

3. Part I of this report will provide the background of Chile's current Periodic Report; Part II will summarize the basic obligations under the Convention that are at issue with respect to women's reproductive and sexual health; Part III will then examine the factual background, nature and violation of the specific obligations of the state party with respect to each of the above-listed areas of critical concern. Finally, Part IV contains suggested recommendations to hasten Chile's compliance with the Convention.

I. BACKGROUND OF THE REPORT.

4. The Committee last reviewed Chile's record under the ICESCR in 1988. In relation to reproductive and sexual health, the Committee found that state initiatives designed to improve health access led to a decrease in infant undernourishment from 15.5% to 9.1% over an eleven-year period between 1975-1986. The Committee was encouraged by a country-wide effort to improve health services for children under six-years of age and for pregnant women, which led to a decrease of the infant

mortality rate. Nothing was mentioned regarding the maternal mortality rate.[1] Chile's current abortion laws were not in effect in 1988.[2]

5. The Committee requested that Chile respond to the following questions, pertinent to this Shadow Report, regarding women's health and particularly reproductive and sexual health for its 2004 Report:[3]

    a. "Please provide data, based on the results of the national system of gender indicators . . . on the areas deemed critical for the creation of equal opportunities for men and women in the enjoyment of economic, social and cultural rights."[4]
    b. "Please provide updated information on the reproductive and sexual health of women. How does the State party address the negative effect of the low age of sexual consent (12 years) on the reproductive health of girls and boys? How does Chilean legislation classify and regulate abortion? Please provide up-to-date information on the number of abortions carried out."[5]

6. This Report will address Chile's responses as well as signal other important issues reflecting Chile's failure to comply with its obligations under Article 12 of the Convention.[6]

II. INTERNATIONAL LEGAL STANDARDS AND OBLIGATIONS

7. The violations discussed herein constitute grave violations of Article 12(1)'s right of everyone "to the enjoyment of the highest attainable standard of physical and mental health," as elaborated, in particular, by Comment 14.[7]

8. Article 12 of the ICESCR creates two kinds of obligations on states parties: 1) all states parties must meet core obligations under article 12 regardless of the socio-economic conditions of the country; and 2) all states parties must progressively realize the right to health by taking "deliberate, concrete and targeted" steps toward full realization of the right.[8]

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[1] *See* Chile, CESCR E/1988/14 at paras. 198-200.
[2] *See* Center for Reproductive Law and Policy and Open Forum on Reproductive Health and Rights, *Women Behind Bars: Chile's Abortion Laws. A Human Rights Analysis*, at 43 (1998). (herinafter, "Women Behind Bars").
[3] CESCR, List of issues: Chile. E/C.12/Q/CHL/1 (18/12/2003).
[4] *Id.* at para. 9.
[5] *Id.* at para. 29.
[6] *See Responses from the Chilean Government,* [Respuestas del gobierno de chile]: Chile, 20/08/2004, CESCR/NONE/2004/5. (hereinafter, "Chile Report").
[7] *The Right to the Highest Attainable Standard of Health*, General Comment No. 14, CESCR E/C.12/2000/4.
[8] *See id.* at para. 30.

9. Pursuant to General Comment No. 14, states parties have core obligations under the covenant, including:
    - "Providing essential primary health care, which requires measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."[9]
        - "Reproductive health" means that "women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth."[10]
        - Implicit in this obligation is the removal of all barriers interfering with access to health services, education and information in the area of sexual and reproductive health.[11]
        - Also implicit in this obligation is that patients should be ensured confidentiality in health care delivery.[12]
    - ensuring the right of access to health facilities, goods, and services on non-discriminatory basis, especially with regard to vulnerable or marginalized groups;[13]
    - ensuring equitable distribution of all health facilities, goods, and services;[14]
    - providing essential drugs;[15]
    - implementing a national public health strategy on the basis of epidemiological evidence that addresses the health concerns of the whole population.[16]
    - providing education and access to information concerning main health problems in the community (such as reproductive and sexual health), including the incorporation of methods of preventing and controlling them;[17] and
    - ensuring adequate training for health personnel, including education on health and human rights.[18]

10. States parties have immediate obligations regarding the right to health to 1) guarantee that the right to health be exercised and protected without discrimination and 2) to take "deliberate, concrete and targeted" steps towards the full realization of article 12.[19]

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[9] *See id.* at para. 14.
[10] *Id* at para. 14 citing note 12.
[11] *Id.* at paras. 21 and 34.
[12] *Id.* at paras. 12(c) and 23.
[13] *Id.* at para. 43(a).
[14] *Id.* at para. 43(e).
[15] *Id* at para. 43(d).
[16] *Id* at para. 43(f).
[17] *Id.* at para. 44(d).
[18] *Id.* at para. 44(e).
[19] *Id.* at para. 30.

11. States parties are also obliged to take steps to progressively realize the right to health. Progressive realization means that States parties have an immediate as well as continuing obligation to take "deliberate, concrete and targeted"[20] steps as well as to move as expeditiously as possible[21] toward the full realization of article 12. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they are justified by the totality of the rights provided for in the Covenant in the context of the full use of the State's party's maximum available resources.[22]

III. AREAS OF CRITICAL CONCERN

A. GENERAL HEALTH SITUATION OF WOMEN

12. Chile posee un sistema público y un sistema privado de salud. El 69.2% de las mujeres chilenas mayores de 15 años pertenece al sistema público de salud[23]. La proporción de mujeres controladas en los servicios de regulación de la fecundidad del Programa de Salud de la Mujer (Ministerio de Salud) bordea el 30% de las mujeres en edad fértil. En 2003, a través de este programa se atendió a un millón 66 mil 124 mujeres, lo que corresponde a una cobertura del 29,3% de las mujeres de 15 a 44 años (Censo 2002).

13. En 1981 se crearon en Chile las Instituciones de Salud Previsional (ISAPRE). Las mujeres constituyen el 35,2% de las cotizantes, concentrándose en el tramo de edad entre 25 y 49 años[24]. Las ISAPRE establecen costos diferenciados sobre la base de los riesgos en la salud que pueden tener los grupos de cotizantes.

14. Desde el año 2002 se inició un proceso de reforma al sistema de salud, en el que destaca una iniciativa consistente en la formulación de una serie de garantías explícitas exigibles por las personas para determinados problemas de salud en términos de calidad, oportunidad y protección financiera, sistema conocido como Plan de Acceso Universal de Garantías Explícitas, AUGE. Esta reforma ha suscitado polémica en parte de los gremios médicos y de los trabajadores/as de la salud, como en organizaciones de mujeres que trabajan en el tema. Esto, porque este nuevo plan prioriza un número determinados de enfermedades, que excluye del sistema a los y las usuarias que no padecen los problemas a la salud consignados en dicho sistema. Muchas de esas enfermedades son las que afectan principalmente a las mujeres, entre las principales están la osteoporosis, las várices, patologías

[20] *Id.*
[21] *Id.* at para. 31.
[22] *Id.* at para. 32.
[23] Ministerio de Planificación y Cooperación, "Análisis de la VIII Encuesta de Caracterización Socioeconómica (CASEN 2000). Documento N° 11. Situación de la mujer en Chile 2000" Santiago, Chile, 2001.
[24] Superintendencia de ISAPRE, en Informe Alternativo sobre el Cumplimiento de la CEDAW en Chile, Ciudadanía y Derechos Humanos Corporación La Morada, 2003

benignas a las mamas, vagina, ovarios, trompas y útero; depresiones, artrosis, entre otras enfermedades.

15. El Fisco financia este sistema (AUGE) para los indigentes, pero no aporta recursos para aquellas personas con carencia, es decir, para aquellas cuya cotización no alcanza a cubrir el valor de la prima del régimen de garantías de su grupo familiar. Sobre esta base, las mujeres serán mayoritariamente discriminadas por el AUGE por no contar con la cotización suficiente.[25]

1. Factual background

i. Facts stated in Chile's report

16. En su informe el Estado destaca la disminución de la tasa de fecundidad de las mujeres chilenas. No obstante, manifiesta su preocupación respecto del aumento en el promedio de hijos/as en las mujeres menores de 20 años.

17. En Chile, la edad promedio en que ocurre la primera relación sexual presenta diferencias entre mujeres y hombres, no obstante, en las nuevas generaciones disminuye la brecha de género en el inicio de la vida sexual. Las mujeres tienden a incorporarse más tardíamente que los hombres a la vida sexual activa. El 90% de los hombres entre los 20 y los 24 años se ha iniciado sexualmente, las mujeres alcanzan ese porcentaje en el rango de 25 a 29 años (Estudio Nacional de Comportamiento Sexual en Chile, CONASIDA 1998).

18. Sostiene que existe un crecimiento relativo mayor de casos de SIDA en mujeres con relación a los hombres, incluyendo en todos los mecanismos de transmisión. Esto se refleja en la proporción entre hombres y mujeres, cuya brecha se ha acortado a través del tiempo, llegando de 5,8:1 en 1999. La principal vía de transmisión del SIDA en el país es la sexual, que alcanza el 93,8%.

19. El Gobierno está desarrollando una política de educación sexual que da especial énfasis a la participación de las familias y a la valoración de la maternidad y del rol de los padres y madres en la relación con sus hijas e hijos.

ii. Facts not stated in Chile's report

20. El Sistema de Salud Privado discrimina a las mujeres. Un Plan de ISAPRE para una mujer entre 20 y 60 años puede triplicar el valor del plan de un hombre con iguales beneficios. Las razones que se esgrimen para justificar el mayor costo y la menor cobertura de los planes de salud femeninos son la mayor esperanza de vida, el

[25] Informe Alternativo sobre el Cumplimiento de la CEDAW en Chile. Informe sobre la Situación de los Derechos Humanos de las Mujeres en Chile 2003. Área de Ciudadanía y Derechos Humanos. Corporación La Morada

hecho de hacer uso de mayores atenciones en salud, el uso de más licencias médicas, pero por sobretodo, la función reproductiva es el "mayor riesgo".[26] Considerando lo anterior, las ISAPRE han creado los planes de salud "sin útero", más económicos y que limitan la cobertura del parto y de las atenciones al recién nacido. Al no cubrir estos gastos, las mujeres se comprometen a postergar su maternidad o bien a no ser cubiertas por el seguro que si debiera enfrentar estos gastos.[27]

21. A las discriminaciones derivadas de la función reproductiva de la mujer, se suman otras. Las ISAPRE no sólo encarecen los planes a las mujeres, sino que también disminuyen su cobertura en determinadas prestaciones: según informaciones de la Superintendencia de ISAPRE, las coberturas efectivas promedio son más bajas para las mujeres en consultas médicas, exámenes de laboratorio, imagenología, día cama de hospitalización, Unidad de Tratamiento Intensivo, derechos de pabellón y honorarios médico – quirúrgico.[28]

22. Finalmente, cabe señalar que las más afectadas por la ausencia de una política fuerte de prevención en materia de VIH-SIDA, han sido las mujeres, contagiadas principalmente por sus parejas estables. En efecto, durante las últimas campañas de prevención de la epidemia se ha insistido en señalar como factor que evita el contagio, el tener una pareja estable, en campañas comunicacionales en las que la Iglesia Católica ha tenido una fuerte incidencia.

2. Violations of obligations under the Convention

23. De acuerdo a lo ya señalado, el Estado de Chile viola el derecho a la no discriminación en lo referido a la salud en el sistema privado de salud (ISAPRE), en la medida que durante su edad reproductiva, ellas deben pagar casi tres veces más que un hombre por una misma cobertura de salud. Chile está contraviniendo su obligación de garantizar la asistencia médica a todas las personas, sin discriminación, en conformidad a lo establecido en los Arts. 2.2, 3 y 12 del Pacto. Por otro lado, en el caso del VIH-SIDA, las medidas de salud preventiva implementadas por el Estado han resultado claramente ineficaces en el caso de las mujeres, vulnerando el derecho de las mujeres a la educación y a la información sobre salud sexual y reproductiva.

B. CONTRACEPTION AND EMERGENCY CONTRACEPTION

[26] *Id*.
[27] *Id*.
[28] Informe Alternativo sobre el Cumplimiento de la CEDAW en Chile. Informe sobre la Situación de los Derechos Humanos de las Mujeres en Chile 2003. Área de Ciudadanía y Derechos Humanos. Corporación La Morada.

1. Factual background

24. El sistema público de salud ofrece como métodos de "planificación familiar" básicamente dispositivos intrauterinos (DIU) y anticonceptivos hormonales orales. En una mínima proporción ofrece preservativos. Aún cuando los servicios de regulación de la fecundidad se definen como dirigidos a mujeres y/o parejas, en el año 2002 sólo 6.112 hombres recibieron preservativos, lo que corresponde al 0,6% del total de usurios/as de Métodos Anticonceptivos (MAC) en dicho sistema.[29]

25. Los dispositivos intrauterinos y los hormonales orales concentran el 92% de las usuarias: un 60% utiliza DIU y un 32% los MAC orales. El sistema público al entregar Métodos Anticonceptivos mayoritariamente a mujeres, revela el sesgo de género que tiene, al dejar en las mujeres la responsabilidad exclusiva en la prevención del embarazo.

26. La mayoría de las de las víctimas de agresiones sexuales son mujeres menores de 18 años. De acuerdo al Servicio Médico Legal (SML) un 83% las víctimas de violación y un 78% de las víctimas de abuso sexual son mujeres. La mayoría de las víctimas de violación tienen entre 10 y 29 años (74%) y las víctimas de abuso sexual, entre 0 y 14 años de edad.[30]

i. Facts stated in Chile's report

27. El Estado de Chile no informa respecto de las políticas públicas orientadas a informar y suministrar a mujeres y hombres, adultos y jóvenes, métodos anticonceptivos y anticonceptivos de emergencia.

ii. Facts not stated in Chile's report

28. Las encuestas sobre sexualidad en adolescentes revelan que una proporción importante de los jóvenes inicia su vida sexual antes de los 19 años y que la edad de inicio se ha adelantado en la última década. Según la Tercera Encuesta Nacional de la Juventud, la edad promedio de inicio de las relaciones sexuales de los y las jóvenes encuestadas fue de 16.2 años en los hombres y de 17.8 años en las mujeres[31]. El porcentaje de jóvenes que inicia sus relaciones sexuales entre los 15 y 29 años aumentó de un 66% a un 74%, entre 1994 y 2000.[32]

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[29] *Id*.

[30] Anuario Estadístico 2000. Subdirección Técnica. Unidad Estadística y Archivo Médico Legal. Servicio Médico Legal, Chiloé, 2000, en Chile: Diagnóstico de la Salud y los Derechos Sexuales y Reproductivos, CORSAPS, ICMER y SERNAM

[31] Tercera Encuesta Nacional de Juventud, Informe Final INJ, Chile 2001 en Chile: Situación de la Salud y Los Derechos Sexuales y Reproductivos, CORSAPS, SERNAM, ICMER (diciembre 2003)

[32] *Id*.

29. Cada año nacen en Chile 40 mil hijos/as de madres menores de 20 años, lo que representan cerca del 15% de los nacimientos. El 85% de estas madres es soltera y en el 12% de los casos, se trata de mujeres menores de 20 años que han tenido su segundo o tercer hijo[33]. Esto revela la urgente necesidad de información y acceso a servicios de salud sexual y reproductiva. Pero además la necesidad de que estas jóvenes cuenten con las políticas que les permitan continuar con sus estudios y acceder a niveles de educación superior que les permita acceder a capacitación laboral y al mercado del trabajo en condiciones de igualdad y respeto de sus derechos.

30. La educación sexual ha sido una materia compleja de abordar por las instancias gubernamentales. Han existido diversas iniciativas como "Política de Educación en Sexualidad" (Ministerio de Educación 1993), las "Jornadas de Conversación sobre Afectividad y Sexualidad" (JOCAS), la "Política Nacional de Salud para Adolescentes y Jóvenes" (Ministerio de Salud 1999), y el "Plan de Sexualidad Responsable" de carácter triminesterial (SERNAM y Ministerios de Educación y Salud), pero ninguna de ellas ha logrado instalar la educación sexual y el acceso a servicios de salud sexual y reproductiva como derechos para las y los adolescentes[34]. El fracaso de establecer políticas en materia de educación sexual se debe principalmente a la resistencia de los sectores políticos conservadores de la sociedad chilena, principalmente de la Iglesia Católica. Otro ejemplo, es la oposición sostenida que estos mismos grupos han hecho a las campañas públicas para prevenir el VIH – SIDA. Estas iniciativas no han prosperado en medios de comunicación – especialmente en canales de televisión abierta – por no contar con el respaldo de la línea editorial de dichas instituciones, línea que se rige por concepciones valóricas propias de la Iglesia Católica.

31. En Chile, las estadísticas de planificación familiar no cuentan con información completa debido a la ausencia de un sistema nacional de información, que incluya al servicio privado de salud, la venta de anticonceptivos a través de farmacias, encuestas de población y seguimiento de los/las usuarios/as. Según las estadísticas del Ministerio de Salud, en el año 2000 el porcentaje de usuarias nuevas de Métodos Anticonceptivos en sistema de salud público fue de sólo un 9,5%, una cifra que se mantiene desde 1990. Los datos de la Encuesta Nacional de Calidad de Vida y Salud, muestra que un porcentaje importante de mujeres obtienen los métodos anticonceptivos en consultas privadas y en farmacias (39,8%). Este mismo estudio revela que la prevalencia de uso de métodos anticonceptivos es menor en las personas con menor nivel educacional y aumenta en la población con más de un año de educación.[35]

[33] Anuario de Estadísticas Vitales 2000, Instituto Nacional de Estadísticas, en Informe Alternativo sobre el Cumplimiento de la CEDAW en Chile, Ciudadanía y Derechos Humanos Coporación La Morada, 2003

[34] Informe Alternativo sobre el Cumplimiento de la CEDAW en Chile. *op. cit.*

[35] Chile: Situación de la Salud y Los Derechos Sexuales y Reproductivos, CORSAPS, SERNAM, ICMER (diciembre 2003)

32. El acceso a la anticoncepción de emergencia (AE) está severamente restringido. La AE está disponible en los servicios públicos y consultorios sólo para las mujeres que hayan sido víctimas de violación. No obstante, la entrega de estos medicamentos también está sujeta al arbitrio del personal responsable. En los consultorios (atención primaria) – dependiente de los municipios/gobiernos locales – los criterios para la entrega de la AE se rigen por las creencias valóricas del personal o de la autoridad comunal, lo que implica que un número importante de mujeres no accede a este método de emergencia, pese a los riesgos de enfrentar un potencial embarazo no deseado. En otros casos, se niega el acceso AE si la mujer no "prueba", a través de peritajes o constatación médica, que ha sido víctima de una violación. Por otro lado, las mujeres que no han sido víctimas de violación y necesitan acceder a la AE –por falla en el uso del método anticonceptivo habitual– sólo pueden adquirirla con una receta médica que se retiene en la farmacias para su venta.

2. Violations of obligations under the Convention

33. El Estado incumple las obligaciones contenidas en el Pacto, en lo referido al acceso a métodos de planificación familiar. En efecto, al respecto ni siquiera es posible contar con la información completa en relación al país, ya que no hay información disponible respecto de esta materia en las personas que se encuentran afiliadas al sistema privado de salud (ISAPRE). Por otro lado, el acceso a estos métodos es restringido en varios sentidos. Así, la oferta de MAC está principalmente orientada a las mujeres, a quienes por este medio se les refuerza el estereotipo cultural de acuerdo al cual ellas son las responsables del control de la fecundidad, fomentando también la irresponsabilidad masculina al respecto. Por otra parte, dentro de la limitada oferta de MAC que están disponibles para las mujeres en Chile, es particularmente grave la severa restricción de la AE sólo a mujeres que han sido víctimas de una violación –y que deben hacer la denuncia respectiva-, y aquellas que pueden contar con una receta médica que será retenida para tal efecto, sin contar con las prácticas detectadas en diversos consultorios de salud en que se niega este MAC a las mujeres por otras causas.

34. Chilean restrictions on the accessibility of contraception to all women constitute a further violation in that they contribute to the absence of ready access to safe, confidential contraception services. This also contributes to the high rate of illegal abortion and its unforgivably high rate of maternal mortality and adverse health effects on women.

C. ABORTION

1. Factual background

35. En Chile desde 1989 el aborto en está penalizado en cualquier circunstancia, sin excepciones, y su práctica en el país se realiza ilegalmente. Las cifras públicas sólo dan cuenta de los abortos a través de los registros de los egresos hospitalarios por

complicaciones derivadas del aborto ilegal. Es decir, existe una cifra oculta de los abortos que se realizan clandestinamente y que no generan complicaciones en la salud de las mujeres.

i. Facts stated in Chile's report

36. As requested by this Committee, Chile's report acknowledges that the Chilean Penal Code criminalizes intentional abortion under all circumstances, that there is no exception for therapeutic abortion "that is accepted in all legislations except the Chilean." [36] Chile's abortion laws criminalizes the woman herself who commits the abortion as well third parties who do so (with qualified persons punished more severely than any other third party). The law criminalizes third parties performing abortions in decreasing levels of severity: 1) third parties who commit abortions "with violence;" 2) third parties who commit abortions "without violence but without the consent" of the woman; and 3) third parties who commit abortions with the consent of the woman. Of the laws criminalizing the pregnant woman herself, the abortion, the abortion is considered "basic" if she carries out her own abortion; it is "attenuated" if there is motivation to "hide" the "dishonor."[37] All crimes are punishable by incarceration.

37. According to Chile's report, twenty pregnant women out of every 100,000 die as a result of pregnancy complications.[38] Around one third of these deaths are related to complications caused by abortion procedures.[39] Moreover, in 2001, 34,479 women were hospitalized due to complications related to abortion, and the public health system was responsible for 74% of all discharges relating to abortion.[40] Chile concedes that this represents a major public health problem that requires policies of prevention.[41] Chile admits that its statistics underestimate the real abortion numbers because the criminalization leads to hidden and unaccounted for abortion procedures.[42]

38. Chile does not appear to answer the Committee's question on how the State party addresses the negative effect of the low age of sexual consent on the reproductive health of girls and boys, except to note that the age has been raised to 14.[43] Chile states, however, that 16.2% of live births were born to girls less than 20 years old,

[36] *Chile Report*, *supra* note 6 at paras. 164-167. Chile states, "En Chile existe una penalización del aborto sin excepciones, incluido el aborto terapéutico, que es aceptado en todas las legislaciones menos la chilena."
[37] *Id.* at paras. 165 and 166.
[38] *See id.* at para. 158.
[39] *Id.*
[40] *Id*.
[41] *Id*. "El mayor porcentaje de los egresos por aborto se dan en el sistema público de salud (74,1% al año 2001), evidenciándose un problema de salud público que requiere de políticas de prevención."
[42] *Id*.
[43] *See* Chile Report at para. 162.

while 11.8% of live births were to women over 35.[44] Chile does not supply figures on young women and abortion.

39. Despite its recognition of the severity of its laws and the gravity of the public health problem they produce, Chile concludes its discussion of abortion by stating that the government has not considered decriminalization of its abortion laws because social conditions do not allow for a healthy public debate. The report states,

> "The current government has not considered in its term of office the decriminalization of abortion, given that conditions do not exist to approach this theme in the public debate, let alone in relation to therapeutic abortion. The resistance to scrutinizing this phenomenon—which affects many women—by certain groups, including the conservative media, religious groups and political parties that oppose the possibility of abortion, has had a strong effect on public opinion in the last several years."[45]

ii. Facts not included in Chile's report

40. As Chile admits, because abortion in Chile is both illegal and clandestine, it is virtually impossible to decipher accurate statistics with regard to abortion or the severe health effects of illegal and unsafe abortion procedures. Nonetheless, the information available signals a major crisis in women's health rights as well as multi-layered discrimination, most urgently, in terms of mortality and morbidity inflicted upon women as a result of Chile's draconian abortion law.

41. The Chilean Penal law on abortion is the harshest in the world, and, thus, Chile joins El Salvador and Vatican City as the only governments that criminalize all forms of abortion.[46] Chilean law is also unusual in that it criminalizes the conduct of the pregnant woman as well as those who assist her. By contrast, Chile's law permitted therapeutic abortion from 1931 to 1989. The current absolute prohibition was implemented during the last weeks of the Pinochet regime, purportedly based on the premise that "modern medicine" has made therapeutic abortion unnecessary.[47]

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[44] *See id.* at *para.* 157, citing footnote [1].

[45] *See id.* at para. 167. ["El actual Gobierno no ha considerado en su mandato la despenalización del mismo, dado que no existen aún condiciones para abordar este tema en el debate público, ni siquira en relación al aborto terapéutico. La cerrada resistencia a analizar este fenómeno—que afecta a muchas mujeres—por parte de los medios de comunicación conservadores, de sectores religiosos que se oponenen a la posbilidad del aborto, y de partidos políticos que comparten este rechazo, han tenido un fuerte efecto en la opinión pública a lo largo de las últimos años."]

[46] *See Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000*, fourth edition, World Health Organization, Geneva, at 3 (2004). *See also* http://www.reproductiverights.org/pub_fac_abortion_laws.html (last visited November 10, 2004) indicating that only Chile and El Salvador prohibit abortion altogether with no possibility even of necessity defense where the life of the woman is at stake.

[47] *See Women Behind Bars, supra* note 2.

42. La reposición del aborto terapéutico ha sido ampliamente discutida a través de la presentación de una iniciativa legislativa que pretende reponerlo en el ordenamiento jurídico nacional; iniciativa patrocinada por parlamentarios de la Concertación. Este debate se agitó a raíz de dos casos de mujeres que solicitaron a través de los medios de comunicación que se les practicara un aborto terapéutico (inviabilidad del feto fuera del vientre materno y embarazo molar, respectivamente)[48]. Desde 1999, se han realizado periódicamente sondeos y encuestas de opinión respecto de la despenalización del aborto y bajo qué circunstancias se aceptaría está práctica. A diferencia de lo que manifiesta el informe del Estado de Chile, existe una mayoría social que está a favor de despenalizar el aborto cuando se toman en consideración determinadas circunstancias que ponen en riesgo la salud de la mujer. La Encuesta Nacional Percepciones políticas e implicancias electorales de las mujeres inscritas en los registros electorales de cara a las elecciones 2004 – 2005" (septiembre 2004) evidenció que el 86,1 % de las encuestadas consideraba que en caso de no existir acuerdo sobre la decisión de un aborto, la mujer es la que tiene la última palabra. Sondeos de opinión de la Fundación Futuro (Agosto 2002) arrojan una mayoría de encuestados a favor del aborto en determinadas circunstancias como: en caso de violación o incesto; malformación del feto, si está en peligro la vida de la madre. La Encuesta Nacional realizada por el Grupo Iniciativa (Enero 1999) también demuestra que existe una mayoría que acepta el aborto cuando "está en riesgo la vida de la madre", "cuando el embarazo es resultado de violación o incesto", o "cuando el feto no está bien".

43. All abortion crimes are punishable by at least a three year prison term, unless the woman who consented to an abortion did so to "conceal her dishonor," in which case the prison sentence is reduced. The abortion laws are under Title VII of the Chilean Penal Code—which is called "crimes against family order and public morality."[49]

44. Chilean criminal procedure law contains a provision which obliges health professionals to report to authorities when they find in person or corpse indications of a crime or misdemeanor.[50] This has led some Chilean health professionals –particularly in the public hospitals--to interrogate women and report illegal abortions to the police and prosecutors, a practice that has drawn sharp criticism from the U.N. Committee Against Torture (CAT).[51]

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[48] Se trata de los casos de Gladys Pavez y Giselle Rojas, cuyas implicancias fueron ampliamente debatidas en los medios de comunicación a inicios del 2003.

[49] *See* Article 342-345 of the Chilean Penal Code.

[50] *See* Article 175 (d) of Chile's Penal Procedure Code (stating ["Los jefes de establecimientos hospitalarios o de clínicas particulares y, en general, los profesionales en medicina, odontología, química, farmacia y otras ramas relacionadas con la conservación o restablecimiento de la salud, y los que ejerzan profesiones auxiliares de ellas, que noten en una persona o en un cadáver señales de envenenamiento o de otro crimen o simple delito"]).

[51] *See* Committee Against Torture, Conclusions and Recommendations, CAT/C/CR/32/5, 14 June 2004. *See also* paragraph 24 of this shadow report for further discussion.

45. Las estimaciones del número de abortos clandestinos que se practican anualmente en el país varían entre 159.650 (438 per day),[52] 200 mil (547 per day),[53] 60 mil (164 per day).[54]

46. This is the highest rate in Latin America, and represents 35% of the total pregnancies in Chile.[55] It is estimated that 40% of the women having abortions are under the age of 18.[56]

47. According to both Chile and the UN, complications resulting from clandestine abortion are a major health problem in Chile.[57] Complications resulting from abortion are the leading cause of maternal mortality in Chile.[58] At a minimum, 34,479 women, or 95 women per day, were hospitalized in 2001 as a result of health problems due to illegal abortions in Chile.[59] This represents an increase from 1990, when 31,930 were hospitalized for abortion complications.[60]

48. Si bien en los últimos años han disminuido notoriamente las muertes maternas y las muertes por aborto, en el año 2000 – último año del que se disponen estadísticas vitales – las complicaciones derivadas del aborto clandestino causaron la cuarta parte de las muertes maternas, ubicando al aborto como la primera causa de mortalidad materna en Chile.[61]

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[52] Aborto Clandestino: Una realidad Latinoamericana. The Alan Guttmacher Institute (1994), en Chile: Situación de la Salud y Los Derechos Sexuales y Reproductivos, CORSAPS, SERNAM, ICMER. *See also Chile tiene mayor tasa de abortos en America Latina* [Chile has the highest number of abortions in Latin America], El Mercurio, 19 October 2004 *available at* http://www.emol.com/noticias/nacional/detalle/detallenoticias.asp?idnoticia=161301 (last visited November 3, 2004).

[53] Requena M. (ed) Aborto Inducido en Chile. Edición Sociedad Chilena de Salud Pública. Santiago, 1990, en Chile: Situación de la Salud y Los Derechos Sexuales y Reproductivos, CORSAPS, SERNAM, ICMER.

[54] Lavin P. y col. Informe Preliminar sobre la caracterización de los casos y costos del tratamiento hospitalizado en Santiago de Chile. Ponencia presentada en el Encuentro de Investigadores sobre Aborto Inducido en América Latina y El Caribe. Universidad Externado de Colombia. Santa Fé, Bogotá, 1994 en Chile: Situación de la Salud y Los Derechos Sexuales y Reproductivos, CORSAPS, SERNAM, ICMER.

[55] *See id. See also* The Alan Guttmacher Institute, *El Aborto Clandestino una Realidad Latinoamericana*, [Clandestine Abortion, A Latin American Reality] New York (1994).

[56] Zoraida Portillo, *Latin American Population: Increase in the Numbers of Teenage Mothers*, INTERPRESS SERVICE, September 24, 1997.

[57] *See UN Population Division, Chile,* http://www.un.org/esa/population/publications/abortion/doc/chiles1.doc (last visited November 3, 2004).

[58] Lidia Casas and Nuria Nuñez, Instituto De La Mujer, *Aborto: Argumentos Para Una Dicusión Necesaria* [Abortion: Arguments for a Necessary Debate] (1988), at p. 12.

[59] *See Chile Report*, CESCR/NONE/2004/5 at para. 158.

[60] *See* The Alan Guttmacher Institute, *An Overview of Clandestine Abortion in Latin America*, http://www.guttmacher.org/pubs/ib12.html (last visited November 1, 2004).

[61] Atención Humanizada del Aborto Inseguro en Chile. *op. cit.* Cálculos en base a la información sobre causas detalladas de muertes contenida en el Anuario de Estadísticas Vitales 2000, Instituto Nacional de Estadísticas.

49. De acuerdo a la información "Partos normales, distócicos vaginales, cesáreas y abortos atendidos en establecimiento del Servicio Nacional de Salud y extrasistema en Chile 1990 – 2000[62], el número de abortos ha disminuido: en 1990 se registraron 36.885 y en 2000, 30.146. Este descenso se puede explicar a la utilización de mejores técnicas en la realización de abortos, que reduce la asistencia de mujeres a servicios de salud.

50. Poor women, who cannot afford costly and safe clandestine abortion care, are the most severely affected by the criminalization of abortion, as they have no alternative to high-risk abortion procedures under non-antiseptic conditions.[63] Women without access to basic health services and trained physicians resort to particularly dangerous methods of causing an abortion. Among the common informal abortion procedures are: 1) falling, punching, or excessive physical activity, 2) consuming orally or vaginally infusions of tea/seaweed/and or other local remedies; 3) ingesting or infusing vaginally manufactured products, such as beer, wine, or even bleach, dye, soapy materials or potassium salts; 4) inserting physical objects in the uterus such as catheters (rubber tubing) used to flush toxic fluids; or sharp objects such as wire, knitting needles and sticks; 5) ingestion of hormones.[64]

51. Clandestine abortion procedures lead to devastating consequences to women's health. The World Health Organisation (WHO) has identified the following repercussions as a result of the aforementioned type of abortions:

> "Sepsis, hemorrhage, and uterine perforation all of which may be fatal if left untreated and often lead to infertility, permanent physical impairment and chronic morbidity; gas gangrene and acute renal failure, which contribute to abortion deaths as secondary complications; chronic pelvic pain pelvic inflammatory disease, tubal occlusion, secondary infertility, as well as a high risk of ectopic pregnancy, premature delivery and future spontaneous abortions; and reproductive tract infections, of which 20-40% lead to pelvic inflammatory disease and consequent infertility."[65]

52. Chilean laws place women suffering complications in further jeopardy since the very need to obtain life-saving emergency treatment puts them at risk of prosecution. Again, while those with access to well-paid professional providers can usually get this care surreptitiously, poor women are the major targets and victims of criminalization. Approximately 80% of all abortion prosecutions are initiated by

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[62] En Atención Humanizada del Aborto Inseguro en Chile. El Monitoreo como una práctica Ciudadana de las Mujeres. Foro – Red de Salud y Derechos Sexuales y Reproductivos – Chile / Red de Salud de las Mujeres Latinoamericanas y del Caribe (RSMLAC)

[63] *See id.*

[64] *See Clandestine Abortion: A Latin American Reality*, New York, 1994; and S. Singh and D. Wulf, "Estimated Levels of Induced Abortion in Six Latin American Countries," *International Family Planning Perspectives*, 20:4-13, 1994. *See also* http://www.guttmacher.org/pubs/ib12.html#12, (last visited November 3, 2004).

[65] World Health Organization, Unsafe Abortion 3 (1998).

employees of state hospitals.[66] It has been documented that some public hospitals interrogate women and insist on confessions as a condition to providing emergency treatment to women suffering abortion complications. Thus, the right to prompt treatment is conditioned on the woman admitting that she had an intentional abortion and who did it, exacerbating women's immediate suffering and the health risks, as well as to exposing them to the risk of death or of long term damage to their health, including their capacity to have children in the future. This practice, it should be noted, affects women who have also had miscarriage or spontaneous abortions.[67]

53. The Committee Against Torture (CAT) has recently found that this practice violates the CAT Convention, stating unequivocally that Chile should change its state practices with regard to abortion:

> The Committee recommends that the State party should:…
> (m) Eliminate the practice of extracting confessions for prosecution purposes from women seeking emergency medical care as a result of illegal abortion; investigate and review convictions where statements obtained by coercion in such cases have been admitted into evidence, and take remedial measures including nullifying convictions which are not in conformity with the Convention. In accordance with World Health Organization guidelines, the State party should ensure immediate and unconditional treatment of persons seeking emergency medical care. . . ..[68]

54. The CAT Committee emphasized the urgency of these recommendations in calling upon Chile to report back on these measures within one year. It is likewise urgent that this Committee assure both that these practices have been stopped and that Chile advise women suffering complications that they can seek hospital care without fear of prosecution.

55. This practice of reporting also violates the right to confidential health care which is an essential component of the right to health according to General Comment No. 14.[69] The CEDAW Committee's Recommendation No. 24, Women and Health, also stresses that without confidential services, "women will be less willing (than men)…to seek medical care for…contraception or for incomplete abortion and in cases where they have suffered sexual or physical violence.[70] Likewise, the Beijing

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[66] *See* Lorenzini, Kena. *Informe Alternativo sobre el cumplimiento de la CEDAW en Chile* (Alternative Report on the compliance of CEDAW in Chile), Citizenry and Human Rights Division, Corporacion la Morada, Santiago, 2003, p.33.

[67] *See* Committee Against Torture, Conclusions and Recommendations, CAT/C/CR/32/5, 14 June 2004.

[68] *Id.* at paras. 7, 8.

[69] *See* General Comment No. 14, CESCR E/C.12/2000/4 (paras. 12(b), 12(c), and 23). *See also CRC,* Adolescent health and development in the context of the Convention on the Rights of the Child, General Comment No. 4 (2003), CRC/GC/2003/4 at para. 39(b), 1 July 2003 (mentioning the right to confidentiality as part of the right to health in the context of adolescents).

[70] *See* Committee to End Discrimination Against Women, *General Recommendation No. 24: Women and Health*, UN Doc. A/54/38/Rev.1, chapter I, para. 12(d) (2 February 1999).

Programme of Action also calls for states, in collaboration with non-governmental organizations and employers' and workers' organizations and with the support of international institutions, to ensure the right to privacy and confidentiality with regard to health.[71] This practice is also contrary to Chilean Penal Code, Article 247 (2) which categorises as crime the acts of anyone who whilst exercising their profession reveals the secrets or confidential information of patients undergoing treatment.[72]

56. Chile also fails to identify any "deliberate, concrete, and targeted" steps it is taking to confront the public health problem of the vast numbers of complications from abortion.

2. Violations of obligations under the convention

57. Chile violates the CESCR in the following ways:

58. Chile has failed to provide for essential primary care, including minimal sexual and reproductive health services.

59. This Committee has recognized that the provision of reproductive and sexual health care, including access to safe abortion, is part of primary health care and that clandestine abortion negatively impacts women's right to health.[73] This Committee has called upon states parties to take measures urgently to reduce maternal mortality rates which directly correlate with high numbers of clandestine abortion and maternal mortality as well as morbidity.[74]

60. In 2001, this Committee urged Nepal, another country like Chile which criminalized all forms of abortion to change its law and make some types of abortion legal (when pregnancies are life threatening or a result of rape or incest).[75] This Committee has also urged states with high numbers of clandestine abortion to undertake more effective reproductive and sexual health programmes in schools and colleges.[76]

61. Other UN human rights treaty bodies, which also exercise jurisdiction over Chile, have similarly recognized that restrictions on access to abortion services negatively

[71] *See* United Nations Fourth World Conference on Women, Beijing Programme, UN DOC A/Conf. 177/20, 17 October 1995 at para. 106 (f).
[72] *See* Chilean Penal Code, Article 247 (2).
[73] *See The Right to the Highest Attainable Standard of Health*, General Comment No. 14, CESCR E/C.12/2000/4. *See also* CESCR Concluding Observations, Mexico, ICESCR, E/2000/22 (1999) 62 at paras. 383, 391, 399,405; Bolivia, ICESCR, E/2002/22 (2001) 52 at paras. 278, 298; Panama, ICESCR, E/2002/22 (2001) 73 at paras. 458, 475.
[74] *See* CESCR Concluding Observations, Bolivia, ICESCR, E/2002/22 (2001) 52 at paras. 278, 298; *See* CESCR Concluding Observations, Panama, ICESCR, E/2002/22 (2001) 73 at paras. 458, 475.
[75] See CESCR Concluding Observations Nepal, ICESCR E/2002/22 (2001) at para. 571. Nepal legalized abortion in 2002, thanks to national and international-level advocacy efforts.
[76] See CESCR Concluding Observations, Senegal, ICESCR, E/2002/22 (2001) 61 at paras. 352, 373.

impact women's human rights under their respective Conventions. For example, the CEDAW Committee, in its *General Comment 24: Women and Health,* has asserted that discriminatory barriers to health care include "laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures."[77]

62. Indeed, in 1995, the CEDAW Committee recommended that Chile revise its criminal abortion laws taking into account the relationship between clandestine abortion and maternal mortality.[78]

63. In l999, the Human Rights Committee (CCPR) recommended, in its Concluding Observations to Chile, that Chile revise its abortion law by establishing some exceptions and by protecting the confidential nature of the medical information. The Committee noted that the absolute criminalization of abortion caused women to seek illegal abortions which put their lives in danger and that the State needs to guarantee the right to life to everyone including pregnant women who decide to terminate their pregnancy.[79]

64. The CCPR has also specifically recommended that other states amend their legislation criminalizing abortion, referring to such legislation as a violation of the right to life. The HRC has repeatedly discussed illegal and unsafe abortion, and the maternal mortality it produces, as a violation of article 6 (right to life) of the ICCPR.[80]

65. The CCPR, in its General Comment 28: Equality of Rights Between Men and Women, has also called upon States parties to report to the Committee any laws or practices that may interfere with women's right to enjoy privacy on the basis of equality with men, including where States compel health professionals and doctors by law to report when women undergo abortion.[81]

66. Chile's criminal abortion laws and polices thus violates article 12. Despite having admitted that illegal abortion threatens the lives and health of many women and constitutes a severe public health problem, women and girls are denied timely access to primary health care services, and facilities, including safe abortion, in violation of the immediate obligation to ensure women a core minimum of essential health services without discrimination and to take steps to remedy the situation.

67. Moreover, for women suffering complications of abortion (both voluntary and spontaneous) many health providers, particularly in the public hospitals, refuse to

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[77] Committee on the Elimination of Discrimination Against Women, *General Recommendation 24: Women and Health* (20th Session 1999), para. 14.
[78] *See* CEDAW, A/50/38 (1995) 35 at para. 158.
[79] Chile, Concluding Observations, 30/03/99, ICCPR/C/79/Add.104. at para. 15.
[80] *See* Concluding Observations, Peru, ICCPR, A/52/40 vol. I (1997) 28 at paras. 160 and 167. *See also* Tanzania, A/53/40 vol. I (1998) 57 at para. 399; Guatemala, A/56/40 vol. I (2001) 93 at para. 85(19).
[81] Human Rights Committee, *General Comment 28: Equality of Rights between Men and Women*, *ICCPR*/C/21/Rev.1/Add.10, General Comment No. 28, 29 March 2000, para. 20.

provide needed health care until the woman admits that she had an abortion. As recognized by the CAT Committee last May, the Chilean public health system inflicts torture and cruel, inhuman or degrading treatment on women by denying treatment to women who need vital health care for life-threatening complications.[82]

68. Public health professionals breach the obligation of confidentiality, under both this Convention and Chilean law, by reporting abortions to police authorities, an essential component of the right to health.[83]

69. Chile has also failed to ensure the right of access to health facilities, goods, and services on non-discriminatory basis, especially with regard to particularly marginalized groups, specifically:

70. Chilean abortion laws discriminate against all women. The criminalization of safe abortion as well as the failure to properly and unconditionally treat complications of abortion discriminate against women because they deny women an essential health service that only women need. [84] Chile has an urgent and immediate obligation to end this discrimination, as women continue to suffer serious physical harm, including death, as a result of the denial of an important health service.

71. Chilean abortion laws discriminate most harshly against poor women. The laws create an impermissible two-tiered system of reproductive and sexual health—one for poor women and another for wealthy women. Wealthy Chilean women attain a higher standard of health because they can afford the high cost, secrecy and protection afforded them by well-paid doctors who perform abortions while maintaining patient confidentiality. Chile also fails to enforce abortion laws against wealthy women because they tend not to visit the public hospital system. Poor women not only have limited access to quality abortion services; they are overwhelmingly the ones deterred from life-saving services as well as convicted and incarcerated under the Chilean abortion laws because they depend primarily on public hospitals. Poor women may never seek treatment for fear of incarceration, and are at a greater risk of suffering dangerous complications which can cause death.[85]

72. Chilean abortion laws discriminate against younger women and girls. Forty (40) percent of the women who have abortions are under the age of 18. Even young women of means, like poor women and girls, have little access to the private health care system when unassisted by or afraid to seek help from parents, and are thus disproportionately denied reproductive health services. Young women are also discriminated against because of Chile's failure to provide contraception to women

[82] *See* para. 24, 25 *supra.*
[83] *See* CESCR General Comment No. 14, at paras. 12(b), 12(c), 23. *See also* CRC *General Comment No. 4,* at para. 39(b), 1 July 2003 (mentioning the right to confidentiality as part of the right to health in the context of adolescents).
[84] *See* CEDAW, Women and Health (Article 12), *General Recommendation 24*, UN GAOR, 1999, Doc. No. A/54/38/ Rev.1
[85] Lagos, Claudia. *Aborto en Chile* [*Abortion in Chile*], LOM ediciones, Santiago, April 2001, p. 100.

before their first pregnancy, despite administrative pronouncements stating that the legal age range for obtaining contraceptives is 15 to 44. [86] The Committee on the Rights of the Child (CRC) recognizes the particularly negative health effects of clandestine abortion on adolescent girls, and recommends that states take measures to reduce maternal mortality rates caused by unsafe abortion practices.[87] The CRC Committee also asserts that States have an obligation that counseling and health services for sexual and reproductive health are available to all adolescents;[88] that adolescents have access to information that is critical for their health and that they are able to participate in decisions impacting their health (including the right to confidentiality);[89] and that adolescents have the opportunity to participate in the planning of their health.[90]

73. Chile's report fails to indicate whether there is a disproportionate effect on rural as opposed to urban women. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood and abortion services, particularly in rural areas.[91] The lack of information prevents the committee from evaluating whether the Chilean health system is discriminatory with respect to geography.

74. Chile's report also fails to indicate whether there is a disproportionate effect on indigenous women, and such a lack of information similarly prevents the committee from evaluating whether the Chilean health system is also discriminatory in this respect.

75. The Chilean government has also violated the Convention's basic principle against retrogressive measures. Since this Committee's last review of Chile in 1988, Chile criminalized all therapeutic abortion in 1989 as well as subjected women who self-perform or seek voluntary abortion to criminal sanction and pursued this draconian law through coercing women seeking treatment for complications to confess as a condition of treatment. This Committee has made clear that deliberately retrogressive measures can be justified only if introduced after "the most careful consideration of all alternatives" and only if justified by reference to the totality of rights and the full use of the State's resources."[92]

76. The failure to take immediate steps to correct this situation constitutes an egregious and continuing violation of the Convention. Recognizing that the government would face opposition to efforts to decriminalize abortion legislatively does not exempt Chile from taking steps to eliminate the consequences of unsafe clandestine abortions as well as to move deliberately and expeditiously toward

[86] *Id*. at p. 53.
[87] *See CRC,* Adolescent health and development in the context of the Convention on the Rights of the Child, General Comment No. 4 (2003), CRC/GC/2003/4 at para. 31, 1 July 2003.
[88] *Id.* at para. 39(c).
[89] *Id.* at para. 39(b).
[90] *Id.* at para. 39(d).
[91] *See* CESCR General Comment No. 14 at para. 12(b).
[92] *Id*. at para. 32, and 48.

decriminalization. Otherwise, the possibility of legislative opposition could be asserted by states parties to undermine the whole range of protected human rights. This Committee has distinguished between a state's *unwillingness* to take steps as opposed to an *inability* based on resources. [93] Chile's failure to take steps is admittedly based on an unwillingness to develop and implement a plan to overcome this opposition to fundamental human rights of women. This failure constitutes a clear violation of the Convention.

77. The government of Chile has the power—as well as the obligation under this and other Conventions to which it has bound itself--immediately to

(1) to utilize its executive and other powers to minimize the impact of the criminal laws;
(2) to develop and implement programs to minimize, to the extent possible, through reproductive and sexual health education and contraceptive services, the exceedingly high rate of abortion; and
(3) to take steps to promote the legislative revision to decriminalize abortion through developing and implementing a plan. The means by which Chile can implement new programmes and policies are outlined in the Part IV Recommendations hereinafter.

78. In other words, it is of the highest urgency that Chile take steps to eliminate this barrier to women's health care created by illegal abortion as statistics show that women are dying and suffering health-destroying complications on an epidemic scale in increasing numbers.

D. PARENTAL LEAVE

1. Factual background

79. En Chile las/os trabajadoras/es tienen derecho a licencia médica[94] en caso de enfermedad grave del hijo o hija menor de un año de edad.[95] Este derecho, llamado conocido como "licencia maternal" fue establecido en el año 1985 para las madres trabajadoras, ampliándose en el año 1993 también a los padres de hijos/as menores de un año. Este derecho ha sido establecido como una forma de asegurar la protección de la maternidad de las mujeres trabajadoras, y a la vez compatibilizar el derecho al trabajo de las mujeres y la protección de la familia.

80. En cuanto a las cifras de participación femenina en la fuerza laboral, existe un sostenido aumento en los últimos años. La tasa de crecimiento de la población económicamente activa femenina fue entre 1992 y 2002 de 4,1%, siendo la masculina 1,6%. La fuerza de trabajo femenina en 1990 correspondía a un 31,7% y en 2002 llega a 35,6%. Este aumento es aún mayor (49,1%) en mujeres entre 25 y

[93] *Id.* at para. 47.
[94] Permiso para ausentarse del trabajo, con derecho a subsidio pagado por el Estado.
[95] Establecido en el Art. 199 del Código del Trabajo.

34 años, grupo que aportaba el 46% de la fecundidad total en 1999 y que además concentra casi la mitad de las cotizantes (48,8%) del sistema de ISAPRE. Lo anterior se refuerza si consideramos que en 1990 una de cada cuatro madres que dio a luz tenía subsidio. En el 2000, la mitad de las madres tenían subsidio, es decir, existe un claro aumento en el porcentaje de mujeres que dan a luz siendo trabajadoras.

i. Facts stated in Chile's report

81. Este materia no fue abordada por el informe de Chile.

ii. Facts not stated in Chile's report

82. En el mes de Octubre de 2003, el Gobierno presentó al Congreso un proyecto de ley "Sobre racionalización de subsidios de incapacidad laboral y licencias médicas"[96], el cual, fundándose en la necesidad de liberar fondos fiscales para destinarlos a seguridad ciudadana y en el supuesto abuso que las madres han hecho de este derecho, pretende restringir las licencias maternales por enfermedad grave de hijos/as menores de un año, en términos que se exige que sea una enfermedad que importe riesgo vital o de grave discapacidad posterior para el niño o niña.[97]

83. La presentación y tramitación parlamentaria de este proyecto, constituye una amenaza de regresividad en materia de derechos económicos, sociales y culturales, vulnerando el principio de progresividad que debe regir en la materia. En efecto, la obligación mínima asumida por el Estado al respecto es la obligación de *no regresividad*, es decir, la prohibición de adoptar políticas y medidas, y por ende, de sancionar normas jurídicas, que empeoren la situación de los derechos económicos, sociales y culturales de los que gozaba la población al momento de adoptado el tratado internacional respectivo, o bien en cada mejora "progresiva"."[98] En el mismo sentido, los Principios de Maastricht consideran violatorias de los derechos económicos, sociales y culturales, "la derogación o suspensión de la legislación

[96] Boletín Legislativo N.º 3398-11. http://www.camara.cl (última visita 09 Noviembre de 2004)

[97] Actualmente el Artículo 199 del Código del Trabajo establece que: "Cuando la salud de un niño menor de un año requiera de atención en el hogar con motivo de enfermedad grave, circunstancia que deberá ser acreditada mediante certificado médico otorgado o ratificado por los servicios que tengan a su cargo la atención médica de los menores, la madre trabajadora tendrá derecho al permiso y subsidio que establece el artículo anterior por el período que el respectivo servicio determine. En el caso que ambos padres sean trabajadores, cualquiera de ellos y a elección de la madre, podrá gozar del permiso y subsidio referidos. (...)." El proyecto de ley en cuestión, modifica el referido artículo, quedando del siguiente tenor: "Cuando la salud de un niño menor de un año requiera atención con motivo de enfermedad grave, debidamente acreditada mediante licencia médica otorgada por el médico tratante, la madre trabajadora tendrá derecho al permiso y al subsidio que establecen el artículo anterior, por el período que se autorice. Para los efectos de este artículo, se entenderá por enfermedad grave del niño menor de un año aquella que ponga en riesgo su vida o que comprometa su crecimiento o desarrollo, al punto de significar un riesgo evidente de minusvalía en las etapas posteriores de su ciclo vital. En ambos casos deberá requerir de cuidados directos y permanentes de la madre o del padre, según correspondiere. (...)."

[98] Abramovich, Víctor y Courtis, Christian. Los derechos sociales como derechos exigibles. Editorial Trotta. Madrid, España. 2002. p. 94.

necesaria para el goce continuo de un derecho económico, social y cultural del que ya se goza" (principio 14 a), "la adopción de legislación o de políticas manifiestamente incompatibles con obligaciones legales preexistentes relativas a esos derechos, salvo que su propósito y efecto sean el de aumentar la igualdad y mejorar la realización de los derechos económicos, sociales y culturales para los grupos más vulnerables" (principio 14 d) y "la adopción de cualquier medida deliberadamente regresiva que reduzca el alcance en que se garantiza el derecho" (principio 14 e).

84. De ser adoptada esta legislación, se verían afectadas gran parte de las mujeres trabajadoras en Chile, ya que son ellas quienes principalmente ejercen este derecho, y dentro de éstas, las mujeres más pobres, en la medida que no cuentan con los ingresos necesarios para pagar por servicios de cuidado de sus hijos/as menores de un año cuando están gravemente enfermos (en tales circunstancias, no son recibidos por las salas cunas o establecimientos dedicados al cuidado de niños/as).

2. Violations of obligations under the Convention

85. La tramitación y eventual aprobación de esta normativa, constituye una clara violación de la obligación de progresividad en materia de derechos económicos, sociales y culturales, reconocido en el Art. 2.1 del Pacto, así como al derecho al trabajo de las mujeres y a la salud de los niños y niñas.

IV. RECOMMENDATIONS

Recommendations with respect to general health situation of women:

86. Chile debiera eliminar la discriminación de que son objeto las mujeres en edad fértil en el sistema privado de salud (ISAPRE), equiparándose sus cotizaciones a las de los varones por el mismo plan de salud, e igualándose los cobros que se les realizan por las mismas prestaciones de salud.

87. El Comité debiera instar a Chile a incluir en sus programas de salud preventiva políticas orientadas directamente a las mujeres, en tanto que tienen un riesgo mayor de contraer enfermedades graves como el VIH-SIDA.

Recommendations with respect to contraception:

88. Chile should make the "anticoncepcion emergencia" ("morning after" pill or emergency contraception) immediately and readily available without a prescription to everyone who seeks it in Chile.

89. The Committee should urge Chile to make the pill immediately available and affordable for all women and for girls without parental authorization.

90. The Committee should urge Chile to immediately promote a public education campaign of reproductive and sexual rights as well as reproductive and sexual health services such as contraception as part of its revision of the abortion laws. As part of this campaign, Chile should promote contraception and emergency contraception in the public and private health sector as well as in schools and in the media.

91. The Committee should urge Chile to widely disseminate the Committee's Concluding Observations to their report as well as General Comment No. 14 which clearly articulates sexual and reproductive health services as part of the right to health with which the State is obliged to comport.

92. The Committee should urge the Government to provide and widely distribute easy to read, multilingual flyers and websites which clearly explain different types of contraception and abortion available and how one can access it in Chile.

Recommendations with respect to abortion:

94. This Committee should urge Chile to take immediate, deliberate, concrete, and targeted steps to remove the legal and practical barriers to the primary health service of abortion and to confidential emergency health care for any complications that result from either voluntary or involuntary abortions as well as to lessen, to the extent possible, the need for abortion. Specifically:

95. The Committee should urge Chile to take immediate steps to ensure that abortion services and other confidential reproductive health care services, such as contraception, counseling and information, are accessible, accurate, comprehensive and affordable as part of primary health care to all women of childbearing age, including adolescents.

96. The Committee should investigate whether Chile has stopped the practice in the public hospitals of obtaining and using confessions of women seeking emergency medical treatment for complications of abortion, as the Committee Against Torture recommended in May 2004. If not, this Committee should call upon the government of Chile to do so immediately and to ensure that all women presenting with complications of abortion be provided humane, emergency treatment in accordance with WHO guidelines.

97. The Committee should urge Chile to advise the medical profession that it deems the treatment of abortion complications to fall within the legal and ethical obligation of confidentiality and to make this change of policy clear to women and girls in all parts of the country.

98. The Committee should urge Chile to exercise prosecutorial discretion and desist from prosecuting women and girls for having abortions as well as those that perform them with consent whether professionals or lay. In this way, women and girls will, at least, be enabled to seek early emergency treatment without fear of prosecution.

99. Further, the Committee should recommend that the government of Chile develop a program to train and equip the lay practitioners to utilise safe and antiseptic practices so as to maximize the safety of abortion procedures, particularly for poor, young, and indigenous women.

100. The Committee should reject Chile's claim of impotence in the face of religious and cultural opposition and insist that Chile develop a plan for legislative reform of its draconian abortion laws. Specifically, the government has at its disposal many means to promote the rights of women and should be urged, at least, to do the following:

(1) investigate and publicize the impact of criminal abortion laws on women's life and health;

(2) educate the public as to the terrible impact of illegal abortion and the futility of stopping it through criminal or other sanction; and

(3) seek the consultation and participation of the many communities—religious, legal, medical, social work, youth, academic, feminist, health, education, and human rights, for example—who support legalization of abortion and protection of women's right to choose and to protect her health;

(4) develop a multi-faceted strategy and plan to address and overcome the discriminatory imposition of the cultural and religious beliefs of one part of the population, thereby depriving women of the right to decide whether to bear a child and, in so many instances, of their lives and health.

101. The Committee should request Chile to provide disaggregated data on abortion complications, treatment and consequences by poverty and economic status, age, rural v. urban, indigenous and other marginalized status.

102. The Committee should urge Chile to immediately develop and implement a public sex education plan and curriculum for use in schools and communities.

103. The Committee should urge Chile to immediately create and implement a curriculum of training in Chile's medical schools in safe abortion procedures as well as emergency treatment of abortion complications.

104. The Committee should urge Chile to report back to the Committee within one year on its compliance with its Recommendations.

Recommendations with respect to parental leave:

105. El Comité debiera instar al Gobierno de Chile a retirar de tramitación parlamentaria el proyecto de ley "Sobre racionalización de subsidios de incapacidad laboral y licencias médicas", por constituir una amenaza de regresión en materia de derechos económicos, sociales y culturales, en particular respecto al derecho al trabajo de las mujeres y el derecho a la salud de los niños y niñas.

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