



THE DANISH
INSTITUTE FOR
HUMAN RIGHTS



UNITED NATIONS
HUMAN RIGHTS
OFFICE OF THE HIGH COMMISSIONER



REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS

A HANDBOOK FOR NATIONAL
HUMAN RIGHTS INSTITUTIONS



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NOTE

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Symbols of the United Nations documents are composed of capital letters combined with figures. Mention of such a figure indicates a reference to a United Nations document.

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LIST OF ABBREVIATIONS

ACHPR	African Charter on Human and Peoples' Rights
ACHR	American Convention on Human Rights
AIDS	Acquired immunodeficiency syndrome
ECHR	European Convention on Human Rights
FBO	Faith-based organization
HIV	Human immunodeficiency virus
HRBA	Human rights-based approach
IACHR	Inter-American Commission on Human Rights
ICPD	International Conference on Population and Development, Cairo 1994
LGBT	Lesbian, gay, bisexual and transgender
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
NGO	Non-governmental organization
NHRI	National human rights institution
OHCHR	Office of the United Nations High Commissioner for Human Rights
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGA	United Nations General Assembly
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UPR	Universal Periodic Review
WHO	World Health Organization



THE ROLE OF THE UNITED NATIONS POPULATION FUND

It is the mission of the United Nations Population Fund (UNFPA), *“to deliver a world where every pregnancy is wanted, every birth is safe and every young person’s potential is fulfilled.”*

UNFPA’s 2014-2017 Strategic Plan furthers this agenda by identifying the agency’s goal to achieve universal access to sexual and reproductive health, secure reproductive rights, and reduce maternal mortality to accelerate progress on the ICPD agenda. UNFPA focuses on improving the lives of adolescents and youth, and women and ensures the integration of human rights,

gender equality and population dynamics in its work. With respect to human rights and gender equality, UNFPA focuses on mainstreaming human rights in sexual and reproductive health programming as well as in strengthening national protection systems for advancing reproductive rights, promoting gender equality and non-discrimination, addressing gender-based violence and enhancing accountability. UNFPA is working in the context of its strategic plan to also develop the capacities of National Human Rights Institutions to monitor and protect reproductive rights.

THE ROLE OF THE OFFICE OF THE UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS

The Office of the United Nations High Commissioner for Human Rights (OHCHR) is mandated to promote and protect the enjoyment and full realization, by all people, of all rights established in the Charter of the United Nations and in international human rights law. It is guided in its work by the mandate provided by the General Assembly in resolution 48/141, the Charter of the United Nations, the Universal Declaration of Human Rights and subsequent human rights instruments, the Vienna Declaration and Programme of Action of the 1993 World Conference on Human Rights, and the 2005 World Summit Outcome Document.

The mandate includes preventing human rights violations, securing respect for all human rights, promoting international cooperation to protect human rights, coordinating related activities throughout the United Nations, and strengthening and streamlining United Nations human rights work. In addition to its mandated responsibilities, it leads efforts to integrate a human rights approach within all work carried out by the United Nations system.

THE ROLE OF THE DANISH INSTITUTE FOR HUMAN RIGHTS

The Danish Institute for Human Rights (DIHR) is Denmark's National Human Rights Institution. It is established by law and mandated to promote and protect human rights and equal treatment in Denmark and internationally. DIHR wishes to set standards and generate change. DIHR bases its international activities on the human rights recognized by the international community. Within Denmark, DIHR is the equality body regarding race, ethnicity and gender and the body monitoring the implementation of the United Nations convention on the rights of persons with disabilities.

The Danish Institute for Human Rights protects and promotes human rights through partnerships with state, civil society, the business community and independent institutions, such as National Human Rights Institutions, as well as in strategic cooperation with international and regional actors, including United Nations organs and the International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights. DIHR works through research, documentation, education, training and communication activities. Currently, DIHR is active in Europe, Africa, the Middle East and Asia.

ACKNOWLEDGEMENTS

The Handbook is a joint publication of UNFPA, OHCHR and the Danish Institute for Human Rights. The concept of and overall coordination for the publication was provided by UNFPA. The Danish Institute for Human Rights developed the Handbook under the direction of Ulrik Spliid and Camilla Silva Fløistrup, with substantive human rights input from OHCHR. The partners wish to extend special thanks to the National Human Rights Institutions of South Africa, Uganda, India and the Bolivarian Republic of Venezuela for their valuable contributions to the Handbook and participation in a validation workshop in New York, in September 2011. National Institutions from these countries, along with Portugal,

El Salvador, Kenya, Namibia, Senegal and Uzbekistan, also provided information on their activities related to reproductive rights. National institutions from the Asia-Pacific region provided valuable insight during and after the Asia-Pacific Forum in Kuala Lumpur, in June 2011.

The partners acknowledge the contributions of peer reviewers appointed through internal quality assurance procedures of UNFPA and OHCHR. Appreciation is also extended to Rajat Khosla and Marilou McPhedran as external reviewers. A special note of thanks goes to Gretchen R. Kail for her thorough editorial review of the publication.

PREFACE

Article 1 of the Charter of the United Nations sets the goal “to achieve international cooperation ... in promoting and encouraging respect for human rights and for fundamental freedoms ...”. As part of this overarching vision, National Human Rights Institutions (NHRIs) are in a unique position to hold governments accountable to their commitment to respect, protect and fulfil reproductive rights as defined in the International Conference on Population and Development (ICPD) Programme of Action and further articulated in international human rights documents, national laws and other consensus documents. Furthermore, NHRIs are uniquely placed to support governments to meet the commitment to integrate the promotion and protection of human rights in their development and cooperation policies, as decided by States in the World Summit Outcome in 2005.

At the Eleventh International Conference of the International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights, which took place in Amman, Jordan from 5-7 November 2012, the Amman Declaration and Programme of Action was adopted.

Through the Programme of Action, NHRIs pledged to:

Protect and promote reproductive rights without any discrimination, recognizing reproductive rights include the right to the highest attainable standard of sexual and reproductive health, the right of all to decide freely and responsibly the number, spacing and timing of their children, and on matters related to their sexuality, and to have the information and means to do so free from discrimination, violence or coercion, as laid out in the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development.

In support of all the above mentioned commitments, this Handbook is intended to equip NHRIs with tools and resources to strengthen their role in promoting and protecting reproductive rights.

INTRODUCTION

“[R]eproductive rights embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.”

Source: International Conference on Population and Development, Programme of Action, Para 7.3

PURPOSE

The purpose of this Handbook is to provide NHRIs with tools and guidance on how to integrate reproductive rights into their work. Each NHRI is as unique as the country in which it has been established but that does not mean that many of the challenges, including within the field of reproductive rights, are not the same or similar for many NHRIs. This Handbook is intended to give an introduction to reproductive rights, both what they mean in practice and their normative background, and how NHRIs can work within this field. Naturally, many NHRIs already work within the reproductive rights field, and a number of experiences from NHRIs have been gathered and are mentioned in the Handbook.

In line with the ICPD Programme of Action, all development should be centred on peoples’ rights. Development should happen, and funds be spent, in a way that not only respects basic tenets of human rights but also furthers their realization, without discrimination, as the ultimate development

objective. Inherent to that understanding is the notion that the recipients of development and public services are not passive recipients of “charity” but are individuals with rights (rights-holders) who should be empowered to demand these from duty-bearers (principally states).¹ This is central in the area of reproductive rights where the importance of empowering rights-holders, particularly women and adolescent girls, cannot be overstated.

The United Nations Common Understanding of a Human Rights-Based Approach (HRBA), reached by consensus among various United Nations agencies in 2003, guides UNFPA’s work, as it does for all United Nations agencies.

¹ For more on HRBA, see: UNFPA. *A Human Rights-Based Approach to Programming*, 2010. OHCHR. *Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation*, 2006. UNFPA. *Rights into Action, UNFPA implements Human Rights-Based Approach*, 2005. HRBA is also the subject of Chapter 3 of this Handbook.

United Nations Statement on a Common Understanding of Human Rights-Based Approach

1. All programmes of development cooperation, policies and technical assistance should **further the realization of human rights** as laid down in the Universal Declaration of Human Rights and other international human rights instruments.
2. **Human rights standards contained in, and principles derived from, the Universal Declaration of Human Rights and other international human rights instruments guide all development cooperation and programming** in all sectors and in all stages of the programming process.
3. Development cooperation contributes to the **development of the capacities of 'duty-bearers' to meet their obligations and/or of 'right-holders' to claim their rights.**

UNFPA also works in accordance with the key elements of cultural sensitivity and gender-responsiveness.²

NHRIs have a clear role and duty in placing all human rights, including reproductive rights, on the agenda and to help ensure that human rights, such as reproductive rights, are not violated and where violated, that offenders do not enjoy impunity.

2 UNFPA- *A Human Rights-Based Approach to Programming*, 2010, p. 70.

Reproductive rights should be an area where NHRIs take charge, help set the public agenda and assist the state in living up to its responsibilities in a way that is transparent, participatory, non-discriminatory, empowering and sustainable.

Naturally, it is not possible to provide all relevant information on reproductive rights in a Handbook of this kind but for NHRIs deciding to work on reproductive rights issues, there are many avenues of assistance. UNFPA works with NHRIs and is available for assistance and cooperation. OHCHR has also been involved in the protection and promotion of reproductive rights and, together with UNDP, has a long and deep experience in working with and assisting NHRIs. These are all relevant partners for NHRIs wishing to work within the field of reproductive rights.

Of course, in this as in all other endeavours it is also relevant for NHRIs to work together. NHRIs should seek assistance from each other and within the International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights. Additionally NHRIs should reach out to the regional networks, being the Asia-Pacific Forum,³ the Network of African National Human Rights Institutions, the Network of National Institutions for the Promotion and Protection of Human Rights on the American Continent and the European Network of National Human Rights Institutions.

3 As mentioned above, the Asia-Pacific Forum has already taken steps in this respect with its 2010-2011 study on Integrating Reproductive Rights into the Work of National Human Rights Institutions of the Asia-Pacific Region in collaboration with UNFPA and the follow up consultation on 20-21 June 2011 in Kuala Lumpur.

BOX 1. A BRIEF SITUATION DESCRIPTION AND KEY FIGURES

Maternal mortality, gender-based violence, lack of access to appropriate health care and an absence of family planning services drive violations of reproductive rights across the world. An estimated 287,000 maternal deaths occurred worldwide in 2010; most of them preventable. However, the aggregate data masks gross inequalities both within and between countries. For instance, the risk of dying during pregnancy, and when giving birth, for a woman in a developing region is 15 times higher than in developed regions. In total, 99% of maternal deaths occur in the developing world, mainly in Africa and South Asia.⁴

In addition, more than 200 million women annually are estimated to experience life-threatening complications in connection with pregnancy, often leading to serious disability.⁵ Three million babies die in the first week of life and even more are stillborn every year.⁶ The main reason behind the large number of preventable maternal deaths, health complications, infant mortality and underpinning the disparities between and within the world's regions, is a lack of quality health care.

Despite an increased focus on voluntary family planning, among other interventions, there are still major lacunae in the availability of contraceptive services, not least in sub-Saharan Africa and certain other developing countries where unmet need is close to 25 per cent while the global average is around 11 per cent.⁷ In absolute figures, more than 120 million women have unmet needs for family planning services.⁸ The affected women are left unable to decide freely on whether to have children and the number and timing of child bearing, and in addition are rendered more at risk of contracting HIV/AIDS and other sexually transmitted infections (STIs).

4 *Trends in Maternal Mortality, 1990 to 2008*, WHO, UNICEF, UNFPA and World Bank, 2010.

5 World Health Organization, Journal Paper. The Lancet: Anna Glasier, A. Metin Gülmezoglu, George P Schmid, Claudia Garcia Moreno, Paul FA Van Look. "Sexual and reproductive health: a matter of life and death." The Lancet Sexual and Reproductive Health Series, October 2006.

6 WHO, "Making Pregnancy Safer", In: Maternal and New Born Health Topics. Available from: http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/index.html

7 Calculated as the percentage of women between 15 and 49 years of age not using contraception, either married or in another form of domestic union, who are fecund and sexually active and who do not want any more children or would like to delay the birth of their next child for at least two years, statistics taken from "How Universal is Access to Reproductive Health, A review of the evidence" (UNFPA, 2010).

8 United Nations. Millennium Development Goals Report, 2011. Available from www.un.org/millenniumgoals/11_MDG%20Report_EN.pdf.

BOX 1. A BRIEF SITUATION DESCRIPTION AND KEY FIGURES (CONT.)

Lack of access to family planning services also increases the rate of abortions, including unsafe abortions. Of the estimated 80 million unwanted or unintended pregnancies each year, an estimated 45 million are terminated. Of these 45 million abortions, 19 million are unsafe with 40 per cent done on women below 25 years of age. About 68, 000 women die every year from complications of unsafe abortion.⁹

Other surveys show that the poorer an adolescent girl (aged between 15 and 19 years of age) is and the less access she has to education, the more likely she is to become pregnant: an adolescent girl without formal education is more than four times as likely to become pregnant than an adolescent girl with secondary education.¹⁰ This not only reflects the human cost paid when information on and access to family planning is insufficient; it also illustrates a world in which adolescent girls are forced or otherwise coerced into sex and/or marriage. Child, early and forced marriages (and early unions without marriage) are among the many harmful practices affecting young girls, primarily in the developing world. These violations of reproductive rights – childbirth before physical and mental readiness – a common consequence of early marriages, can lead to obstetric fistula and other detrimental health consequences for both babies and mothers. Additionally, surveys show that adolescent mothers are much less likely to have access to education than adolescent girls not affected by motherhood.¹¹

The international community has acknowledged that maternal mortality is primarily a human rights challenge and a social justice issue. Maternal mortality and infant death are avoidable in the overwhelming majority of cases and States have a positive obligation to prevent them.¹² The Human Rights Council in 2012 adopted a Technical Guidance on a Human Rights-Based Approach to Policies and Programmes on preventable maternal mortality and morbidity to ensure a more integral response to this critical human rights and development challenge¹³ and to ensure remedies in case of human rights abuses. For instance, the adoption or perpetuation of legal barriers preventing women and men from accessing family planning services is a violation of their right to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. Similarly, it is a violation of the right

9 World Health Organization, Journal Paper. The Lancet: Anna Glasier, A Metin Gülmezoglu, George P Schmid, Claudia Garcia Moreno, Paul FA Van Look. "Sexual and reproductive health: a matter of life and death." The Lancet Sexual and Reproductive Health Series, October 2006.

10 Statistics for sub-Saharan Africa from UNFPA. "How Universal is Access to Reproductive Health: A review of the evidence", 2010.

11 See UNFPA. *Giving girls today and tomorrow, Breaking the cycle of adolescent pregnancy*, 2007.

12 As acknowledged by the Human Rights Council in resolutions A/HRC/RES/21/6, A/HRC/RES/18/2, A/HRC/RES/15/17 and A/HRC/RES/11/8.

13 Report of the Office of the High Commissioner on preventable maternal mortality and morbidity, UN Doc. A/HRC/14/39.

BOX 1. A BRIEF SITUATION DESCRIPTION AND KEY FIGURES (CONT.)

to be free from harmful practices and the right to make decisions concerning reproduction free of discrimination, coercion and violence when adolescent girls become pregnant because they are forced into early marriages. Family planning, on the other hand, allows potential parents to focus on the future. When individuals and couples can plan when and whether to have children, they can focus on both their own education and that of their children.

Gender-based violence is a profound abuse of human rights that also affects the enjoyment of reproductive rights. It undermines women's sexual and reproductive autonomy and jeopardizes their physical and mental health. It increases the risks of unwanted pregnancies, STIs and adverse pregnancy outcomes. Put simply, gender equality is not possible if women are not able to exercise control over their bodies while substandard maternal and infant health services cost individuals, families and societies fortunes every year.

Improvement of reproductive and sexual health goes far beyond the right to life and the right to health of women and girls. It directly affects equitable and sustainable development, the attainment of various Millennium Development Goals, including the goal of poverty reduction.¹⁴



14 Cf. Principles 4-6 and the Objective (Section 3.16) of the 1994 Program of Action of the International Conference on Population and Development (ICPD), and Section 57 (g) of the 2005 World Summit Outcome. For a complete account, see UNFPA. *Sexual and Reproductive Health for All, Reducing poverty, advancing development and protecting human rights* 2010.

KEY DEFINITIONS

The following are key definitions in relation to sexual and reproductive health and reproductive rights consistent with the ICPD Programme of Action, the Beijing Platform for Action and other international sources.

Reproductive Health	Reproductive Health is a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are: the rights of men and women to be informed, have access to safe, effective, affordable and acceptable methods of family planning including methods for regulation of fertility, which are not against the law; and the right of access to appropriate health care services to enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant. ¹⁵ Reproductive health is a component of reproductive rights, see below.
Reproductive Health Care	Reproductive Health Care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. Reproductive health care includes care for sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases. ¹⁶

¹⁵ International Conference on Population and Development (ICPD), Program of Action, UN Doc. A/CONF.171/13 1994, chap. 7.A.

¹⁶ Ibid, chap. 7.A.

<p>Reproductive Rights</p>	<p>Reproductive Rights embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.¹⁷</p>
<p>Respect for bodily integrity</p>	<p>The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the bodily integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.¹⁸</p>
<p>Sexual Health</p>	<p>Sexual Health deals with the enhancement of life and personal relations, not merely counselling and care related to reproduction and sexually transmitted diseases.¹⁹ It refers to the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love.²⁰ Sexual health is a component of reproductive rights, see above.</p>

17 Ibid, para. 7.3.

18 Beijing Declaration and Platform for Action (5) 1995.

19 ICPD, UN Doc. A/CONF.171/13 1994, para 7.3.

20 WHO. "Defining sexual health: Report of a technical consultation on sexual health. 28-31 January 2002, Geneva.



OVERVIEW

The outline of this Handbook is as follows:

Chapter 1: Promoting the Reproductive Rights Agenda – an overview of the meaning of sexual and reproductive health together with a summary of the main global commitments

Chapter 2: The National Human Rights Institution Mandate – how NHRIs can advance reproductive rights under their mandate

Chapter 3: Promoting a Human Rights-Based Approach to Reproductive Health – how a human rights-based approach can be utilized for the advancement of reproductive rights

Chapter 4: Reproductive Rights and Human Rights Standards and Principles – the normative human rights basis for what is understood as reproductive rights

A list of publications for further reading can be found preceding the annexes. The annexes contain information on United Nations Treaty Bodies and their practice, as well as an overview of the experiences of regional bodies and NHRIs.

1

PROMOTING THE REPRODUCTIVE RIGHTS AGENDA

REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS

There is no single human rights instrument dedicated to reproductive rights. Rather, the main United Nations and regional human rights instruments protect the various elements of reproductive rights. Various declarations and similar documents adopted by consensus by practically all of the world's nations and further developed in the practice of the United Nations and regional human rights bodies confirm the diverse and rich nature of reproductive rights.

According to Paragraph 7.3 of the International Conference on Population and Development (ICPD) Programme of Action, reproductive rights are based on the right of couples and individuals to decide free from discrimination, coercion and violence whether to have children, how often and when to do so, having the necessary information and means to make such decisions. It is also connected with their right to the highest attainable standard of sexual and reproductive health.

ICPD makes it clear that reproductive rights are not a new set of rights. Reproductive rights are a constellation of freedoms and entitlements that are already recognized in national laws, international human rights instruments and other consensus documents. Reproductive rights refer to a diversity of civil, political, economic, social and cultural rights affecting the sexual and reproductive life of individuals and couples. The various legal elements that together constitute reproductive rights are set out in detail in Chapter 4 below.

An important international instrument is the Convention on the Elimination of All Forms of Discrimination against Women which obligates the states parties to ensure “access to health care services, including those related to family planning” and mentions appropriate services in connection with pregnancy and the right to decide on the number and spacing of children (Articles 12 and 16). The general right to the highest attainable standard of health is protected by the International Covenant on Economic, Social and Cultural Rights (Article 12). Discrimination against women is prohibited by the Convention on the Elimination of All Forms of Discrimination against Women, the International Covenant on Economic, Social and Cultural Rights and several other global and regional instruments.

The Convention on the Rights of the Child also protects children's right to the highest attainable standard of health (Article 24). The Convention on the Rights of Persons with Disabilities specifically mentions the right of persons with disabilities to sexual and reproductive health (Article 25). The high level of preventable maternal mortality further violates the right to life, set out in the International Covenant on Civil and Political Rights (Article 6). An example of a very clear regional provision is Article 14 in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, which specifically refers to the right to sexual and reproductive health.

The United Nations Treaty Bodies, established to monitor the implementation of the respective treaties and offer authoritative interpretations of their provisions, have recognized reproductive rights as legally binding and have in that respect addressed the various elements of reproductive rights as presented in Chapter 4 below and further documented in Annex 1. The Committee on the Rights of the Child, the Human Rights Committee (that monitors implementation of the International Covenant on Civil and Political Rights), the Committee on Economic, Social and Cultural Rights and, to a lesser extent, the Committee against Torture and the Committee on the Elimination of Racial Discrimination have all made statements on various aspects of reproductive rights. The Inter-American Commission on Human Rights and the African Commission on Human and Peoples' Rights have recognized reproductive rights as human rights. In addition, the European Court of Human Rights has made various decisions on matters relating to reproductive rights, including finding that the right to private life incorporates the right to respect for the decisions both to become and not to become a parent.¹

Finally, United Nations member states have adopted by consensus a number of

1 Judgment by the Grand Chamber of the European Court of Justice, *Evans vs. the UK* 6339/05, (10 April 2007), para. 71.

documents on reproductive rights as human rights. The most important such document, the 1994 ICPD, mentioned above, was adopted by consensus, albeit with a number of reservations, and later endorsed by the United Nations General Assembly.² Another important document, also adopted by consensus and endorsed by the United Nations General Assembly,³ is the Beijing Declaration and Platform for Action, adopted in 1995 at the Fourth World Conference on Women. Furthermore, the 2005 World Summit Outcome, adopted by the United Nations General Assembly in 2005,⁴ and the commitment to both sexual and reproductive health in the outcome document of the 2010 United Nations Summit on the Millennium Development Goals, adopted by the United Nations General Assembly in 2010,⁵ further confirmed the commitment to reproductive health. In June 2012, the United Nations reaffirmed its commitment to reproductive rights in the United Nations Conference on Sustainable Development, Rio+20.⁶

2 United Nations General Assembly Resolution A/RES/49/128.

3 United Nations General Assembly Resolution A/RES/50/203.

4 United Nations General Assembly Resolution A/RES/60/1.

5 United Nations General Assembly Resolution A/RES/65/1.

6 UN Doc. A/CONF.216/16.

EXAMPLES OF KEY PRACTICAL ELEMENTS OF REPRODUCTIVE RIGHTS

The aforementioned definition of reproductive rights in paragraph 7.3 of the ICPD Programme of Action establishes three

main elements. The first guarantees all couples and individuals the right to decide freely and responsibly the number, spacing

and timing of their children and to have the information and means to do so. In practice, this means that everyone should have access to contraception and to the necessary information on reproductive health issues. Contraception and the necessary information should also be available to marginalized groups, meaning that it should be available both in towns and in rural areas and for all women and men, adults and adolescents. Information should be available in all relevant languages and in age- and gender-appropriate forms.

Marriage and childbearing are closely connected in most cultures. Consequently, the right to decide freely the number, spacing and timing of children also includes the right not to be married before reaching adulthood and the right not to be forced to marry. The proper legislation should be in place and implemented and necessary sensitization should take place.

The second part of the definition guarantees the right to attain the highest standard of sexual and reproductive health. Sexual and reproductive health is concerned not only with issues related to child bearing but also securing a safe and satisfying sex life. The right to the highest standard of sexual and reproductive health contains the access to a comprehensive package of health services including voluntary family planning, abortion where it is not against the law, post-abortion care, ante- and post-natal care, both for mother and for child, and to prevention and treatment for sexually transmitted infections (STIs), including HIV/AIDS. As set out above, such services must be truly available to all, including marginalized and vulnerable groups who are also the groups most likely to have reproductive health threatened.

Consequently, sexual and reproductive health services cannot be offered only in the main population centres but must be made available also in rural and underserved areas.

The last part of the definition guarantees the right to make decisions concerning reproduction free of discrimination, coercion and violence. In addition to what has already been set out, this means that persons with disabilities, ethnic minorities and other groups in situation of vulnerability or exclusion are entitled to the same sexual and reproductive health services as all other groups. In certain countries, persons with disabilities have been subject to sterilization without their free, prior and informed consent; the same has been the case for ethnic minorities. In many places, lesbian, gay, bisexual and transgender (LGBT) persons are provided access to sexual and reproductive health services; this is clearly a manifestation of discrimination. The right not to be subject to harmful practices such as female genital mutilation (FGM), child, early or forced marriage is an additional protection against violence and coercion affecting the girl child. The state must ensure that no one is coerced into entering into marriage, bearing of children or sexual relations, including with their spouse. This for example necessitates implementing provisions on minimum age for marriage and criminalizing marital rape. Gender-based violence also has the potential to curtail the free choice of in particular women. Studies have shown a close link between domestic violence and lack of enjoyment of reproductive rights; this means that provisions should be in place to combat this scourge.

See Chapter 2 for specific guidance on the role of NHRIs in furthering reproductive rights.

UNDERSTANDING SEXUAL AND REPRODUCTIVE HEALTH

Reproductive healthcare is defined as the constellation of methods, techniques, services, goods and facilities that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.⁷

Sexual health and reproductive health overlap and, in addition to supporting physiological functions such as pregnancy and childbirth, aim to reduce adverse outcomes of sexual activity and reproduction. They are also about enabling people of all ages, including adolescents and those older than the reproductive years, to have safe and satisfying sexual relationships by tackling obstacles such as gender discrimination, inequalities in access to health services,

restrictive laws, sexual coercion, exploitation, and gender-based violence.

According to the World Health Organization (WHO), sexual and reproductive health involves five key components, namely:

- Ensuring contraceptive choice and safety and infertility services;
- Improving maternal and new born health;
- Reducing sexually transmitted infections, including HIV, and other reproductive morbidities;
- Eliminating unsafe abortion and providing post-abortion care; and
- Promoting healthy sexuality, including adolescent health, and reducing harmful practices.⁸

7 International Conference on Population and Development, 1994 Program of Action (United Nations, 1995).

8 UNFPA. *Sexual and Reproductive Health for All*. 2010.

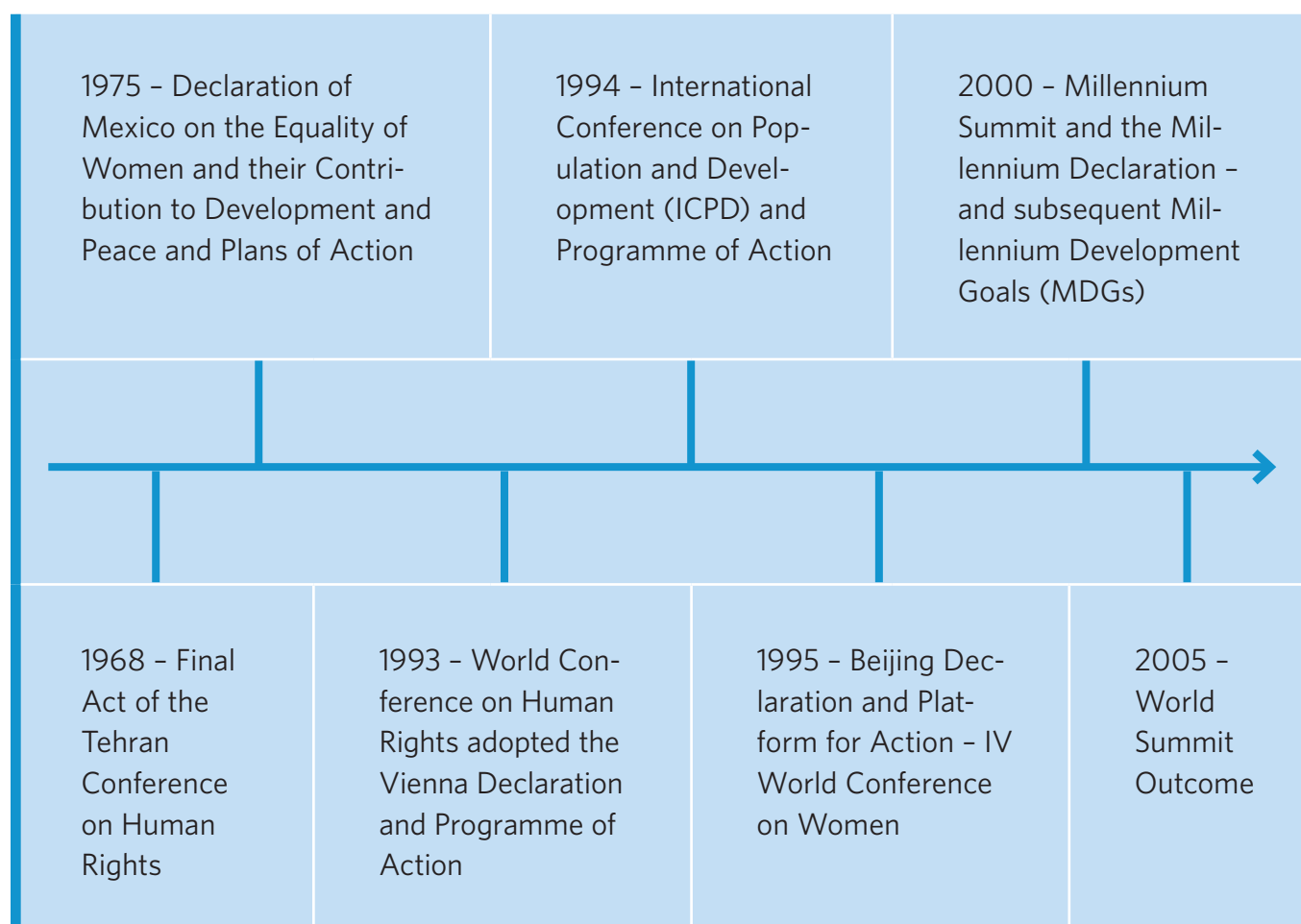
INTERNATIONAL COMMITMENTS – A HISTORICAL OVERVIEW

Before the 1990's, issues related to reproductive health focused on controlling women's fertility in order to diminish population growth and not much more than that. Health was the key entry point and rather than reproductive wellbeing more broadly. This is no longer the case. Several consensus documents explaining the relationship between human rights and sexual and

reproductive health have been developed; some examples are as follows:

The first document to formally embed reproductive rights within human rights was the 1968 Final Act of the Tehran Conference on Human Rights,⁹ which states in

9 UN Doc. A/CONF. 32/41.



section 16 *"Parents have a basic human right to decide freely and responsibly on the number and spacing of children and a right to adequate education and information in this respect"*. The General Assembly endorsed the Final Act in December 1968.¹⁰

The 1975 Declaration of Mexico on the Equality of Women and their Contribution to Development and Peace confirms the principle of equal rights within the family and the principle of inviolability of the human body as per Principle 12, *"[e]very couple and every individual has the right to decide freely and responsibly whether or not to have children as well as to determine their number and spacing,*

and to have the information, education and means to do so".¹¹

In 1993, the World Conference on Human Rights adopted the Vienna Declaration and Programme of Action, another document signalling a worldwide consensus on the right to sexual and reproductive health. Section 3 of the Programme of Action¹² deals with women's rights and their right to accessible and adequate health care and the widest range of family planning services, as well as equal access to education at all levels, including sexuality education.

¹⁰ UNGA Resolution 2442 (XXIII).

¹¹ UN Doc. E/CONF. 66/34.

¹² UNGA Resolution A/RES/48/121.

BOX 2. MEN AND REPRODUCTIVE RIGHTS

The focus of reproductive rights has been on protecting the reproductive rights of women, and reproductive rights are part of women's rights. For biological and social reasons women are more directly affected than men by decisions with respect to reproduction; decisions which in turn are shaped by issues related to gender equality, stereotypical gender roles and the role of women in society more broadly. Reproductive rights matters are crucially important to women as they affect women's mental and physical integrity, their health and sexual autonomy, *"their ability to enter and end relationships, their education and job training, their ability to provide for their families, and their ability to negotiate work-family conflicts in institutions organized on the basis of traditional sex-role assumptions"*.¹³

Nonetheless, men too should be involved in sexual and reproductive health programmes. *"Men's general knowledge and attitudes concerning the ideal family size, gender preference of children, ideal spacing between child births, and contraceptive method use greatly influence women's preferences and opinions"*.¹⁴ Only in societies where men and women have equal rights and responsibilities will reproductive rights be equally shared by all.

The non-involvement of men and boys in matters related to reproductive rights contributes to *"the poor preparation of men for adulthood, contraceptive use, and safe sex"*.¹⁵ As men are usually responsible for the decision making processes within families, including with regard to reproduction, family size and contraception use, involving men can assist in the process of empowering women.

Men have a stake in reproductive rights through their multiple roles as sexual partners, husbands, fathers, family and household members, community leaders and gatekeepers to health information and services. In addition, not all men live in traditional families but still have needs related to their sexual and reproductive health. To be effective, reproductive health programmes need to address men's behaviour in these various roles as well as their reproductive rights needs simply as human beings. Involving men can:

13 Siegal, Reva B., *"Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression"*. (2007) Faculty Scholarship Series. Paper 1137.

14 Macellina Y Ijadunola, Titilayo C Abiona, Kayode T Ijadunola, Olusegun T Afolabi, Olapeju A Esimai and Funmilola M Ola Olorun, *"Male Involvement in Family Planning Decision Making in Ile-Ife, Osun State, Nigeria"* (2010) African Journal of Reproductive Health, December; 14 (4).

15 Kumar, Anant, *"Role of Males in Reproductive and Sexual Health Decisions"* (2007), The Bihar Times.

BOX 2. MEN AND REPRODUCTIVE RIGHTS (CONT.)

- Enhance equity and gender equality;
- Share the burden of preventing diseases and health complications;
- Promote satisfying sexual lives for men and women;
- Inform men and women about male and female anatomy, contraception, STIs and HIV/AIDS prevention and women's health care needs during pregnancy and childbirth.¹⁶

Men's sexual and reproductive health must also be addressed by focusing on:

- Uro-genital infections;
- STIs;
- Infertility and erectile dysfunction; and
- Prostate and testicular cancer.¹⁷

The 1994 International Conference on Population and Development (ICPD) in Cairo placed reproductive rights on the global agenda. Its Programme of Action clearly affirmed and articulated that reproductive and sexual health is protected by the human rights already recognized by both national and international law. In addition, the Programme of Action contributed to the recognition of the complex links between population growth and gender equality. The generally acknowledged definition of reproductive rights is taken from the ICPD Programme of Action.

16 Examples of initiatives targeting the attitudes of men and boys with respect to gender roles etc. can be found in Plan International. *"Because I am a Girl: the State of the World's Girls"* 2011.

17 UNFPA, *Male Involvement in Reproductive Health*,

In 1995, the Fourth World Conference on Women took place in Beijing.¹⁸ The Beijing Declaration and Platform for Action, adopted at the Conference, among other things highlights the right to equal access to and equal treatment of women and men in education and health care and the enhancement of women's sexual and reproductive health as well as education. Both the ICPD Programme of Action and the Beijing Declaration and Platform for Action show that alongside health and health care, education is a crucial tool in promoting and protecting reproductive rights.

Including Family Planning and Sexual Health. Technical Report No. 28, 1995.

18 United Nations General Assembly Resolution A/RES/50/203.

At the Millennium Summit in September 2000, all the then 189 members of the United Nations adopted the United Nations Millennium Declaration.¹⁹ Based on the Millennium Declaration, primarily Section III on development and poverty eradication, the eight Millennium Development Goals (MDGs) were established.

Four out of eight MDGs relate to reproductive and sexual health and rights. MDG 5 concerns maternal health and contains two targets:

- a) to reduce the maternal mortality ratio by three quarters between 1990 and 2015 and
- b) to achieve universal access to reproductive health by 2015.²⁰ MDG 4 is to reduce the mortality of children under five with two thirds between 1990 and 2015. MDG 3 deals with promoting gender equality and empowerment of women. Finally, MDG 6 concerns the combat of HIV/AIDS, malaria and other diseases. Based on current data, MDG 5 is considered the least likely of all the MDGs to be achieved within the timeline set.²¹

The World Summit in 2005 was a follow up to the Millennium Summit in 2000. The 2005 World Summit Outcome²² confirms the commitment to the Millennium Declaration and reiterates the “*determination to ensure the timely and full realization of the ... Millennium Development Goals*”. In addition, the World Summit Outcome contains new commitments, four of which became part of the revised MDGs during 2006-2007. One is the achievement of universal access to reproductive health by 2015 (that became an addition to MDG 5); another is universal access to HIV/AIDS treatment by 2010 (that became an addition to MDG 6).

As mentioned above in Chapter 1, these international declarations and statements are underpinned by binding human rights instruments that contain the specific standards of reproductive rights. This will be further elaborated in Chapter 4.

19 United Nations General Assembly Resolution A/55/L.2.

20 This latter element of MDG 5 was only agreed to at the World Summit in 2005.

21 According to Francesca Perucci, chief of the Statistical Planning and Development Section, UN DESA, MDG 5 has seen the least progress and is the least likely to be achieved, cf. <http://www.endpoverty2015.org/es/node/576>.

22 UNGA Resolution A/RES/60/1.

BOX 3. HIV/AIDS AND REPRODUCTIVE RIGHTS

HIV and AIDS are critical aspects of the sexual and reproductive health and rights challenge, and access to quality sexual and reproductive healthcare services is crucial for women and men living with HIV and AIDS. Sexual and reproductive health services are also vital for prevention of new HIV infections. Some 80% of HIV cases globally are transmitted sexually and a further 10% are transmitted during pregnancy, labour and delivery, or through breast-feeding. Sexual and reproductive health (SRH) programmes can make an important contribution to HIV prevention, treatment, care and support, and SRH services are important for those living with HIV and AIDS.²³

The following measures should be taken for HIV and AIDS prevention:

- Voluntary counselling and testing for HIV should be available;
- Sexual behaviour should be influenced through education on risk reduction strategies and provision of the skills and means to negotiate and practice safer sex;
- Comprehensive sexuality education should cover adolescents in and out of school settings, with a particular focus on addressing the information needs of adolescent girls who often carry the burden of new transmissions and deaths;
- Male and female condoms for both family planning and prophylactic reasons should be provided;
- Family planning, antenatal, delivery and post-partum care and STI services should be expanded;
- Condoms should be promoted as a primary form of protection and the importance of dual protection to avoid unwanted pregnancy and STIs should be stressed;
- Anti-retroviral drugs (HIV medicine), on the WHO Model List of Essential Medicines, should be made available to persons infected with HIV.

23 Berer, Marge. "HIV/AIDS, sexual and reproductive health: intersections and implications for national programmes", *Health Policy and Planning* 19, Suppl. 1, (Oxford University Press, 2004).

BOX 3. HIV/AIDS AND REPRODUCTIVE RIGHTS (CONT.)

It is also relevant that family planning and contraceptive services focus on use of condoms. Both men and women must be educated in relation to the importance of condoms not only for the prevention of pregnancy, but also, and most importantly, as an efficient way to prevent the transmission of STIs and HIV. Additionally, it is important that married women are included in HIV/AIDS prevention initiatives along with other groups of women, who have often been marginalized by these kinds of initiatives, such as young single women, migrant and refugee women, injection drug users and women selling or trading sex for money and support.

Special focus should be on female sex workers, as they often have high rates of STIs and are at high risk of violence. These infections and frequent unprotected sexual exposure put women in prostitution, their clients and other partners, and their clients' partners all at high risk of acquiring HIV/STIs. Other groups that might be in high risk with respect to HIV/STIs are male homosexuals, especially in countries where the LGBT community is marginalized due to legislation, attitudes etc.; this should be taken into account when designing HIV/AIDS policies. Men in prostitution are also a group of risk.

Pregnancy-related care – before, during and after delivery – is an obvious place to situate attention to HIV and AIDS testing and counselling, prevention and treatment services and information for both women and infants. It is crucial to invest in drugs that prevent vertical transmission (mother to child transmission). This has helped prevent the infection of many infants but there is still a lot to be done, such as addressing the issue in rural areas and investing in births assisted by a healthcare professional.

Whereas preventing transmission of HIV/AIDS is naturally a key element of securing the sexual and reproductive health and rights of the population, it is also important to keep in mind the reproductive rights of persons who are already infected. Legislation and policies should be in place to secure that infected persons are not discriminated against, and infected persons should be secured access to all reproductive and sexual health care services. In countries where the state provides fertility services, such services should in general also be offered to persons infected with HIV/AIDS.²⁴

24 See also, OHCHR and UNAIDS, *Handbook on HIV and Human Rights for National Human Rights Institutions*. (2007).

2

THE NATIONAL HUMAN RIGHTS INSTITUTION MANDATE

NHRIs are very different when it comes to legislative basis, powers and structure but they are all supposed to adhere to the Paris Principles, adopted in 1991, approved by the United Nations General Assembly in 1993 and being the universally accepted framework for NHRIs. The Paris Principles set out in detailed form the minimum mandate for NHRIs.¹ In addition to the mandatory tasks, NHRIs may be given the authority to hear and consider complaints in individual cases. In many countries, this is considered the most important part of their work.

NHRIs are supposed to play a key role in both the promotion and the protection of human rights in their respective countries. As has been set out above, reproductive rights as defined primarily in the ICPD Programme of Action are human rights; the various elements are protected by both the main global and the main regional human rights instruments. In consequence, NHRIs have an important role to play in the promotion and protection of reproductive

¹ Accordingly, an NHRI shall have the responsibilities, cf. Section A of the Paris Principles:

- “a) To submit to the government, parliament and any other competent body, on an advisory basis either at the request of the authorities concerned or through the exercise of its power to hear a matter without higher referral, opinions, recommendations, proposals and reports on any matters concerning the protection and promotion of human rights. The national institution may decide to publicize them. These opinions, recommendations, proposals and reports, as well as any prerogative of the national institution, shall relate to the following areas:*
- i) Any legislative or administrative provisions, as well as provisions relating to judicial organization, intended to preserve and extend the protection of human rights. In that connection, the national institution shall examine the legislation and administrative provisions in force, as well as bills and proposals, and shall make such recommendations as it deems appropriate in order to ensure that these provisions conform to the fundamental principles of human rights. It shall, if necessary, recommend the adoption of new legislation, the amendment of legislation in force and the adoption or amendment of administrative measures;*
 - ii) Any situation of violation of human rights which it decides to take up;*
 - iii) The preparation of reports on the national situation with regard to human rights in general, and on more specific matters;*
 - iv) Drawing the attention of the government to situations in any part of the country where human rights are violated and making proposals to it for initiatives to put an end to such situations and, where necessary, expressing an opinion on the positions and reactions of the government;*
- b) To promote and ensure the harmonization of national legislation, regulations and practices with the international human rights instruments to which the State is a party, and their effective implementation;*
- c) To encourage ratification of the above-mentioned instruments or accession to those instruments, and to ensure their implementation;*
- d) To contribute to the reports which States are required to submit to United Nations bodies and committees, and to regional institutions, pursuant to their treaty obligations, and, where necessary, to express an opinion on the subject, with due respect for their independence;*
- e) To cooperate with the United Nations and any other agency in the United Nations system, the regional institutions and the national institutions of other countries which are competent in the areas of the protection and promotion of human rights;*
- f) To assist in the formulation of programmes for the teaching of, and research into, human rights and to take part in their execution in schools, universities and professional circles;*
- g) To publicize human rights and efforts to combat all forms of discrimination, in particular racial discrimination, by increasing public awareness, especially through information and education and by making use of all press organs.”*

rights. Not only can NHRIs take numerous steps to further reproductive rights; due to their constitutional or legislative mandate and their official role in protecting and promoting human rights, they can also help establish the normative basis for

reproductive rights in a different way than civil society. NHRIs can unequivocally confirm that reproductive rights are enforceable freedoms and entitlements which all persons can claim.



BOX 4. NHRIS' COMMITMENTS TO REPRODUCTIVE RIGHTS: THE AMMAN DECLARATION AND PROGRAMME OF ACTION

The Eleventh International Conference of the International Coordinating Committee (ICC) of National Institutions for the Promotion and Protection of Human Rights took place in Amman, Jordan, 5-7 November 2012. The focus of the Conference was "The human rights of women and girls: Promoting gender equality: The role of national human rights institutions." At the Conference, participants affirmed that women's and girls' rights are human rights, which are guaranteed in all human rights treaties.

The Amman Declaration and Programme of Action includes a section of commitments with regard to Women's Health and Reproductive Rights, as follows:

- Paragraph 25: Protect and promote reproductive rights without any discrimination, recognizing reproductive rights include the right to the highest attainable standard of sexual and reproductive health, the right of all to decide freely and responsibly the number, spacing and timing of their children, and on matters related to their sexuality, and to have the information and means to do so free from discrimination, violence or coercion, as laid out in the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development;
- Paragraph 26: Encourage and aid the compilation of an evidence base (e.g. data, inquiries, research) concerning the exercise of reproductive rights and the right to sexual and reproductive health, including but not limited to cases of *de jure* and *de facto* discrimination in access to sexual and reproductive health care information and services, forced sterilization, forced abortion, child marriage, forced marriage, female genital mutilation/cutting, biased sex selection and other harmful practices;
- Paragraph 27: Review national laws and administrative regulations relating to reproductive rights such as those governing family, sexual and reproductive health, including laws which are discriminatory or criminalize access to sexual and reproductive health services, and propose recommendations to assist States in meeting their human rights obligations; and
- Paragraph 28: Promote measures to ensure access to comprehensive sexual and reproductive health information and services and to remove barriers which hinder such access, and support the establishment of accountability mechanisms for the effective application of the laws and the provision of remedies when obligations have been breached.

BOX 4. NHRIS' COMMITMENTS TO REPRODUCTIVE RIGHTS: THE AMMAN DECLARATION AND PROGRAMME OF ACTION (CONT.)

Additionally, the Amman Declaration and Programme of Action contains the following broad principles and areas of work for NHRIs of relevance to reproductive rights:

- Principle 4: Respond to, conduct inquiries into and investigate allegations of violations of women's and girls' human rights, including...violations of reproductive rights... These investigations and reports should result in recommendations to the State to meet their obligations to ensure women's and girls' human rights, and to combat impunity;
- Principle 9: Monitor and encourage the implementation of ...resolutions of United Nations intergovernmental bodies, including the General Assembly, Human Rights Council, Commission on the Status of Women (CSW) and the Commission on Population and Development (CPD);
- Principle 11: Forge strategic partnerships with United Nations agencies such as UN Women, UNDP, UNICEF, UNFPA, and OHCHR to strengthen cooperation with, and the capacities of, NHRIs to more effectively promote and protect women's and girls' human rights; and
- Principle 16: Prioritize and promote the human rights of women and girls and gender equality through their engagement with all international and regional human rights mechanisms, and in their engagement with global processes such as ... the ICPD Beyond 2014 Global Review.

Regarding this last principle and area of work, NHRIs have engaged actively in various stages of the ICPD beyond 2014 Global Review, including the International Conference on Human Rights held in the Netherlands in July 2013. Echoing the commitments made by the ICC of NHRIs in Amman, the Human Rights Conference recommended the strengthening of NHRIs and ombudspersons to inquire broadly into sexual and reproductive rights issues, including investigating individual complaints; making recommendations directly to governments on alleged human rights violations; and reviewing national laws and policies relating to sexual and reproductive rights, including those which are discriminatory or criminalize access to sexual and reproductive health information, education and services.

AFGHAN INDEPENDENT HUMAN RIGHTS COMMISSION

SUPPORT IN CHANGING LEGISLATION

In Afghanistan, violence against women is a major obstacle to effective realization of reproductive rights. The Afghan Independent Human Rights Commission has prioritized this issue. In 2008, the Commission worked closely with the government in drafting a new law on violence against women. The law has been finalized and is now in force. The Office of the Attorney General established a new department dedicated to issues of violence against women which now operates in several provinces.

ASSESSING WORKPLACE POLICIES AND BUILDING THE REPRODUCTIVE RIGHTS COMPETENCE OF STAFF

NHRIs can do a lot to further the cause of reproductive rights. To play such a role, however, there are some preconditions:

4. The NHRI should consider its **mandate**. Most NHRIs have a mandate that covers all human rights. Since the main global and regional human rights instruments protect reproductive rights, a mandate to protect and promote human rights in general also includes reproductive rights. Some NHRIs have a mandate that refers only to human rights protected by national law. If national law incorporates the provisions of the main international human rights instruments, either by reference or by repetition,² even without mentioning reproductive rights directly, this will normally be a sufficient mandate. If national law limits the mandate to, for instance, civil and political rights, NHRIs can address the elements of

reproductive rights that are part of civil and political rights.

5. The main practical precondition is **knowledge**. The first step is to make sure that the NHRI has the necessary knowledge in house. Not only should the NHRI ensure that relevant texts (such as the ICPD Programme of Action, the various publications from OHCHR, UNFPA, WHO, etc.) are available; it must also ensure that there are staff members with knowledge of reproductive rights. Ideally, all professional staff members should have a basic knowledge of reproductive rights sufficient to identify such issues in their general work, just as all staff members are expected to have basic knowledge of all other areas of human rights. To secure such a broad knowledge, NHRIs should consider in-house training, combined with in depth education for staff working directly on reproductive rights issues. Relevant partners can be of

² A law can incorporate an international convention by expressly mentioning the name of the convention, or the law can repeat the text of the convention.

particular help. The NHRI in the **Maldives** has for instance asked the UNFPA Country Office for technical assistance to carry out such training and the NHRIs in Bangladesh and Nepal both plan to develop an internal orientation programme on reproductive rights with expertise drawn from UNFPA, NGOs and government. In addition to UNFPA, women's commissions, women's groups, health professionals and academic institutions for example will often have relevant information to share on reproductive rights.³ Practice can also generate learning and knowledge. Once the basic knowledge is available, there is no reason why a NHRI should not start working within reproductive rights and then expand its knowledge in parallel to working within the area.

6. Given that reproductive rights are a constellation of rights that straddle several of the basic human rights instruments, their scope and meaning is not always clear. Consequently, once some initial knowledge has been acquired, it might be advisable to prepare a **position paper or a policy document**, setting out the NHRI's understanding and position on reproductive rights and how the NHRI plans to promote and protect these rights in practice. On this basis, the NHRI could make a plan for its first goals and corresponding activities within the field of reproductive rights.
7. Another question concerns the **administrative assignment** of the responsibility for reproductive rights. Should the NHRI

³ Working with such groups was a recommendation from the UNFPA Asia-Pacific Forum in Kuala Lumpur 20-21 June 2011.

set up a new department or unit or focal point focusing on reproductive rights, or should reproductive rights rather be split up and dealt with by existing departments, for instance departments dealing with women's rights, children's rights and the right to health? An example of the latter approach is the NHRI in the Bolivarian Republic of **Venezuela**. If reproductive rights are placed in, for example, the women's rights department, it is important to remember to cover also the issues that might not normally fall within the ambit of the department, such as the reproductive rights of men.

Some NHRIs are not organized around substantive human rights but rather based on the different tasks set out in the Paris Principles, with one department dealing with complaints, another with monitoring, one with education etc. In such a case, reproductive rights must be anchored in all departments. The NHRI in **Uganda** deals with reproductive rights in several of its directorates, including the Directorate of Monitoring and Inspections but also has units such as the Health Unit and the Vulnerable Person's Unit that are involved in reproductive rights.

Some NHRIs might find that they can have more impact if one department is dedicated to work on reproductive rights. Others may decide, perhaps due to the controversial aspects of reproductive rights, to link the work to other interventions. How the government deals with reproductive rights is a factor to take into consideration: Working with reproductive rights in a way that mirrors

the organization within government may be the most productive for the NHRI. In any event, for its internal purposes a NHRI should monitor all work done within the field of reproductive rights, regardless of organization.

8. Many NHRIs are doing work within reproductive rights without being aware of this. They might have considered complaints of lack of access to maternal care but seen this as only a violation of the right to health. They might have done promotional work on early marriages but seen this as an issue only relating to the rights of women and/or children. Consequently, a NHRI should consider making a **review** of what it already does within the field of reproductive rights. This will also enable the NHRI to consider if some of the activities being carried out can be strengthened and if a reproductive rights angle can be added to its other activities.
9. In addition, or as an alternative, to developing its own plan of action, a NHRI could develop a **joint plan** with relevant partners. Such partners could include other independent commissions (some countries like **India** have for example women's commissions or ombudspersons), ministries or departments within government (some countries have special secretaries dealing with women's rights, for example), professional groups, and relevant parts of civil society, who might have more or different knowledge with respect to reproductive rights. A NHRI could consider involving other relevant state actors in this work, such as law enforcement, the judiciary, or the health and education departments, etc.
10. Many NHRIs have incorporated the practice of developing periodic **strategic plans**. Rather than carrying out unrelated individual activities while worthy and important, a strategic plan enables a NHRI to consider how each of its activities furthers its overall goals and whether the activities can be organized in such a way as to create synergies. A NHRI that decides to take on the challenges of reproductive rights should include reproductive rights in its strategic plan.
11. It is always good to lead by **example**. Therefore, a NHRI should ensure to have internal policies, programmes and regulations in place that protect, respect and promote the reproductive rights of the staff within the NHRI. This includes the following:
 - a. Female staff should be allowed **maternity leave** for at least 16 weeks in accordance with WHO recommendations and with reasonable pay. Naturally, this is less of a concern in countries that have sufficient rules and practices in place in general. Leave should also be available to fathers. This is not only for the fathers' sake but also emphasizes the responsibility of both parents. Breast-feeding mothers should be able to plan their work in such a way as to enable breastfeeding according to WHO advice (exclusive breastfeeding for the first six months of the child's life). The NHRI in **India** provides six months maternity leave with further options for childcare leave and gives 15 days paternity leave at the time of birth.

- b. If the NHRI offers **health insurance** or other kinds of support for health care, the NHRI should ensure that this includes access to the full range of reproductive health services, including family planning and contraception. This is for example the case for the NHRIs in **Uganda** and **Jordan**.
- c. The NHRI should have a policy in place with respect to sexually transmitted infections, in particular **HIV/AIDS**, based on human rights principles and including access to prevention, such as male and female condoms.
- d. The NHRI should have other relevant policies and guidelines in place, such as a policy regarding **sexual harassment** and a policy on **non-discrimination**, including on the basis of sex, age, disability, sexual orientation, marital status, or any other status.

LEGISLATIVE AND ADMINISTRATIVE PROVISIONS

NHRIs can use this part of the mandate in several ways:

1. NHRIs could conduct a **review of legislative and administrative regulations** specifically focusing on reproductive rights. When considering such regulations, the benchmark should be both the relevant international human rights obligations and the national provisions as set out in, for example, the constitution. The focus could be on areas of legislation that would seem particularly relevant for the enjoyment of reproductive rights:
 - a. One such area is **family law** where the NHRI could for instance look at provisions on marriage age and on equality; as set out in the next chapter, the marriage age should be identical for men and woman, and family law regulations should be devoid of provisions reinforcing the still common view of women as less valuable than men.
 - b. Another area is laws on **access to quality health services**; such laws and regulations should establish clear, objective and measurable standards of access, quality and cultural acceptability of healthcare services and cement the right to reproductive health services while respecting various tenets of human rights, such as the right to consent, the right to privacy even for adolescents etc. Standard setting is fundamental to strengthen the regulatory role of the state in cases where basic sexual and reproductive health services are privatized. It is important to ensure that the legislation contains sufficient safeguards so that privatization does not hamper, in any way, access to quality reproductive and sexual health services in particular by vulnerable and marginalized groups.⁴

⁴ This is among the issues raised at the UNFPA-Asia Pacific Forum consultation 20-21 June 2011 in Kuala Lumpur, cf. the report of this meeting, p. 6.

- c. There has been much discussion on legislation on **sexually transmitted infections**, including HIV/AIDS. Such legislation should respect the human rights of infected and affected persons, including their right to privacy, while encouraging testing and preventive precautions.
- d. NHRIs can also look into **criminal legislation** to ensure that there are provisions in place prohibiting harmful practices such as female genital mutilation and other violations of reproductive rights. NHRIs should similarly work to ensure that criminal laws are human rights compliant and do not contain provisions that discriminate or work against achieving reproductive rights for all. Examples of discriminatory legislation are laws that criminalize same sex activities between consenting adults and laws that restrict access to sexual and reproductive health services for unmarried couples and adolescents. Other laws, such as laws criminalizing sex work, can also have negative impacts with respect to the enjoyment of reproductive rights and other human rights.
- e. A country's ability to fulfil human rights, including reproductive rights, depends to a large degree on its **budgeting**, as for example necessary sexual and reproductive health can only be secured if sufficient funds are allocated to this area. On that account, a NHRI should review the public budgets and budgeting processes to ensure a human rights-based approach, see further below in Chapter 4.
- f. An important part of human rights is the right to **effective remedies** in case of violations. A NHRI should assess whether there are legislation and regulations in place to provide effective and accessible remedies to persons whose reproductive rights have been violated. For instance, if a woman has not been provided with reproductive health services, e.g. with respect to natal care, there should be easily accessible means of complaining with the potential for remedies such as compensation.
- g. Some countries have a parallel system of **customary law**, being metered out by traditional leaders according to cultural and/or religious values. Customary law can be much more important to people than the laws created by parliament and enforced in the courts of law, not least regarding reproductive rights, such as marriage law. Consequently, when reviewing existing law, a NHRI should include customary law. This will normally entail some research as customary law is rarely documented in the same way as formal law. In order to be culturally sensitive, such a review should focus on ensuring that customary law does not go against recognized tenets of human rights and that it does not promote harmful practices, but without diminishing its value as a legitimate source of law.
- h. In addition to looking at the contents of legislation and other regulation, a NHRI should look at the **processes** used when enacting legislation, regulations and policies. According to the

Belgrade principles, NHRIs should be consulted by parliaments on the content and applicability of a proposed new law to ensure that human rights norms and principles are correctly reflected therein. Additionally, parliaments should involve NHRIs in the legislative process.⁵ In line with the Human Rights-Based Approach, see Chapter 4, such processes should be inclusive and enable the participation by and input from affected population groups, including the most vulnerable, marginalized and excluded.

In its feedback to parliament and government, a NHRI should not only indicate problematic provisions but also **propose and advocate for the necessary changes**.

2. NHRIs are supposed to examine **draft legislation** in addition to enacted laws to ensure adherence to human rights provisions, be it in national or international human rights instruments. Ideally, there should be systems in place to ensure that legislation is never passed by parliament without having been subject to scrutiny by the NHRI. If such systems are not in place, the NHRI should address government to ensure that all bills are transmitted to the NHRI for comments before or at the latest simultaneously with presentation to parliament. The NHRI should also enter into dialogue with parliament to ensure systematic notification of private member's bills and that parliament receives input from the NHRI before voting on a bill.

⁵ Belgrade Principles, International Expert Seminar, Belgrade, 22-23 February 2012. Report of the Secretary General to the General Assembly (A/HRC/20/9), Annex 17 principles 27 and 28.

HUMAN RIGHTS COMMISSION OF MALAYSIA

INFLUENCING LEGISLATION

The Human Rights Commission of Malaysia was involved in consultations for the development of a national policy on reproductive and social health. Not all the Commission's recommendations were accepted but its involvement helped to strengthen the link between reproductive issues and human rights. The Commission identified several matters as issues of concern to be reflected in the population policy. These included the stigma around unwed motherhood leading to unsafe abortions by adolescents and abandonment of babies. The Commission subsequently provided recommendations to the Government on how these problems could be effectively addressed in a way that respects human rights.

When the NHRI subjects bills and legislation to scrutiny, reproductive rights should be among the matters that are routinely considered. NHRIs may decide to use **checklists** or put other scrutiny systems in place to secure the necessary focus on reproductive rights.

UGANDA HUMAN RIGHTS COMMISSION

TACKLING THE ANTI-HOMOSEXUALITY BILL

One of the most controversial pieces of legislation to come before the Ugandan Parliament in recent years is the Anti-Homosexuality Bill. The bill, introduced as a private member's bill on 14 October 2009, increases the penalty for homosexual acts to life imprisonment in certain cases. It also criminalizes the promotion of homosexuality, including publishing of most material and views on homosexuality as well as the failure to report known homosexual activities.

The bill immediately sparked off protests especially from the international community, while it acquired support from many Ugandans including some religious leaders, based on tradition, religion and moral values.

The Uganda Human Rights Commission, as part of its mandate to analyse and review bills before Parliament to ensure compliance with human rights standards, subjected the bill to a detailed analysis, drawing from human rights standards set out in the Ugandan Constitution, treaties and the practice of relevant United Nations human rights bodies. The conclusion, based entirely on legal arguments, was that the Anti-Homosexuality Bill contradicted international human rights standards, including the right to privacy, equality and non-discrimination, as well as the freedoms of speech, expression, association and assembly. The 12th Annual Report 2009 of the Ugandan Human Rights Commission presented the analysis.

Despite the advocacy efforts of the Uganda Human Rights Commission and other national and international actors, the President of Uganda promulgated the bill in slightly amended form in February 2014, representing a grave setback for the rights, personal security and wellbeing of lesbian, gay, bisexual and transgender persons in Uganda.

3. Ideally, in addition to scrutinizing all proposed bills, a NHRI should scrutinize all **new administrative regulations** and **major policy documents**. Whereas it will normally be feasible for a NHRI to consider all new bills and possible to establish procedures securing that this takes place, administrative regulations and policies come into being in a much less formalized manner than legislation, making it more difficult to establish procedures ensuring continuous monitoring of all new administrative regulations. In addition, the sheer volume of administrative regulations can make it difficult for a NHRI to have the capacity to go through all new and proposed administrative regulations – of which many will probably be irrelevant from a human rights perspective in any case.

What a NHRI can do is to establish such a close relationship with the relevant departments and other administrative units bearing direct relevance that the departments and other administrative units will be prepared to and interested in sharing all relevant proposed administrative regulations with the NHRI. With respect to reproductive rights, departments and agencies dealing with health, gender issues, women, children

(adolescents) and justice and legal issues would seem relevant. In some countries close contact can be established with strong civil society actors that are already monitoring new legal and administrative developments; this is but one of many good reasons for establishing close relations with civil society actors that address reproductive rights, see further below under Monitoring and reporting at the national level.

MONITORING AND REPORTING AT THE NATIONAL LEVEL

UGANDA HUMAN RIGHTS COMMISSION

MONITORING REPRODUCTIVE RIGHTS AND MINORITY RIGHTS

To enhance monitoring, the Ugandan Human Rights Commission has established the Vulnerable Persons Unit that handles issues of women's rights, rights of persons with disabilities and the rights of persons living with HIV/AIDS, among other groups. A specific unit, also under the Directorate of Monitoring and Inspections, has been established to focus on the right to health; this unit monitors the situation on the right to health in general. Both these units are involved with issues of reproductive rights.

According to the Paris Principles a NHRI shall make **reports** and advise the government, parliament and any other competent bodies on the national human rights situation in general and with respect to specific matters, on situations of human rights violations in any part of the country with proposals for mitigating actions, and on any human rights violation. Based on monitoring as set out below, a NHRI should include matters with respect to reproductive rights in general reports on human rights to the relevant competent bodies. The NHRI in **India** will

commence including issues of reproductive rights in its Annual Report to Parliament.

A NHRI should also consider the benefits of preparing **special reports** on reproductive rights and taking steps to push the competent bodies to consider such reports and take relevant action. All such reports should in ordinary cases be shared with civil society and be disseminated via the press. It is important that all efforts with respect to monitoring and reporting are not seen only as the NHRI giving its expert opinions to

government; given the NHRI's unique role as interlocutor between the state authorities and the population the NHRI should also try to channel the concerns of the citizens, naturally in a way that reflects the human rights issues at stake.

In order to **monitor** effectively the status of reproductive rights nationally, a NHRI could consider the following steps:

1. When receiving **individual complaints** a NHRI should not simply treat these on an individual basis but also consider them as a means of obtaining information on what is going on in the country on a more general level. Information from individual complaints, respecting the tenets of confidentiality, should be systematized and taken into account as part of monitoring of national trends.
2. Most NHRIs will **categorize** their work, especially complaints, according to type of human rights and this will be followed when making statistics. Thus, several NHRIs, including the NHRIs in **Nepal, Maldives, Jordan, India** and **Bangladesh**, are considering including reproductive rights as a specific category to get a clearer picture of the situation with respect to reproductive rights. Often, a case will concern alleged violations of various human rights; a violation of a person's reproductive rights might also be categorized as a women's rights issue, a child rights issue, an issue concerning the right to health etc. The same will also often be the case for other types of human rights violations. For this reason, NHRIs should consider implementing systems where a matter can be placed in several categories.
3. According to the Paris Principles NHRIs are to develop ties with **civil society**. Civil society is a primary source of information. If a NHRI has close ties and regular interaction with civil society, the NHRI can obtain a wealth of information about the situation in the country. To do so the NHRI must think beyond the human rights NGOs, important as they are, and try to cultivate relationships also with women's organizations (particularly important for reproductive rights), children's organizations, community based organizations, rural organizations, trade unions, professional bodies (including law and medical associations and societies), churches, traditional leaders, development organizations, etc. Especially with respect to reproductive rights, it is important to establish relationships with the main hospitals and with associations of health professionals. It is important not to forget organizations and associations representing the most vulnerable and marginalized groups, such as the LGBT community, sex workers, etc. Developing relationships with medical associations and with providers of health services seems of particular importance with respect to reproductive rights in order to get access to relevant information.

The NHRI should also try to develop relationships with academic institutions, such as universities, that might produce research that can be used by the NHRI in its monitoring. A very basic way of getting information is to use **the press**. Even though it is probably not advisable to base interventions purely on press reports, tracking information systematically in the papers, the radio, television and websites can be a useful source.

4. Going on **visits** around the country should also be part of monitoring. The availability, accessibility and quality of reproductive rights services tends to differ substantially between the main urban centres and the rural areas, making missions outside of the capital necessary. Based on information from civil society and the press a NHRI should be able to decide where to go and whom to visit. With respect to reproductive rights, it will normally be relevant to visit hospitals and clinics providing family planning services and pre- and post-natal care, and check the availability of essential medicines, including modern contraceptive methods, and assess the reliability of procurement and supply chains. It is also relevant to visit schools, interview teachers responsible for sexuality education, and visit other places where youth gather. Attempts should furthermore be made to get in contact with parts of the population that do not normally access formal structures such as hospitals, for example because they are based in very remote areas or because they belong to stigmatized groups.
5. In addition to monitoring the general situation with respect to reproductive rights, a NHRI should attempt to monitor the **implementation of public policies and programmes** that have a potential to influence the enjoyment of reproductive rights. As mentioned above, customary and traditional law and practice tend to weigh heavily on the enjoyment of reproductive rights so a NHRI should take steps to monitor how the state deals with such issues.
6. Reproductive rights is one of the areas where certain categories, namely women and adolescents, are at greatest risk of violations and where certain vulnerable groups, such as poor rural communities, LGBT persons and others, are easily overlooked or might be subject to factual discrimination even if the law or policy appears neutral. Consequently, monitoring should focus on cases of **discrimination**.

SOUTH AFRICAN HUMAN RIGHTS COMMISSION

MONITORING ECONOMIC AND SOCIAL RIGHTS

As part of its constitutional duties, the South African Human Rights Commission (SAHRC) annually monitors the implementation of economic and social rights. Its 7th such report from 2010 focused on the attainment of the MDGs, including MDG 5 on maternal mortality. SAHRC concluded that maternal mortality actually seemed to be on the increase in South Africa and repeated its calls for the Department of Health to investigate child and maternal mortality.



REPRODUCTIVE RIGHTS: A TOOL FOR MONITORING STATES' OBLIGATIONS⁶

NHRIs can monitor whether or not states are complying with their obligations under international human rights law in the field of reproductive rights. The table below is inspired on the tool of the same name developed by the Center for Reproductive Rights on the basis of the jurisprudence developed

by United Nations Treaty monitoring Bodies. The table shows:

1. The right or issue related to rights;
2. The components of the States' Obligations; and
3. How to assess compliance

⁶ Based on *Reproductive Rights: A tool for Monitoring State Obligations*, Center for Reproductive Rights for UNFPA, 2012.

Human Rights-related issues	Components of State's Obligations	Assessing compliance
<p>Freedom from Discrimination</p>	<ul style="list-style-type: none"> ▪ Sexual and reproductive health information, goods and services should be accessible to all in law and practice without discrimination. ▪ States should adopt measures to achieve equality and eliminate discrimination with respect to sexual and reproductive health for all. 	<ul style="list-style-type: none"> ▪ To what extent has State developed and implemented measures to eliminate discrimination in the field of sexual and reproductive health through policy? ▪ What steps has the State taken to ensure that reproductive health services that only women need, such as services related to pregnancy, and pregnancy-related complications, are available, accessible, acceptable and of good quality both in law and in practice? ▪ What steps has the State taken to eliminate laws or policies that require third party (e.g., parental, spousal, or judicial) authorization for access to sexual and reproductive health information and services? ▪ What steps has the State taken to decriminalize specific forms of consensual sexual activity, such as same-sex or extra-marital sexual activity? ▪ What measures has the State taken to prevent or eliminate discriminatory policies or practices in both the public and private spheres, such as mandatory pregnancy testing or policies or practices that target ethnic or racial minorities and groups, women living with HIV, or women with disabilities for involuntary surgical sterilization?

Human Rights-related issues	Components of State's Obligations	Assessing compliance
		<ul style="list-style-type: none"> ▪ How does the State ensure affordable access, such as through free or subsidized care, for low-income women or those who may face heightened barriers to seeking sexual and reproductive health care? ▪ What steps has the State taken to integrate gender and sexuality perspectives into their policies, plans, and programmes on sexual and reproductive health, such as involving women in the planning, implementation, and monitoring of such policies, plans, and programmes? ▪ What mechanisms are in place to ensure access to justice for persons who have suffered discrimination in access to sexual and reproductive health services, goods and information?
Contraceptive Information and Services	<ul style="list-style-type: none"> ▪ States should take steps to ensure that all individuals have access to comprehensive, scientifically accurate, unbiased information regarding contraceptive methods. ▪ States should take steps to ensure a full range of contraceptive methods are available, accessible, acceptable and of good quality. 	<ul style="list-style-type: none"> ▪ To what extent has the State developed and implemented a national strategy or plan that includes measures to ensure access to contraceptive information and services? ▪ To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans?

Human Rights-related issues	Components of State's Obligations	Assessing compliance
	<ul style="list-style-type: none"> ▪ States should take steps to ensure that all individuals are able to make informed and voluntary decisions about the contraceptive method that is suitable for them, both in law and in practice. ▪ States should develop public education campaigns and programmes that raise awareness about the importance of contraceptive use through the media and other alternative forums. ▪ States should collect, analyse, and disseminate disaggregated data to better understand and monitor unmet needs for modern contraceptive methods, contraceptive use and primary barriers to accessing contraceptive information and services. 	<ul style="list-style-type: none"> ▪ What measures has the State taken to ensure that a full range of contraceptive methods, including emergency contraception, are available, accessible, acceptable, and of good quality, both in law and in practice? ▪ What steps has the State taken to eliminate third-party authorization (e.g., parental, spousal, or judicial) for particular contraceptive methods? ▪ What measures has the State taken to prevent or eliminate involuntary practices or policies (e.g., involuntary sterilization)? ▪ To what extent does the State ensure that access to contraceptive information and services is not impeded by the exercise of conscientious objection by a health care provider or pharmacist? ▪ What steps has the State taken to ensure that such administrative or judicial safeguards are accessible and timely?

Human Rights-related issues	Components of State's Obligations	Assessing compliance
<p>Pregnancy and Childbirth</p>	<ul style="list-style-type: none"> ▪ States should take steps to ensure availability of and access to the underlying determinants for a healthy pregnancy, include adequate nutrition, potable water, education, transportation and sanitation. ▪ States should take steps to ensure that reproductive health information, goods and services—including access to perinatal care, skilled attendance during birth, emergency obstetric care, and medicines and technology essential to sexual and reproductive health—are available, accessible, acceptable, and of good quality. ▪ States should take steps to ensure access to good quality maternal and reproductive health care. 	<ul style="list-style-type: none"> ▪ To what extent has the State developed and implemented a national strategy or plan to ensure access to maternal and reproductive health information, goods, and services and the reduction of maternal mortality and morbidity? ▪ To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans? ▪ What steps has the State taken to ensure that reproductive health goods or services essential to maternal health—such as uterotonic drugs (e.g., misoprostol) to stop haemorrhaging are legally available and, in the case of drugs, registered for obstetric use? ▪ What measures has the State taken to eliminate any policies or practices that prioritize the foetus over life- or health-saving medical care for pregnant woman and girls? ▪ What measures has the State taken to eliminate harmful practices that can contribute to high-risk pregnancies, such as female genital mutilation or early or forced marriages? ▪ What steps has the State taken to ensure that women and girls are not exposed to preventable health risk because of pregnancy?

Human Rights-related issues	Components of State's Obligations	Assessing compliance
	<ul style="list-style-type: none"> ▪ States should take steps to ensure access to special care and assistance during pregnancy and for a period following childbirth. ▪ States collect, analyse, and disseminate disaggregated data necessary to evaluating and responding to primary causes—both direct and indirect—of maternal mortality and morbidity. 	<ul style="list-style-type: none"> ▪ What steps has the State taken to combat early or unwanted pregnancy by ensuring access to comprehensive sexuality education and access to contraceptive information and services, including for adolescents? ▪ What mechanisms are in place to ensure accountability where there have been failures to ensure the right to a safe and healthy pregnancy?
<p>Unsafe Abortion and Post-Abortion Care</p>	<ul style="list-style-type: none"> ▪ States should take steps to reduce the number of unsafe abortions and the attendant risks to women's and girl's health and lives. ▪ States should take steps to ensure access to post-abortion care for all women and girls free from discrimination, violence or coercion. 	<ul style="list-style-type: none"> ▪ To what extent has the State developed and implemented measures to reduce the risks of unsafe or clandestine abortions? ▪ To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans? ▪ To what extent has the State eliminated or refrained from imposing restrictions on access to abortion services, where these are legal, such as laws requiring third-party authorization (e.g., parental, spousal, or judicial) to access abortion services?

Human Rights-related issues	Components of State's Obligations	Assessing compliance
		<ul style="list-style-type: none"> ▪ What efforts has the State taken to ensure effective access to quality, respectful post-abortion care, irrespective of the legal status of abortion? ▪ What measures has the State taken to regulate conscientious objection by health care providers to ensure that women and girls have access to abortion, where it is legal and post-abortion care? ▪ To what extent has the State refrained from imposing or eliminated policies or practices conditioning access to post-abortion care on confessing to having undergone an illegal abortion or denouncing the abortion provider?
Comprehensive Sexuality Education	<ul style="list-style-type: none"> ▪ States should take steps to ensure the ability of all individuals to see, receive and impart information on sexual and reproductive health. ▪ States should take steps to ensure that all individuals have access to comprehensive sexuality education, both within and outside of the formal education system. 	<ul style="list-style-type: none"> ▪ To what extent has the State developed and implemented a national strategy or plan to ensure access to comprehensive sexuality education both within and outside of educational institutions? ▪ To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans? ▪ To what extent has the State developed comprehensive sexuality education curricula and teacher training materials?

Human Rights-related issues	Components of State's Obligations	Assessing compliance
	<ul style="list-style-type: none"> States should take steps to ensure that comprehensive sexuality education are free from harmful sex- or gender-based or heteronormative stereotypes, or those based on mental or physical ability. 	<ul style="list-style-type: none"> What steps has the State taken to eliminate the dissemination of biased or factually incorrect information on sexuality or sexual and reproductive health?
Freedom from Violence against Women	<ul style="list-style-type: none"> States should recognize and take steps to prevent all forms of violence against women, including sexual harassment, sexual assault, trafficking, and female genital mutilation. States should exercise due diligence to investigate and punish the perpetrators of violence against women. 	<ul style="list-style-type: none"> To what extent has the State developed and implemented national strategies and plans aimed at preventing, punishing, and eradicating all forms of violence against women, including harmful or abusive practices against adolescents? To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans? To what extent does the State penalize violent crimes against women? What steps has the State taken to eliminate loopholes for escaping liability, for instance by allowing a rapist to escape criminal liability by marrying his victim?

Human Rights-related issues	Components of State's Obligations	Assessing compliance
	<ul style="list-style-type: none"> ▪ States should collect, analyse and disseminate disaggregated data on the extent, causes, and effects of violence against women, and on the effectiveness of measures to prevent and deal with violence. ▪ States should develop public education campaigns to combat the root causes of violence against women; promote the rights of women and girls who may be susceptible to gender-based violence; raise awareness of the issue; and reduce stigma and discrimination that contributes to, and is directed at, survivors of violence. 	<ul style="list-style-type: none"> ▪ What steps has the State taken to eliminate violence against women in institutional settings, such as violence against girls in educational institutions or involuntary sterilization in health facilities? ▪ What steps has the State taken to eliminate violence against women in conflict or post-conflict settings? ▪ What steps has the State taken to prevent violence against women in the private and community sphere? ▪ What measures are in place for the State to exercise due diligence to investigate and punish acts of violence against women? ▪ What steps has the State taken to ensure that accountability mechanisms that facilitate access to justice are available to survivors of violence, and to what extent are these mechanisms responsive to the specific obstacles women and girls face when seeking justice?

Human Rights-related issues	Components of State's Obligations	Assessing compliance
<p>HIV/AIDS</p>	<ul style="list-style-type: none"> ▪ States should take steps to eliminate the social and cultural factors that exacerbate women and girls' heightened risk of contracting HIV. ▪ States should take steps to ensure access to HIV prevention, treatment, and care for all individuals. This includes the obligation to ensure information and education on HIV, access to condoms (including female condoms), voluntary and confidential counselling and testing for HIV, non-discriminatory health care, and affordability of necessary medications for individuals living with HIV. ▪ States should take steps to ensure that all individuals living with HIV are able to make informed and voluntary decisions around childbearing. This includes the obligation to ensure access to contraceptive information and services, safe abortion services, where legal, and reproductive technologies. 	<ul style="list-style-type: none"> ▪ To what extent has the State developed and implemented a national strategy or plan aimed at ensuring prevention, treatment, and control of HIV, including by ensuring access to prevention and treatment programmes (including programmes to reduce vertical transmission) and eliminating discrimination against individuals living with HIV? ▪ To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans? ▪ To what extent has the State enacted legislative or regulatory protections to ensure the rights of individuals living with HIV to give informed and voluntary consent to health goods and services, including HIV testing, and to ensure confidentiality in testing and treatment? ▪ What measures has the State taken to eliminate involuntary or punitive measures in HIV testing, prevention, or treatment programmes, such as the involuntary HIV testing of pregnant women or girls?

Human Rights-related issues	Components of State's Obligations	Assessing compliance
	<ul style="list-style-type: none"> ▪ States should take steps to ensure that all individuals living with HIV are able to access reproductive health information, goods, and services, including access to perinatal care, skilled attendance during birth, emergency obstetric care, and medicines and technology essential to sexual and reproductive health. ▪ States should develop scientifically accurate public education campaigns on HIV to raise awareness of the virus, including methods of transmission and prevention, and to reduce stigma against, and promote the rights of, individuals living with HIV. 	<ul style="list-style-type: none"> ▪ What steps has the State taken to respect the rights of individuals living with HIV to make voluntary decisions around childbearing, for instance by eliminating policies or programmes that promote or condone involuntary sterilization or abortion for women living with HIV? ▪ To what extent has the State enacted, implemented, or enforced laws and policies to safeguard individuals living with HIV from discrimination in the private sphere, such as termination of an employee living with HIV? ▪ What types of administrative or judicial safeguards has the State enacted to provide remedy and redress where an individual living with HIV has been denied essential health care based on his or her HIV status, or received abusive or discriminatory treatment in health care settings?



RATIFICATION OF INTERNATIONAL INSTRUMENTS

NHRIs shall encourage ratification of all international instruments. Within the context of promoting reproductive rights, NHRIs should take steps to encourage the ratification of United Nations human rights treaties and regional treaties which are of key importance to promoting reproductive rights, see Annex I and II.

It is important not only to focus on the ratification of treaties, the corresponding optional protocols and similar instruments but also on reservations that diminish the impact and range of the treaties and on specific declarations that, if made, increase protection. NHRIs should encourage the withdrawal of reservations and the making of declarations just as it should encourage ratification of human rights instruments.

Among the specific steps to be taken are the following:

1. When making **reports on specific areas** of human rights, such as reproductive rights, the NHRI could include a section on international instruments that have not been ratified and that are relevant for this particular area of human rights.
2. Many NHRIs make annual or other **periodic reports** on the general human rights situation in the relevant country. It would appear logical to include a section on international instruments not yet ratified in such reports.
3. In its formal and informal contacts with government and parliament, a NHRI can **lobby** for the ratification of international instruments.
4. According to Section C.7 of the Paris Principles, NHRIs should work together with NGOs. If a NHRI decides to

campaign for the ratification of specific treaties, this is something that could be done in collaboration with civil society organizations, for example by holding joint meetings or hearings to discuss such matters before presenting the results to government and/or parliament.

5. When providing **input to international examinations**, especially of the more general kind such as the examination before the United Nations Human Rights Council (the Universal Periodic Review) and the examination by the African Commission on Human and Peoples' Rights, a NHRI could highlight lack of ratification, reservations and declarations not yet made.
6. As part of its research mandate, the NHRI could do **research into the consequences of ratification**, in particular the extent to which the relevant country already adheres to the provisions of the said treaties and what further measures

would need to be taken to ensure full compliance. In this connection, the NHRI could also obtain information on the ratification status for comparable countries.

7. There are several **international documents advocating ratification** of international human rights instruments, both addressed to specific countries as part of concluding observations from United Nations human rights committees and directed more generally, for example in statements from meetings of policy organs, such as the Summit of the African Union or the Organization of American States. In all its work, a NHRI should keep in mind that even if a treaty, including a human rights instrument, has only been **signed and not ratified**; it still entails some obligations for the country. According to Article 18 of the Vienna Convention on the Law on Treaties, a state that has signed a treaty is obliged to refrain from acts which would defeat the object and purpose of a the treaty.

INTERNATIONAL REPORTING

The Paris Principles set out that NHRIs should contribute to state reports to United Nations bodies and to regional institutions and, where necessary, express an opinion in this respect, however with due respect for their independence. In some countries there is lack of clarity on the **exact role of NHRIs** with respect to state reporting to the various United Nations human rights committees and regional mechanisms like the African Commission on Human and Peoples' Rights.

The meaning of the relevant provision of the Paris Principles is to clarify that NHRIs have a role to play in the reporting process but only to the extent this does not conflict with their independence. In practice this means that a government cannot outsource its responsibility for state reporting to the NHRI but must itself carry the ultimate responsibility to draft such reports. As stressed in several concluding observations and clearly prescribed in the Paris Principles, a government should not draft the report alone

but should invite **input from the NHRI and from civil society**.

In some countries every time a state report is due, the government organizes a **truly inclusive process** that ensures input from civil society, the NHRI and other relevant stakeholders and takes care to reflect such input fairly in the state report in question. In particular in connection with the UPR process (the Universal Periodic Review process of the Human Rights Council) many governments hold workshops and meetings to get input. It does not encroach on the independence of a NHRI to assist the government in organizing an inclusive process and in helping to ensure that all relevant issues, such as reproductive rights, are put on the agenda for the process. If the government is not prepared to lead a participatory process, nobody is better placed than the NHRI to take the initiative to gather the stakeholders to provide input that can both be communicated to the government for inclusion in some form in the state report and be used for shadow reporting (the term normally used for reports by NHRIs, civil society and other stakeholders to supplement the official state reporting).

Since the NHRI is centrally placed with respect to international reporting, no matter the position of the government, the NHRI can take steps to ensure that reproductive rights are considered for all reports, including reports for the **UPR process**. If the government does not include this issue in a satisfactory way in the actual state reporting, the NHRI should make sure this is included, for instance, in the UPR stakeholders' report or in shadow reports to United Nations Treaty Bodies.

The United Nations human rights committees are pleased to welcome representatives of NHRIs to their meetings and will in some cases even give NHRIs the right to make its **own presentation**, independent of the presentation of the government, as part of the examination process. This is an excellent platform to highlight issues relating to reproductive rights.

The United Nations human rights committees have made broad ranging **statements on reproductive rights** in their general comments/recommendations and concluding observations as can be seen in Annex 1. In addition many policy documents, several of them universally approved or adopted by governments at the highest level, contain statements and commitments with respect to reproductive rights. When providing input on reproductive rights, either to state reporting or in shadow reports, it strengthens the arguments if the input is supported by reference to such statements.

Once the human rights body in question has made its final pronouncement based on the examination, the NHRI again has an important role to play. The **concluding observations** should be scrutinized by the NHRI, and the NHRI should monitor to what extent the state is implementing these.

As indicated above, the NHRI can also play a role in assuring that **civil society** takes steps to play a similar constructive role when it comes to examination by United Nations human rights committees.

BOX 5. COLLABORATION WITH THE UNITED NATIONS

The United Nations accords great importance to NHRIs as partners in promoting good governance, the rule of law and human rights and, ultimately, sustainable human development. Among other things, this is evidenced by the special role accorded to Paris Principle compliant NHRIs by the United Nations Human Rights Council (the right to speak, present documents etc.). Moreover, the United Nations has assisted more than 60 NHRIs. All of the United Nations is committed to working within a human rights-based framework which entails the development of national capacities for the promotion and protection of human rights, thus making NHRIs obvious partners for all United Nations agencies.

During the consultation 20-21 June 2011 in Kuala Lumpur for NHRIs from the Asia-Pacific Forum, the many representatives from UNFPA country offices all expressed eagerness to work with NHRIs on reproductive rights issues.

The following United Nations agencies and programmes can assist NHRIs:

- OHCHR - works on all human rights and with NHRIs out of its National Institutions and Regional Mechanisms Section in Geneva (present on the ground in 12 regional offices, 12 national offices and with human rights advisors deployed as part of United Nations country teams);
- UN Women - works on women's rights and gender equality;
- UNAIDS - works on issues relating to HIV and AIDS;
- UNDP - works on development in general, including the MDGs, and has a declared intention to work with NHRIs (present in 176 countries);
- UNESCO - works on issues relating to sexuality education;
- UNFPA - is specifically mandated to promote and support advancement of reproductive rights all over the world (present in 126 countries);
- UNICEF - works on issues relating to children and adolescents, in a whole range of civil, political, economic, social and cultural fields, including health, education, eradication of child marriage, female genital mutilation and other harmful practices, sexual violence, trafficking in children, etc.;
- WHO - works on sexual and reproductive health.

In light of the potential of working with NHRIs, OHCHR and UNDP in December 2010 published a joint UNDP-OHCHR Toolkit for United Nations collaboration with NHRIs.

BOX 5. COLLABORATION WITH THE UNITED NATIONS (CONT.)

This document is meant as a practical guide for United Nations staff on how best to support NHRIs with policy advice, technical assistance, and capacity development. It can also be used by NHRIs that wish to get ideas on how they can benefit from working with United Nations country teams. United Nations country teams can provide both material support to activities within the field of reproductive rights and provide technical assistance, such as training and expertise.

UNDP-OHCHR Toolkit for collaboration with National Human Rights Institutions, December 2010, can be downloaded from www.ohchr.org/Documents/Countries/NHRI/1950-UNDP-UH-CHR-Toolkit-LR.pdf.

OTHER FORMS OF INTERNATIONAL ACCOUNTABILITY AND COOPERATION

THE OMBUDSMAN'S OFFICE OF THE BOLIVARIAN REPUBLIC OF VENEZUELA

SUCCESSFUL EXPERIENCES WORKING WITH UNFPA

The Venezuelan NHRI has been working on reproductive rights since 2002 with the support of UNFPA. Firstly a training course was conducted in order to shed light on the subject among the staff of the NHRI. In 2005, the NHRI conducted an educational programme directed at young people aged 13 to 23 in areas where sexual and reproductive health and rights are not respected.

In November 2008 the NHRI participated in a symposium organized by UNFPA and the Ministry of Health on how to diminish the number of teenage pregnancies. The following are some decisions taken during the aforementioned symposium:

1. Consequences of early pregnancies should be considered a public health issue and attention should be directed at their prevention;
2. Multi- and intersectional strategies on sexuality education and the promotion of sexual and reproductive health should be implemented;
3. The involvement of the family, the community and adolescents is crucial for the prevention of early pregnancies and the promotion of sexual and reproductive health.

According to the Paris Principles, NHRIs shall cooperate with United Nations and its various agencies, regional institutions and other NHRIs. Part of such cooperation is the provision of information in connection with **examination of states** by the various United Nations human rights committees and the regional institutions and the monitoring of the follow up as outlined above. NHRIs can utilize international cooperation to further reproductive rights in other ways:

1. Some of the United Nations human rights committees can receive **individual complaints**, as set out in the annexes. The various regional bodies can also receive such complaints. Consequently, assuming that the country in question has made the relevant declaration, signed the relevant optional protocol or refrained from making invalidating reservations, a NHRI can help bring individual cases before such bodies, thus contributing to the creation of international jurisprudence within the field of reproductive rights.
2. Both the United Nations and the various regional mechanisms have **Special Procedures**, such as the working groups, special rapporteurs and independent experts established by the United Nations Human Rights Council or the relevant body of the regional human rights mechanisms. None of these are specifically focused on reproductive rights but for example the mandate of the United Nations Special Rapporteur

on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health includes reproductive health, and the Special Rapporteur has done work in this field, as touched more upon in the next chapters and in greater detail in Annex 1. The present and the former Rapporteur on violence against women (VAW), its causes and consequences have considered reproductive rights, including issues relating to HIV/AIDS, and the connection between domestic and other violence against women and reproductive rights. In 2010 the Special Rapporteur on the right to education prepared a report on the right to sexuality education.

Special Rapporteurs normally do **country visits**. When visiting a country the Special Rapporteur will normally want to visit the NHRI in that country. Briefing the Special Rapporteur on the situation of reproductive rights can be a very good way to put this issue on the agenda.

In many cases Special Procedures will be prepared to consider **individual matters** and take urgent actions. Therefore, if a NHRI has become aware of a particularly egregious human rights violation and has the impression that it is not being resolved, it can inform the relevant Special Procedure and ask him or her to look into the matter.

United Nations Special Procedures Working with Reproductive Rights	Mandate
Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health	Focus on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, as reflected in Article 25, paragraph 1, of the Universal Declaration of Human Rights, Article 12 of the International Covenant on Economic, Social and Cultural Rights, Article 24 of the Convention on the Rights of the Child and Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women, as well as on the right to non-discrimination as reflected in Article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination. ⁷
Special Rapporteur on violence against women, its causes and consequences	Within the framework of the Universal Declaration of Human Rights and all other international human rights instruments, including the Convention on the Elimination of All Forms of Discrimination against Women and the Declaration on the Elimination of Violence against Women, ⁸ focus on violence against women.
Special Rapporteur on the right to education	Focus on the right to education, as laid down in Article 26 of the Universal Declaration of Human Rights and in the relevant and applicable provisions of the International Covenant on Economic, Social and Cultural Rights. ⁹
Special Rapporteur on trafficking in persons especially women and children	Focus on the human rights aspects of the victims of trafficking in persons, especially women and children. ¹⁰

7 Commission on Human Rights resolution 2002/31.

8 Commission on Human Rights resolution 1994/45.

9 Commission on Human Rights resolution 1998/33.

United Nations Special Procedures Working with Reproductive Rights	Mandate
Special Rapporteur on the rights of indigenous peoples	Focus on gathering information on violations of the human rights and fundamental freedoms of indigenous people, formulating recommendations and proposals, and work in close relation with other Special Procedures and Treaty Bodies etc. ¹¹
Special Rapporteur on the situation of human rights defenders	With the framework of the 1998 Declaration on human rights defenders ¹² examine and respond to information on human rights defenders, establish cooperation and conduct dialogue with governments and other interested actors and recommend effective strategies better to protect human rights defenders and follow up on these recommendations. ¹³
Working group on the issue of discrimination against women in law and in practice	Focus on developing dialogue and undertaking studies with relevant actors, including national human rights institutions, on best practices to eliminate laws that discriminate against women and to make recommendations on the improvement and implementation of legislation to contribute to the realization of the MDGs. ¹⁴

10 Commission on Human Rights resolution 2004/110.

11 Commission on Human Rights resolution 2001/57.

12 Human Rights Commission resolution 1998/7 as endorsed by UNGA, General Assembly Resolution A/RES/53/144.

13 Human Rights Commission resolution 2000/61.

14 HRC resolution 15/23

United Nations Special Procedures Working with Reproductive Rights	Mandate
Special Rapporteur on torture and other cruel, inhumane or degrading treatment or punishment	Based on the Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment with a focus on transmitting urgent appeals and undertaking fact-finding missions. ¹⁵

3. Despite differences in structure and capacity, the Paris Principles guide the work of all NHRIs, which face many of the same issues and challenges. The **provision of cooperation** with other NHRIs in the Paris Principles is a compelling reason for NHRIs to collaborate, including in the context of South-South cooperation. There are structures in place that can facilitate this process. Globally, NHRIs are organized in the International Coordinating Committee of NHRIs (ICC). In addition, each of the four regions under the ICC, Africa, the Americas, the Asia-Pacific region and Europe has regional organizations of NHRIs. Consequently, if a NHRI decides that it wants to commence work within the field of reproductive rights or carry out special activities in this respect, an early step could be to contact other NHRIs, especially in comparable countries, and the relevant regional organization of NHRIs for sharing knowledge, information on experiences etc. Inviting

colleagues from other NHRIs to provide experiences at workshops and similar gatherings is one possibility. Another possibility is for NHRIs in the same area to come together and discuss issues of reproductive rights, share experiences and agree on the best steps forward, such as joint workshops, cross-border research etc. The relevant United Nations institutions and agencies will normally be willing to provide assistance and expertise to such initiatives.

15 CHR resolution 1985/33

HUMAN RIGHTS EDUCATION AND RESEARCH

THE HUMAN RIGHTS COMMITTEE OF SENEGAL

EXPERIENCES WITH HUMAN RIGHTS EDUCATION

The Human Rights Committee of Senegal is involved in a project to address the reproductive health of adolescents, including the scourge of sexual violence in schools. This project is managed by the Ministry of Education with the Human Rights Committee being responsible for the human rights aspects, including issues of reproductive rights. As part of this project, separate guides/manuals have been prepared for trainers, teachers and pupils, and so far the administrative staff of 14 schools has been trained. As part of the project, a group of teachers and pupils will be trained to sensitize all the pupils at the said schools and to prevent and manage eventual cases of sexual violence and abuse. The overall purpose is to promote gender equality and make the new generation aware of the issues of sexual health, gender, human rights and the negative consequences of sexual violence and abuse.

According to the Paris Principles, NHRIs should assist in formulating programmes for the teaching of, and research into human rights, and take part in the execution of such programmes in schools, universities and professional circles. Adolescents are among the most vulnerable groups with regard to reproductive rights and the behavioural changes that are necessary to secure reproductive rights for all must start with children and adolescents. Many other groups are also important for the protection and promotion of reproductive rights. Consequently, a NHRI has several opportunities within teaching and research to further reproductive rights:

1. It is universally acknowledged that **human rights education** should start **in school**. Such education should be age appropriate and at a suitable time, and include issues relating to

reproductive rights. It should not only focus on the entitlements to health services but also on the responsibilities of each person, irrespective of gender, to respect the reproductive rights of others. With its connection to sexuality and the familiar conflict with certain cultural and traditional practices, reproductive rights are among the more controversial human rights to teach but that does not mean that NHRIs should refrain from pushing for the inclusion of reproductive rights in human rights education in schools. A NHRI involved in providing reproductive rights education to children should consider ways to reach children not in school, e.g. by working with institutions and organizations targeting street children and other children excluded from the education system, as such children often engage earlier in sexual

activities and are at a higher risk of sexual violence and abuse.

2. In some countries **human rights clubs** have been established at schools; this is for example the case in **Uganda**. This can be a good way to encourage open discussions on human rights among children and adolescents. Especially within a culturally sensitive area like reproductive rights it is important to provide a safe environment for discussions.
3. Human rights should be taught at **universities**, in particular as part of the curriculum for law students. NHRIs should work with law faculties to ensure that reproductive rights are among the rights being taught as part of the human rights education of law and health care students.
4. To secure the full enjoyment of reproductive rights by all, it is necessary that certain **professional groups** have a sufficient understanding of reproductive rights, including the importance of treating women, adolescents and other groups with dignity, respect and confidentiality and in an age appropriate manner. Key among such groups are health professionals and social workers. Hence, NHRIs should work with the relevant authorities to make sure that reproductive rights are part of the curriculum for doctors, nurses, midwives and social workers. NHRIs should also try to develop short courses and teaching material to ensure health professionals and social workers who did not receive such teaching during their primary studies get the necessary knowledge and skills.

Certain aspects of reproductive rights concern criminal law, such as sexual violence and harmful practices. It is important that law enforcement professionals and judges have received the necessary training within these areas. These professionals should receive training on violation of reproductive rights and access to justice. NHRIs can be instrumental in promoting and providing this type of training.

5. The Paris Principles also mention the participation in **programmes for research** in human rights matters. Proper and in-depth knowledge in reproductive rights is an important steppingstone for all other activities such as evidence-based advocacy and policy reform. If it has the necessary resources, a NHRI can carry out its own research into matters relating to reproductive rights. If not, it can work with universities and other research institutions. Whenever reproductive rights, or certain aspects of reproductive rights, such as for instance the rights of LGBT groups, are considered too controversial to commence very visible public activities, research can be a good way to start work and get a clearer picture as to what are the real issues and how they might be addressed. It is important that NHRIs do not shy away from dealing with controversial issues but this does not mean that controversial issues cannot be dealt with in a low-key manner if this is considered most efficient.

BOX 6. COMPREHENSIVE SEXUALITY EDUCATION: PROMOTING REPRODUCTIVE RIGHTS AND GENDER EQUALITY

The ICPD Programme of Action stresses the need for sustainable and appropriate information and education on sexual and reproductive health and reproductive rights.¹⁶ The Special Rapporteur on the Right to Education in his 2010 report to the United Nations General Assembly¹⁷ interprets ICPD to mean, “states must ensure that they do not restrict individuals’ access to appropriate services and necessary information and must remove social and regulatory barriers to information on sexual and reproductive health and health care”. It is through education that populations can learn more about their rights and how to access them; this includes reproductive rights.

As set out in the Report of the Special Rapporteur on the Right to Education, sexuality is an aspect inherent in all human beings and includes various personal and social factors. Nonetheless, sexuality is many times kept hidden due to religion, ideology or culture. These reasons are often connected to patriarchy, which is a system of social order imposing the supremacy of men over women and determining strict roles for men and women. This system causes and perpetuates serious and systematic human rights violations, such as violence and discrimination against women. Education is a main tool in combating patriarchy, promoting equality between individuals and advancing reproductive rights.

States must guarantee that all persons receive sufficient education to prepare them to claim their rights, including reproductive rights, and support gender equality; this kind of education acts as a guarantor of a democratic and pluralistic environment. A comprehensive sexuality education from the outset of schooling and through the educational process will enable individuals to look after their own health responsibly and respectfully, allowing men and women to claim their reproductive rights and respect other persons’ reproductive rights. A comprehensive sexuality education will also consider and challenge stereotypical gender roles. It will not only look into women’s issues, but will also involve men, who can benefit from less rigid roles and more egalitarian relationships.

Sexuality education must be adapted to different age groups and cultures.¹⁸ Furthermore, teaching methodologies must take the differences between boys and girls into account. Sexuality education is extremely important in the view of the threat of HIV/AIDS and sexually transmitted infections, especially for vulnerable groups, such as women and girls exposed to sexual violence and children living on the street. Enjoyment of the right to sexuality education plays a crucial preventive role and may be a question of life or death.

16 See e.g. Chapters 7 and 11

17 A/65/162 Report of the United Nations Special Rapporteur on the Right to Education, 23 July 2010.

18 See UNESCO. *International Guidelines on Sexuality Education: An evidence informed approach to effective sex, relationships and HIV/STI education*, 2009.

BOX 6. COMPREHENSIVE SEXUALITY EDUCATION: PROMOTING REPRODUCTIVE RIGHTS AND GENDER EQUALITY (CONT.)

Sexuality education is especially important in ensuring the enjoyment of women's right to live free of violence and gender discrimination, given the historically unequal relations between men and women. The Committee on the Elimination of Discrimination Against Women has called upon state parties to implement sexuality education programmes and has recommended the expansion of sexual and reproductive health programmes as a necessary means for preventing high abortion and maternal mortality rates.

Additionally, comprehensive sexuality education is a basic tool for achieving many of the Millennium Development Goals, such as promoting gender equality and empowering women (Goal 3), reducing child mortality (Goal 4), improving maternal health (Goal 5), and combating HIV/AIDS (Goal 6).



INCREASE PUBLIC AWARENESS

THE OMBUDSMAN'S OFFICE FOR THE DEFENCE OF HUMAN RIGHTS

DEEPENING THE KNOWLEDGE ON REPRODUCTIVE RIGHTS IN EL SALVADOR

The Salvadorian NHRI has worked with reproductive rights in its department dealing with women's and family rights. The department has deepened its knowledge in this area and has worked to promote these rights in Salvadorian society.

The *Procuraduría* has campaigned in order to promote and educate the citizenry on women's rights focusing on the reporting of any kind of violence committed against women. These campaigns have included the promotion of reproductive rights.

AUSTRALIAN HUMAN RIGHTS COMMISSION

WORKING FOR A BETTER WORK ENVIRONMENT

In 2001 the Australian Human Rights Commission issued Pregnancy Guidelines, which sets out the rights of employees and the obligations of employers in relation to pregnancy. The Guidelines, which were prepared after consultation with unions and employers, cover issues of pregnancy-based discrimination through all aspects of the employment relationship, including recruitment, employment and dismissal. They also address the overlap between discrimination and industrial and occupational health and safety obligations. The Guidelines use basic principles and case studies to illustrate rights and responsibilities and to provide practical advice.

NHRIs should take steps to increase public awareness about human rights and efforts to combat all forms of discrimination, especially through information and education and by making use of the press, cf. the Paris Principles. A NHRI can take various steps to increase awareness of reproductive rights:

1. **Broad information campaigns**, targeting all of the population, can be useful. Even though the burden of reproductive rights

violations falls on women – and precisely because of that – it is important that information campaigns (and other initiatives with respect to reproductive rights) target both women and men and all age groups. Such campaigns can have many elements that should be based on a thorough assessment of the best way to reach broad audiences:

- a. The NHRI can print and make available reading materials such as **pamphlets and posters** and similar material. Such material should be translated into all relevant languages and should be available for persons with disabilities, such as seeing and hearing impaired.
 - b. A broad information campaign should include a **media strategy**. In many countries electronic media like television and particularly radio reaches a much broader audience than print media.
 - c. **Performing arts**, such as drama, dance and song, can be effective tools in creating awareness and stimulating discussions.
 - d. Ideally **community outreach** should be part of broad information campaigns.
2. In addition to broad based campaigns, it should be considered which **special groups** need particular attention:
- a. Certain **professional groups** should be targeted. Additionally to health care professionals, social workers, teachers, law enforcement professionals, and prison staff should be sensitized about the special needs of persons they come into contact with. Prison staff, for example, should be sensitized on pregnant prisoners and prisoners with young children and of the risk of sexual abuse and transmission of STIs within correctional facilities.
 - b. It is central that **decision-makers**, such as parliamentarians and local politicians, have a reasonable understanding of reproductive rights, especially since many aspects of reproductive rights can only be realized by positive action by the states.
 - c. In most countries and cultures **traditional or religious leaders** are of primary importance, especially when it comes to matters touching upon gender and family issues, such as reproductive rights. Since religion and culture can be seen as principal obstacles to achieving certain aspects of reproductive rights, the value of getting traditional and religious leaders on-board cannot be overstated.
 - d. Special steps might be needed to reach **marginalized, excluded and vulnerable groups**. It cannot be assumed that groups that are outside mainstream society will necessarily be reached by information campaigns aimed at the broad population. Such groups might include remote communities, indigenous communities and the extremely poor. When assessing the success of awareness raising, in addition to – or maybe rather than – looking at the number of persons reached, it should be considered whether the most excluded groups have been reached.
- Certain groups might be stigmatized, such as sex workers, while at the same time being at particular risk of threats to reproductive and sexual health. In many countries

moral stigmatization is compounded by criminal laws and restrictive regulations, female sex workers especially prone to sexual abuse not just from customers and pimps but also from the police force. Special strategies are needed to reach sex workers. Similar issues may be relevant for LGBT persons.

3. A specific way of raising awareness while also monitoring the situation, giving victims and other stakeholders a chance to be heard and coming up with concrete proposals for steps to take with respect to both legislation and policy is the **national inquiry**. There is no clear-cut definition of a national inquiry but it will normally mean a

process that includes a study and analysis of complaints received and other material already accessible to the NHRI; additional desk and field research, if needed; public meetings; and a comprehensive report with description and analysis of the situation and proposals for changes to regulations and policy. A national inquiry will normally be relevant in cases where widespread violations are expected or documented and where it seems likely that systemic problems rather than (or in addition to) individual transgressions are to blame. It will be relevant to consider partnerships, both nationally and with development partners, like UNFPA and other United Nations organs.

KENYA NATIONAL COMMISSION ON HUMAN RIGHTS (KNCHR)

NATIONAL PUBLIC ENQUIRY ON SEXUAL AND REPRODUCTIVE HEALTH

After receiving a complaint from two civil society organizations, alleging violations of reproductive rights at public health facilities, in particular at a specific maternity hospital, supported by research showing widespread problems, such as delays in providing reproductive health care, inadequate access due to prohibitively high fees, the detention of women at health facilities due to the inability to pay bills, negligence and mistreatment during delivery, and issues relating to discrimination and lack of consent for HIV testing, KNCHR decided to carry out a national public inquiry on sexual and reproductive health. Preliminary research had indicated widespread violations and problems and it seemed relevant to give victims a platform to speak out. The inquiry was launched on 7 June 2011.

The objectives were established as follows:

1. To establish the legal and policy framework governing the implementation of sexual and reproductive health rights in Kenya and its effectiveness;

KENYA NATIONAL COMMISSION ON HUMAN RIGHTS (KNCHR) (CONT.)

2. To assess compliance by the government and non-state actors with sexual and reproductive health rights;
3. To determine the extent of sexual and reproductive health awareness and utilization;
4. To identify and document cases of discrimination and violation of sexual and reproductive health and rights.

The steps taken included preliminary desk and field research, a public launch at the start, a comprehensive literature review, visits to health facilities and focus group discussions countrywide, six public hearings (with a panel involving both commissioners and external experts) and a final experts' forum to weave together the issues raised. In addition to the public hearings, written submissions were invited.

Two forums were held for stakeholders to provide input to the objectives of the hearing and to discuss how victims could be mobilized to participate.

At the end of the process, a report with findings and recommendations was presented to Parliament and Government (April 2012) for adoption and implementation. KNCHR will continue to lobby for this to happen and will monitor progress.

The report can be found on

http://www.knchr.org/Portals/0/Reports/Reproductive_health_report.pdf.

COMPLAINTS HANDLING

A NHRI with a general mandate to receive and consider individual human rights complaints is by definition in a position to receive and consider complaints pertaining to reproductive rights. These complaints should not be handled any differently than other human rights complaints. Just as it is the case with all other complaints, it is of key importance to have staffs that are knowledgeable with respect to the legal area in question. As

stated above, having staffs that are properly trained on issues relating to reproductive rights is in any event necessary for a NHRI that wants to work in this field.

Reproductive rights are part of the larger right to health, protected among other things by the International Covenant on Economic, Social and Cultural Rights. According to the Covenant, the right to health is

subject to **progressive realization**. NHRIs can use the complaint handling mechanism to monitor the progressive realization of reproductive rights. Complaints can indicate the government's failure to take determined steps (such as establishing benchmarks and targets), retrogression, discriminatory measures and failure to use maximum available resources. On the other hand, total lack of complaints concerning reproductive rights can be a symptom that the general population is not aware of their rights or of the right to complain.

If the NHRI in question is not used to dealing with rights subject to progressive realization (which is the case for most of the rights protected by International Covenant on Economic, Social and Cultural Rights), complaints concerning the right to sexual and reproductive health might be difficult to handle. The principle is set out in Article 2.1 of the Covenant, according to which each state party *“undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures”*. General Comment 3 (1990) of the Committee on Economic, Social and Cultural Rights clarified the meaning of progressive realization. Accordingly, states are obliged to *“move as expeditiously and effectively as possible towards [full realization]. Moreover, any deliberately retrogressive measures in that regard would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full*

use of the maximum available resources”. The General Comment also refers to **minimum core obligations** that must in any event be provided; this includes, among other, essential primary health care, the provision of essential drugs (including medicines related to reproductive health and essential contraceptive commodities) and the provision of reproductive maternal and child health care.

Another difficulty that would seem mainly to be relevant in cases concerning lack of provision of medical services is that certain cases will hinge on **very technical medical evaluations**. For this reason the **Portuguese NHRI** declines to handle cases concerning alleged lack of proper medical attention leading to maternal and/or infant mortality and rather refers such cases to authorities considered more proper. It could be argued that courts are also not equipped with medical knowledge and still have to deal with complex issues of medical errors and other cases of similar complexity. Rather than simply declining to consider such issues, NHRIs should consider ways in which to get sufficient information to handle such cases. This could involve obtaining affidavits from relevant experts or hearing expert witnesses, in a manner similar to the actions of a court, and then, just like a court would do, make a legal, human rights and evidence-based assessment.

A NHRI can only be an effective route to justice in individual cases if the general population is **aware of the possibility to submit complaints** to it. Information on how to exercise these mechanisms should be an important component of broad campaigns on reproductive rights.

A NHRI might have the power to **bring matters to court** if its decisions are not being adhered to; NHRIs should be prepared to use this power also with respect to reproductive rights. NHRIs should also consider intervening in court cases touching upon reproductive rights issues as friends of the court (*amicus curiae*) to ensure that the relevant human rights provisions are taken

into account by the courts. When deciding what cases to bring, a NHRI should consider the public interest in a given matter, e.g. whether there is a good chance of establishing new legal precedents that will enhance the protection of reproductive rights. Such strategic litigation can be done in collaboration with civil society, unless this might prejudice the independence of the NHRI.



3

PROMOTING REPRODUCTIVE RIGHTS THROUGH A HUMAN RIGHTS-BASED APPROACH TO DEVELOPMENT

A Human Rights-Based Approach (HRBA) can be defined as a conceptual and analytical framework that integrates human rights norms, standards and principles into all development work. The United Nations Statement of Common Understanding of Human Rights-Based Approach to development cooperation and programming includes:

1. All programmes of development cooperation, policies and technical assistance should further the realization of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments.
2. Human rights standards contained in, and principles derived from, the Universal Declaration of Human Rights and other international human rights instruments guide all development cooperation and programming in all sectors and in all stages of the programming process.
3. Development cooperation contributes to the development of the capacities of 'duty-bearers' to meet their obligations and of 'right-holders' to claim their rights.

In addition, UNFPA includes the key elements of cultural sensitivity and

gender-responsiveness within its understanding of a HRBA to programming.¹

In a HRBA to programming, all development efforts pursue a desirable **outcome** through a legitimate **process**. In a HRBA to development, human rights standards define the desirable outcome, and human rights principles ensure the legitimacy of the process. In that sense a HRBA offers objective criteria in defining both the ends and means of development efforts.

HRBA is based on a list of basic human rights principles developed by the United Nations that are of consequence for development initiatives. The principles that form the fundamental basis of a HRBA are:

- Universality, inalienability, and indivisibility of human rights;
- Interdependence and inter-relatedness;
- Equality and non-discrimination;
- Participation and inclusion; and
- Accountability and rule of law.

¹ UNFPA *A Human Rights-Based Approach to Programming*, 2010, p. 70. This whole chapter owes much to Module 2 of the said publication.

Under a HRBA, all phases of the programme cycle are anchored in a system of rights and corresponding obligations established by international law. While there is no universal recipe for a HRBA, a HRBA can add important dimensions to development practice such as:

- When human development is based on a HRBA, it provides a strengthened platform for political advocacy and social mobilization, since programming goals are based on universally agreed principles and national and international legal frameworks that underline the accountability of duty bearers.
 - HRBA provides an analytical lens to understand the complexity of development problems, including the identification of underlying and root causes of problems, in order to put in place more integral policy and programming responses. In the area of sexual and reproductive health, for instance, a HRBA can contribute to more integral multisectoral responses beyond a health sector approach and vertical programming interventions such as in the areas of maternal health or family planning.
 - HRBA increases focus on the most marginalized and excluded in society as their human rights are the most widely denied.
 - HRBA increases human rights awareness and participation of the most marginalized in development processes. By empowering people to exercise their rights, a HRBA leads to more sustainable results and reduces risks of setbacks in the development agenda.
- HRBA promotes the rule of law thereby reducing impunity, creating avenues for accountability and increasing access to justice.
 - The integration of human rights principles of participation, accountability and equality and non-discrimination in the development process reduces the risk of elite capture of development resources and enhances the capacity to challenge underlying structures leading to inequality.
 - HRBA helps to reduce the risk of violence by detecting growing conflicts and providing a legitimate framework of entitlements and obligations to address them.

United Nations agencies first designed and implemented HRBA in the context of development programming during the 1990's. Since then, more organizations, including cooperation agencies, multilateral organizations and NGOs, have been gradually incorporating a HRBA in their policies and practices. Following a commitment by member states to integrate human rights in their development policies at the World Summit Outcome in 2005, more states are adopting a HRBA in the area of planning and budgeting as well as in other spheres of governments' work. NHRIs, NGOs and other stakeholders working on human rights and development are instrumental in supporting the government to apply a HRBA while also adopting a HRBA in their internal policies and practices.

UNIVERSALITY, INALIENABILITY, INDIVISIBILITY AND INTERDEPENDENCE OF HUMAN RIGHTS

Human rights are universal, meaning that they apply to all human beings all over the world, and inalienable, meaning that they can neither be voluntarily given up nor forcibly taken away. Consequently, when monitoring the work done by the state with respect to reproductive rights and when providing advice to government and parliament, attention should be paid to ensuring that no groups are ignored (such as adolescents, women living in poverty, rural groups, indigenous groups, LGBT persons, sex workers, persons with disabilities, migrants, children etc.). When designing its own programmes, a NHRI should make sure to consider all groups even though a NHRI can decide to focus on one or more groups based on a needs assessment. Similarly, due to resource constraints, a government might legitimately decide to begin by providing services to the most excluded groups.

In addition, human rights are indivisible. Whether of a civil, cultural, economic, political or social nature, they are all inherent to the dignity of every human person. Therefore, they all have equal status as rights, and cannot be ranked, a priori, in a hierarchical

order.² With respect to reproductive rights, a NHRI should make sure all elements of reproductive rights are protected, respected and promoted.

Lastly, human rights are interdependent and interrelated. The realization of one right often depends on the realization of another right. The right to life can be affected by the lack of access to reproductive health care, and women's right to political participation can be connected to the effectiveness of reproductive rights (women who can decide whether and when to have children have a better chance to participate in the political debate, for example). This principle encourages NHRIs to take a holistic look when considering reproductive rights. It also encourages NHRIs to look broadly when considering with whom to collaborate in the furthering of reproductive rights.

In Chapter 4 the different rights that together constitute reproductive rights are expounded upon, stressing the interdependence and interrelatedness of human rights.

² United Nations. *The human rights based approach to development cooperation: Towards a common understanding among United Nations agencies.* (2003).

EQUALITY AND NON-DISCRIMINATION

According to the Universal Declaration of Human Rights all individuals are equal as human being. By virtue of the inherent dignity of each human person all individuals shall be treated without discrimination of any kind, such as on the basis of sex, age, race, colour, religion, property, disability,

language, national or social origin, political or other opinion, birth or other status, such as sexual orientation and marital status.³

³ Committee on Economic, Social and Cultural Rights General Comment No. 20.

Non-discrimination is linked to equality and to providing special attention to vulnerable groups in order to secure actual equal treatment. Discrimination is unacceptable even when it is not intentional, and, by virtue of the state obligation to protect, states are accountable even if the discrimination is caused by a private actor. At the work place, for instance, a private employer cannot discriminate against a woman due to her marital status and the fact that she is in her reproductive years. If that happens, the state has the obligation to intervene. The lack of action by the state to prevent this type of discrimination is a breach of the right to non-discrimination and the violating state can be held accountable.

Discrimination by private actors is especially relevant to health issues, including reproductive health issues, as it is forbidden to deny a person access to health care based on this person's attachment to a particular group, nationality, gender, age, HIV-status etc. For example, if health professionals deny young unmarried women access to contraceptives based on marital status, a case of discrimination under state responsibility could be made. The state must ensure such incidents do not happen by passing non-discrimination legislation as well as ensuring suitable contractual provisions and education initiatives.

It is prohibited to deny women access to healthcare, including reproductive health-care, because they are women. This is understood to mean that the state cannot deny health services that only women need, such as services related to pregnancy, pregnancy related complications, and post abortion care. It is also forbidden to discriminate against women due to their marital status or

for any other reason, such as HIV status or pregnancy.

Non-discrimination obligations go beyond states' non-interference with individuals' rights. Arising from their obligations to combat discrimination, states have a duty to ensure that health information and services are made available to all individuals, including marginalized and excluded groups. It is also crucial that states take action and ensure that the laws passed and their policies not only do not discriminate against specific groups but also secure actual equal treatment. Laws must take into consideration *de facto* differences to guarantee equality. Furthermore, states must take steps to empower women to make decisions in relation to their sexual and reproductive health free of coercion, violence and discrimination. It is the state that has to ensure that women and girls can make these decisions free from discrimination. If women and girls do not have this right, the state must take measures to ensure that they do by, for example, using affirmative measures. The principle of non-discrimination also obliges the state to make sure that all groups have similar access to (reproductive) health care, irrespective of sex, age, ethnicity, domicile, disability, etc. This entails among other things making sure that even the poorest person living far from urban centres can access reproductive health care.

Non-discrimination and equality measures have to be thought through the entire state apparatus. It is not sufficient for a piece of legislation to be for example gender neutral if in practice discriminates against women or other groups. Laws and policies approved by states have to promote *de facto* equality, which is to say that results and



consequences of these laws or policies are actually equal for all persons.

According to the Committee on the Elimination of All Forms of Discrimination against Women, violence against women is a form of discrimination against women. States must take action to redress violence against women and ensure that there are sensitive counselling services available for the survivors of gender-based violence, including rape and incest. As it has been explained above, violence against women directly affects women's reproductive rights and their right to sexual health.

Furthermore, states should ensure that adolescents are not discriminated against but are able to receive information, including on family planning and contraceptives, the

dangers of early pregnancy and the prevention of sexually transmitted infections including HIV/AIDS, as well as appropriate services for sexual and reproductive health.⁴ Adolescents should not be discriminated against due to their young age; on the contrary, they have to be placed at the centre of policies and laws dealing with reproductive matters.

It is a fundamental role for a NHRI to monitor that a state does not discriminate with respect to the protection of reproductive rights and to provide relevant input in this respect when the state develops and implements its policies.

4 Paul Hunt and Judith Bueno de Mesquita. *The Rights to Sexual and Reproductive Health*. University of Essex, Human Rights Centre.

BOX 7. AGEING WOMEN AND REPRODUCTIVE RIGHTS

When working with reproductive rights, the focus tends to be on persons of reproductive age – and rightly so since many of the most egregious issues, such as preventable maternal mortality and morbidity, are most relevant for this age group. However, it is important not to overlook the fact that persons above the reproductive age have reproductive health issues that should be taken into account when taking a holistic approach to reproductive rights. The ICPD refers to the need to secure reproductive health services “suitable for different age and cultural groups and for different phases of the reproductive cycle”.⁵ The need to take a life cycle approach has also been confirmed in the practice of e.g. the Committee on the Elimination of All Forms of Discrimination against Women.⁶ This box aims at given some information on the issues relevant to ageing women, even though it is acknowledged that ageing men also have health concerns based on sex.⁷ Nevertheless, there are more women in older age than there are men and women bear a heavier burden. Due to women’s structural discrimination in general and their role in reproduction, reproductive health issues for ageing women are more acute than for ageing men.

“Older women” normally refers to women aged 50 and older, whereas the term ageing women acknowledges that ageing is a process that occurs differently for different individuals and groups. Women who endure a lifetime of poverty, malnutrition and heavy labour may be chronologically young but functionally old at age 40. Women are usually more vulnerable than men are in older age. Specific issues include: lack of access to education; childbirth without the adequate health care; low income and inequitable access to decent work; domestic violence, which may begin in childhood, continue in marriage and is a common form of elder abuse; and cultural traditions and attitudes that limit access to health care in older age.

Some issues are especially relevant when ageing women and reproductive rights are concerned. One of them is the fact that ageing women remain at risk for HIV/AIDS and other sexually transmitted infections. Once infected, ageing women face a disproportionate burden of illnesses directly or indirectly caused by STIs, including AIDS resulting from HIV infection and cervical cancer as a result of the transmission of the human papillomavirus (HPV).

Cervical cancer kills approximately 274,000 women every year; it is the most common cancer in women and the leading cause of cancer deaths in developing countries. Providing girls with a vaccine to prevent the infection from HPV raises the possibility of eliminating the

5 ICPD Program of Action, sect. 12.12.

6 See Committee on the Elimination of All Forms of Discrimination against Women, General Recommendation, No. 27 on older women and protection of their rights and Concluding Observations, e.g. Panama and Uzbekistan, both in 2010.

7 For more information, see *Women, Ageing and Health: A framework for action*, WHO and UNFPA, (2007) which is also the main basis for this box.

BOX 7. AGEING WOMEN AND REPRODUCTIVE RIGHTS (CONT.)

incidence of cervical cancer in the future. Meanwhile, it is crucial to provide ageing women pap smear screening or other low-cost prevention and screening technologies.

NHRIs working with reproductive rights must try to dispel the myth that older women are not sexually active. Sexual health care, education and knowledge about STIs and HIV/AIDS are important not only for women of reproductive age, but for girls and for women in all stages of life. NHRIs should allow and promote the participation and representation of older people, and older women in particular, in HIV/AIDS programme planning at local, district and national levels to improve the response to HIV/AIDS.

Another concern connected to ageing women and reproductive rights is abuse and gender-based violence in the home. Many older women are abused or neglected while sometimes still remaining caregivers to those who abuse them. Older women who are abused are more likely to suffer from depression, anxiety and physical disabilities. The effects may also be fatal as a result of homicide, severe injury, or suicide. NHRIs have to address violence against women and include older women in their programmes of action.

PARTICIPATION AND INCLUSION

Participation is a human right guaranteed in several human rights instruments. Participation and inclusion means that every person and all groups are entitled to active, free and meaningful participation in, contribution to and enjoyment of development in which human rights and fundamental freedoms can be realized. This ensures that everyone feels ownership to both the processes and the results.

Participation and empowerment are interrelated. Participation is not only about consultation, but also about actual empowerment of people, enabling them to take part in decision-making processes that affect them. It is necessary to create specific channels for participation throughout any programming process focusing especially on the most vulnerable and marginalized groups. Where reproductive rights are concerned, focus

must be put on women, especially adolescent girls. Young men and adolescent boys must also be included, in particular when the use of contraceptives is concerned and when steps are taken to alter conceptions of gender roles. It is important to empower women so that they can freely decide on the issues that affect their bodies and to educate men to support gender equality.

Empowerment further entails inclusion and accountability. Consequently, beneficiaries, stakeholders and partners must be included when deciding about reproductive rights strategies and goals, and services providers must always be held accountable. Empowerment should not only be a concern for the outcome of development, but also for the *process* by which it is achieved and for the organizations implementing it.

Participation should be regarded not only as a tool but also as a goal for achieving universal access to reproductive rights because participation means that the affected people have decided for themselves. Participation is closely connected to ownership and is therefore paramount when implementing reproductive rights.

Empowerment and participation are also connected to the right to information as one cannot be empowered and participate without proper information. In the case of reproductive rights, information on contraceptives, HIV/AIDS and other STIs, cervical cancer, family planning and pre- and post-natal health care should be widely available. Similarly, access to information, including information on government policies, budgetary allocations and public expenditure, is a prerequisite for

accountability and meaningful participation in all stages of policymaking, implementation and monitoring and evaluation. On that account, local, regional and national entities dealing with sexual and reproductive health and reproductive rights must be accessible to the population. Information relating to reproductive rights should be available, transparent and timely and in a form and language that can be accessed also by the most vulnerable, the illiterate etc.

In its own programmes, a NHRI should take steps to ensure the participation of all stakeholders, including marginalized groups. Among the issues that a NHRI should focus on when working with reproductive rights is that the state designs its programmes in such a way as to ensure proper participation and empowerment of the concerned individuals and groups.

ACCOUNTABILITY AND RULE OF LAW

States and other duty-bearers have to comply with the legal norms and standards enshrined in human rights instruments. Where they fail to do so, rights-holders should be able to institute proceedings for appropriate redress before a competent court, a NHRI, an administrative body or similar in accordance with rules and procedures provided by law, thereby holding duty-bearers accountable for the non-compliance with human rights norms and standards. Planning, design and implementation of government policy should be done in a transparent manner to give right-holders a real possibility to hold duty-bearers accountable during all phases.

This requires clear roles and responsibilities, transparent decision-making processes and criteria, access to information, and effective mechanisms to demand accountability. In addition to ensuring that the processes are transparent at all levels and that there are recourse opportunities, it is necessary to build the capacity of rights-holders (individuals and groups) to ensure that they can make use of the means afforded them.

Accountability is not only important in the duty-bearer/rights-holders relationship, but also among duty-bearers themselves. In the health system, especially where reproductive health is concerned, accountability between health workers and the users they

serve is linked to internal accountability between health workers and the health systems in which they work. In Ceará, **Brazil**, the central government helped create such a synergy by actively establishing relationships between government, communities and health workers. Central government would only start a programme if communities demanded local government to co-sponsor it. Once started, the programme recruited health workers through transparent and public processes that informed communities about the nature of the programme, the qualifications required of health workers, and their expectations with respect to the services provided. In addition to community support and monitoring, health workers were supported through technical training, supervision, and morale building publicity campaigns. Lastly, central government ensured that all stakeholders stood to gain from supporting the programme and thus

pre-empted negative interference from both supervising nurses and local party representatives.⁸

A NHRI can help to secure accountability and rule of law by carrying out its protective mandate, including by accepting complaints concerning alleged violations of human rights and by monitoring closely how the state adheres to decisions and recommendations. It can also help by advising government on how to design transparent and open processes. Sensitization campaigns should help build capacity among the rights-holders on how to hold the duty-bearers to account.

⁸ George, Asha, "Accountability in Health Services, Transforming Relationships and Contexts". Harvard Center for Population and Development Studies, Harvard School of Public Health, Working Paper Series, Vol. 13, No. 1, February 2003.

THE 3AQ – AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND QUALITY

Reproductive rights are directly connected to the right to health (among other rights, see Chapter 4). The right to health entitles women "to reproductive health care services, goods and facilities that are"⁹ available, accessible, acceptable and of good quality. HRBA applies the normative content of the right to health by ensuring that development outcomes and interventions are consistent with the guidance provided by the 3AQ framework. For instance, public policies aiming at universal access to sexual and reproductive health should include con-

crete interventions and programme deliverables to ensure that health services meet a minimum level of quality and are culturally acceptable for the intended users.

The 3AQ framework in relation to reproductive rights is further developed below:¹⁰

Availability: Sexual and reproductive health and health care facilities, goods and services, as well as programmes, should be available in sufficient quantity within the country. This includes not only hospitals,

⁹ Special Rapporteur's Report A/61/338 to the UNGA, "The right of everyone to the enjoyment of the highest attainable standard of physical and mental health", 2006

¹⁰ Greatly inspired by and quoting from "UNFPA – A Human Rights-Based Approach to Programming", 2010, pp. 177-178.

clinics and other health-related facilities with trained medical and professional personnel and essential drugs (including antiretroviral therapy) as defined by the WHO Action Programme on Essential Drugs but also other sexual and reproductive health related services, such as information material and contraception. Underlying determinants of the right to health such as safe and potable drinking water and adequate sanitation facilities are normally also considered included.

Accessibility: Sexual and reproductive health facilities, goods and services have to be accessible to everyone without discrimination, within the country. Accessibility has four overlapping dimensions:

1. *Non-discrimination:* Sexual and reproductive health facilities, goods and services must be accessible to all, especially the most marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds, such as ethnicity, belief, age, sex, health status, disability, or any other status such as sexual orientation and marital status.
2. *Physical accessibility:* Sexual and reproductive health facilities, goods and services must be within safe physical reach for all sections of the population, especially marginalized groups, such as women, those living in poverty, adolescents and youth; women survivors of violence and abuse; persons living with HIV; sex workers; minorities and indigenous people; persons living with disabilities; refugees and internally displaced persons; and aging persons. Accessibility also implies that medical services and underlying determinants of health, such

as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities. Information material must be accessible in all languages and to the visually impaired and the illiterate.

3. *Economic accessibility (affordability):* Sexual and reproductive health facilities, goods and services must be affordable for all. Payment for sexual and reproductive health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equality, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equality demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
4. *Information accessibility:* Accessibility includes the right to seek, receive and impart information and ideas concerning sexual and reproductive health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

Acceptability: All sexual and reproductive health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned. As can be seen, this

deals with issues similar to UNFPA's additional key element of a HRBA, namely being cultural sensitive and gender-responsive.

Quality: Sexual and reproductive health facilities, goods and services must be

scientifically and medically appropriate and of good quality. This requires, for example, skilled medical personnel, scientifically approved and unexpired drugs, hospital equipment and contraception, safe and potable water, and adequate sanitation.

APPLYING A HRBA TO THE DEVELOPMENT OF POLICIES AND PROGRAMMES¹¹

PLANNING AND BUDGETING

Guaranteeing the right to health obliges states to adopt a national public health strategy and plan of action that contains a sexual and reproductive health and rights strategy, encompassing maternal health, sexuality education and access to voluntary family planning. In addition to having a sectoral health strategy that incorporates sexual and reproductive health, multisectoral strategies, such as national development strategies and poverty reduction strategies are key in addressing underlying determinants of health and reproductive rights issues that usually fall outside the responsibility of the health sector but are essential for achieving more sustainable and equitable health outcomes.

Obviously, the obligation of adopting a national development strategy and a national public health strategy and plan of action goes beyond the capacity of a NHRI; nonetheless, the NHRI can be a key player in

the development and monitoring of such strategies.

A comprehensive national public health strategy requires a situational analysis, where the most severely affected rights-holders are recognized and the duty-bearers with corresponding obligations towards those marginalized and excluded rights-holders are identified. This situational analysis then identifies the capacity gaps of rights-holders to claim their rights and of duty-bearers to meet their obligations. This analysis will translate into policies and plans that address the identified institutional and capacity gaps.

A HRBA to a situational analysis is guided by the following simple questions:

- What is happening to whom and where?
- Why is it happening? (What factors are e.g. preventing women, or certain women, from going safely through pregnancy and childbirth and enjoying their reproductive rights more broadly?)
- Who or what institutions are responsible for such factors, and for addressing the problem?

¹¹ The session has been inspired by the Report of the Office of the United Nations High Commissioner for Human Rights, A/HRC/21/22 *Concise Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, 18 May 2012.

- How to take action? (What do different duty-bearers need to do to address each factor?)¹²

NHRIs can assist governments in conducting rights-based analyses of sexual and reproductive health problems and in identifying the institutional and capacity gaps that need to be addressed.

In countries experiencing serious sexual and reproductive health challenges – such as for instance high levels of maternal mortality and high prevalence of new HIV infections –, governments, as the main duty-bearers, will typically be confronted by gaps in their ability to ensure that sexual and reproductive health services are available, accessible, and acceptable and of good quality. According to WHO, the following are essential interventions to improve maternal health¹³ (and to the realization of reproductive rights):

- Family planning;
- Prevention and management of sexual transmitted infections, including HIV;
- Management of unintended pregnancies, including access to safe abortion services, wherever legal, and post-abortion care;
- Detection of domestic violence;
- Management of pre-labour rupture of membranes and preterm labour;
- Induction of labour for prolonged pregnancies;

¹² A/HRC/21/22, para 46

¹³ A/HRC/21/22, para 26

- Prevention and management of postpartum haemorrhage;
- Caesarean sections; and
- Appropriate postpartum care.

The role of NHRIs is to make sure, through involvement in the policy making process or by reviewing the policy, that all these elements are part of the national public health strategy.

From a rights-holders perspective, NHRIs can ensure that health strategies and plans and, more broadly, national development strategies also address the legal barriers as well as the institutional and capacity gaps that prevent marginalized and vulnerable groups from accessing sexual and reproductive health services, from claiming their rights and from participating actively in the formulation of the said strategies and plans.

To ensure effective implementation in furthering universal access to sexual and reproductive health, the national public health strategy has to be accompanied by deliberate steps in terms of financing, population coverage and service expansion. Ensuring a HRBA continuum in the interface between policy and budget formulation is another important step in the planning process for which the contribution of NHRIs is fundamental.

As part of a multi-sectoral response, the government has to match up the identified institutional and capacity gaps with relevant budgetary allocations across a range of ministries, departments and institutions. *“For example, addressing adolescent pregnancy must be done in conjunction with the Ministry*

of Education and will require adequate budgets for both health and education sectors.”¹⁴ Increasing budgetary allocations to NHRIs should also be considered in cases where the strengthening of national accountability systems for the protection of reproductive rights is one of the identified priorities.

NHRIs can play a special advocacy role in making sure that policy and budgetary decisions do not place a disproportionate financial burden on people, in particular women, living in poverty. Payment for certain health services should not impede accessibility to care. Furthermore, budgets should include provisions for ensuring accountability, including monitoring, access to justice for the poor, and both judicial and non-judicial mechanisms to facilitate timely redress.

IMPLEMENTATION

Depending on the issues identified as gaps in the provision of reproductive rights and the corresponding policy and budgetary decisions taken, NHRIs can be one of the duty-bearers in charge of taking action. For instance this will be the case where one of the main priority areas identified concerns the strengthening of national accountability systems and redress mechanisms for the protection of reproductive rights. As seen in the previous chapter, this can include the implementation of interventions to develop the internal capacities of the NHRI to engage with reproductive rights and the implementation of specific research, assessment and monitoring activities. Furthermore the NHRI can assist the government to implement specific training programmes to develop the capacity of state institutions and public officials from the

judiciary, the police and the administration to promote and protect reproductive rights.

As seen in the previous chapter, NHRIs can also support governments in the implementation of specific programmes aiming at the empowerment of rights holders to know and claim their reproductive rights. This can include the implementation of awareness raising campaigns or conducting trainings for civil society organizations, women’s groups, parents’ associations, journalists and professional associations regarding the human rights implications of sexual and reproductive health.

In cases where the NHRI acts as a duty-bearer through the implementation of public policies public, programmes and funds, a HRBA calls to ensure that appropriate mechanisms be put in place for the meaningful participation of concerned rights-holders, including marginalized and vulnerable groups, in the implementation process.

MONITORING

NHRIs can play a crucial role in monitoring as it has been shown above in Chapter 2. When monitoring the implementation of public policies, programmes and budgets for the realization of reproductive rights, NHRIS should look into:

- a. Changes in structural factors over time such as examining whether laws are adopted recognizing reproductive rights;
- b. Policy and budgetary efforts within and beyond the health sector such as the delivery of comprehensive quality sexual and reproductive health services and the implementation of

¹⁴ OHCHR, A/HRC/21/22, para. 37.

comprehensive sexuality education in schools;

- c. Concrete results in terms of women's sexual and reproductive health. This includes assessing the impact of sexual and reproductive health policies in reducing fertility rates, adolescent birth rates, maternal mortality ratios and the prevalence of sexually transmitted infections.

When dealing with quantitative factors, NHRIs need to assemble disaggregated data on sex, age, urban/rural residence, and ethnicity, level of education, wealth, disability and geographical location (if possible). Additionally, these indicators should be:

- a. Continuously or frequently measurable;
- b. Objective so as to permit comparison across time, countries and/or sub-regions;
- c. Programmatically relevant to enable priority setting and identification of accountability gaps; and
- d. Where possible subject to local audit to promote accountability to the populations served.¹⁵

One distinct feature of HRBA to monitoring and evaluation is the principle of accountability, ensuring independent review of governmental policy and budgetary efforts. NHRIs in compliance with the Paris Principles are in a privileged position to participate in government-led monitoring and

evaluation systems and to provide shadow reports, whenever necessary. NHRIs should bear in mind that the ultimate aim of monitoring and evaluation is to identify policy and systemic failures in order to recommend corrective actions and influence the formulation of the next policy cycle from a human rights perspective.

15 OHCHR A/HRC/21/22, para. 63.

4

REPRODUCTIVE RIGHTS AND HUMAN RIGHTS STANDARDS AND PRINCIPLES

The ICPD Programme of Action affirms in its paragraph 7.3 that reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. The following chapter outlines the legal basis for the rights that collectively constitute reproductive rights. In addition to referring to binding international and regional human rights instruments, reference will be

made to decisions, comments and concluding observations of the various international human rights bodies and mechanisms. An outline of these bodies and mechanisms can be found in Annex 1, which also contains extensive quotes of most of the United Nations comments, decisions and statements mentioned in this Chapter. Annex 1 also includes information on the African, American and European human rights systems.

NON-DISCRIMINATION AND EQUAL TREATMENT

NON-DISCRIMINATION AND EQUAL TREATMENT IN LAW

Articles 2(1), 3 and 26 of International Covenant on Civil and Political Rights contain provisions on non-discrimination. Article 2 reads: *“Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”*

Article 2(2) of International Covenant on Economic, Social and Cultural Rights also establishes the prohibition on discrimination, as does Article 2 (1) of the Convention on the Rights of the Child. The three main regional human rights treaties all contain non-discrimination clauses: Article 14 of the European Convention on Human Rights (ECHR), Article 1 of the American Convention on Human Rights (ACHR) and Article 2 of the African Convention on Human and Peoples’ Rights (ACHPR).

Especially relevant for reproductive rights issues is the Convention on the Elimination of All Forms of Discrimination against Women. Article 1 of the Convention on the Elimination of All Forms of Discrimination against Women defines discrimination against women, while Article 2 sets out what states shall do to combat such discrimination. This includes to:

NON-DISCRIMINATION AND EQUAL TREATMENT IN LAW (CONT.)

“embody the principle of the equality of men and women in their national constitutions or other appropriate legislation”;

“adopt appropriate legislative and other measures ... prohibiting all discrimination against women”;

“establish legal protection of the rights of women”, including through public institutions;

“refrain from engaging in any act or practice of discrimination”;

“take all appropriate measures to eliminate discrimination” by non-state actors;

“modify or abolish existing laws, regulations, customs and practices which constitute discrimination”; and

“repeal all national penal provisions which constitute discrimination”

The International Convention on the Elimination of all Forms of Racial Discrimination specifically prohibits of discrimination based on *“race, colour, descent, or national or ethnic origin”*, cf. Article 1. In the Convention on the Rights of Persons with Disabilities non-discrimination is among its general principles, cf. Article 3, and it is among the obligations of states to *“ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability”*. Article 5 recognizes the right to equal protection and equal benefit of the law, and Article 6 specifically recognizes the issue of double discrimination of women and girls with disabilities.

Temporary special measures can be used to ensure substantive equality (affirmative action) and do not constitute prohibited discrimination, cf. Convention on the Elimination of All Forms of Discrimination against Women Article 4, Convention on the Elimination of All Forms of Racial Discrimination Article 1 and Convention on the Rights of Persons with Disabilities Article 5.

Non-discrimination is a core principle guiding the human rights system. Every person has a right to enjoy human rights without discrimination. In addition, non-discrimination is a right in itself. The prohibition on discrimination can be found in all human rights

treaties. This right is paramount for the fulfilment of all other human rights and is an obligation of immediate effect. The right not to be discriminated against obligates states to take positive action to ensure equal enjoyment of rights.

Women's right to control their fertility through invoking the prohibition against all forms of discrimination against women may be considered a fundamental key that opens up women's capacity to enjoy other human rights.¹ When health clinics for example deny treatment to women that do not have their husband's consent, the health clinics are violating the non-discrimination clauses of the Convention on the Elimination of All Forms of Discrimination against Women and discriminating against women based on their marital status.

The equal enjoyment by men and women of the rights protected by the International Covenant on Economic, Social and Cultural Rights need to be addressed, having multiple discrimination in mind.² Multiple discriminations occur when a person is discriminated not just due to being, for example, a woman but also for being, for example, a member of an indigenous group. It is important to acknowledge this issue when considering how to secure reproductive rights for all as women belonging to vulnerable groups are often those with least access to reproductive services.³ It is similarly important to recall that formal equality, meaning laws and policies that on paper treat all in an equal manner, is not sufficient; laws and policies must be made in such a manner as to alleviate the disadvantage suffered by various groups, leading to substantive equality.

1 Cook, Rebecca, "International Protection of Women's Reproductive Rights", *New York University Journal of International Law and Politics*, Vol. 24, p. 645, 1991-1992.

2 Committee on Economic, Social and Cultural Rights General Comment No. 16 from 2005 on the equal rights of men and women.

3 In CEDAW/C/49/D/17/2008, Ms. Da Silva Pimentel vs. Brazil. The Committee on the Elimination of All Forms of Discrimination against Women found that the victim had been the subject of triple discrimination.

An example of indirect discrimination which not only treats women differently to men but which also violates the rights of women to decide if and when to have children is when women are not hired or are given low-level jobs because they might get pregnant. The notion of female inferiority and stereotypical gender roles perpetuate violations of women's reproductive rights and states are obliged to tackle such assumptions of inferiority.

"Eliminating discrimination in practice requires paying sufficient attention to groups of individuals which suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations. States parties must therefore immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination."

Source: Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 20, 2009

States should address discrimination in the private sphere, for example within families, by adopting measures, including legislation, to ensure that individuals are not discriminated on prohibited grounds in the private sphere. This is relevant for example when considering steps to prevent marital rape or women's lack of autonomy when it comes to decisions on reproductive rights.⁴

4 Committee on Economic, Social and Cultural Rights, General Comment No. 20, 2009.

In order to promote equality between men and women, biological as well as socially and culturally constructed differences must be taken into account. Under certain circumstances, such differences will require non-identical treatment. This is an important principle to keep in mind when dealing with sexual and reproductive health.⁵

On a few occasions, the Committee on the Elimination of All Forms of Discrimination against Women and the Committee on the Rights of the Child have mentioned that inequality between women and men often makes women unable to secure safe sexual practices, leading to increased exposure to HIV, and the need to empower girls and women in general.⁶

Unequal power relations based on gender are a core concern for reproductive rights, as inequality makes it difficult or impossible for women and adolescent girls to refuse sex or insist on safe and responsible sex practices. Inequality also influences the occurrence of harmful practices, such as female genital mutilation, polygamy and marital rape, increasing women's risk of contracting HIV/AIDS and other STIs.⁷

5 Committee on the Elimination of All Forms of Discrimination against Women, General Recommendation No. 25 from, 2004.

6 Committee on the Elimination of All Forms of Discrimination against Women Papua New Guinea, 2010, Committee on the Rights of the Child Angola 2010, Committee on the Elimination of All Forms of Discrimination against Women Burkina Faso 2010, Committee on the Elimination of All Forms of Discrimination against Women Uganda 2010.

7 Committee on the Elimination of All Forms of Discrimination against Women, General Recommendation No. 24, from 1999 on women and health.

Regarding HIV/AIDS, states should:

1. Intensify information dissemination to increase public awareness of HIV and AIDS, especially with respect to women and children;
2. Ensure that programmes to combat AIDS give special attention to the rights and needs of women and children and the factors relating to the reproductive role of women and their subordinate position in some societies; and
3. Ensure the active participation of women in primary health care and as care providers, health workers and educators in the prevention of infection with HIV.⁸

In relation to the girl-child, states should address the issue of gender-based discrimination. In combination with judgmental views on the sexual activities of girls, discrimination limits girls' access to preventive measures and other services. States should also take steps to protect the lives of children by paying attention to sexuality and behaviour even if it is outside of what is considered socially acceptable. Moreover, states must protect girls against harmful practices, such as early and forced marriages, which not only violate girls' rights but also increase the risk of contracting HIV. States are further obliged to put in place prevention programmes taking into account the reality of adolescent lives and ensuring equal access to appropriate information, life skills, and to preventive measures. Children, including

8 Committee on the Elimination of All Forms of Discrimination against Women, General Recommendation No. 15, from 1990 concerns discrimination against women in national strategies for the prevention and control of AIDS.

those affected by HIV/AIDS, should be involved in designing and implementing the relevant programmes and plans.⁹

In his report of 27 February 2007 to the Human Rights Council,¹⁰ the Special Rapporteur

on the rights of indigenous peoples noted the triple discrimination to which indigenous women are often victims (being indigenous, poor and female) and mentioned some examples of the consequences of this, such as substantially higher infant mortality and lower access to medical care during childbirth. These issues must be addressed by states.

9 General Comment No. 3 on HIV/AIDS and the rights of the child from 2003.

10 OHCHR A/HRC/4/32.

BOX 8. REPRODUCTIVE RIGHTS AND DISABILITIES

According to the WHO an estimated 15% of the world's population, more than 1 billion people, live with a disability.¹¹ Just as is the case for persons without disabilities, persons with disabilities have sexual and reproductive needs and are entitled to have their reproductive rights respected. Most of the barriers to their exercise of their rights stem from the ignorance and attitudes of societies and individuals, including health-care providers, rather than from the actual disabilities.

It is frequently assumed that persons with disabilities are not sexually active and therefore have no need for sexual and reproductive health services. This is not the case. Research shows¹² that persons with disabilities are as sexually active as persons without disabilities. Their reproductive rights need to be respected as much as the rights of non-disabled persons.¹³ Nonetheless, persons with disabilities are more often denied information about sexual and reproductive health. They have also been denied the right to decide whether, when and with whom to have a family.

Rights of persons with disabilities to access sexual and reproductive health are also connected to development. As mentioned, persons with disabilities make up 15% of the world's population overall. However, lower-income countries have a higher prevalence of persons with disabilities than higher-income countries. Disability is more common among women, older people, children and adults who are poor.

11 WHO. *Disability and Health*, Fact Sheet No. 352, (June 2011).

12 WHO and UNFPA. *Promoting sexual and reproductive health for persons with disabilities* (2009).

13 The Standard Rules on the Equalization of Opportunities for Persons with Disabilities, annexed to United Nations General Assembly resolution 48/96 of 20 December 1993, states in Rule 9, paragraph 2, that "persons with disabilities must not be denied the opportunity to experience their sexuality, have sexual relationships and experience parenthood".

BOX 8. REPRODUCTIVE RIGHTS AND DISABILITIES (CONT.)

A major step taken by the international community to promote and protect the rights of persons with disabilities was the adoption of the Convention on the Protection of the Rights of Persons with Disabilities (CPRD) in 2006. The Convention came into force in 2008. One of the most important characteristics of the Convention is its paradigm shift, making disabilities a societal problem, and not an individual one. State parties, not the individual person with disabilities, are responsible for the promotion of rights, including reproductive rights. Several articles of the Convention refer to sexual and reproductive health. Article 25 is especially relevant, requiring states to ensure equal access to health services for persons with disabilities, with specific mention of sexual and reproductive health and population based public health programmes.

While the promotion of rights for persons living with disabilities has generally progressed, there is still a long way to go. For example, according to WHO, *“persons with disabilities are up to three times more likely than non-disabled persons to be victims of physical and sexual abuse and rape. Persons with intellectual and mental disabilities are the most vulnerable”*.¹⁴

NHRIs can play a role promoting the rights of persons with disabilities through training, monitoring and raising awareness of the human rights issues involved. Just as NHRIs should try to mainstream their programmes with respect to gender, so they should with respect to disabilities. UNFPA and the WHO have come up with *“Ten key messages that raise awareness:”*

1. Disability is everyone's business.
2. Persons with disabilities are not necessarily sick.
3. Persons with disabilities have sex too.
4. Access means more than ramps.
5. Persons with disabilities want the same things in life that everyone wants.
6. For persons with disabilities prejudice can be the biggest barrier.
7. Everywhere and always, persons with disabilities are entitled to self-determination, privacy, respect and dignity.
8. It is best and usually easy to mainstream health services that accommodate persons with disabilities.

14 WHO and UNFPA, *Promoting sexual and reproductive health for persons with disabilities* (2009).

BOX 8. REPRODUCTIVE RIGHTS AND DISABILITIES (CONT.)

9. Persons with disabilities are a crucial constituency in all programmes.
10. Programmes best suit persons with disabilities when persons with disabilities help to design them. “Nothing about us without us” is a key principle.

RIGHT TO LIFE

THE RIGHT TO LIFE IN LAW

The right to life is protected by Article 3 of the Universal Declaration of Human Rights, Article 6 of the International Covenant on Civil and Political Rights, and the main regional human rights instruments such as ACHPR Article 4, ACHR Article 4, and ECHR Article 2. The right to life of the child and to survival is specifically protected by Article 6 of Convention on the Rights of the Child which obliges the member states “to ensure to the maximum extent possible the survival and development of the child”.

The most obvious human right violated by avoidable death, both for the mother and the child, during and after pregnancy and childbirth is the right to life. The World Health Organization has assessed that over 1,500 women and girls die every day as a result of preventable complications occurring before, during and after pregnancy and childbirth, and that, globally, maternal mortality is the leading cause of death among women and girls of reproductive age.¹⁵ A woman’s right to life entitles her to access basic reproductive health services. An infant’s right to life entitles him or her to basic health services at the time of and after birth to avoid for example the transfer of HIV.

The right to life should not be too narrowly interpreted but rather entails obligations on the states to adopt positive measures, e.g. to reduce infant mortality. This interpretation also obliges states to take other positive measures to protect life, including with respect to maternal mortality, prevention and treatment of illnesses such as HIV/AIDS.¹⁶ Article 6 of the International Covenant on Civil and Political Rights considers the issues of pregnancy- and childbirth-related deaths of women as well as practices such as female infanticide, the burning of widows and dowry killings.¹⁷

¹⁵ OHCHR A/HRC/11/L.16/Rev.1.

¹⁶ HRC, General Comment No. 6 on the right to life, adopted in 1982.

¹⁷ HRC, General Comment No. 28 from 2000 on equality between men and women.

BOX 9. RELIGIOUS AND CULTURAL ISSUES

The ICPD Programme of Action clearly acknowledged the importance of religious and cultural values for the area of reproductive rights, stating as one of the principles that the “*implementation of the recommendations contained in the Programme of Action is the sovereign right of each country, consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally recognized international human rights.*”

Reproductive rights deal with issues at the core of human existence. Many of the problematic issues, such as female genital mutilation, early marriages and the view of women as less valuable than men stem from cultural beliefs. Thus, the importance of religion, ethics and cultural beliefs within this field of human rights cannot be overstated. In the foreword to its publication, *CULTURE MATTERS Lessons from a Legacy of Engaging Faith-based Organizations*,¹⁸ UNFPA stresses that engaging faith-based organizations (FBO) and local leaders is critical to UNFPA’s development work and the promotion of reproductive rights. They are often reference points for their communities, are respected having high credibility in addition to providing the communities with spiritual and moral support and (in many cases) educational and health services. Furthermore, even though their approaches may differ, institutions like UNFPA and NHRIs, FBO and local leaders ideally share the same objective, being to uphold human dignity, serve people and to respond to the needs of the poor, the marginalized and the excluded. Finally, it is a matter of respect for the communities being served that their beliefs are taken seriously while upholding human rights including the right to development and gender equality as consistent and unwavering objectives.

In the 2010-2011 study *on Integrating Reproductive Rights into the Work of National Human Rights Institutions of the Asia-Pacific Region*, most respondents (all from NHRIs) identified culture and religion as major impediments to working with reproductive rights and this was repeated during the follow-up consultation in June 2011 in Kuala Lumpur. This was the case irrespective of the dominant religion of the country. There is every reason to assume that similar views would be expressed by NHRIs outside the Asia-Pacific region.

The Special Rapporteur on freedom of religion has undertaken a comprehensive study on freedom of religion or belief and the status of women in light of religion and traditions, which explains that much discrimination against women is “based on or imputed to religion.” The

18 *Culture Matters: Lessons from a Legacy of Engaging Faith-based Organizations*, UNFPA, 2008, can be downloaded from www.unfpa.org/public/home/about.

BOX 9. RELIGIOUS AND CULTURAL ISSUES (CONT.)

recommendations of this study highlight key actions required under human rights law to combat impermissible discrimination against women, and also points to the importance of working with religious groups and leaders as a key aspect of prevention.¹⁹

It is crucial for a NHRI that wants to engage in reproductive rights to consider how to deal with religious and cultural issues. Not only can this be considered a positive obligation in order to respect the views of the people being served, it is also often imperative if results are to be achieved. The question then remains how to do this. In this respect it is important to consider religion and cultural values not only as obstacles (which they can be) but also as potential beneficial factors. Certain religious and traditional values can actually be seen as benefiting reproductive rights just as religious and traditional leaders can become important allies in the struggle for the same rights.²⁰ It should also be kept in mind that in some countries religion is so important and religious leaders so powerful that without some collaboration with the religious structures, the chance of impact is extremely limited. However, working with religious leaders must not undermine the work of NHRIs in promoting gender equality, respecting the universal human rights of women and girls and promoting reproductive rights in general.

The big question, then, seems not to be whether religious and traditional leaders and structures should be involved when working with respect to reproductive rights but how best to do this. There are some examples, such as discussions with Buddhist monks in **Sri Lanka**, of efforts to correlate religious views with human rights.

Among the important lessons learned by UNFPA in this respect are the following:

- Candid, respectful dialogue can go a long way in achieving common ground between advocates for reproductive rights, UNFPA, FBOs and religious and cultural leaders. Bringing in experts who speak the language of religion and can actually use religious arguments for the respect for life and human rights and building arguments based on facts (such as providing national epidemiological data on HIV) can be highly successful tools in such efforts. It is very seldom that there is only one view within the relevant religious and/or traditional circles and it will thus often be possible to identify sympathetic religious and traditional leaders that are amenable to a human rights

¹⁹ E/CN.4/2002/73/Addendum 2.

²⁰ In Azerbaijan, UNFPA conducted a study on gender equality by comparing the Convention on the Elimination of All Forms of Discrimination against Women with some widely recognized Islamic references and books. This showed parallels between the Convention and the spirit of the Islamic faith.

BOX 9. RELIGIOUS AND CULTURAL ISSUES (CONT.)

discourse and willing to make an effort to reconcile religious/traditional views with human rights and gender equality.

- Promoting behaviour change often begins by identifying religious leaders who have the capacity and legitimacy to motivate and mobilize communities. Efforts in, for instance, **Central Asian countries** have shown that partnering with local religious leaders can be the best strategy in gaining wider acceptance and ownership of programmes that promote gender equality and reproductive health, not least to get men on-board in the struggle for reproductive rights.
- Advocacy campaigns that are closely tailored to the religious and cultural contexts in which they are launched (without compromising on human rights) are superior in dealing with sensitive subjects. Campaigns should reflect not only the views of sympathetic religious and tradition leaders but also try to take into account the views of potential adversaries and should draw from sources that are popular within a given culture. Examples from **Eritrea** have shown that it is possible to work with various religious groupings, such as both Christian and Muslim leaders, at the same time.
- Making the effort to understand the objectives of the faith-based organizations and religious and cultural leaders makes it possible to find the common ground that mostly does exist. This can be aided by using language that appreciates the nuances of religion and religious sensitivities. In this respect it is also important to acknowledge the constraints of religious and traditional partners and find ways to work also in areas where direct collaboration is not possible.

When considering how to tackle religious, cultural and ethical values with the potential to both help and hinder reproductive rights, a NHRI should consider seeking advice from NHRIs in comparable countries, from civil society organizations with experience within this area, from local United Nations staff, including UNFPA country officers, and from religious and traditional groupings themselves.

RIGHT TO PHYSICAL INTEGRITY

THE RIGHT TO PHYSICAL INTEGRITY IN LAW

The right to freedom from torture and other cruel, inhuman or degrading treatment can be found in Article 7 of the International Covenant on Civil and Political Rights, Article 3 of the ECHR, Article 5 of the ACHPR and Article 5 of the ACHR as well as in the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. The Convention prohibits torture in Article 2 and other cruel, inhuman or degrading treatment and punishment in Article 16.

The right to physical integrity implies that all persons have the right to control their own bodies, including their sexual and reproductive life, and be free from any intervention, medical or otherwise, save with their full, free and informed consent.

The prohibition against cruel, inhuman and degrading treatment is non-derogable like the prohibition against torture, and a state violates Convention against Torture if it fails to prevent acts prohibited by the Convention, including gender-based violence, such as rape, domestic violence, and female genital mutilation and trafficking. *“Deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence by private actors in communities and homes”* are potential violations of CAT; states are in this respect asked to identify situations where *“men and women and boys and girls may be subject to violations of the Convention on the basis of their actual or perceived non-conformity with socially determined gender roles”*.²¹

²¹ Committee against Torture, General Comment No. 2 on the implementation of Article 2 of CAT.

Domestic and other forms of violence against women, including rape, forced abortion and sterilization, and female genital mutilation may constitute violations of International Covenant on Civil and Political Rights Article 7. Furthermore, in order not to violate the prohibition against torture, detained pregnant women must receive humane treatment, in particular during birth and while caring for newborn children; this includes medical treatment and healthcare for such mothers and their babies.²²

In 2006²³ the Human Rights Committee found that a state had violated Article 7 of International Covenant on Civil and Political Rights on the grounds of cruel, inhuman or degrading treatment by refusing to allow an abortion when it was clear that there was a life-threatening risk for the complainant. The Committee stressed, *“The right set out in article 7 of the Covenant relates not only to physical pain but also to mental suffering, and*

²² Human Rights Committee, General Comment No. 28 on equality between men and women from 2000.

²³ CCPR/C/85/D/1153/2003, Miss K.L.N.H. vs. Peru.

that the protection is particularly important in the case of minors”.

In his report to the United Nations Human Rights Council of January 2008,²⁴ the United Nations Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment emphasized that forced abortions and sterilizations of women with disabilities against their will may constitute torture or ill-treatment.

Reproductive rights will not be realized until violence against women has been eliminated. One of the many forms of violence against women is Female Genital Mutilation/Cutting (FGM/C).²⁵ The Committee on the Elimination of All Forms of Discrimination against Women emphasizes steps states must take to eradicate this practice.²⁶ These steps include:

1. collecting and disseminating necessary data;
2. supporting women’s organizations working to eliminate such practices;
3. encouraging decision makers and trend-setters to influence attitudes towards the eradication of FGM/C; and
4. introducing appropriate educational and training programmes.

States should also include eradication strategies in their national health policies, including the special responsibility of health

24 A/HRC/7/3

25 A/HRC/7/3

26 Committee on the Elimination of All Forms of Discrimination against Women General Recommendation No. 14 on female circumcision from 1990

personnel, which encompasses traditional birth attendants, to explain the harmful effects of FGM/C.

In order to combat violence against women, states must enact adequate laws and policies against family violence and abuse, rape, sexual assault and other gender-based violence and have in place support and compensation for victims; take steps against attitudes, customs and practices that hinder equality between women and men and thus perpetuates violence against women; take measures against FGM/C and other harmful practices; and prevent coercion in regard to fertility and reproduction.²⁷

Issues related to physical integrity have also been dealt with in the concluding observations of the United Nations human rights committees. Sexual abuse, particular of girls, has consistently been highlighted as violence against women and children, and the United Nations human rights committees have stressed the need both to take preventive measures, including sensitization, and to properly investigate cases and provide treatment to victims.²⁸ The need to criminalize marital rape has been mentioned.

The Special Rapporteur on violence against women, its causes and consequences highlights the intersection between violence against women and HIV/AIDS in her report of 2005.²⁹ According to her, gender inequality and discrimination against women can

27 Committee on the Elimination of All Forms of Discrimination against Women General Recommendation No. 19 on violence against women from 1992.

28 For an overview of the Concluding Observations of the various United Nations human rights treaty monitoring bodies, see Annex 1.

29 E/CN.4/2005/72

materialize in violence against women, not only increasing women's risk of contracting HIV/AIDS but also seriously affecting the way women with HIV/AIDS are treated. To her, the worst discrimination encountered by HIV-infected women relates to family planning, pregnancy and childcare, often extinguishing the right to choose whether to have children and to make informed decisions on how to avoid transmitting the disease to an unborn child or a newborn infant.

In order to combat this form of discrimination, states should:

1. Enact laws to combat violence against women and discrimination against people living with HIV/AIDS, including with respect to sexual and reproductive health;
2. Raise awareness of discriminatory and oppressive practices pursued in the name of culture and of gender imbalances;
3. Train judges, health-care providers and other relevant officials on how to treat HIV-positive women;
4. Document, investigate and prosecute systemic HIV-related violations of human rights;
5. Provide holistic sexuality education;
6. Ensure women have access to health care; and
7. Provide voluntary counselling and testing for pregnant women who are making decisions about prenatal and post-natal care.

BOX 10. VIOLENCE AGAINST WOMEN AND GIRLS

Studies show that violence perpetrated against women by their spouse or intimate partner is widespread.³⁰ In Zambia in 2001, statistics indicate that 27% of women were victims of such violence during the latest 12 months and that 48% had been victims at some point during their lifetime. Figures from other parts of Africa are similar. In Bangladesh, the percentage is even higher. Figures from 2000 indicates that in Thailand just over 20% of women suffered domestic violence during the previous 12 months and just over 40% during their lifetimes. In some provinces of Peru, more than two thirds of women according to figures from 2000 had been subject to violence from their partner at some point during their lifetime, with a similar figure in towns of around half. In Brazil the same figures for 2000/2001 were 29% in the cities and 37% in the provinces. In Europe, figures from the UK (2006/2007) and Germany (2003) show 29% for lifetime and 6 and 3% respectively for the previous 12 months. On this basis, it is clear that domestic violence against women is a large and global problem. Surveys³¹ show that many women find their husband justified in hitting or beating them, for example for refusing to have sex (for instance 37% in Burkina Faso (2003), 51% in Ethiopia (2000), 21% in Turkmenistan, 7% in Indonesia, and 14% in Haiti); for other reasons, e.g. neglecting the children or going out without informing the husband, the percentage is generally even higher.

Research has shown that violence against women has serious health consequences, not least with respect to reproductive health.³² Women who suffer abuse from their partner have less ability to control the timing of sex and the use of contraception and consequently have more children. This violates their right to choose freely the timing and number of children; it may even lead to young women having children before maturity with a greater risk of mortality and morbidity. Women victims of intimate partner abuse have a significantly greater prevalence of gynaecological problems and STIs. Significant percentages of abuse happens during pregnancy, leading to pregnancy complications, stillbirths etc.³³

30 Statistics taken from Table 6.B of The World's Women 2010, compiled by the United Nations Statistics Division from national and international reports.

31 From Table 6.D of The World's Women 2010.

32 A short publication, explaining this link, is Outlook Volume 20, Number 1, September 2002, published by PATH and UNFPA. See www.path.org/files/EOL20_1.pdf

33 For a country specific analysis from 2011, see "Domestic Violence in the United States" - A Preliminary Report prepared for Rashida Manjoo, U.N. Special Rapporteur on Violence Against Women, 18 April 2011 (reproductiverights.org/sites/crr.civicactions.net/files/newsletter/DV%20in%20the%20US_Br%20Paper%20to%20SR%20on%20VAW.pdf) which deals with reproductive rights on pages 39-47. In her report to the Human Rights Council on her mission to the USA (A/HRC/17/26/Add. 5 from June 2011 para 21) the Special Rapporteur on violence against women, its causes and consequences stated "Women victims of violence also face enormous challenges in terms of their sexual and reproductive health. Abusers usually exercise control over victims' access to contraception, abortion and other reproductive health services."

BOX 10. VIOLENCE AGAINST WOMEN AND GIRLS (CONT.)

Much can be done to combat domestic violence against women, including by NHRIs. Legislation needs to be in place criminalizing all acts of violence against women, including marital rape. This is something NHRIs can attack in their review of legislation and advice to the executive and legislature. An example is the NHRI in India that in the 2002 examined the provisions of the Protection from Domestic Violence Bill and made detailed suggestions which it followed-up on. All these suggestions were incorporated in the Protection of Women from Domestic Violence Act, 2005.

The mind-set of both men and women needs to be changed; NHRIs can consider being involved in sensitization campaigns. Providers of health and counselling services need to be aware of the issue of domestic violence and intimate partner abuse; NHRIs can monitor that training is in place and that these issues are taken into account. In some cases it can be useful to work with religious and traditional leaders to thoroughly deal with unfortunate views on gender and rights, see Box on Religious and Cultural Issues. As has been mentioned in several places in this Handbook, there are indications that the rural female population is more at risk than the urban population; this should be taken into account when dealing with these issues.



RIGHT TO MARRY AND FOUND A FAMILY

THE RIGHT TO MARRY AND FOUND A FAMILY IN LAW

Article 23 of the International Covenant on Civil and Political Rights, and Article 19 of the International Covenant on Economic, Social and Cultural Rights, both recognize the family as a *“natural and fundamental group unit of society”*. The same is the case for ACHPR Article 18, ACHR Article 17, ECHR Article 12, and the African Charter on the Rights and Welfare of the Child, Article 18.

Article 16 of the Convention on the Elimination of All Forms of Discrimination against Women sets out the obligation to *“eliminate discrimination against women in all matters relating to marriage and family relations”* and goes on to specify that this includes the rights to *“enter into marriage”*, to *“freely ... choose a spouse and to enter into marriage only with their free and full consent”* and to *“decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights”* as well as the same rights and responsibilities *“during marriage and at its dissolution”*, *“as parents, irrespective of their marital status, in matters relating to their children”* and *“with regard to guardianship, stewardship, trusteeship and adoption of children”*.

Article 16 further guarantees the *“same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation”* and the *“same rights for both spouses in respect of the ownership, acquisition, management, administration, enjoyment and disposition of property”*. Finally, the *“betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory”*.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Articles 6 and 7, in slightly different terms guarantee the same rights for women as for men with respect to marriage. The right to equality regarding marriage is set out in Article 5 of the 7th Protocol to the ECHR.

The right to found a family goes beyond the right to conceive, gestate and deliver a child; it involves the right of the couple to decide whether or not to have children, when to have them, and the space between them.

The right to marry and found a family can be limited by laws that are reasonably related to a family-based objective, such as laws requiring a minimum age for marrying. This minimum age should be the same for men and women in order to provide both with the same opportunities to education

and welfare; a different minimum age is furthermore a violation of the general prohibitions of discrimination based on gender that can be found in, among others, Article 16 of the Convention on the Elimination of All Forms of Discrimination against Women.

Men and women have the right to marry and to found a family; nonetheless there is a need for free and full consent of the intended spouses. A minimum age for marriage is necessary to make full and free consent possible. Furthermore, the possibility to procreate being inherent in the right to found a family should entail family planning policies which are compatible with the International Covenant on Civil and Political Rights and other human rights conventions and, as such, neither discriminatory nor compulsory.³⁴

It is a duty of states to treat men and women equally in relation to the right to marry; a minimum age for marriage (the same for both sexes) that enables an informed and un-coerced decision must be set, and rules making the guardian's consent to marriage more important than the consent of the bride-to-be must be prohibited. This free choice must also be a reality for rape victims; laws extinguishing or mitigating criminal responsibility for the rapist in case of marriage or reducing the marriageable age of rape victims should be eliminated.³⁵

Persons with disabilities also have the right to marry and establish a family, and women

³⁴ HRC, General Comment No. 19 on the protection of the family, the right to marriage and equality of the spouses, paras. 4-5.

³⁵ HRC, General Comment No. 28 from 2000 on equality between men and women.

with disabilities have the right to protection and support in relation to motherhood and pregnancy. Such rights are often ignored, for example by the sterilization of, or performance of abortions on, women with disabilities without prior informed consent, constituting a serious violation of Article 10 of the International Covenant on Economic, Social and Cultural Rights,³⁶ and human rights standards.

According to the Convention on the Elimination of All Forms of Discrimination against Women, women have a right to freely choose their spouses and enter freely into marriage; this right must be protected, for example against forced and coerced marriages, and enforced by law. Women's reproductive rights are not protected if they cannot freely choose with whom to establish a family. In addition, women are to be considered equal to men in marriage. The often subordinate role of women makes it more difficult for them to refuse sex and to demand safe sexual practices. Moreover, women's responsibilities to bear and raise children affect their right of access to education, employment and other activities related to their personal development and their physical and mental health; this emphasizes the need for women to be able to decide on the number and spacing of their children.³⁷

³⁶ Committee on Economic, Social and Cultural Rights, General Comment No. 5 on persons with disabilities, adopted in 1994, paras. 30-31.

³⁷ Committee on the Elimination of All Forms of Discrimination against Women, General Recommendation No. 21, adopted in 1994, paras. 16 17 and 21.

All people must have information about contraceptive measures and their use and be guaranteed access to sexuality education and family planning services in order to make informed decisions about safe and reliable contraceptive measures and thus on whether to have children or not. The health, development and well-being of all members of the family improve where there are freely available and appropriate measures for the voluntary regulation of fertility.

In one of its decisions concerning an individual complaint,³⁸ the Committee on the Elimination of All Forms of Discrimination against Women found that the sterilization of a woman without full informed consent had been a violation of Article 16 (the right to decide the number and spacing of children) by permanently depriving her of her natural reproductive capacity.

³⁸ CEDAW/C/36/D/4/2004, Ms. A. S. vs. Hungary

RIGHT TO PRIVACY AND FAMILY LIFE

THE RIGHT TO PRIVACY AND FAMILY LIFE IN LAW

The right to privacy and family life can be found in, for example, Article 17 of the International Covenant on Civil and Political Rights, *“no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation”*. Similar provisions are contained in the Convention on the Rights of Persons with Disabilities, Article 8 of the ECHR and Article 11 of the ACHR. Article 16 of the Convention on the Rights of the Child guarantees the freedom of the child from *“arbitrary or unlawful interference with his or her privacy, family, home or correspondence”*. A similar provision is contained in Article 10 of the African Charter on the Rights and Welfare of the Child.

Though interconnected, the right to privacy and family life differs from the right to found a family. This right includes access to available reproductive health care technology, including safe and acceptable contraceptive methods. It also comprises the right to confidentiality, for example HIV/AIDS-status, pregnancy, visits to reproductive health care service providers, etc. Such confidentiality in treatment and counselling should also be ensured for adolescents.

One area where states may fail to respect women’s privacy relates to their reproductive functions. It is for example a violation of a woman’s right to privacy to require the husband’s authorization for sterilization, or to impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion.³⁹ In

³⁹ HRC, General Comment No. 28, para. 20.

a decision from 2006,⁴⁰ the Human Rights Committee found that an unlawful interference in the complainant's private life had occurred by a hospital's refusal to perform an abortion in a case where this would have been lawful under the applicable national law.

The European Court of Human Rights has ruled that certain aspects of reproductive rights, such as the right to decide whether to have children and the space between them, fall within the sphere of the right

⁴⁰ CCPR/C/85/D/1153/2003, Miss K.L.N.H. vs. Peru

to private and family life (Article 8 of the ECHR).⁴¹

⁴¹ "The Court recalls that the notion of "private life" within the meaning of Article 8 of the Convention is a broad concept which encompasses, *inter alia*, the right to personal autonomy and personal development (see *Pretty v. the United Kingdom*, cited above, § 61). It concerns subjects such as gender identification, sexual orientation and sexual life (for example, *Dudgeon v. the United Kingdom*, judgment of 22 October 1981, Series A no. 45, pp. 18-19, § 41; and *Laskey, Jaggard and Brown v. the United Kingdom*, judgment of 19 February 1997, Reports of Judgments and Decisions 1997-I, p. 131, § 36), a person's physical and psychological integrity (*TysiŃc v. Poland* judgment, cited above, § 107) as well as decisions both to have and not to have a child or to become genetic parents (*Evans v. the United Kingdom* [GC], cited above, § 71). Case of A, B, C v. Ireland, Application no. 25579/05.

RIGHT TO INFORMATION AND EDUCATION

THE RIGHT TO SEEK, RECEIVE AND IMPART INFORMATION IN LAW

This right can be found in Article 19 of the International Covenant on Civil and Political Rights which stresses the right to "seek, receive and impart information and ideas of all kinds", Article 10 of the ECHR, Article 13 of the ACHR, and Article 9 of the ACHPR. Article 17 of the Convention on the Rights of the Child guarantees children's right to information. The Convention on the Rights of Persons with Disabilities also guarantees accessible information for persons with disabilities in its Article 4(h). Article 10 (h) of Convention on the Elimination of All Forms of Discrimination against Women sets out the right to "access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning".

The rights to seek, receive, and impart information are protected by many human rights instruments. These rights are essential to the realization of reproductive rights. All persons have the right to information and counselling on health and family planning.

The information relating to sexual and reproductive health should be gender-sensitive and age-appropriate, free from stereotypes, and presented in an objective, critical and pluralistic manner. This information should enable all persons to make decisions related

to their sexual and reproductive life with full, free and informed consent. Lastly, it is important to emphasize that all persons have the right to full information as to the relative benefits, risks and effectiveness of all methods of fertility regulation and the prevention of unplanned pregnancies.

Together with the right to information, the right to education also serves the goal of reproductive rights. Women have greater access to contraceptives when they can read and understand the risks to their health and their children caused by close birth spacing. More than that, guaranteeing reproductive rights promotes the right to education. When women are able to determine whether to, when to and how often to have children, their opportunities to advance towards secondary and superior education is improved.

According to UNFPA, fewer children mean that families and governments can spend more per child.⁴² This is especially relevant for girls, whose education is often sacrificed if resources are lacking. Furthermore, avoiding early pregnancies and early marriages encourages girls to stay in school. Guaranteeing the right to information regarding family planning and the use of contraceptives is also important to avoid early pregnancies.

The right to receive information on sexual and reproductive health issues has been stressed on numerous occasions in the practice of the United Nations human rights committees. The Committee on Economic, Social and Cultural Rights, in General

42 UNFPA. *“Sexual and Reproductive Health for All: Reducing Poverty, Advancing Development and Protecting Human Rights”* (2010)

Comment No. 14 (2000) on the right to health, stresses the need to remove barriers to women’s access to information and education; affirms that adolescents must receive appropriate information and counselling; and refers to information campaigns with respect to HIV/AIDS and sexual and reproductive health and rights. General Comment No. 24 (1999) of the Committee on the Elimination of All Forms of Discrimination against Women on women and health underlines the obligation to provide adequate sexual and reproductive health education, including on HIV/AIDS and other STIs, to women and adolescents, including to trafficked women and girls and irrespective of their residency status. This obligation is emphasized by the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities.

All adolescents, irrespective of marital status and parental or guardian consent, should be provided with sufficient information on sexual and reproductive health, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted infections (STIs). Such information is to be developed with the active involvement of adolescents. Indigenous adolescents and adolescents with disabilities should also have access to sexual and reproductive health and rights information.⁴³

43 Committee on the Rights of the Child, General Comment No. 4 from 2003 on adolescent health and development, Para. 28; Committee on the Rights of the Child, General Comment No. 11 on indigenous children from 2009, Para. 54; Committee on the Rights of the Child, General Comment No. 9 from 2006, Para. 59.

In one of its decisions on an individual complaint,⁴⁴ the Committee on the Elimination of All Forms of Discrimination against Women found that a state had violated Article 10 (h) (access to information) by failing to provide appropriate information and advice on family planning to a Roma woman who had been sterilized in connection with the removal of a dead foetus. The only form of consent had been a handwritten note to the extent that she requested a sterilization, a term she did not know and only understood after the procedure had been done.

44 CEDAW/C/36/D/4/2004, Ms. A. S. vs. Hungary

In their Concluding Observations as part of the state reporting procedure, the United Nations Committees have focused much on the duty to ensure education and awareness on sexual and reproductive health, including on HIV, and have in that respect highlighted the special needs of indigenous groups, ethnic and linguistic minorities and other vulnerable groups and of adolescents.⁴⁵

45 For an overview of the Concluding Observations, see Annex 1.

RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH IN LAW

Article 12 of the International Covenant on Economic, Social and Cultural Rights recognizes the right of all persons to the highest attainable standard of health. The same right for children is set out in Article 24 of the Convention on the Rights of the Child, and for persons with disabilities in Article 25 of the Convention on the Rights of Persons with Disabilities. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women prohibits discrimination against women in the field of healthcare and furthermore guarantees women *“appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation”*. In Article 14 on rural women, securing *“access to adequate health care facilities, including information, counselling and services in family planning”* is set out as an obligation. The ACHPR recognizes the right to health in Article 16, and Article 14 of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa seeks to ensure the right to health, especially to sexual and reproductive health. Article 8 of the ECHR has been understood to include the right to health.

The right to health includes the right to sexual and reproductive health and is paramount to the advancement of women's rights as a whole.⁴⁶ According to the Committee on Economic, Social and Cultural Rights, *"the right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health"*.⁴⁷

In General Comment No. 14, the Committee also explains that the right to health includes both freedoms and entitlements, including *"the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation"*. This General Comment also contains the reference to the 3AQ: *availability* (existence of relevant facilities, services and programmes, including drugs), *accessibility* (non-discrimination, within physical reach, affordable and including health information), *acceptability* (including sensitivity to gender and life cycle) and *quality*.⁴⁸

The Committee on the Elimination of All Forms of Discrimination against Women in its General Recommendation No. 24 (1999) on women and health emphasizes the

46 OHCHR and WHO, Fact Sheet on *"The Right to Health"*.

47 Cf. Para. 14 of General Comment No. 14 on the right to the highest attainable standard of health, 2000.

48 Committee on Economic, Social and Cultural Rights General Comment No. 14 from 2000 on the right to health.

obligation of states to eliminate all discrimination against women in access to health services *"throughout the life cycle, particularly in the areas of family planning, pregnancy, confinement and during the post-natal period."* This should be done paying special attention *"to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities"*. It is inappropriate for *"a health care system [to lack] services to prevent, detect and treat illnesses specific to women"* and it is *"discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women"*. Furthermore, States cannot *"restrict women's access to health services ... on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women."* Nor can States *"criminalize medical procedures only needed by women"* and *"punish women who undergo those procedures"*.⁴⁹

The Committee on the Elimination of All Forms of Discrimination against Women⁵⁰ found that a woman's right to health care (Article 12.1) had been violated when the state did not secure fully informed consent to sterilization. Consequently, the Committee recommended clarifying the provisions on consent to sterilization and monitoring facilities providing sterilization. In another

49 Committee on the Elimination of All Forms of Discrimination against Women, General Recommendation No. 24 from 1999 on women and health, paras. 2, 11 and 14.

50 CEDAW/C/36/D/4/2004, Ms. A. S. vs. Hungary

case,⁵¹ the Committee found that a state had violated its obligation under Article 12.2 to provide appropriate services in connection with pregnancy, confinement and the post-natal period by failing to provide proper obstetric care following the delivery of a stillborn foetus, which led to the death of the mother. In connection with this case, the Committee refuted the argument that the state could be free of responsibility due to the service provider being a private enterprise. This was a case of triple discrimination where the Committee found the victim to have been discriminated against not only due to her sex but also due to her ethnicity, being of African descent, and socio-economic background. In addition to the recommendations directly concerning the provision of healthcare, the Committee stressed the need for effective remedies and, in this connection, the provision of training for the judiciary and law enforcement personnel.

The obligations to take measures to reduce infant mortality, including ensuring access to essential health services for the child and pre- and post-natal care for mothers, and to adopt effective and appropriate measures to abolish harmful practices, such as early marriage and female genital mutilation (FGM), can be found in General Comment No. 14. According to it, states have an obligation to ensure that adolescents can participate in decisions affecting their health and receive appropriate information and counselling and to provide youth-friendly health care, including appropriate sexual and reproductive health services.

⁵¹ CEDAW/C/49/D/17/2008, Ms. Da Silva Pimentel vs. Brazil

Adolescents are an especially vulnerable group where reproductive rights are concerned. Health services should take into account the needs of children and adolescents, including HIV-related information, counselling and testing, confidential sexual and reproductive health services, and free or low-cost contraceptive methods and services, as well as HIV-related care and treatment. Special care should be taken to reach vulnerable children, such as children with disabilities, indigenous children, children belonging to minorities, and children living in rural areas or in extreme poverty. Testing should be conducted only after informed consent has been given. In the case of children, either the parent/guardian or the child must consent. States should also focus on vertical transmission and work on the prevention of HIV among parents-to-be and the prevention of unintended pregnancies in HIV-positive women. The necessary anti-retroviral drugs and the necessary antenatal, delivery and post-partum care, should be available.⁵²

Adolescent health should be prominent in states' policies in order to promote reproductive rights. There should be minimum legal ages (equal for boys and girls) for sexual consent, marriage and the possibility of medical treatment without parental consent. Harmful practices, including early marriage and female genital mutilation, should be eliminated by awareness-raising campaigns, education programmes and legislation.

In relation to STIs, goods and services necessary to prevent and treat them

⁵² Committee on the Rights of the Child, General Comment No. 3 on HIV/AIDS and the rights of the child, from 2003, paras. 20- 26.

should be provided, taking into account the need to overcome taboos and barriers. States should take steps to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and should support adolescent parents. In that respect, programmes that provide access to sexual and reproductive health services,

including family planning, contraception and, where legal, safe abortion services, adequate and comprehensive obstetric care and counselling, and post-abortion care should be developed and implemented by the state.⁵³

53 Committee on the Rights of the Child, General Comment No. 4 from 2003 on adolescent health and development, paras. 6, 9, 24 and 30-31.

“The rights to sexual and reproductive health have an indispensable role to play in the struggle against intolerance, gender inequality, HIV/AIDS and poverty” ... “increased attention [should] be devoted to a proper understanding of reproductive health, reproductive rights, sexual health and sexual rights”. Ill health is a human rights violation when caused by the failure of the state to respect, protect or fulfil a human rights obligation. Specifically with respect to reproductive and sexual health, the question is whether the states are doing all in their power to dismantle the barriers for the full enjoyment by individuals of their right to sexual and reproductive health.

Source: The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 2004

The human rights treaty bodies have in many of their concluding observations, expressed concern with respect to high maternal mortality rates. The committees have made note of disadvantaged groups, including indigenous persons and persons in rural and remote areas, stressing the need for equitable distribution of benefits.⁵⁴ The need for effective programmes to combat vertical transmission of HIV has been specifically mentioned in a few cases, as has the need for fully subsidized HIV/AIDS treatments. Promotion of breastfeeding has been encouraged by the Committee on the Rights of the Child.

54 For an overview of Concluding Observations, see Annex 1.

Equally consistent have been the committees' insistence on the obligation to ensure all-encompassing access to sexual and reproductive health services, including contraceptives, for women and adolescents, as well as for indigenous persons, ethnic and linguistic minorities, internally displaced persons (IDPs) and persons in rural or remote areas.

The Special Rapporteur's Report of 13 September 2006⁵⁵ focuses on maternal mortality and access to medicines. According to him the right to health should not be seen as a right to specific health-related goods, services and facilities but rather as

55 A/61/338.

an “entitlement to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities and accessible to all”. Such a holistic approach can be useful in preventing maternal deaths.

In its General Comment No. 14 from 2000 on the right to health, the Committee on Economic, Social and Cultural Rights underlines that even though the right to health is among the rights that are to be realized progressively, states still have a “specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of” this right, cf. Para. 31.

According to states’ obligations to protect, respect and fulfil reproductive rights, states have to ensure that:

- Harmful practices do not interfere with pre- and post-natal care and family-planning;
- Third parties do not coerce women to undergo harmful practices, such as female genital mutilation; and
- Measures are taken to protect all vulnerable or marginalized groups of society, including women, children and adolescents.

In order to fulfil the right to health, states should at least adopt a national health policy with a detailed plan for the realization of the right to health. Public health infrastructure should provide sexual and reproductive health services, including safe motherhood, particularly in rural areas. Information campaigns, in particular with respect to HIV/

AIDS, sexual and reproductive health, traditional practices and domestic violence, should be carried out.⁵⁶

One core obligation in relation to the progressive realization of the right to health is to secure access to health facilities and services on a non-discriminatory basis, especially for vulnerable or marginalized groups, and to ensure equitable distribution of all such facilities and services. For instance, the High Commissioner for Human Rights has explained that LGBT and intersex persons face particular barriers in exercising their right to health.⁵⁷ In addition, each state shall adopt and implement a national public health strategy and plan of action addressing the health concerns of the whole population (with particular attention to all vulnerable or marginalized groups).

Another obligation is to provide essential drugs as defined under the WHO Action Programme on Essential Drugs. Among the drugs listed on the WHO Model List of Essential Medicines⁵⁸ are anti-retroviral drugs (HIV medicine), medicine for neonatal care (caffeine citrate used to treat breathing problems in premature infants) and contraceptives, including p-pills, p-injections, intrauterine devices, condoms, diaphragms and implantable contraceptives.

56 Committee on Economic, Social and Cultural Rights, General Comment No. 14.

57 OHCHR, “Born Free and Equal : Sexual Orientation and Gender Identity under International Human Rights Law”, p. 45 (2012)

58 16th list (updated), March 2010. For further details, see Annex 1.

RIGHT TO BENEFIT FROM SCIENTIFIC PROGRESS

Article 15 of International Covenant on Economic, Social and Cultural Rights recognizes the right of all persons to benefit from scientific progress and its application.⁵⁹ The right to benefit from scientific progress is important because it is through scientific investigation that the most modern forms

of contraceptives have been created, just as scientific progress has made the present maternal and child mortality and morbidity unnecessary. It is also due to medical and scientific development that assisted reproduction is possible. Women's freedom from unwanted pregnancy by means of safe, effective, and convenient contraceptives has been achieved by scientific progress.

59 See also Report of the Special Rapporteur, A/HRC/20/26 on the field of cultural rights (2012)



BOX 11. NEW TECHNOLOGY AND REPRODUCTIVE RIGHTS

Medical progress and new technology has made it possible to save mothers and children whom, only a few years ago, would have perished. Developments keep making new treatments possible and in some cases even make existing forms of treatment more accessible. However, not all technology has had beneficial effects.

Certain technological developments, such as advances in assisted pregnancy, including in vitro fertilization, raise a number of ethical issues. The ICPD refers to the “*basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so*”. Does this include the right to assistance for persons who cannot become parents unassisted, whether for medical reasons or because they are single or live in same sex relationships? Advances in assisted pregnancy make it possible for the HIV male partner to have biological children without the risk of spreading the infection. The wording of ICPD could imply this to be the case but many would say that such assistance falls beyond reproductive rights, leaving people to pay such costs themselves, thus augmenting the difference between the rich and poor.

Other questions concern the practice of surrogacy. Many countries forbid commercial surrogacy whereas it is legal in countries such as the USA and India. Some people say that prohibiting commercial surrogacy is necessary to protect the rights of poor and vulnerable women whereas others say that it contravenes the right of women to use their body the way they want. In all these issues, the need to balance the rights of potential parents with the rights of other persons and the rights of the unborn child remain in focus.

Undoubtedly, other issues will arise as technology develops and globalization makes the various countries of the world more and more interconnected. It is advisable for NHRIs working within reproductive rights to try to keep abreast of new developments, discuss this with other NHRIs and national stakeholders, and try to maintain such an understanding of reproductive rights issues that new issues can be solved within the relevant human rights framework.

FURTHER READING

Assessing the Effectiveness of National Human Rights Institutions (International Council on Human Rights Policy, 2005) (www.ohchr.org/Documents/Publications/NHRlen.pdf)

Applying a Human Rights-Based Approach: An Inspirational Guide for Civil Society (DIHR, 2007) (humanrights.inforce.dk/files/pdf/Publikationer/applying%20a%20rights%20based%20approach.pdf)

Bringing Rights to Bear Series of the Center for Reproductive Rights (<http://reproductiverights.org/en/resources/publications/briefing-papers>)

Handbook on HIV and Human Rights for National Human Rights Institutions (OHCHR-UNAIDS, 2007) (data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf)

How Universal is Access to Reproductive Health: A Review of Evidence (UNFPA, 2010) (www.unfpa.org/public/home/publications/pid/6532)

ICPD and Human Rights: 20 years of advancing reproductive rights through UN treaty bodies and legal reform (UNFPA- Center for Reproductive Rights 2013) (http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/icpd_and_human_rights_20_years.pdf)

Integrating Reproductive Rights into the Work of National Human Rights Institutions of the Asia Pacific Region (Asia Pacific

Forum-UNFPA, 2011) (www.asiapacificforum.net/files/NHRIs_and_Reproductive_Rights.pdf)

International Guidelines on HIV/AIDS and Human Rights (UNAIDS, 2006) (data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf)

Making Reproductive and Sexual and Reproductive Health a Reality for All (UNFPA, 2011) (www.unfpa.org/public/publications/pid/7602)

Making the Linkages: HIV/AIDS and Sexual and Reproductive Rights (Youth Coalition, 2006) (www.summitfdn.org/foundation/pdfs/hiv-booklet.pdf)

Promoting Sexual and Reproductive Health for Persons with Disabilities WHO/UNFPA Guidance note (WHO/UNFPA, 2009) (www.unfpa.org/public/publications/pid/385)

Protecting Girls' Rights- the Foundation for Addressing Motherhood in Childhood (UNFPA 2013)

(<http://www.unfpa.org/webdav/site/global/shared/swp2013/Background%20paper%20on%20human%20rights%20by%20Christina%20Zampas.pdf>)

Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights to the Human Rights Council, 16 April 2010 (A/HRC/14/39) (www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.39.pdf)

Reproductive Rights: A Tool for Monitoring State Obligations (Center for Reproductive Rights and UNFPA, 2012) (reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_Monitoring_Tool_State_Obligations.pdf)

Rights into Action, UNFPA Implements Human Rights Based Approach (UNFPA, 2006) (www.unfpa.org/public/publications/pid/1338)

Sexual and Reproductive Health and HIV – Linkages: Evidence Reviews and Recommendations (UNFPA, 2009) (www.unfpa.org/public/publications/pid/1341)

Sexual and Reproductive Health for All: Reducing Poverty, Advancing Development and Protecting Human Rights (UNFPA, 2010) (www.unfpa.org/public/publications/pid/6526)

Technical guidance on the application of a human rights- based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality (Report of the Office of the United

Nations High Commissioner for Human Rights, 2 July 2012)

(http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf)

UNDP-OHCHR – Toolkit for Collaboration with National Human Rights Institutions (UNDP-OHCHR, 2010) (www.ohchr.org/Documents/countries/NHRI/1950-UNDP-UHCHR-Toolkit-LR.pdf)

UNFPA – A Human Rights Based Approach to Programming – Practical Implementation Manual and Training Materials (UNFPA, 2010) (www.unfpa.org/webdav/site/global/shared/documents/publications/2010/hrba/hrba_manual_in%20full.pdf)

Women, HIV/AIDS and Human Rights: An Annotated Syllabus (International Reproductive and Sexual Health Law Program, Faculty of Law, University of Toronto, 2008) (http://www.law-lib.utoronto.ca/diana/women_hiv_aids/HIV_AIDS_Syllabus_Update_18_April_2.pdf)

ANNEX 1: THE INTERNATIONAL HUMAN RIGHTS TREATY BODIES AND REPRODUCTIVE RIGHTS

ROLE OF TREATY BODIES

The human rights treaty bodies are committees of independent experts that monitor implementation of the core international human rights treaties. They are created in accordance with the provisions of the treaty that they monitor.¹ They normally meet two or three times a year for three weeks at a time.² The Office of the High Commissioner for Human Rights (OHCHR) provides secretariat assistance to the treaty bodies. There are at present ten treaty bodies:

- The Human Rights Committee that monitors the International Covenant on Civil and Political Rights;
- The Committee on Economic, Social and Cultural Rights that monitors the International Covenant on Economic, Social and Cultural Rights;
- The Committee on the Elimination of all Forms of Discrimination against Women that monitors the Convention on the Elimination of all Forms of Discrimination against Women;
- The Committee on the Rights of the Child that monitors the Convention on the Rights of the Child;
- The Committee on Elimination of Racial Discrimination that monitors the International Convention on the Elimination of all Forms of Racial Discrimination;
- The Committee Against Torture that monitors the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment;
- The Sub-Committee on the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment that monitors the Optional Protocol to the Convention Against Torture;
- The Committee on All Migrant Workers and Members of Their Families that monitors the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families;
- The Committee on the Rights of Persons with Disabilities that monitors the Convention on the Rights of Persons with Disabilities;
- The Committee on Enforced Disappearances that monitors the International Convention on the Protection of All Persons from Enforced Disappearances.

1 Excepting the Committee on Economic, Social and Cultural Rights that was established by ECOSOC Resolution 1985/17 as the International Covenant on Economic, Social and Cultural Rights, assigned monitoring functions to the United Nations Economic and Social Council (ECOSOC).

2 The sessions of the Committee against Torture last four weeks whereas the sessions of the Committee on Migrant Workers and the Committee on the Rights of Persons with Disabilities only last one week.

One of the main functions of the Committees is to consider state reports. State reporting is a mechanism to monitor the implementation of human rights by the states parties. When a country ratifies one of the treaties, it assumes a legal obligation to submit regular reports to the monitoring Committee on how the rights in this particular treaty are being implemented in the country. It is the responsibility of the government to prepare the state reports but the reports should be the result of an inclusive process involving civil society and the NHRI. In addition, the Committees encourage civil society and NHRIs to provide additional information. Reports from other institutions than the government of the state in question are commonly referred to as shadow reports. Furthermore, information is gathered from public sources, other United Nations agencies and other international organizations.

The actual examination of a state party takes place at a public meeting of the Committee in question. Here the government presents its report and then submits to questioning by the Committee members. Several Committees encourage the NHRI of the state party to make its own presentation. Civil society may give information at informal meetings between the formal sessions. Based on this dialogue with government and the other information available, the Committee at a private session discusses and adopts its concluding observations, containing its concerns and recommendations. The concluding observations are made publicly available online.

Ideally, the relationship between the Committees and NHRIs should be one of mutual benefit. NHRIs help bring national human rights concerns to the knowledge of the Committees, and the NHRIs can then use the pronouncements by the Committees in their national work. Given

the Committees' legal mandate to help assure adherence to the various treaties and monitor their implementation, the Committees' pronouncements, in whatever way they are made, have considerable legal standing even though they are not strictly speaking legally binding. Consequently, using the concluding observations and other statements of the Committees only strengthens the hand of NHRIs.

In addition to their role in state reporting, the Committees issue general comments or general recommendations. Whereas some of these general comments deal with formal matters, for example related to state reporting, most of them provide interpretation and other assistance to states on how to implement the treaty in question. An example of this is General Recommendation No. 24 of the Committee on the Elimination of all Forms of Discrimination against Women from 1999 on women and health.

Six of the treaty bodies (Human Rights Committee, Committee on the Elimination of All Forms of Discrimination against Women, Committee on Elimination of Racial Discrimination, Committee against Torture, Committee on the Rights of Persons with Disabilities, and Committee on Enforced Disappearances³) can consider individual complaints if the country in question has either ratified an optional protocol or made a specific declaration.

The purpose of this Annex is to provide an overview of the pronouncements on matters relating to reproductive rights made by the treaty bodies. With respect to the concluding observations, the analysis covers all the treaty bodies in the period 2005-2012.⁴

3 CMW will also get this function once the necessary numbers of declarations have been made

4 Including June 2012

GENERAL COMMENTS OR RECOMMENDATIONS

HUMAN RIGHTS COMMITTEE

Article 40 of the International Covenant on Civil and Political Rights gives the Human Rights Committee the mandate to publish General Comments. To date the Committee

has published 43 such General Comments. A few of these touch upon reproductive rights.

General Comment	Provisions related to Reproductive Rights
General Comment No. 6 – Right to Life, 1982	According to Paragraph 5, <i>“The right to life has been too often narrowly interpreted. The expression “inherent right to life” cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.”</i>
General Comment No. 17 – Rights of the Child, 1989	According to Paragraph 3, <i>“Every possible economic and social measure should be taken to reduce infant mortality”.</i>
General Comment No. 19 – Protection of the family, the right to marriage and equality of the spouses, 1990	<p>According to Paragraph 4, <i>“no marriage shall be entered into without the free and full consent of the intending spouses ... The Covenant does not establish a specific marriageable age either for men or for women, but that age should be such as to enable each of the intending spouses to give his or her free and full personal consent”.</i></p> <p>Paragraph 5 stipulates that the <i>“right to found a family implies, in principle, the possibility to procreate and live together. When States parties adopt family planning policies, they should be compatible with the provisions of the Covenant and should, in particular, not be discriminatory or compulsory”.</i></p>

General Comment	Provisions related to Reproductive Rights
<p>General Comment No. 28 - The equality of rights between men and women, 2000</p>	<p>According to Paragraph 10, <i>“States 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. States parties should also report on measures to protect women from practices that violate their right to life, such as female infanticide, the burning of widows and dowry killings.”</i></p> <p>According to Paragraph 11, <i>“To assess compliance with article 7 of the Covenant, as well as with article 24, which mandates special protection for children, the Committee needs to be provided with information on national laws and practice with regard to domestic and other types of violence against women, including rape. It also needs to know whether the State party gives access to safe abortion to women who have become pregnant as a result of rape. The States parties should also provide the Committee with information on measures to prevent forced abortion or forced sterilization. In States parties where the practice of genital mutilation exists, information on its extent and on measures to eliminate it should be provided. The information provided by States parties on all these issues should include measures of protection, including legal remedies, for women whose rights under article 7 have been violated.”</i></p> <p>According to Paragraph 15A <i>“Pregnant women who are deprived of their liberty should receive humane treatment and respect for their inherent dignity at all times, and in particular during the birth and while caring for their newborn children; States parties should report on facilities to ensure this and on medical and health care for such mothers and their babies.”</i></p>

**General
Comment**

Provisions related to Reproductive Rights

According to Paragraph 20A *“An example of such interference [with women’s right to enjoy privacy and other rights protected by article 17 on the basis of equality with men] arises where the sexual life of a woman is taken into consideration in deciding the extent of her legal rights and protections, including protection against rape. Another area where States may fail to respect women’s privacy relates to their reproductive functions, for example, where there is a requirement for the husband’s authorization to make a decision in regard to sterilization; where general requirements are imposed for the sterilization of women, such as having a certain number of children or being of a certain age, or where States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion. In these instances, other rights in the Covenant, such as those of articles 6 and 7, might also be at stake. Women’s privacy may also be interfered with by private actors, such as employers who request a pregnancy test before hiring a woman.”*

Paragraph 23 explains, *“Men and women have the right to enter into marriage only with their free and full consent, and States have an obligation to protect the enjoyment of this right on an equal basis. Many factors may prevent women from being able to make the decision to marry freely. One factor relates to the minimum age for marriage. That age should be set by the State on the basis of equal criteria for men and women. These criteria should ensure women’s capacity to make an informed and un-coerced decision. A second factor in some States may be that either by statutory or customary law a guardian, who is generally male, consents to the marriage instead of the woman herself, and thereby preventing women from exercising a free choice.”*

General Comment	Provisions related to Reproductive Rights
	<p>According to Paragraph 24, “Another factor that may affect women’s right to marry only when they have given free and full consent is the existence of social attitudes which tend to marginalize women victims of rape and put pressure on them to agree to marriage. A woman’s free and full consent to marriage may also be undermined by laws that allow the rapist to have his criminal responsibility extinguished or mitigated if he marries the victim. States parties should indicate whether marrying the victim extinguishes or mitigates criminal responsibility and, in the case in which the victim is a minor, whether the rape reduces the marriageable age of the victim, particularly in societies where rape victims have to endure marginalization from society. (...)It should also be noted that equality of treatment with regard to the right to marry implies that polygamy is incompatible with this principle. Polygamy violates the dignity of women. It is an inadmissible discrimination against women. Consequently, it should be definitely abolished wherever it continues to exist.”</p>

COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

Section (f) of Economic and Social Council resolution 1985/17 setting up the Committee on Economic, Social and Cultural Rights gives the Committee the mandate to prepare General Recommendations. To date the Committee has communicated 21 General

Recommendations. Some of these touch upon reproductive rights whereas one of them is specifically about the role of NHRIs in protecting economic, social and cultural rights (General Comment No. 10 from 1998).

General Comment	Provisions related to Reproductive Rights
<p>General Comment No. 5 – Persons with disabilities, 1994</p>	<p>On the right to marry, Paragraph 30 affirms, <i>“These rights are frequently ignored or denied, especially in the case of persons with mental disabilities. In this and other contexts, the term “family” should be interpreted broadly and in accordance with appropriate local usage. States parties should ensure that laws and social policies and practices do not impede the realization of these rights. Persons with disabilities should have access to necessary counselling services in order to fulfil their rights and duties within the family.”</i></p> <p>Paragraph 31 states, <i>“Women with disabilities also have the right to protection and support in relation to motherhood and pregnancy. As the Standard Rules state, “persons with disabilities must not be denied the opportunity to experience their sexuality, have sexual relationships and experience parenthood” (...) Both the sterilization of, and the performance of an abortion on, a woman with disabilities without her prior informed consent are serious violations of article 10 (2)”</i>.⁵</p>

⁵ In the General Recommendation reference is made to the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, annexed to United Nations General Assembly resolution 48/96 of 20 December 1993, which in Rule 9, paragraph 2, states that *“persons with disabilities must not be denied the opportunity to experience their sexuality, have sexual relationships and experience parenthood”*.

General Comment	Provisions related to Reproductive Rights
<p>General Comment No. 10 – The role of NHRIs in the protection of economic, social and cultural rights, 1998</p>	<p>In Paragraph 3, <i>“The Committee notes that national institutions have a potentially crucial role to play in promoting and ensuring the indivisibility and interdependence of all human rights. Unfortunately, this role has too often either not been accorded to the institution or has been neglected or given a low priority by it. It is therefore essential that full attention be given to economic, social and cultural rights in all of the relevant activities of these institutions. The following list is indicative of the types of activities that can be, and in some instances already have been, undertaken by national institutions in relation to these rights:</i></p> <ol style="list-style-type: none"> <li data-bbox="523 869 1417 1070">1. <i>The promotion of educational and information programmes designed to enhance awareness and understanding of economic, social and cultural rights, both within the population at large and among particular groups such as the public service, the judiciary, the private sector and the labour movement;</i> <li data-bbox="523 1122 1417 1279">2. <i>The scrutinizing of existing laws and administrative acts, as well as draft bills and other proposals, to ensure that they are consistent with the requirements of the International Covenant on Economic, Social and Cultural Rights;</i> <li data-bbox="523 1330 1417 1453">3. <i>Providing technical advice, or undertaking surveys in relation to economic, social and cultural rights, including at the request of the public authorities or other appropriate agencies;</i> <li data-bbox="523 1505 1417 1583">4. <i>The identification of national-level benchmarks against which the realization of Covenant obligations can be measured;</i> <li data-bbox="523 1635 1417 1792">5. <i>Conducting research and inquiries designed to ascertain the extent to which particular economic, social and cultural rights are being realized, either within the State as a whole or in areas or in relation to communities of particular vulnerability;</i> <li data-bbox="523 1843 1417 1966">6. <i>Monitoring compliance with specific rights recognized under the Covenant and providing reports thereon to the public authorities and civil society; and</i>

General Comment	Provisions related to Reproductive Rights
	<p>7. <i>Examining complaints alleging infringements of applicable economic, social and cultural rights standards within the State.</i></p> <p>In Paragraph 4, <i>“The Committee calls upon States parties to ensure that the mandates accorded to all national human rights institutions include appropriate attention to economic, social and cultural rights”.</i></p>
<p>General Comment No. 14 - The right to the highest attainable standard of health, 2000</p>	<p>According to Paragraph 8, <i>“The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”</i></p> <p>Paragraph 9 further explains, <i>“Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.”</i></p> <p>According to Paragraph 11, <i>“The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.”</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>Paragraph 12 sets out the elements that together constitute the right to health, the so-called 3AQ: <i>“The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:</i></p> <ol style="list-style-type: none"> <li data-bbox="518 689 1428 1153">1. <i>Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party’s developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.</i> <li data-bbox="518 1205 1428 1534">2. <i>Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:</i> <ol style="list-style-type: none"> <li data-bbox="571 1370 1428 1534">a) <i>Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.</i>

General Comment	Provisions related to Reproductive Rights
	<p>b) <i>Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.</i></p> <p>c) <i>Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.</i></p> <p>d) <i>Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.</i></p> <p>3. <i>Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>4. Quality. <i>As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.</i></p> <p>According to Paragraph 14, <i>“The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child” (art. 12.2 (a)) may be understood as requiring 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.</i>”</p> <p>Specifically on women’s health and issues of discrimination, the Committee says in Paragraph 21, <i>“To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women’s right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women’s health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotional and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.”</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>According to Paragraph 23, <i>“States parties should provide a safe and supportive environment for adolescents that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.”</i></p> <p>Paragraph 27 highlights states’ obligations with respect to indigenous peoples: <i>“The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health.”</i></p> <p>Paragraph 35 deals with the obligation to protect: <i>“States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people’s access to health-related information and services.”</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>Paragraphs 36 and 37 deal with the obligation to fulfil: <i>“Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country.”</i></p> <p>The core obligations with respect to health, meaning the obligations that cannot be derogated from, are set out in Paragraph 43, <i>“In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration⁶ provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee’s view, these core obligations include at least the following obligations:</i></p> <ol style="list-style-type: none"> <li data-bbox="518 1375 1404 1496">1. <i>To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;</i> <li data-bbox="518 1547 1404 1668">2. <i>To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;</i> <li data-bbox="518 1720 1404 1794">3. <i>To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;</i>

⁶ The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

General Comment	Provisions related to Reproductive Rights
	<p>4. <i>To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;⁷</i></p> <p>5. <i>To ensure equitable distribution of all health facilities, goods and services;</i></p> <p>6. <i>To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.”</i></p> <p>In Paragraph 44 the “Committee also confirms that the following are obligations of comparable priority:</p> <p>1. <i>To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;</i></p> <p>2. <i>To provide immunization against the major infectious diseases occurring in the community;</i></p> <p>3. <i>To take measures to prevent, treat and control epidemic and endemic diseases;</i></p>

⁷ Among the drugs listed on the WHO Model List of Essential Medicines (16th list (updated), March 2010) are anti-retroviral drugs (HIV medicine), medicine for neonatal care (caffeine citrate used to treat breathing problems in premature infants) and contraceptives, including p-pills, p-injections, intrauterine devices, condoms, diaphragms and implantable contraceptives

General Comment	Provisions related to Reproductive Rights
	<p data-bbox="518 439 1359 560">4. <i>To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;</i></p> <p data-bbox="518 607 1350 685">5. <i>To provide appropriate training for health personnel, including education on health and human rights.”</i></p> <p data-bbox="518 734 1430 1111">In addition, <i>“National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party’s obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children’s Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination”, cf. Paragraph 57.</i></p> <p data-bbox="518 1160 1426 1536">Paragraph 59 deals with remedies and accountability: <i>“Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients’ rights associations or similar institutions should address violations of the right to health.”</i></p>

<p>General Comment</p>	<p>Provisions related to Reproductive Rights</p>
<p>General Comment No. 16 – The equal right of men and women to the enjoyment of all economic, social and cultural rights, 2005</p>	<p>According to Paragraph 5, <i>“Women are often denied equal enjoyment of their human rights, in particular by virtue of the lesser status ascribed to them by tradition and custom, or as a result of overt or covert discrimination. Many women experience distinct forms of discrimination due to the intersection of sex with such factors as race, colour, language, religion, political and other opinion, national or social origin, property, birth, or other status, such as age, ethnicity, disability, marital, refugee or migrant status, resulting in compounded disadvantage”.</i></p> <p>Paragraphs 7-8 deal with formal and substantive equality: <i>“Formal equality assumes that equality is achieved if a law or policy treats men and women in a neutral manner. Substantive equality is concerned, in addition, with the effects of laws, policies and practices and with ensuring that they do not maintain, but rather alleviate, the inherent disadvantage that particular groups experience. Substantive equality for men and women will not be achieved simply through the enactment of laws or the adoption of policies that are, prima facie, gender-neutral.”</i></p> <p>Paragraph 15 deals with the issues of temporary special measures: <i>“The principles of equality and non-discrimination, by themselves, are not always sufficient to guarantee true equality. Temporary special measures may sometimes be needed in order to bring disadvantaged or marginalized persons or groups of persons to the same substantive level as others. Temporary special measures aim at realizing not only de jure or formal equality, but also de facto or substantive equality for men and women. However, the application of the principle of equality will sometimes require that States parties take measures in favour of women in order to attenuate or suppress conditions that perpetuate discrimination. As long as these measures are necessary to redress de facto discrimination and are terminated when de facto equality is achieved, such differentiation is legitimate.”</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>Paragraph 24 sets out that states <i>“should reduce the constraints faced by men and women in reconciling professional and family responsibilities by promoting adequate policies for childcare and care of dependent family members”</i>.</p> <p>According to Paragraph 27: <i>“Gender-based violence is a form of discrimination that inhibits the ability to enjoy rights and freedoms, including economic, social and cultural rights, on a basis of equality. States parties must take appropriate measures to eliminate violence against men and women and act with due diligence to prevent, investigate, mediate, punish and redress acts of violence against them by private actors.”</i></p> <p>Paragraph 29 stresses that states must address <i>“the ways in which gender roles affect access to determinants of health, such as water and food; the removal of legal restrictions on reproductive health provisions; the prohibition of female genital mutilation; and the provision of adequate training for health-care workers to deal with women’s health issues”</i>.</p>

General Comment	Provisions related to Reproductive Rights
<p>General Comment No. 20 – Non-Discrimination in Economic, Social and Cultural Rights, 2009</p>	<p>According to Paragraph 8, <i>“Eliminating discrimination in practice requires paying sufficient attention to groups of individuals which suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations. States parties must therefore immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination.”</i></p> <p>Paragraph 11 on discrimination in the private sector states, <i>“Discrimination is frequently encountered in families, workplaces, and other sectors of society. For example, actors in the private housing sector (e.g. private landlords, credit providers and public housing providers) may directly or indirectly deny access to housing or mortgages on the basis of ethnicity, marital status, disability or sexual orientation while some families may refuse to send girl children to school. States parties must therefore adopt measures, which should include legislation, to ensure that individuals and entities in the private sphere do not discriminate on prohibited grounds.”</i></p> <p>According to Paragraph 29, <i>“unequal access by adolescents to sexual and reproductive health information and services amounts to discrimination”.</i></p>

COMMITTEE ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

The mandate of the Committee on the Elimination of All Forms of Discrimination against Women to make general recommendations is set out in Article 21 of the Convention. Several of Committee's recommendations are relevant to reproductive rights. In 2012, a Committee working group

was developing a General Recommendation on Women affected by conflict, including a section on women's sexual and reproductive health and there is also a joint working group of Committee and developing a General Comment/Recommendation on harmful practices.

General Recommendation	Provisions related to Reproductive Rights
<p>General Recommendation No. 14 – Female Circumcision, 1990 (Female Genital Mutilation – FGM)</p>	<p>States should:</p> <ol style="list-style-type: none"> 1. <i>“Take appropriate and effective measures with a view to eradicating the practice of female circumcision. Such measures could include:</i> <ol style="list-style-type: none"> a) <i>The collection and dissemination by universities, medical or nursing associations, national women’s organizations or other bodies of basic data about such traditional practices;</i> b) <i>The support of women’s organizations at the national and local levels working for the elimination of female circumcision and other practices harmful to women;</i> c) <i>The encouragement of politicians, professionals, religious and community leaders at all levels, including the media and the arts, to co-operate in influencing attitudes towards the eradication of female circumcision;</i> d) <i>The introduction of appropriate educational and training programmes and seminars based on research findings about the problems arising from female circumcision;</i>

General Recommendation	Provisions related to Reproductive Rights
	<ol style="list-style-type: none"> 2. <i>Include in their national health policies appropriate strategies aimed at eradicating female circumcision in public health care. Such strategies could include the special responsibility of health personnel, including traditional birth attendants, to explain the harmful effects of female circumcision;</i> 3. <i>Invite assistance, information and advice from the appropriate organizations of the United Nations system to support and assist efforts being deployed to eliminate harmful traditional practices;</i> 4. <i>Include in their reports to the Committee under articles 10 and 12 of the Convention on the Elimination of All Forms of Discrimination against Women information about measures taken to eliminate female circumcision."</i>
<p>General Recommendation No. 15 – Discrimination against women in national strategies for the prevention and control of AIDS, 1990</p>	<p>The Committee recommends:</p> <ol style="list-style-type: none"> 1. <i>"That States parties intensify efforts in disseminating information to increase public awareness of the risk of HIV infection and AIDS, especially in women and children, and of its effects on them;</i> 2. <i>That programmes to combat AIDS should give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection;</i> 3. <i>That States parties ensure the active participation of women in primary health care and take measures to enhance their role as care providers, health workers and educators in the prevention of infection with HIV;</i>

General Recommendation	Provisions related to Reproductive Rights
	<p>4. <i>That all States parties include in their reports under article 12 of the Convention information on the effects of AIDS on the situation of women and on the action taken to cater to the needs of those women who are infected and to prevent specific discrimination against women in response to AIDS."</i></p>
<p>General Recommendation No. 19 – Violence against women, 1992</p>	<p>Paragraph 24 includes recommendations for states to “ensure that laws against family violence and abuse, rape, sexual assault and other gender-based violence give adequate protection to all women, and respect their integrity and dignity. Appropriate protective and support services should be provided for victims. Gender-sensitive training of judicial and law enforcement officers and other public officials is essential for the effective implementation of the Convention”. States further “in their reports should identify the nature and extent of attitudes, customs and practices that perpetuate violence against women and the kinds of violence that result. They should report on the measures that they have undertaken to overcome violence and the effect of those measures ... Effective measures should be taken to overcome these attitudes and practices. States should introduce education and public information programmes to help eliminate prejudices that hinder women’s equality”. Finally, states 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.”</p>

General Recommendation	Provisions related to Reproductive Rights
<p>General Recommendation No. 21 – Equality in marriage and family relations, 1994</p>	<p>According to Paragraph 16, <i>“A woman’s right to choose a spouse and enter freely into marriage is central to her life and to her dignity and equality as a human being. An examination of States parties’ reports discloses that there are countries which, on the basis of custom, religious beliefs or the ethnic origins of particular groups of people, permit forced marriages or remarriages. Other countries allow a woman’s marriage to be arranged for payment or preferment and in others women’s poverty forces them to marry foreign nationals for financial security. Subject to reasonable restrictions based for example on woman’s youth or consanguinity with her partner, a woman’s right to choose when, if, and whom she will marry must be protected and enforced at law.”</i></p> <p>According to Paragraph 21, <i>“The responsibilities that women have to bear and raise children affect their right of access to education, employment and other activities related to their personal development. They also impose inequitable burdens of work on women. The number and spacing of their children have a similar impact on women’s lives and also affect their physical and mental health, as well as that of their children. For these reasons, women are entitled to decide on the number and spacing of their children.”</i></p>

General Recommendation	Provisions related to Reproductive Rights
	<p>Paragraphs 22-23 deal more specifically with reproductive health issues: <i>“Some reports disclose coercive practices which have serious consequences for women, such as forced pregnancies, abortions or sterilization. Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government. In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services, as provided in article 10 (h) of the Convention There is general agreement that where there are freely available appropriate measures for the voluntary regulation of fertility, the health, development and well-being of all members of the family improves. Moreover, such services improve the general quality of life and health of the population, and the voluntary regulation of population growth helps preserve the environment and achieve sustainable economic and social development.”</i></p> <p>On minimum marriageable age, Paragraph 36 says, <i>“the Committee considers that the minimum age for marriage should be 18 years for both man and woman. When men and women marry, they assume important responsibilities. Consequently, marriage should not be permitted before they have attained full maturity and capacity to act. According to the World Health Organization, when minors, particularly girls, marry and have children, their health can be adversely affected and their education is impeded. As a result their economic autonomy is restricted.”</i></p>

General Recommendation	Provisions related to Reproductive Rights
<p>General Recommendation No. 24 - Women and Health, 1999</p>	<p>According to Paragraph 2, <i>“special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities”.</i></p> <p>According to Paragraph 11, <i>“Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers”.</i></p> <p>This is followed up in Paragraph 13, <i>“The duty of States parties to ensure, on a basis of equality between men and women, access to health care services, information and education implies an obligation to respect, protect and fulfil women’s rights to health care. States parties have the responsibility to ensure that legislation and executive action and policy comply with these three obligations. They must also put in place a system which ensures effective judicial action. Failure to do so will constitute a violation of article 12.”</i></p>

General Recommendation	Provisions related to Reproductive Rights
	<p>According to Paragraph 14, <i>“The obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals. States parties should report on how public and private health care providers meet their duties to respect women’s rights to have access to health care. For example, States parties should not restrict women’s access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women. Other barriers to women’s access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures.”</i></p> <p>Paragraph 15 deals with gender-based violence: <i>“The obligation to protect rights relating to women’s health requires States parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations. Since gender-based violence is a critical health issue for women, States parties should ensure:</i></p> <ol style="list-style-type: none"> <li data-bbox="564 1290 1378 1491">1. <i>The enactment and effective enforcement of laws and the formulation of policies, including health care protocols and hospital procedures to address violence against women and abuse of girl children and the provision of appropriate health services;</i> <li data-bbox="564 1547 1390 1659">2. <i>Gender-sensitive training to enable health care workers to detect and manage the health consequences of gender-based violence;</i> <li data-bbox="564 1715 1374 1827">3. <i>Fair and protective procedures for hearing complaints and imposing appropriate sanctions on health care professionals guilty of sexual abuse of women patients;</i>

General Recommendation	Provisions related to Reproductive Rights
	<p data-bbox="555 439 1401 517">4. <i>The enactment and effective enforcement of laws that prohibit female genital mutilation and marriage of girl children.</i>"</p> <p data-bbox="555 566 1401 1406">Paragraph 18 deals more specifically with reproductive rights issues: <i>"The issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health. Adolescent girls and women in many countries lack adequate access to information and services necessary to ensure sexual health. As a consequence of unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices. Harmful traditional practices, such as female genital mutilation, polygamy, as well as marital rape, may also expose girls and women to the risk of contracting HIV/AIDS and other sexually transmitted diseases. Women in prostitution are also particularly vulnerable to these diseases. States parties should ensure, without prejudice and discrimination, the right to sexual health information, education and services for all women and girls, including those who have been trafficked, even if they are not legally resident in the country. In particular, States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their rights to privacy and confidentiality."</i></p> <p data-bbox="555 1456 1401 1624">According to Paragraph 20, <i>"Women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives."</i></p>

General Recommendation	Provisions related to Reproductive Rights
	<p>Paragraph 21 lists among the barriers <i>“that women face in gaining access to health care services ... requirements or conditions that prejudice women’s access such as high fees for health care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and absence of convenient and affordable public transport”</i>.</p> <p>In Paragraph 22, the Committee stresses, <i>“Acceptable services are those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women’s rights to informed consent and dignity”</i>.</p> <p>Paragraph 23 further underlines the duty to provide <i>“timely access to the range of services which are related to family planning, in particular, and to sexual and reproductive health in general. Particular attention should be paid to the health education of adolescents, including information and counselling on all methods of family planning.”</i></p> <p>On older women, the Committee says in Paragraph 24, <i>“States parties should take appropriate measures to ensure the access of older women to health services that address the handicaps and disabilities associated with ageing.”</i></p>

**General
Recommendation**

Provisions related to Reproductive Rights

Paragraph 25 deals with women with disabilities: *“Women with disabilities, of all ages, often have difficulty with physical access to health services. Women with mental disabilities are particularly vulnerable, while there is limited understanding, in general, of the broad range of risks to mental health to which women are disproportionately susceptible as a result of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation. States parties should take appropriate measures to ensure that health services are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity.”*

Paragraphs 26-27 concern pregnancy, childbirth and the post-natal period, with the Committee stating that, *“Reports should also include what measures States parties have taken to ensure women appropriate services in connection with pregnancy, confinement and the post-natal period. Information on the rates at which these measures have reduced maternal mortality and morbidity in their countries, in general, and in vulnerable groups, regions and communities, in particular, should also be included. States parties should include in their reports how they supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women. Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services. The Committee notes that it is the duty of States parties to ensure women’s right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.”*

General Recommendation	Provisions related to Reproductive Rights
	<p>According to Paragraph 28, “When reporting on measures taken to comply with article 12, States parties are urged to recognize its interconnection with other articles in the Convention that have a bearing on women’s health. Those articles include article 5 (b), which requires States parties to ensure that family education includes a proper understanding of maternity as a social function; article 10, which requires States parties to ensure equal access to education, thus enabling women to access health care more readily and reducing female students’ drop-out rates, which are often due to premature pregnancy; article 10(h) which provides that States parties provide to women and girls specific educational information to help ensure the well-being of families, including information and advice on family planning; article 11, which is concerned, in part, with the protection of women’s health and safety in working conditions, including the safeguarding of the reproductive function, special protection from harmful types of work during pregnancy and with the provision of paid maternity leave; article 14 (2) (b), which requires States parties to ensure access for rural women to adequate health care facilities, including information, counselling and services in family planning, and (h), which obliges States parties to take all appropriate measures to ensure adequate living conditions, particularly housing, sanitation, electricity and water supply, transport and communications, all of which are critical for the prevention of disease and the promotion of good health care; and article 16 (1) (e), which requires States parties to ensure that women have the same rights as men to decide freely and responsibly on the number and spacing of their children and to have access to information, education and means to enable them to exercise these rights. Article 16 (2) also proscribes the betrothal and marriage of children, an important factor in preventing the physical and emotional harm which arise from early childbirth.”</p>

General Recommendation	Provisions related to Reproductive Rights
	<p>Paragraph 31 provides further concrete recommendations: <i>“States parties should also, in particular:</i></p> <ol style="list-style-type: none"> <li data-bbox="555 566 1410 770">1. <i>Place a gender perspective at the centre of all policies and programmes affecting women’s s health and should involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women;</i> <li data-bbox="555 824 1385 1070">2. <i>Ensure the removal of all barriers to women’s access to health services, education and information, including in the area of sexual and reproductive health, and, in particular, allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS;</i> <li data-bbox="555 1124 1420 1370">3. <i>Prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion;</i> <li data-bbox="555 1424 1378 1541">4. <i>Monitor the provision of health services to women by public, non-governmental and private organizations, to ensure equal access and quality of care;</i> <li data-bbox="555 1594 1347 1711">5. <i>Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice;</i> <li data-bbox="555 1765 1385 1921">6. <i>Ensure that the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women’s health and human rights, in particular gender-based violence.”</i>

General Recommendation	Provisions related to Reproductive Rights
<p>General Recommendation No. 25 – Temporary special measures, 2004</p>	<p>The Committee stresses, <i>“a purely formal legal or programmatic approach is not sufficient to achieve women’s de facto equality with men, which the Committee interprets as substantive equality. In addition, the Convention requires that women be given an equal start and that they be empowered by an enabling environment to achieve equality of results. It is not enough to guarantee women treatment that is identical to that of men. Rather, biological as well as socially and culturally constructed differences between women and men must be taken into account. Under certain circumstances, non-identical treatment of women and men will be required in order to address such differences. Pursuit of the goal of substantive equality also calls for an effective strategy aimed at overcoming underrepresentation of women and a redistribution of resources and power between men and women.”</i></p>
<p>General Recommendation No. 26 – Women migrant workers, 2008</p>	<p>The country of origin should <i>“Deliver or facilitate free or affordable gender- and rights-based pre-departure ... information on general and reproductive health, including HIV/AIDS prevention”,</i> cf. Paragraph 24 (b) (i).</p> <p>Among the duties of the country of destination are to ensure <i>“linguistically and culturally appropriate gender-sensitive services for women migrant workers are available, including ... health-care services ... programmes designed especially for isolated women migrant workers, such as domestic workers and others secluded in the home, in addition to victims of domestic violence. Victims of abuse must be provided with relevant emergency and social services, regardless of their immigration status”,</i> cf. Paragraph 26 (i); to ensure <i>“pregnant and breastfeeding mothers [in detention] have access to appropriate services”,</i> cf. Paragraph 26 (j); and to provide <i>“undocumented women migrant workers ... legal remedies and justice ... if they face deprivation of fulfilment of basic needs, including in times of ... pregnancy and maternity”,</i> cf. Paragraph 26 (l).</p>

General Recommendation	Provisions related to Reproductive Rights
<p>General Recommendation No. 27 – Older women and the protection of their human rights, 2010</p>	<p>According to Paragraph 21, <i>“The right to self-determination and consent regarding health care of older women are not always respected. Social services, including provisions for long term care, for older women might be disproportionately reduced when public expenditure is cut. Postmenopausal, post-reproductive and age-related physical and mental health conditions and diseases tend to be neglected in research, academic studies, public policy and service provision. Information on sexual health, HIV and AIDS is rarely provided in a form that is acceptable, accessible and appropriate for older women.”</i></p>

COMMITTEE ON THE RIGHTS OF THE CHILD

Article 45 of the Convention on the Rights of the Child gives the Committee on the Rights of the Child the mandate to make

General Comments. To date the Committee has published eleven General Comments.

General Comment	Provisions related to Reproductive Rights
<p>General Comment No. 2 – The role of NHRIs in promoting and protecting the rights of the child, 2002</p>	<p>The General Comment provides an overview of activities that NHRIs could carry out to implement children’s rights, cf. Paragraph 18:</p> <ol style="list-style-type: none"> 1. <i>“Undertake investigations into any situation of violation of children’s rights, on complaint or on their own initiative, within the scope of their mandate;</i> 2. <i>Conduct inquiries on matters relating to children’s rights;</i>

General Comment	Provisions related to Reproductive Rights
	<ol style="list-style-type: none"> 3. <i>Prepare and publicize opinions, recommendations and reports, either at the request of national authorities or on their own initiative, on any matter relating to the promotion and protection of children's rights;</i> 4. <i>Keep under review the adequacy and effectiveness of law and practice relating to the protection of children's rights;</i> 5. <i>Promote harmonization of national legislation, regulations and practices with the Convention on the Rights of the Child, its Optional Protocols and other international human rights instruments relevant to children's rights and promote their effective implementation, including through the provision of advice to public and private bodies in construing and applying the Convention;</i> 6. <i>Ensure that national economic policy makers take children's rights into account in setting and evaluating national economic and development plans;</i> 7. <i>Review and report on the Government's implementation and monitoring of the state of children's rights, seeking to ensure that statistics are appropriately disaggregated and other information collected on a regular basis in order to determine what must be done to realize children's rights;</i> 8. <i>Encourage ratification of or accession to any relevant international human rights instruments;</i> 9. <i>In accordance with article 3 of the Convention requiring that the best interests of children should be a primary consideration in all actions concerning them, ensure that the impact of laws and policies on children is carefully considered from development to implementation and beyond;</i>

General Comment	Provisions related to Reproductive Rights
	<p>10. <i>In light of article 12, ensure that the views of children are expressed and heard on matters concerning their human rights and in defining issues relating to their rights;</i></p> <p>11. <i>Advocate for and facilitate meaningful participation by children's rights NGOs, including organizations comprised of children themselves, in the development of domestic legislation and international instruments on issues affecting children;</i></p> <p>12. <i>Promote public understanding and awareness of the importance of children's rights and, for this purpose, work closely with the media and undertake or sponsor research and educational activities in the field;</i></p> <p>13. <i>In accordance with article 42 of the Convention which obligates States parties to "make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike", sensitize the Government, public agencies and the general public to the provisions of the Convention and monitor ways in which the State is meeting its obligations in this regard;</i></p> <p>14. <i>Assist in the formulation of programmes for the teaching of, research into and integration of children's rights in the curricula of schools and universities and in professional circles;</i></p> <p>15. <i>Undertake human rights education which specifically focuses on children (in addition to promoting general public understanding about the importance of children's rights);</i></p> <p>16. <i>Take legal proceedings to vindicate children's rights in the State or provide legal assistance to children;</i></p> <p>17. <i>Engage in mediation or conciliation processes before taking cases to court, where appropriate;</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>18. <i>Provide expertise in children's rights to the courts, in suitable cases as amicus curiae or intervener;</i></p> <p>19. <i>In accordance with article 3 of the Convention which obliges States parties to "ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision", undertake visits to juvenile homes (and all places where children are detained for reform or punishment) and care institutions to report on the situation and to make recommendations for improvement;</i></p> <p>20. <i>Undertake such other activities as are incidental to the above."</i></p>

General Comment	Provisions related to Reproductive Rights
<p>General Comment No. 3 - HIV/AIDS and the rights of the child, 2003</p>	<p>According to Paragraph 8, <i>“Of particular concern is gender-based discrimination combined with taboos or negative or judgmental attitudes to sexual activity of girls, often limiting their access to preventive measures and other services. Of concern also is discrimination based on sexual orientation. In the design of HIV/AIDS-related strategies, and in keeping with their obligations under the Convention, States parties must give careful consideration to prescribed gender norms within their societies with a view to eliminating gender-based discrimination as these norms impact on the vulnerability of both girls and boys to HIV/AIDS. States parties should, in particular, recognize that discrimination in the context of HIV/AIDS often impacts girls more severely than boys.”</i></p> <p>According to Paragraph 11, <i>“Children have the right not to have their lives arbitrarily taken, as well as to benefit from economic and social policies that will allow them to survive into adulthood and develop in the broadest sense of the word. State obligation to realize the right to life, survival and development also highlights the need to give careful attention to sexuality as well as to the behaviours and lifestyles of children, even if they do not conform with what society determines to be acceptable under prevailing cultural norms for a particular age group. In this regard, the female child is often subject to harmful traditional practices, such as early and/or forced marriage, which violate her rights and make her more vulnerable to HIV infection, including because such practices often interrupt access to education and information. Effective prevention programmes are only those that acknowledge the realities of the lives of adolescents, while addressing sexuality by ensuring equal access to appropriate information, life skills, and to preventive measures.”</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>Paragraph 12 highlights the need to involve children in developing programmes: <i>“Children are rights holders and have a right to participate, in accordance with their evolving capacities, in raising awareness by speaking out about the impact of HIV/AIDS on their lives and in the development of HIV/AIDS policies and programmes. Interventions have been found to benefit children most when they are actively involved in assessing needs, devising solutions, shaping strategies and carrying them out rather than being seen as objects for whom decisions are made. In this regard, the participation of children as peer educators, both within and outside schools, should be actively promoted. States, international agencies and non-governmental organizations must provide children with a supportive and enabling environment to carry out their own initiatives, and to fully participate at both community and national levels in HIV policy and programme conceptualization, design, implementation, coordination, monitoring and review. A variety of approaches are likely to be necessary to ensure the participation of children from all sectors of society, including mechanisms which encourage children, consistent with their evolving capacities, to express their views, have them heard, and given due weight in accordance with their age and maturity (art. 12, para. 1). Where appropriate, the involvement of children living with HIV/AIDS in raising awareness, by sharing their experiences with their peers and others, is critical both to effective prevention and to reducing stigmatization and discrimination. States parties must ensure that children who participate in these awareness-raising efforts do so voluntarily, after being counselled, and that they receive both the social support and legal protection to allow them to lead normal lives during and after their involvement.”</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>In Paragraph 17, the Committee states <i>“States parties must make efforts to address gender differences as they may impact on the access children have to prevention messages, and ensure that children are reached with appropriate prevention messages even if they face constraints due to language, religion, disability or other factors of discrimination. Particular attention must be paid to raising awareness among hard-to-reach populations. In this respect, the role of the mass media and/or oral tradition in ensuring that children have access to information and material, as recognized in article 17 of the Convention, is crucial both to providing appropriate information and to reducing stigmatization and discrimination. States parties should support the regular monitoring and evaluation of HIV/AIDS awareness campaigns to ascertain their effectiveness in providing information, reducing ignorance, stigmatization and discrimination, as well as addressing fear and misperceptions concerning HIV and its transmission among children, including adolescents.”</i></p> <p>On counselling and testing, see Paragraph 22: <i>“The accessibility of voluntary, confidential HIV counselling and testing services, with due attention to the evolving capacities of the child, is fundamental to the rights and health of children. Such services are critical to children’s ability to reduce the risk of contracting or transmitting HIV, to access HIV-specific care, treatment and support, and to better plan for their futures.”</i> Section 23 deals with consent: <i>“States parties must refrain from imposing mandatory HIV/AIDS testing of children in all circumstances and ensure protection against it. While the evolving capacities of the child will determine whether consent is required from him or her directly or from his or her parent or guardian, in all cases, consistent with the child’s right to receive information under articles 13 and 17 of the Convention, States parties must ensure that, prior to any HIV testing, whether by health-care providers in relation to children who are accessing health services for another medical condition or otherwise, the risks and benefits of such testing are sufficiently conveyed so that an informed decision can be made.”</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>Paragraph 26 deals with vertical transmission: <i>“To prevent MTCT of HIV, States parties must take steps, including the provision of essential drugs, e.g. anti-retroviral drugs, appropriate antenatal, delivery and post-partum care, and making HIV voluntary counselling and testing services available to pregnant women and their partners. The Committee recognizes that anti-retroviral drugs administered to a woman during pregnancy and/or labour and, in some regimens, to her infant, have been shown to significantly reduce the risk of transmission from mother to child. However, in addition, States parties should provide support for mothers and children, including counselling on infant feeding options. States parties are reminded that counselling of HIV-positive mothers should include information about the risks and benefits of different infant feeding options, and guidance on selecting the option most likely to be suitable for their situation. Follow-up support is also required in order for women to be able to implement their selected option as safely as possible.”</i></p> <p>The specific recommendations of the Committee are set out in Paragraph 40:</p> <ol style="list-style-type: none"> 1. <i>“To adopt and implement national and local HIV/AIDS-related policies, including effective plans of action, strategies, and programmes that are child-centred, rights-based and incorporate the rights of the child under the Convention, including by taking into account the recommendations made in the previous paragraphs of the present General Comment and those adopted at the United Nations General Assembly special session on children (2002);</i> 2. <i>To allocate financial, technical and human resources, to the maximum extent possible, to supporting national and community-based action (art. 4), and, where appropriate, within the context of international cooperation (see paragraph 41 below).</i>

General Comment	Provisions related to Reproductive Rights
	<p>3. <i>To review existing laws or enact new legislation with a view to implementing fully article 2 of the Convention, and in particular to expressly prohibiting discrimination based on real or perceived HIV/AIDS status so as to guarantee equal access for of all children to all relevant services, with particular attention to the child's right to privacy and confidentiality and to other recommendations made by the Committee in the previous paragraphs relevant to legislation;</i></p> <p>4. <i>To include HIV/AIDS plans of action, strategies, policies and programmes in the work of national mechanisms responsible for monitoring and coordinating children's rights and to consider the establishment of a review procedure, which responds specifically to complaints of neglect or violation of the rights of the child in relation to HIV/AIDS, whether this entails the creation of a new legislative or administrative body or is entrusted to an existing national institution;</i></p> <p>5. <i>To reassess their HIV-related data collection and evaluation to ensure that they adequately cover children as defined under the Convention, are disaggregated by age and gender ideally in five-year age groups, and include, as far as possible, children belonging to vulnerable groups and those in need of special protection;</i></p> <p>6. <i>To include, in their reporting process under article 44 of the Convention, information on national HIV/AIDS policies and programmes and, to the extent possible, budgeting and resource allocations at the national, regional and local levels, as well as within these breakdowns the proportions allocated to prevention, care, research and impact reduction. Specific attention must be given to the extent to which these programmes and policies explicitly recognize children (in the light of their evolving capacities) and their rights, and the extent to which HIV-related rights of children are dealt with in laws, policies and practices, with specific</i></p>

General Comment	Provisions related to Reproductive Rights
	<p><i>attention to discrimination against children on the basis of their HIV status, as well as because they are orphans or the children of parents living with HIV/AIDS. The Committee requests States parties to provide a detailed indication in their reports of what they consider to be the most important priorities within their jurisdiction in relation to children and HIV/AIDS, and to outline the programme of activities they intend to pursue over the coming five years in order to address the problems identified. This would allow activities to be progressively assessed over time."</i></p>
<p>General Comment No. 4 – Adolescent health and development, 2003</p>	<p>According to Paragraph 9, <i>"In the context of the rights of adolescents to health and development, States parties need to ensure that specific legal provisions are guaranteed under domestic law, including with regard to setting a minimum age for sexual consent, marriage and the possibility of medical treatment without parental consent. These minimum ages should be the same for boys and girls (article 2 of the Convention) and closely reflect the recognition of the status of human beings under 18 years of age as rights holders, in accordance with their evolving capacity, age and maturity (arts. 5 and 12 to 17). Further, adolescents need to have easy access to individual complaint systems as well as judicial and appropriate non-judicial redress mechanisms that guarantee fair and due process, with special attention to the right to privacy (art. 16)."</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>In Paragraph 10, the Committee underlines the connection between civil rights and freedoms and health: <i>“The Convention defines the civil rights and freedoms of children and adolescents in its articles 13 to 17. These are fundamental in guaranteeing the right to health and development of adolescents. Article 17 states that the child has the right to “access information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health”. The right of adolescents to access appropriate information is crucial if States parties are to promote cost-effective measures, including through laws, policies and programmes, with regard to numerous health-related situations, including those covered in articles 24 and 33 such as family planning, prevention of accidents, protection from harmful traditional practices, including early marriages and female genital mutilation, and the abuse of alcohol, tobacco and other harmful substances.”</i></p> <p>Paragraph 11 deals with privacy and confidentiality: <i>“In order to promote the health and development of adolescents, States parties are also encouraged to respect strictly their right to privacy and confidentiality, including with respect to advice and counselling on health matters (art. 16). Health-care providers have an obligation to keep confidential medical information concerning adolescents, bearing in mind the basic principles of the Convention. Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult’s confidentiality. Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment.”</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>Paragraph 20 mirrors the Committee on the Elimination of All Forms of Discrimination against Women's General Comment No. 21 by raising the issue of early marriage and pregnancy, not just with respect to sexual and reproductive health, but also with respect to general development: <i>"The Committee is concerned that early marriage and pregnancy are significant factors in health problems related to sexual and reproductive health, including HIV/AIDS. Both the legal minimum age and actual age of marriage, particularly for girls, are still very low in several States parties. There are also non-health-related concerns: children who marry, especially girls, are often obliged to leave the education system and are marginalized from social activities."</i></p> <p>Paragraph 28 states, <i>"In light of articles 3, 17 and 24 of the Convention, States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs). In addition, States parties should ensure that they have access to appropriate information, regardless of their marital status and whether their parents or guardians consent. It is essential to find proper means and methods of providing information that is adequate and sensitive to the particularities and specific rights of adolescent girls and boys."</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>Paragraph 31 deals with the adolescent girl: <i>“Adolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs. States parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and to support adolescent parents. Young mothers, especially where support is lacking, may be prone to depression and anxiety, compromising their ability to care for their child. The Committee urges States parties (a) to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education.”</i></p> <p>Paragraph 32-33 deals with informed consent: <i>“Before parents give their consent, adolescents need to have a chance to express their views freely and their views should be given due weight, in accordance with article 12 of the Convention. However, if the adolescent is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself, while informing the parents if that is in the “best interest of the child” (art. 3). 33. With regard to privacy and confidentiality, and the related issue of informed consent to treatment, States parties should (a) enact laws or regulations to ensure that confidential advice concerning treatment is provided to adolescents so that they can give their informed consent. Such laws or regulations should stipulate an age for this process, or refer to the evolving capacity of the child; and (b) provide training for health personnel on the rights of adolescents to privacy and confidentiality, to be informed about planned treatment and to give their informed consent to treatment.”</i></p>

General Comment	Provisions related to Reproductive Rights
<p>General Comment No. 9 – The rights of children with disabilities, 2006</p>	<p>The “Committee notes that children with disabilities are, particularly during their adolescence, facing multiple challenges and risks in the area of establishing relationships with peers and reproductive health. Therefore, the Committee recommends that States parties provide adolescents with disabilities with adequate, and where appropriate, disability specific information, guidance and counselling and fully take into account the Committee’s general comments No. 3 (2003) on HIV/AIDS and the rights of the child and No. 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child”, cf. Paragraph 59.</p> <p>According to Paragraph 60, “The Committee is deeply concerned about the prevailing practice of forced sterilisation of children with disabilities, particularly girls with disabilities. This practice, which still exists, seriously violates the right of the child to her or his physical integrity and results in adverse life-long physical and mental health effects. Therefore, the Committee urges States parties to prohibit by law the forced sterilisation of children on grounds of disability.”</p>
<p>General Comment No. 11 – Indigenous children and their rights under the Convention, 2009</p>	<p>In Paragraph 22 the Committee “underlines that cultural practices provided by article 30 of the Convention must be exercised in accordance with other provisions of the Convention and under no circumstances may be justified if deemed prejudicial to the child’s dignity, health and development. Should harmful practices be present, inter alia early marriages and female genital mutilation, the State party should work together with indigenous communities to ensure their eradication. The Committee strongly urges States parties to develop and implement awareness-raising campaigns, education programmes and legislation aimed at changing attitudes and address gender roles and stereotypes that contribute to harmful practices.”</p>

General Comment	Provisions related to Reproductive Rights
	<p>According to Paragraph 54, “Regarding adolescent health, States parties should consider specific strategies in order to provide indigenous adolescents with access to sexual and reproductive information and services, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted infections (STIs). The Committee recommends States parties to take into account its general comments no. 3 on HIV/AIDS and the rights of the child (2003) and no. 4 on adolescent health (2003) for this purpose.”</p>



COMMITTEE ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION

Article 9 of the International Convention on the Elimination of Racial Discrimination gives the Committee on the Elimination of Racial Discrimination the mandate to make

General Recommendations. To date the Committee has published 33 such General Recommendations, but none focuses on reproductive rights.

General Recommendation	Provisions related to Reproductive Rights
<p>General Recommendation No. 25 – Gender dimension of racial discrimination, 2000</p>	<p>Paragraph 2 says, <i>“Certain forms of racial discrimination may be directed towards women specifically because of their gender, such as sexual violence committed against women members of particular racial or ethnic groups in detention or during armed conflict; the coerced sterilization of indigenous women; abuse of women workers in the informal sector or domestic workers employed abroad by their employers. Racial discrimination may have consequences that affect primarily or only women, such as pregnancy resulting from racial bias-motivated rape; in some societies women victims of such rape may also be ostracized. Women may also be further hindered by a lack of access to remedies and complaint mechanisms for racial discrimination because of gender-related impediments, such as gender bias in the legal system and discrimination against women in private spheres of life.”</i></p>

COMMITTEE AGAINST TORTURE

Article 19 of the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment gives the Committee

against Torture the mandate to make General Comments. To date the Committee has published two such General Comments.

General Comment	Provisions related to Reproductive Rights
<p>General Comment No. 2 – Implementation of Art. 2, 2007</p>	<p>According to Paragraph 18, <i>“The Committee has made clear that where State authorities or others acting in official capacity or under colour of law, know or have reasonable grounds to believe that acts of torture or ill-treatment are being committed by non-State officials or private actors and they fail to exercise due diligence to prevent, investigate, prosecute and punish such non-State officials or private actors consistently with the Convention, the State bears responsibility and its officials should be considered as authors, complicit or otherwise responsible under the Convention for consenting to or acquiescing in such impermissible acts. Since the failure of the State to exercise due diligence to intervene to stop, sanction and provide remedies to victims of torture facilitates and enables non-State actors to commit acts impermissible under the Convention with impunity, the State’s indifference or inaction provides a form of encouragement and/or de facto permission. The Committee has applied this principle to States parties’ failure to prevent and protect victims from gender-based violence, such as rape, domestic violence, female genital mutilation, and trafficking.”</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>According to Paragraph 22, <i>“State reports frequently lack specific and sufficient information on the implementation of the Convention with respect to women. The Committee emphasizes that gender is a key factor. Being female intersects with other identifying characteristics or status of the person such as race, nationality, religion, sexual orientation, age, immigrant status etc. to determine the ways that women and girls are subject to or at risk of torture or ill-treatment and the consequences thereof. The contexts in which females are at risk include deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence by private actors in communities and homes. Men are also subject to certain gendered violations of the Convention such as rape or sexual violence and abuse. Both men and women and boys and girls may be subject to violations of the Convention on the basis of their actual or perceived non-conformity with socially determined gender roles. States parties are requested to identify these situations and the measures taken to punish and prevent them in their reports.”</i></p>

COMMITTEE ON MIGRANT WORKERS

The Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW) does not seem to give the Committee on the Protection of the Rights of All Migrant Workers

and Members of Their Families a specific mandate to issue General Comments. Nevertheless, the Committee has issued one General Comment. This was in 2011 and it concerns migrant domestic workers.

General Comment	Provisions related to Reproductive Rights
<p>General Comment No. 1 – Migrant Domestic Workers, 2011</p>	<p>Paragraph 22 says, <i>“Under some countries’ laws regarding work permit and security bond conditions, women migrants, including domestic workers, who get pregnant or who are found to be HIV positive lose their permit. It is not uncommon for women migrant workers to be subjected to mandatory health testing related to sexual and reproductive health without consent or counselling.”</i></p> <p>Paragraph 24 says, <i>“Domestic workers, especially those who are migrants, are often excluded from rights under national law related to social security. The lack of social security benefits and of gender-sensitive health care coverage further increases the vulnerability of migrant domestic workers and their dependence on their employers.”</i></p> <p>Some recommendations may also be found in Paragraph 38: <i>“Accordingly, labour protections in national law should be extended to domestic workers to ensure equal protection under the law, including provisions related to minimum wages, hours of work, days of rest, freedom of association, social security protection, including with respect to maternity, pension rights and health insurance, as well as additional provisions specific to the circumstances of domestic work. In this regard, migrant domestic workers should enjoy treatment not less favourable than that which applies to nationals of the State of employment (article 25).”</i></p>

General Comment	Provisions related to Reproductive Rights
	<p>This is expanded in Paragraphs 43 and 44: <i>“States should ensure effective access of all migrant domestic workers to any medical care urgently required to avoid irreparable harm to their health (article 28). Particular attention should be given to women migrant domestic workers with irregular status, who are especially vulnerable during pregnancy, as they are often afraid to contact public health services out of fear of deportation. States should not require public health institutions providing care to report data on the regular or irregular status of a patient to immigration authorities. States should ensure that migrant domestic workers in a documented or regular situation enjoy equal treatment with nationals in relation to social and health services (article 43(1)(e)). Moreover, the Committee recalls the obligations assumed by States under other core international human rights treaties, notably the International Covenant on Economic, Social and Cultural Rights, to take appropriate measures towards ensuring to all persons within their jurisdiction, irrespective of their immigration status, the highest attainable standard of physical and mental health and medical care, services and attention in the event of sickness.”</i></p>

COMMITTEE ON THE RIGHTS OF PERSONS WITH DISABILITIES

The Committee on the Rights of Persons with Disabilities that monitors the Convention on the Rights of Persons with Disabilities had its first session in 2009 and it

has yet to prepare its first General Recommendation. It is mandated to make such recommendations under Article 39 of the Convention.

INDIVIDUAL COMPLAINTS

As mentioned above, most of the United Nations treaty bodies have the mandate to hear individual complaints, also called communications, under certain circumstances. The decisions are considered authoritative interpretations of the human rights

provisions in question. The following summary is a selection of some decisions that have dealt with issues of reproductive rights.

INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS

The first optional protocol to International Covenant on Civil and Political Rights, adopted by the United Nations General Assembly in 1966, came into force in 1976, giving the Human Rights Committee the mandate to consider individual complaints. More than 110 states have ratified or acceded to the optional protocol. So far the Committee has made decisions concerning approximately 750 communications.

Case of Miss K.L.N.H. vs. Peru, 2006 (CCPR/C/85/D/1153/2003)

In this case the 17-year-old complainant had been informed by her gynaecologist and obstetrician that the foetus she was carrying had a serious abnormality, and termination of the pregnancy was advised based on the risks to the life of Miss K. The director of the hospital refused to give consent as in his view abortion was only permitted to save the life of the pregnant woman or avoid serious and permanent damage to her health. Miss K. gave birth to a baby girl that, as expected, died after four days. This led to deep depression, requiring psychiatric treatment. The failure to allow termination of the pregnancy in a situation where it was clear that this could have (and actually had) severe effects on the health of Miss K. constituted a violation of Article 7 on the grounds of cruel, inhuman or degrading treatment. Furthermore, the Committee found that refusing abortion in a case where this would have been lawful (regardless of the view of the hospital director) was an unlawful interference in Miss K.'s private life as prohibited by Article 17. In addition, the Committee found Article 24 to have been violated as Miss K. did not receive the

care that she needed and was her due as a minor. Finally, the lack of an adequate legal remedy constituted a violation of Article 2. On this basis, the Committee found that Peru should compensate Miss K. and take appropriate steps to prevent a repeat of the violations.

The reasoning of the Committee was as follows: "6.2. *The Committee notes that the author attached a doctor's statement confirming that her pregnancy exposed her to a life-threatening risk. She also suffered severe psychological consequences exacerbated by her status as a minor, as the psychiatric report of 20 August 2001 confirmed. The Committee notes that the State party has not provided any evidence to challenge the above. It notes that the authorities were aware of the risk to the author's life, since a gynaecologist and obstetrician in the same hospital had advised her to terminate the pregnancy, with the operation to be carried out in the same hospital. The subsequent refusal of the competent medical authorities to provide the service may have endangered the author's life. The author states that no effective remedy was available to her to oppose that decision. In the absence of any information from the State party, due weight must be given to the author's claims.*

6.3. *The author also claims that, owing to the refusal of the medical authorities to carry out the therapeutic abortion, she had to endure the distress of seeing her daughter's marked deformities and knowing that she would die very soon. This experience added further pain and distress to that which she had already borne during the period when she was obliged to continue with the pregnancy. The author attaches a psychiatric certificate dated 20*

August 2001, which confirms the state of deep depression into which she fell and the severe consequences this caused, taking her age into account. The Committee notes that this situation could have been foreseen, since a hospital doctor had diagnosed anencephaly in the foetus, yet the hospital director refused termination. The omission on the part of the State in not enabling the author to benefit from a therapeutic abortion was, in the Committee's view, the cause of the suffering she experienced. The Committee has pointed out in its General Comment No. 20 that the right set out in article 7 of the Covenant relates not only to physical pain but also to mental suffering, and that the protection is particularly important in the case of minors. In the absence of any information from the State party in this regard, due weight must be given to the author's complaints. Consequently, the Committee considers that the facts before it reveal a violation of article 7 of the Covenant. In the light of this finding the Committee does not consider it necessary in the circumstances to make a finding on article 6 of the Covenant.

6.4. The author states that the State party, in denying her the opportunity to secure medical intervention to terminate the pregnancy, interfered arbitrarily in her private life. The Committee notes that a public-sector doctor told the author that she could either continue with the pregnancy or terminate it in accordance with domestic legislation allowing abortions in cases of risk to the life of the mother. In the absence of any information from the State party, due weight must be given to the author's claim that at the time of this information, the conditions for a lawful abortion as set out in the law were present. In the circumstances of the case, the refusal to act in accordance with the author's decision to terminate her pregnancy was not justified and amounted to a violation of article 17 of the Covenant.

6.5. The author claims a violation of article 24 of the Covenant, since she did not receive from the State party the special care she needed as a minor. The Committee notes the special vulnerability of the author as a minor girl. It further notes that, in the absence of any information from the State party, due weight must be given to the author's claim that she did not receive, during and after her pregnancy, the medical and psychological support necessary in the specific circumstances of her case. Consequently, the Committee considers that the facts before it reveal a violation of article 24 of the Covenant.

6.6. The author claims to have been a victim of violation of articles 2 of the Covenant on the grounds that she lacked an adequate legal remedy. In the absence of information from the State party, the Committee considers that due weight must be given to the author's claims as regards lack of an adequate legal remedy and consequently concludes that the facts before it also reveal a violation of article 2 in conjunction with articles 7, 17 and 24."

In addition, the Human Rights Committee has made several decisions where a state has been found in violation of the International Covenant on Civil and Political Rights by treating women and men differently, for example concerning Dutch provisions that prevented married women from receiving unemployment support.⁸ These cases do not, however, specifically deal with reproductive rights.

⁸ The Law provides that "abortion shall not be punishable if performed by a doctor with the consent of the pregnant woman or her legal representative, if any, when it is the only way to save the life of the mother or to avoid serious and permanent harm to her health".

INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

In December 2008 the United Nations General Assembly adopted an Optional Protocol that will give the Committee on Economic, Social and Cultural Rights the mandate to receive and consider individual

communications. At this stage it has not been ratified or acceded to by a sufficient number of states to come into force. Consequently, there are no decisions on individual complaints from this Committee.

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

The optional protocol to Convention on the Elimination of All Forms of Discrimination against Women adopted by the United Nations General Assembly in 1999, came into force in 2000, giving the Committee on the Elimination of All Forms of Discrimination against Women the mandate to consider individual complaints. More than 100 states have ratified or acceded to the optional protocol. So far the Committee has made decisions concerning more than 20 cases. Three of these cases directly concern reproductive rights.

Case of Ms. A. S. vs. Hungary (CEDAW/C/36/D/4/2004)

In this case, the complainant, a Roma woman, in connection with the removal of a dead foetus had signed a consent form with a handwritten note to the extent that she also requested a sterilization, a term she did not know and only understood after the procedure had been done. In its decision from 2006, the Committee found that Hungary had violated Article 10 (h) of the Convention (access to information) by failing to provide appropriate information and advice on family planning which had not enabled her to make a fully informed decision; Article 12 (access to health care) by not ensuring

fully informed consent; and Article 16 (the right to decide the number and spacing of children) by permanently depriving the complainant of her natural reproductive capacity. Consequently, the Committee recommended clarifying the provisions on consent for sterilization in Hungarian law and monitoring facilities providing sterilization.

The decision was as follows: *“11.5. Acting under article 7, paragraph 3 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, the Committee on the Elimination of Discrimination against Women is of the view that the facts before it reveal a violation of articles 10 (h), 12 and 16, paragraph 1 (e) of the Convention and makes the following recommendations to the State party:*

I. Concerning the author of the communication: provide appropriate compensation to Ms. A. S. commensurate with the gravity of the violations of her rights.

II. General:

- *Take further measures to ensure that the relevant provisions of the Convention and the pertinent paragraphs of the Committee’s general recommendations Nos. 19, 21*

and 24 in relation to women's reproductive health and rights are known and adhered to by all relevant personnel in public and private health centres, including hospitals and clinics.

- *Review domestic legislation on the principle of informed consent in cases of sterilization and ensure its conformity with international human rights and medical standards, including the Convention of the Council of Europe on Human Rights and Biomedicine ("the Oviedo Convention") and World Health Organization guidelines. In that connection, consider amending the provision in the Public Health Act whereby a physician is allowed "to deliver the sterilization without the information procedure generally specified when it seems to be appropriate in given circumstances".*
- *Monitor public and private health centres, including hospitals and clinics, which perform sterilization procedures so as to ensure that fully informed consent is being given by the patient before any sterilization procedure is carried out, with appropriate sanctions in place in the event of a breach."*

Case of Ms. Da Silva Pimentel vs. Brazil (CEDAW/C/49/D/17/2008)

In this case, the Committee on the Elimination of All Forms of Discrimination against Women found that the state had violated its obligation under Article 12.2 to provide appropriate services in connection with pregnancy, confinement and the post-natal period by failing to provide proper obstetric care following the delivery of a stillborn foetus which led to the death of the mother. In connection with the case,

the Committee refuted the argument that the state could be free of responsibility due to the service provider being a private enterprise. This is a case of triple discrimination where the Committee found the victim to have been discriminated against not only due to her sex but also due to her ethnicity, being of African descent, and her socio-economic background. In addition to the recommendations directly concerning the provisions of health care, the Committee stressed the need for effective remedies and, in this connection, the provision of training for the judiciary and law enforcement personnel.

The reasoning of the Committee was as follows: "7.3. Although the State party argued that Ms. da Silva Pimentel Teixeira's death was non-maternal and that the probable cause of her death was digestive haemorrhage, the Committee notes that the sequence of events described by the author and not contested by the State party, as well as expert opinion provided by the author, indicate that her death was indeed linked to obstetric complications related to pregnancy. Her complaints of severe nausea and abdominal pain during her sixth month of pregnancy were ignored by the health centre, which failed to perform an urgent blood and urine test to ascertain whether the foetus had died. The tests were done two days later, which led to a deterioration of Ms. da Silva Pimentel Teixeira's condition. The Committee recalls its general recommendation No. 24, in which it states that it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services, and to allocate to these services the maximum extent of available resources. It also states that measures to eliminate discrimination against women are considered inappropriate in a health-care system which lacks services

to prevent, detect and treat illnesses specific to women. In the light of these observations, the Committee also rejects the argument of the State party that the communication did not contain a causal link between Ms. da Silva Pimentel Teixeira's gender and the possible medical errors committed, but that the claims concerned a lack of access to medical care related to pregnancy. The Committee therefore is of the view that the death of Ms. da Silva Pimentel Teixeira must be regarded as maternal.

7.4. The Committee also notes the author's allegation concerning the poor quality of the health services provided to her daughter, which not only included the failure to perform a blood and urine test, but also the fact that the curettage surgery was only carried out 14 hours after labour was induced in order to remove the afterbirth and placenta, which had not been fully expelled during the process of delivery and could have caused the haemorrhaging and ultimately death. The surgery was done in the health centre, which was not adequately equipped, and her transfer to the municipal hospital took eight hours, as the hospital refused to provide its only ambulance to transport her, and her family was not able to secure a private ambulance. It also notes that her transfer to the municipal hospital without her clinical history and information on her medical background was ineffective, as she was left largely unattended in a makeshift area in the hallway of the hospital for 21 hours until she died. The State party did not deny the inappropriateness of the service nor refute any of these facts. Instead it admitted that Ms. da Silva Pimentel Teixeira's vulnerable condition required individualized medical treatment, which was not forthcoming owing to a potential failure in the medical assistance provided by a private health institution, caused by professional negligence, inadequate

infrastructure and lack of professional preparedness. The Committee therefore concludes that Ms. da Silva Pimentel Teixeira was not ensured appropriate services in connection with her pregnancy.

7.7. The Committee notes the author's claim that Ms. da Silva Pimentel Teixeira suffered from multiple discrimination, being a woman of African descent and on the basis of her socio-economic background. In this regard, the Committee recalls its concluding observations on Brazil, adopted on 15 August 2007, where it noted the existence of *de facto* discrimination against women, especially women from the most vulnerable sectors of society such as women of African descent. It also noted that such discrimination was exacerbated by regional, economic and social disparities. The Committee also recalls its general recommendation No. 28 (2010) on the core obligations of States parties under article 2 of the Convention, recognizing that discrimination against women based on sex and gender is inextricably linked to other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste, and sexual orientation and gender identity. The Committee notes that the State party did not rule out that discrimination might have contributed to some extent, but not decisively, to the death of the author's daughter. The State party also acknowledged that the convergence or association of the different elements described by the author may have contributed to the failure to provide necessary and emergency care to her daughter, resulting in her death. In such circumstances, the Committee concludes that Ms. da Silva Pimentel Teixeira was discriminated against, not only on the basis of her sex, but also on the basis of her status as a woman of African descent and her socio-economic background.

The decision was as follows: “8. Acting under article 7, paragraph 3, of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, and in the light of all the above considerations, the Committee is of the view that the State party violated its obligations under article 12 (in relation to access to health), article 2 (c) (in relation to access to justice) and article 2 (e) (in relation to the State party’s due diligence obligation to regulate the activities of private health service providers), in conjunction with article 1, of the Convention, read together with general recommendations Nos. 24 and 28, and makes the following recommendations to the State party:

1. Concerning the author and the family of Ms. da Silva Pimentel Teixeira:

Provide appropriate reparation, including adequate financial compensation, to the author and to the daughter of Ms. da Silva Pimentel Teixeira commensurate with the gravity of the violations against her;

2. General:

1. *Ensure women’s right to safe motherhood and affordable access for all women to adequate emergency obstetric care, in line with general recommendation No. 24 (1999) on women and health;*
2. *Provide adequate professional training for health workers, especially on women’s reproductive health rights, including quality medical treatment during pregnancy and delivery, as well as timely emergency obstetric care;*
3. *Ensure access to effective remedies in cases where women’s reproductive health rights*

have been violated and provide training for the judiciary and for law enforcement personnel;

4. *Ensure that private health-care facilities comply with relevant national and international standards on reproductive health care;*
5. *Ensure that adequate sanctions are imposed on health professionals who violate women’s reproductive health rights;*
6. *Reduce preventable maternal deaths through the implementation of the National Pact for the Reduction of Maternal Mortality at state and municipal levels, including by establishing maternal mortality committees where they still do not exist, in line with the recommendations in its concluding observations for Brazil, adopted on 15 August 2007 (CEDAW/C/BRA/CO/6).”*

Case of L.C. vs. Peru (CEDAW/C/50/D/22/2009)

In this case, the Committee on the Elimination of All Forms of Discrimination against Women examined the situation of LC, a girl who was sexually abused from the age of 13 in 2006 and who became pregnant as a result. In a state of depression upon discovering the pregnancy, she attempted suicide by jumping from a building on 31 March 2007. She survived the suicide attempt but endured extensive injuries including damage to her spinal column causing “paraplegia of the lower and upper limbs requiring emergency surgery.” The surgery was deemed necessary to prevent her injuries from worsening and resulting in permanent disability. The surgery was scheduled for 12 April 2007, but then postponed because of the risk to

the pregnancy. Subsequently, the author and her mother requested a legal termination of the pregnancy⁹ in order to allow the spinal surgery to proceed.

The hospital authorities responded negatively to the request 42 days later considering that the patient's life was not in danger. The Deputy Defender for Women's Rights, having been informed of the case during the period when the hospital was deciding whether to allow the termination, issued a report finding that in these circumstances a therapeutic abortion would be justified. The decision of the medical board was appealed on 7 June 2007. On 16 June 2007, the author suffered a miscarriage. On 27 June 2007, the director of the hospital informed the author that the decision of the board was not subject to appeal. The author underwent spinal surgery on 11 July 2007; about 3.5 months after the injuries were sustained. She is currently paralyzed from the neck down and has only regained partial movement in her hands.

The State party disputed the reasons for the delay in performing the spinal operation, but the Committee found *"that there is a direct relationship between the withdrawal of the surgery, whose necessity cannot be questioned, and L. C.'s pregnancy."* The Committee found that the decision to refuse the abortion did not adequately consider the damage to LC's health, including her mental health. In this regard, it found a violation of her right to health since *"as a pregnant woman, L. C.*

⁹ The law provides that "abortion shall not be punishable if performed by a doctor with the consent of the pregnant woman or her legal representative, if any, when it is the only way to save the life of the mother or to avoid serious and permanent harm to her health".

did not have access to an effective and accessible procedure allowing her to establish her entitlement to the medical services that her physical and mental condition required. Those services included both the spinal surgery and the therapeutic abortion. This is even more serious considering that she was a minor and a victim of sexual abuse, as a result of which she attempted suicide. The suicide attempt is a demonstration of the amount of mental suffering she had experienced." The Committee also found that the victim had been denied an effective remedy, noting that *"since the State party has legalized therapeutic abortion, it must establish an appropriate legal framework that allows women to exercise their right to it under conditions that guarantee the necessary legal security, both for those who have recourse to abortion and for the health professionals that must perform it. It is essential for this legal framework to include a mechanism for rapid decision-making, with a view to limiting to the extent possible risks to the health of the pregnant mother, that her opinion be taken into account, that the decision be well-founded and that there is a right to appeal."*

The Committee recommended that the State party provide reparation to the victim, including adequate compensation. It also recommended that the State party review its laws to establish a mechanism for effective access to therapeutic abortion and take measures in accordance with the Committee's General Recommendation on women's health.

In **CEDAW/C/36/D/2/2003, A.T. v. Hungary**, the Committee found that the absence of effective measures to protect a woman and her family under threat from her abusive former husband constituted a violation of Articles 2, 5 and 16. In its decision the

Committee emphasized its view that that traditional attitudes by which women are regarded as subordinate to men contribute to violence against them. This is the same

attitude that in many cases makes it impossible for women to achieve their reproductive rights.

COMMITTEE ON THE RIGHTS OF THE CHILD

The Committee on the Rights of the Child does not currently have a system for receiving complaints. Work is being undertaken

to draft an optional protocol that would give the Committee this option.

COMMITTEE ON THE ELIMINATION OF RACIAL DISCRIMINATION

Article 14 of the Convention on the Elimination of All Forms of Racial Discrimination mandates the Committee on the Elimination of Racial Discrimination to receive individual

complaints. Since the first complaint in 1984, Committee has received more than 50 cases, but none focus on reproductive rights.

COMMITTEE AGAINST TORTURE

Article 22 of Convention against Torture gives the Committee the mandate to receive individual complaints. To date it has made more than 200 decisions. Three cases concern the question of whether women who had been raped in their country of origin, in two of the cases while under detention, could be ordered to return. Whereas these cases do deal with matters of sexual

violence, they do not say anything substantial directly linked to the issue of reproductive rights. The same can be said about a case concerning a woman who had been forced to marry in her home country and later sentenced to death where the state of residence was asked to ascertain if she was in danger of being tortured if forced to return.

COMMITTEE ON MIGRANT WORKERS

The procedure for receiving individual complaints as set out in the Convention is not

yet in force as an insufficient number of states have accepted this procedure.

COMMITTEE ON THE RIGHTS OF PERSONS WITH DISABILITIES

The Optional Protocol to Convention on the Rights of Persons with Disabilities, adopted in 2006 and in force as of 2008, gives Committee on the Rights of Persons with Disabilities the mandate to receive individual

complaints. No decisions had been made as of 2012.

CONCLUDING OBSERVATIONS AND RECOMMENDATIONS - A SYNTHESIS

During the period 2005-2011,¹⁰ the Committees made observations or recommendations on issues relating to the right to sexual and reproductive health in the concluding observations for 108 countries. Reproductive and sexual health issues are referenced in 166 concluding observations¹¹. The

¹⁰ Including January 2011

¹¹ In order to develop this analysis, the methodol-

ogy used to write the "HIV/AIDS and International Human Rights Treaty Bodies, 2005-2010", was repeated; thus all the 193 member states of the United Nations were reviewed. The search included the following terms: maternal mortality, maternal morbidity, reproductive rights, pregnancy, abortion, child mortality, early marriages, rape, marital rape, HIV/AIDS and STIs, and violence against women.

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Human Rights Treaty Body 2005-2011	Number of Concluding Observations Addressing Reproductive Rights
Human Rights Committee	14
Committee on Economic, Social and Cultural Rights	29
Committee on the Elimination of All Forms of Discrimination against Women	45
Committee on the Rights of the Child	51
Committee on the Elimination of Racial Discrimination	3
Committee against Torture	24
Total sets of Concluding Observations	166

The Committees that have most often addressed issues relating to reproductive rights are the Committee on the Elimination of All Forms of Discrimination against Women, the Committee on the Rights of the Child, and the Committee on Economic, Social and Cultural Rights. This is not surprising as (i) reproductive rights are closely linked to women's rights and women's empowerment; (ii) certain aspects of reproductive rights is directly involves children, such as infant mortality and the reproductive rights of adolescents; and (iii) important aspects of reproductive rights fall under the right to health, which is part of economic, social and cultural rights.

The Committee against Torture has recognized that acts of violence against women as well as acts committed by private persons can amount to violations of the Convention (General Comment No. 2), but there were only eight sets of related concluding observations.

Overall, the Committees have tended to focus on:

- (i) inadequate access to health services in general;
- (ii) lack of reproductive health services and family planning, including with respect to HIV/AIDS;
- (iii) insufficient provision of education and information dissemination on reproductive health and family planning, including with respect to HIV/AIDS; and
- (iv) the specific needs of adolescents.

Committee commentaries in the relevant concluding observations confirm the importance of education and access to information in the campaign for the right to the highest attainable standard of health and universal reproductive health. The need for legislation to allow abortion at least when pregnancy poses a risk to the woman's life or health, in cases of rape or incest and when there is a severe foetal abnormality was mentioned in several of the concluding observations, emphasizing the need for safe abortion services and proper post-abortion care.

Another theme that emerged in the Committee observations included empowerment of women to address violence, abuse, and harmful practices. Several of the observations highlight discrimination and/or non-equitable distribution of resources, illustrating that they are important aspects of the Human Rights-Based Approach to development, i.e. that equal resources and efforts must be utilized to secure equal benefits from health care for men and for women, for urban and rural residents etc.

The Committees have in many cases expressed concern with respect to high maternal mortality and morbidity, emphasizing the need for better access to general and maternal health services. In that connection, the Committees have highlighted intersectional disadvantages experienced by certain groups, including indigenous persons and those living in rural and remote areas, while stressing the need for the equitable distribution of benefits.¹² The need for effective programmes

¹² Committee on the Elimination of All Forms of Discrimination against Women Argentina 2010, Committee on Economic, Social and Cultural Rights

to combat mother-to-child transmission of HIV has been specifically mentioned in a few cases¹³ as has the need for fully

Brazil 2009, Committee on Economic, Social and Cultural Rights Dominican Republic 2010, Committee on the Rights of the Child Ecuador 2010, Committee on the Elimination of All Forms of Discrimination against Women Panama 2010, Committee on Economic, Social and Cultural Rights Uruguay 2010, Committee on the Elimination of All Forms of Discrimination against Women Turkey 2010, Committee on the Elimination of All Forms of Discrimination against Women Fiji 2010, Committee on the Elimination of All Forms of Discrimination against Women Kyrgyzstan 2008, Committee on the Elimination of All Forms of Discrimination against Women Laos 2005, Committee on the Elimination of All Forms of Discrimination against Women Papua New Guinea 2010, Committee on the Elimination of All Forms of Discrimination against Women Uzbekistan 2010, Committee on Economic, Social and Cultural Rights Algeria 2010, Committee on the Elimination of All Forms of Discrimination against Women Burkina Faso 2010, Committee on the Rights of the Child Cameroon 2010, Committee on the Elimination of All Forms of Discrimination against Women Guinea-Bissau 2009, Committee on the Elimination of All Forms of Discrimination against Women Liberia 2009, Committee on the Rights of the Child Mauritania 2009, Committee on the Elimination of All Forms of Discrimination against Women Niger 2007, Committee on the Rights of the Child Nigeria 2006, Committee on the Elimination of All Forms of Discrimination against Women Nigeria 2008, Committee on the Elimination of All Forms of Discrimination against Women Rwanda 2009, Committee on the Elimination of All Forms of Discrimination against Women Tunisia 2010, Committee on the Elimination of All Forms of Discrimination against Women Uganda 2010, Committee on the Elimination of All Forms of Discrimination against Women New Zealand 2007

13 Committee on the Rights of the Child Angola 2010, Committee on the Rights of the Child Burundi 2010, Committee on the Rights of the Child Malawi 2009, Committee on the Rights of the Child Mauritania 2009, Committee on the Rights of the Child Mozambique 2009, Committee on the Rights of the Child Philippines 2009

subsidized HIV/AIDS treatments.¹⁴ Promotion of breastfeeding has been encouraged by the Committee on the Rights of the Child.¹⁵

Equally consistent has been the Committees' insistence on the obligation to ensure all-encompassing access to sexual and reproductive health services, including contraceptives, for women and adolescents, including for indigenous persons, ethnic and linguistic minorities, internally displaced persons (IDPs), persons with disabilities and persons in rural or remote areas.¹⁶ There

14 Committee on the Elimination of All Forms of Discrimination against Women Burkina Faso 2010, Committee on the Rights of the Child Burundi 2010

15 Committee on the Rights of the Child Bolivia 2009, Committee on the Rights of the Child Ecuador 2010, Committee on the Rights of the Child El Salvador 2010, Committee on the Rights of the Child Guatemala 2010, Committee on the Rights of the Child Cameroon 2010, Committee on the Rights of the Child Mauritania 2009

16 Committee on the Elimination of All Forms of Discrimination against Women Argentina 2010, Committee on Economic, Social and Cultural Rights Colombia 2010, Committee on Economic, Social and Cultural Rights Dominican Republic 2010, Committee on the Rights of the Child Ecuador 2010, Committee on the Rights of the Child El Salvador 2010, Committee on the Rights of the Child Guatemala 2010, CERD Panama 2010, Committee on the Elimination of All Forms of Discrimination against Women Panama 2010, Committee on the Elimination of All Forms of Discrimination against Women Albania 2010, Committee on the Rights of the Child Latvia 2006, Committee on Economic, Social and Cultural Rights Netherlands 2010, Committee on Economic, Social and Cultural Rights Poland 2009, Human Rights Committee Poland 2010, Human Rights Committee Moldova 2009, Committee on the Elimination of All Forms of Discrimination against Women Ukraine 2010, Committee on Economic, Social and Cultural Rights Afghanistan 2010, Committee on the Elimination of All Forms of Discrimination against Women Fiji 2010, Committee on the Elimination of All Forms of Discrimination against

has also been a great focus on the duty to ensure education and awareness on sexual and reproductive health, including on HIV/AIDS, in particular to indigenous groups, ethnic and linguistic minorities and other vulnerable groups and to adolescents.¹⁷

Women Kyrgyzstan 2008, Committee on the Elimination of All Forms of Discrimination against Women Laos 2005, Committee on the Rights of the Child North Korea 2009, Committee on the Rights of the Child Pakistan 2010, Committee on Economic, Social and Cultural Rights Sri Lanka 2010, Committee on the Rights of the Child Sri Lanka 2010, Committee on the Elimination of All Forms of Discrimination against Women Papua New Guinea 2010, Committee on the Rights of the Child Burkina Faso 2010, Committee on Economic, Social and Cultural Rights Chad 2009, Committee on the Elimination of All Forms of Discrimination against Women Guinea-Bissau 2009, Committee on the Rights of the Child Mauritania 2009, Committee on the Rights of the Child Mozambique 2009, Committee on the Rights of the Child Niger 2009, Committee on the Elimination of All Forms of Discrimination against Women Niger 2007, Committee on the Rights of the Child Nigeria 2006, Committee on the Elimination of All Forms of Discrimination against Women Nigeria 2008, Committee on the Elimination of All Forms of Discrimination against Women Rwanda 2009, Committee on the Elimination of All Forms of Discrimination against Women Tunisia 2010, Committee on the Elimination of All Forms of Discrimination against Women Uganda 2010, Committee on the Rights of the Child Kiribati 2006, Committee on the Rights of the Child Philippines 2009, Committee on Economic, Social and Cultural Rights Philippines 2008

17 Committee on the Elimination of All Forms of Discrimination against Women Argentina 2010, Committee on the Elimination of All Forms of Discrimination against Women Bolivia 2009, Human Rights Committee Colombia 2010, Committee on Economic, Social and Cultural Rights Colombia 2010, Committee on Economic, Social and Cultural Rights Dominican Republic 2010, Committee on the Rights of the Child Ecuador 2010, Committee on the Rights of the Child El Salvador 2010, Committee on the Elimination of All Forms of Discrimination against Women Panama 2010, Committee on Economic, Social and Cultural Rights Uruguay 2010, Committee on the Elimination of All Forms of Discrimination

against Women Albania 2010, Committee on the Elimination of All Forms of Discrimination against Women Denmark 2009, Committee on the Rights of the Child Latvia 2006, Committee on Economic, Social and Cultural Rights Netherlands 2010, Committee on the Rights of the Child Netherlands 2009, Committee on Economic, Social and Cultural Rights Poland 2009, Human Rights Committee Moldova 2009, Committee on the Rights of the Child Moldova 2009, Committee on Economic, Social and Cultural Rights Switzerland 2010, Committee on the Rights of the Child Macedonia 2010, Committee on the Elimination of All Forms of Discrimination against Women Ukraine 2010, Committee on the Rights of the Child Japan 2010, Committee on Economic, Social and Cultural Rights Kazakhstan 2010, Committee on the Elimination of All Forms of Discrimination against Women Kyrgyzstan 2008, Committee on the Elimination of All Forms of Discrimination against Women Laos 2005, Committee on the Rights of the Child North Korea 2009, Committee on Economic, Social and Cultural Rights Republic of Korea 2009, Committee on Economic, Social and Cultural Rights Sri Lanka 2010, Committee on the Rights of the Child Sri Lanka 2010, Committee on the Elimination of All Forms of Discrimination against Women Papua New Guinea 2010, Committee on the Elimination of All Forms of Discrimination against Women Uzbekistan 2010, Committee on the Rights of the Child Lebanon 2006, Committee on the Rights of the Child Angola 2010, Committee on the Rights of the Child Burkina Faso 2010, Committee on Economic, Social and Cultural Rights Chad 2009, Committee on the Elimination of All Forms of Discrimination against Women Guinea-Bissau 2009, Committee on the Elimination of All Forms of Discrimination against Women Liberia 2009, Committee on the Rights of the Child Malawi 2009, Committee on the Rights of the Child Mauritania 2009, Committee on the Rights of the Child Mozambique 2009, Committee on the Rights of the Child Niger 2009, Committee on the Elimination of All Forms of Discrimination against Women Niger 2007, Committee on the Rights of the Child Nigeria 2006, Committee on the Elimination of All Forms of Discrimination against Women Nigeria 2008, Committee on the Rights of the Child Nigeria 2006, Committee on the Elimination of All Forms of Discrimination against Women Rwanda 2009, Committee on the Elimination of All Forms of Discrimination against Women Tunisia 2010, Committee on the Elimination of All Forms of Discrimination against Women Uganda 2010, Committee on the Rights of

The Committee on the Rights of the Child has urged increased focus on adolescent health issues, including on care, counselling and rehabilitation of adolescents, with a specific emphasis on risky life styles, including early pregnancies, drug and alcohol abuse, and has recommended comprehensive studies as the basis for relevant policies.¹⁸ Access to confidential HIV tests and counselling should be secured also for adolescents.¹⁹ Civil society should be involved in implementing policies on health and development.²⁰

Several Committees have urged review²¹ of legislation criminalizing abortion and

the Child Kiribati 2006, Committee on the Elimination of All Forms of Discrimination against Women Niger 2007, Committee on the Rights of the Child Philippines 2009, Committee on Economic, Social and Cultural Rights Philippines 2008

18 Committee on the Rights of the Child Argentina 2010, Committee on the Rights of the Child Bolivia 2009, Committee on the Rights of the Child El Salvador 2010, Committee on the Rights of the Child Moldova 2009, Committee on the Rights of the Child North Korea 2009, Committee on the Rights of the Child Sri Lanka 2010, Committee on the Rights of the Child Tajikistan 2010, Committee on the Rights of the Child Lebanon 2006, Committee on the Rights of the Child Qatar 2009, Committee on the Rights of the Child Burundi 2010, Committee on the Rights of the Child Cameroon 2010, Committee on the Rights of the Child Malawi 2009, Committee on the Rights of the Child Mauritania 2009, Committee on the Rights of the Child Mozambique 2009, Committee on the Rights of the Child Niger 2009, Committee on the Rights of the Child Nigeria 2005, Committee on the Rights of the Child Tunisia 2010, Committee on the Rights of the Child Kiribati 2006

19 Committee on the Rights of the Child Guatemala 2010, Committee on the Rights of the Child Latvia 2006

20 Committee on the Rights of the Child Nigeria 2006

21 Committee on the Elimination of All Forms of

have concluded that much of the increasing demand for abortion is linked to the lack of access to modern forms of contraception and other family planning measures.²² The Committee on the Elimination of All Forms of Discrimination against Women and the Committee on the Rights of the Child have mentioned that inequality between women and men often makes women unable to secure safe sexual practices, leading to increased exposure to STIs including HIV, and the need to empower girls and women in general.²³

Several Committees highlight sexual abuse, particularly of girls, and violence against

Discrimination against Women Argentina 2010, Committee on Economic, Social and Cultural Rights Brazil 2009, Committee on Economic, Social and Cultural Rights Dominican Republic 2010, Committee on the Rights of the Child El Salvador 2010, Committee against Torture Nicaragua 2009, Committee on Economic, Social and Cultural Rights Netherlands 2010, Human Rights Committee Poland 2010, Committee on Economic, Social and Cultural Rights Sri Lanka 2010, Committee on the Elimination of All Forms of Discrimination against Women Papua New Guinea 2010, Committee on the Rights of the Child Burkina Faso 2010, Committee on the Rights of the Child Mozambique 2009, Committee on the Rights of the Child Nigeria 2006, Committee on the Elimination of All Forms of Discrimination against Women Nigeria 2008, Committee on Economic, Social and Cultural Rights Mauritius 2010, Committee on the Elimination of All Forms of Discrimination against Women Rwanda 2009, Committee on Economic, Social and Cultural Rights Philippines 2008

22 Committee on Economic, Social and Cultural Rights Dominican Republic 2010, Human Rights Committee Mexico 2010, Human Rights Committee Poland 2010, Committee on the Rights of the Child Pakistan 2010

23 Committee on the Elimination of All Forms of Discrimination against Women Papua New Guinea 2010, Committee on the Rights of the Child Angola 2010, Committee on the Elimination of All Forms of Discrimination against Women Burkina Faso 2010, Committee on the Elimination of All Forms of Discrimination against Women Uganda 2010

women and children, addressing the need for both preventive measures, including sensitization, and for proper investigation of cases and treatment to victims.²⁴ The Committees have also highlighted the need to adopt legal frameworks aimed at preventing the abuse and protecting the victim. The need to criminalize marital rape has been mentioned.²⁵ In at least one case, the link

24 Committee on Economic, Social and Cultural Rights Brazil 2009, Human Rights Committee Colombia 2010, Committee on the Rights of the Child Colombia 2010, Committee on Economic, Social and Cultural Rights Colombia 2010, Convention against Torture Colombia 2010, Human Rights Committee Ecuador 2009, Committee against Torture El Salvador 2009, Committee against Torture Honduras 2009, Human Rights Committee Mexico 2010, Committee against Torture Nicaragua 2009, Human Rights Committee Hungary 2010, Committee against Torture Latvia 2008, Human Rights Committee Sweden 2009, Committee on the Elimination of All Forms of Discrimination against Women Fiji 2010, Committee on the Elimination of All Forms of Discrimination against Women India 2010, Committee against Torture Mongolia 2011, Committee on the Elimination of All Forms of Discrimination against Women Papua New Guinea 2010, Human Rights Committee Jordan 2010, Committee on the Elimination of All Forms of Discrimination against Women Lebanon 2008, Committee on the Rights of the Child Burundi 2010, Human Rights Committee Cameroon 2010, Committee against Torture Cameroon 2010, Committee on Economic, Social and Cultural Rights DR Congo 2009, Committee on the Elimination of All Forms of Discrimination against Women Guinea-Bissau 2009, Committee against Torture Kenya 2009, Committee on the Elimination of All Forms of Discrimination against Women Liberia 2009, Committee on the Elimination of All Forms of Discrimination against Women Niger 2007, Committee on Economic, Social and Cultural Rights Mauritius 2010, Committee on the Elimination of All Forms of Discrimination against Women Rwanda 2009, Committee on the Rights of the Child Sierra Leone 2010, Committee on the Rights of the Child Kiribati 2006

25 CAT Latvia 2008, Committee on the Elimination of All Forms of Discrimination against Women Laos 2005, CAT Mongolia 2011, Committee on the Elimination of All Forms of Discrimination against Women Lebanon 2008, Human Rights Committee Cameroon

between violence against women, in particular domestic violence, and sexual health issues has been acknowledged.²⁶

Committees have encouraged steps to be taken to combat female genital mutilation in parallel with the need to combat harmful practices in general, both by legislation and by awareness-raising.²⁷ The Committees have highlighted the need to effectively combat bride abductions, forced marriages²⁸ and marriages involving children.²⁹ In one case, the Committee on the Rights of the Child emphasized the need to establish strategies against harmful practices in a participatory manner, involving civil society and taking into account the views of the victims.³⁰

2010, CAT Cameroon 2010, Committee on Economic, Social and Cultural Rights Mauritius 2010

26 Committee on Economic, Social and Cultural Rights Dominican Republic 2010

27 Committee on the Rights of the Child Pakistan 2010, Committee on the Rights of the Child Cameroon 2010, Committee on Economic, Social and Cultural Rights Chad 2009, Committee on the Rights of the Child Malawi 2009, Committee on the Rights of the Child Niger 2009, Committee on the Rights of the Child Nigeria 2006, Committee on the Rights of the Child Sierra Leone 2010

28 Committee on the Elimination of All Forms of Discrimination against Women Kyrgyzstan 2008, Committee on the Rights of the Child Pakistan 2010, Committee on the Rights of the Child Burkina Faso 2010

29 Committee on the Rights of the Child Sri Lanka 2010, Committee on the Rights of the Child Qatar 2009, Committee on the Elimination of All Forms of Discrimination against Women Guinea-Bissau 2009, Committee on the Rights of the Child Mozambique 2009, Committee on the Rights of the Child Niger 2009, Committee on the Rights of the Child Nigeria 2006, Committee on the Rights of the Child Sierra Leone 2010

30 Committee on the Rights of the Child Sierra Leone 2010

SPECIAL PROCEDURES

OVERVIEW

“Special Procedures” is the term normally used for the mechanisms established by the United Nations Human Rights Council to address both thematic issues and country situations. The mandates of the Special Procedures are established and defined by the Human Rights Council resolution creating them. Normally, such resolutions call on mandate holders to examine, monitor, advise and publicly report on major human rights issues worldwide (thematic mandates) or on human rights situations in specific countries or territories (country mandates). Special procedures can do anything from responding to individual complaints (typically by sending urgent appeals or letters of allegation to the relevant governments) to conducting studies, providing advice on technical cooperation and engaging in general promotional activities. There were 36 thematic and 12 country mandates by September 2012. Generally, Special Procedures are led by an appointed individual with the title of “Special Rapporteur” or “Special Representative of the Secretary-General” or “Independent Expert” but some are led by small working groups. The persons chosen are unpaid independent experts, serving in their personal capacity. Secretariat services for Special Procedures are provided by the Office of the High Commissioner for Human Rights, which provides assisting personnel as well as policy, research and logistical support. Annual reports on their activities are made by each appointed individual or group to the Human Rights Council and the United Nations General Assembly.

An important activity for Special Procedures is country visits to investigate the situation of human rights at the national level. This cannot be done without an invitation from the relevant government. As of 31 December 2011, 91 states had issued standing invitations, meaning that they are in principle prepared to receive a visit from any Special Procedures mandate holder at any time.

Special Procedures mandate holders do not have the same authority to interpret the individual human rights treaties, as do the actual treaty bodies or Committees. However, the United Nations Human Rights Council mandates their work and therefore they speak with a considerable degree of authority. There have not been any Special Procedures established specifically to consider the issue of reproductive rights. Nonetheless, many deal with matters that involve sexual and reproductive health concerns.

The Special Procedures mandate holders often conduct country visits. They will normally be interested in interaction with the NHRI of the visited country and it is also possible for a NHRI to encourage a visit. Following a country visit, a country report will normally be issued and can be useful to the NHRI in the country in question to follow up on findings of the mandate holder.

SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

The right to sexual and reproductive health

The 2004 report (E/CN.4/2004/49) of the Special Rapporteur to the United Nations Human Rights Commission of 2004 focuses on sexual and reproductive health and rights. After stating that at least three of the eight Millennium Development Goals are directly related to sexual and reproductive health, the Special Rapporteur declares that *“the rights to sexual and reproductive health have an indispensable role to play in the struggle against intolerance, gender inequality, HIV/AIDS and poverty”*, and that *“increased attention [should] be devoted to a proper understanding of reproductive health, reproductive rights, sexual health and sexual rights.”*

The account by the Special Rapporteur takes as its point of departure the statement by the United Nations Human Rights Commission in 2003 that *“sexual and reproductive health care integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”*. In Paragraph 13 of this report he states, *“Of course, not all sexual and reproductive ill health represents a violation of the right to health or other human rights. Ill health constitutes a human rights violation when it arises, in whole or in part, from the failure of a duty-bearer – typically a State – to respect, protect or fulfil a human rights obligation. Obstacles stand between individuals and their enjoyment of sexual and reproductive health. From the human rights perspective, a key question is: are human rights duty-bearers doing all in their power to dismantle these barriers?”*

Many of the issues highlighted by the Special Rapporteur in this report are the same as the ones raised by the United Nations human rights treaty bodies, including the right to control one's own body, the need to eliminate the use of non-consensual contraceptive methods (e.g. forced sterilization and forced abortion), and the need to abolish female genital mutilation (FGM) and forced marriage.

Paragraph 28 deals with entitlements: *“The right to health includes an entitlement to a system of health protection, including health care and the underlying determinants of health, which provides equality of opportunity for people to enjoy the highest attainable level of health. For example, women should have equal access, in law and fact, to information on sexual and reproductive health issues.”* This is expanded in Paragraphs 29-30: *“Thus, States have an obligation to ensure reproductive health and maternal and child health services, including appropriate services for women in connection with pregnancy, granting free services where necessary. More particularly, States should improve a wide range of sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information. The Special Rapporteur urges all duty-holders also to ensure access to such vital health services as voluntary testing, counselling and treatment for sexually transmitted infections, including HIV/AIDS, and breast and reproductive system cancers, as well as infertility treatment. 30. ... Women with unwanted pregnancies should be offered reliable information and compassionate counselling, including*

information on where and when a pregnancy may be terminated legally. Where abortions are legal, they must be safe: public health systems should train and equip health service providers and take other measures to ensure that such abortions are not only safe but accessible. In all cases, women should have access to quality services for the management of complications arising from abortion. Punitive provisions against women who undergo abortions must be removed.”

After explaining fairly detailed some of the main issues pertaining to discrimination, vulnerability and stigma in Paragraph 32-38, he sets out the obligations of the states in Paragraphs 39 and 40: “Arising from their obligations to combat discrimination, States have a duty to ensure that health information and services are made available to vulnerable groups. For example, they must take steps to empower women to make decisions in relation to their sexual and reproductive health, free of coercion, violence and discrimination. They must take action to redress gender-based violence and ensure that there are sensitive and compassionate services available for the survivors of gender-based violence, including rape and incest. States should ensure that adolescents are able to receive information, including on family planning and contraceptives, the dangers of early pregnancy and the prevention of sexually transmitted infections including HIV/AIDS, as well as appropriate services for sexual and reproductive health. Consistent with *Toonen v. Australia*³¹ and numerous other international and national decisions, they should ensure that sexual and other health services are available for men who have sex with men, lesbians, and transsexual and bisexual people. It is also important to

ensure that voluntary counselling, testing and treatment of sexually transmitted infections are available for sex workers. 40. Finally, in the context of sexual and reproductive health, breaches of medical confidentiality may occur. Sometimes these breaches, when accompanied by stigmatization, lead to unlawful dismissal from employment, expulsion from families and communities, physical assault and other abuse. In addition, a lack of confidentiality may deter individuals from seeking advice and treatment, thereby jeopardizing their health and well-being. Thus, States are obliged to take effective measures to ensure medical confidentiality and privacy.” In this respect, reference can also be made to the report of 27 April 2010 by the Special Rapporteur (A/HRC/14/20) where the focus is on the relationship between the right to the highest attainable standard of health and the criminalization of three forms of private adult consensual sexual behaviour: same-sex conduct and sexual orientation, sex work, and HIV transmission.

Paragraphs 41-42 deals with the 3AQ: “Analytical frameworks or tools can deepen our understanding of economic, social and cultural rights, including the right to health (*ibid.*, paras. 33-36). One framework that is especially useful in the context of policy-making is that health services, goods and facilities, including the underlying determinants of health, shall be available, accessible, acceptable and of good quality. This analytical framework encompasses sexual and reproductive health. For example, sexual and reproductive health services, goods and facilities must be: available in adequate numbers within the jurisdiction of a State; accessible geographically, economically (i.e. be affordable) and without discrimination; culturally acceptable to, for example, minorities and indigenous peoples, as well as sensitive to gender and life-cycle requirements, and

31 Human Rights Committee, *Toonen v. Australia*, 4 April 1994, (CCPR/C/50/D/488/1992)

respectful of confidentiality; and scientifically and medically appropriate and of good quality. 42. When this framework is applied to sexual and reproductive health, it is clear that the key elements of availability, accessibility and so on are frequently absent. For example, in many countries, information on sexual and reproductive health is not readily available and, if it is, it is not accessible to all, in particular women and adolescents. Sexual and reproductive health services are often geographically inaccessible to communities living in rural areas. These services are sometimes not provided in a form that is culturally acceptable to indigenous peoples and other non-dominant groups. Lastly, services, and relevant underlying determinants of health, such as education, are often of substandard quality."

Finally, the Special Rapporteur stresses the need for a participatory approach, cf. Paragraph 48, and for effective, accessible and transparent mechanisms of accountability, cf. Paragraph 49: "The right to health requires that health policies, programmes and projects are participatory. The active and informed participation of all stakeholders can broaden consensus and a sense of "ownership", promote collaboration and increase the chances of success. Since sexual and reproductive health care integral elements of the right to health, it follows that all initiatives for the promotion and protection of sexual and reproductive health must be formulated, implemented and monitored in a participatory manner. 49. The right to health also demands accountability. Without mechanisms of accountability, the obligations arising from the right to health are unlikely to be fully respected. This applies equally to the integral elements of sexual and reproductive health. Thus, all initiatives for the promotion and protection of sexual and reproductive health must include effective, accessible and

transparent mechanisms of accountability in relation to all duty-bearers."

The right to health and the reduction of maternal mortality

The Special Rapporteur has also written about reproductive rights in other reports, including report A/61/338 of 13 September 2006 to the United Nations General Assembly, focusing on maternal mortality and access to medicine. Apart from highlighting many of the same points mentioned by the various Committees, the Special Rapporteur states that well-functioning primary health-care systems, "from community-based interventions to the first referral-level facility at which emergency obstetric care is available", are a priority to prevent maternal mortality, cf. Paragraph 16.

In Paragraph 21 he explains the "three delays" model: "It has been suggested that maternal mortality is overwhelmingly due to delays in: deciding to seek appropriate medical help for an obstetric emergency (for reasons of cost, lack of recognition of an emergency, poor education, lack of access to information and gender inequality); reaching an appropriate facility (for reasons of distance, infrastructure and transport); and receiving adequate care when a facility is reached (e.g. because there are shortages in staff, or because electricity, water or medical supplies are not available). The "three delays" are interrelated. The right to health encompasses norms and obligations which are relevant in each of these contexts."

The MDGs and reproductive health rights

In 2004 the focus of the Special Rapporteur's report to the United Nations General Assembly, A/59/422 of 8 October 2004,

was health-related Millennium Development Goals. In it the Special Rapporteur discusses the four health-related Millennium Development Goals of which three are directly related to reproductive rights: reduction of child mortality (MDG 4), improvement of maternal health (MDG 5) and combating HIV/AIDS and certain other diseases (MDG 6), cf. Paragraph 11. The Rapporteur further mentions the interdependency of the health related MDGs and several of the other MDGs, such as the eradication of extreme poverty and hunger (MDG 1), developing a global partnership for development (MDG 8), achieving universal primary education (MDG 2) and empowering women (MDG 3). According to Paragraph 13, *“Health is central to the Millennium Development Goals because it is central to poverty reduction and development. Good health is not just an outcome of poverty reduction and development: it is a way of achieving them. But it is also more than that. International law — and numerous national constitutions — recognize the human right to the highest attainable standard of physical and mental health.”*

The right to health and informed consent

Reproductive rights are also mentioned in the Special Rapporteur’s report to the United Nations General Assembly A/64/272 of 10 August 2009, focusing on informed consent. Among other things the report mentions the right of adolescents to have access to sexual and reproductive services and information without parental consent, cf. Paragraph 48: *“As “minors” before the law, children often have their rights relegated to a legal guardian, compromising their exercise of autonomy; varying maturity levels makes appropriately assessing legal capacity very difficult. Children from marginalized*

communities and those in institutional care are particularly vulnerable to being subjected to non-consensual medical interventions. Social preconceptions among adults can present barriers to children’s right to sexual and reproductive health services and information, and while some countries protect it, in many countries, parental consent requirements impede access. States must ensure that adolescents have access to appropriate health information and services regardless of parental consent, particularly those concerning sexual and reproductive health. Given sufficient maturity, adolescents may request confidential health services and information.”

Criminalization of sexual and reproductive health and rights

The Special Rapporteur presented his report to the General Assembly on 3 August 2011 (A/66/254), within which the interaction between criminal laws and other legal restrictions relating to sexual and reproductive health and the right to health are considered.

The Special Rapporteur considers the impact of criminal and other legal restrictions on abortion, on conduct during pregnancy, on contraception and family planning, and on the provision of sexual and reproductive education and information. Some criminal and other legal restrictions in each of those areas, which are often discriminatory in nature, violate the right to health by restricting access to quality goods, services and information. They infringe human dignity by restricting the freedoms to which individuals are entitled under the right to health, particularly in respect of decision-making and bodily integrity. Moreover, the application of such laws as a means to

achieving certain public health outcomes is often ineffective and disproportionate.

In Paragraph 21, the Rapporteur explains how *“Criminal laws penalizing and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realization of women’s right to health and must be eliminated. These laws infringe women’s dignity and autonomy by severely restricting decision-making by women in respect of their*

sexual and reproductive health. Moreover, such laws consistently generate poor physical health outcomes, resulting in deaths that could have been prevented, morbidity and ill-health, as well as negative mental health outcomes, not least because affected women risk being thrust into the criminal justice system. Creation or maintenance of criminal laws with respect to abortion may amount to violations of the obligations of States to respect, protect and fulfil the right to health.”

SPECIAL RAPPORTEUR ON VIOLENCE AGAINST WOMEN, ITS CAUSES AND CONSEQUENCES

Political economy of women’s human rights

The Special Rapporteur on violence against women, its causes and consequences has also addressed reproductive rights in some of her reports. In her report A/HRC/11/6 of 18 May 2009 to the Human Rights Council, focusing on the political economy of women’s human rights, the Special Rapporteur highlights the impact violence against women has on women’s sexual and reproductive health, including on women’s exposure to HIV/AIDS, cf. Paragraphs 59-60: *“VAW [Violence against women] affects women’s sexual and reproductive health, which is a key aspect of women’s right to health. The experience of violence adversely affects reproductive health regardless of wealth. Survivors of VAW have the right to adequate reparation and rehabilitation that covers their physical and mental health. But this support is often not provided. (...) 60. VAW is also considered to be a leading cause of HIV/AIDS, affecting women’s right to health. Given the increasing feminization of HIV/*

AIDS, eliminating VAW is a critical intervention to reduce the pandemic. VAW or fear of it also prevents many women from asking their partners to practice safe sex leading to higher HIV rates. Many women also experience severe violence at the hands of their partners as soon as their diagnosis becomes known. In order to care for family members with HIV/AIDS, they may feel forced into high-risk work such as the sex industry or keep children, especially girls, out of school to help with tasks – thereby entrenching the intergenerational transmission of poverty and violence.”

Intersections of violence against women and HIV/AIDS

The intersection of violence against women and HIV/AIDS is dealt with in greater detail in the report E/CN.4/2005/72 of 17 January 2005 to the United Nations Human Rights Commission. In it the Special Rapporteur expounds on the way in which gender inequality and discrimination against women, among

other things materializing as violence against women, not only vastly increase women's risk of contracting HIV/AIDS but also seriously affects the way women with HIV/AIDS are treated. According to Paragraph 67, *"Because testing is a regular part of prenatal care, the HIV status of a woman is more likely to become disclosed at a hospital or clinic where the principle of confidentiality is often violated, especially when it comes to HIV. Moreover, although health-care providers theoretically have more accurate information than the general public on how HIV is transmitted, this does not necessarily translate into more sensitive care and treatment of HIV patients. The worst discrimination encountered by HIV-infected women relates to family planning, pregnancy and childcare. The choice of whether or not to have children and information on the means of avoiding transmitting the disease to an unborn child or a new born infant make women the focus of intense scrutiny: pregnancy and childcare are areas around which multiple stigmas of family, community and health care converge."*

Intersections between culture and violence against women

In her report A/HRC/4/34 of 17 January 2007 to the Human Rights Council on intersections between culture and violence against women, the Special Rapporteur states that also donor countries can be host to cultural traits that negatively affect the struggle for better sexual and reproductive health, not only in the country itself but also in recipient countries, cf. Paragraph 66: *"Also worrisome are reactionary donor agendas that reinforce conservative norms and threaten gains made by women. Recent policies on reproductive rights as well as HIV and AIDS, which give preference to sexual abstinence and fidelity over condom use, are particularly illustrative. They not only fail to recognize the problems that oppressed women face in asserting their sexual rights against their male partners, but also reinforce ideologies of men's control over women's sexuality (however they may be culturally framed) and thereby contribute to the perpetuation of the root cause of many forms of violence against women."*

SPECIAL RAPPORTEUR ON THE RIGHT TO EDUCATION

Girls' right to education

In the report of 8 February 2006 E/CV.4/2006/45, focused on girls' right to education, the Special Rapporteur denounces the negative impact on education, and especially on girls' education, of the persistent consideration of education as a service rather than a human right. The report insists on the importance of ensuring not only girls' access to school but also their completion of the education cycle. The report identifies obstacles to education for

girls, such as early marriages and pregnancies, child labour (especially domestic work) and armed conflict.

The Rapporteur explains in Paragraph 3, *"Girls' right to education cannot be addressed in isolation from gender issues; and these issues certainly not only affect women's rights but also impose the need to envisage a new form of **masculinity** that is more sensitive, responsible and proactive towards equality, justice and solidarity."*

Sexuality education

In his report of 23 July 2010 (A/65/162), the Special Rapporteur introduces the topic of the right to sexuality education, placing it in the context of patriarchy and control of sexuality. He explains the interdependence of sexuality, health and education and the relationship of this right to other rights from a gender and diversity perspective. The Special Rapporteur introduces the right to sexuality education in the context of international human rights law and analyses

international and regional standards. He then addresses the situation of the right to sexuality education, taking State responsibility into account and analysing regional and national trends, differing perspectives and the key role of the family and the community. The Special Rapporteur concludes his report by reiterating the necessity and the relevance of the right to comprehensive sexuality education and presenting specific recommendations for States and the international community.

SPECIAL RAPPORTEUR ON THE RIGHTS OF INDIGENOUS PEOPLES

In his 2007 report to the Human Rights Council (A/HRC/4/32), the Special Rapporteur notes the triple discrimination of which indigenous women are often victims (being indigenous, poor and female) and mentions some examples of the consequences of this, such as substantially higher infant mortality

and lower access to medical care during childbirth, cf. Paragraphs 67-69. In addition, he highlights the discrimination of indigenous women within their own communities, for example with respect to forced marriages and rape, cf. Paragraph 71.

SPECIAL RAPPORTEUR ON THE SITUATION OF HUMAN RIGHTS DEFENDERS

In her 2010 report on women human rights defenders (A/HRC/16/44), the Special Rapporteur highlighted defenders who work on sexual and reproductive health and rights as a group facing particular risks, cf. Paragraph 45: *“According to the information received, human rights defenders who work on sexual and reproductive health and rights face risks including harassment, discrimination, stigma, criminalization and physical violence.*

As part of this group, medical and health professionals, by providing sexual and reproductive health services, ensure that women can exercise their reproductive rights. In certain countries, these health professionals, as a result of their work, are regularly targeted and suffer harassment, intimidation and physical violence. In some countries, these attacks perpetrated by non-State actors have led to killings and attempted killings of medical professionals.”

ANNEX 2: REGIONAL HUMAN RIGHTS INSTRUMENTS AND REPRODUCTIVE HEALTH

In addition to the global human rights instruments and institutions, the different regions have set up their own institutions working on human rights issues and produced various human rights instruments, some of which deal with matters related to

reproductive rights. While such instruments are only directly applicable in the relevant region, they can also be used referenced by other regional or global bodies and by NHRIs.

AFRICA

As mentioned in above, Africa is the continent with the greatest challenges when it comes to reproductive and sexual health and with considerable attention given to the issue in the various African human rights instruments and in the work of the African Union. For example, mother and child mortality was the over-all theme for the AU Summit of Heads of State and Government in July 2010.

In general, the focus in the various documents, whether they are legally binding instruments, various statements from the African Commission on Human and Peoples' Rights, or declarations, action plans and similar policy statements by the African governments, are very similar to what can be found in the United Nations documents, thus reflecting concern about the prevalence of maternal and child mortality and morbidity, due to insufficient access to healthcare. Another major focus area is insufficient access to family planning services, including contraception. Gender-based analysis is applied to harmful practices and violence

against women with an emphasis on culturally sensitive and appropriate strategies. In the African context, it is generally accepted that reproductive health has a major impact not only on the health related MDGs but also on the right to development.

CONVENTIONS

Under the auspices of the African Union (AU) and its predecessor, the Organization for African Unity (OAU), significant human rights conventions have been created. The **African Charter on Human and Peoples' Rights** contains provisions similar to the provisions in the United Nations human rights treaties that have been used to articulate reproductive rights. Article 2 contains a general prohibition against discrimination with Article 18 specifically prohibiting discrimination against women. Article 5 prohibits not only torture but also cruel, inhuman and degrading treatment. According to Article 16 every individual has the right to the best attainable state of physical and mental health. In addition to prohibiting

discrimination against women, Article 18 demands that the state ensure the physical and moral health of the family.

In 2003 the AU adopted the **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa**. In Article 2, prohibiting and setting out specific steps to root out discrimination, states are specifically ordered to take steps against *"those harmful practices which endanger the health and general well-being of women"*; *"harmful practices"* are defined in Article 1 as *"all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity"*. Article 2 also contains an obligation to take steps to modify the *"social and cultural patterns of conduct of women and men"* with a view, among other things, to eliminate harmful cultural and traditional practices based on ideas of superiority or inferiority of either sex or on stereotypes. Harmful practices is the subject of Article 5 which obligates the states to take all necessary measures, such as awareness campaigns, legislative steps and victim support to eradicate all harmful practices against women, including female genital mutilation.

According to Article 4, all cruel, inhuman or degrading treatment shall be prohibited. This Article further obliges states to enact and enforce laws and take various other steps against all forms of violence against women, including unwanted or forced sex, also in private. This must cover marital rape. With respect to marriage, men and women shall be treated and considered equal, and the full and free consent of both parties shall be a requirement, cf. Article 6, and the

minimum age for women shall be 18. Article 7 sets out that both parties have the same rights with respect to divorce and separation. According to Article 13, women shall be guaranteed adequate and paid pre- and post-natal maternity leave.

Health and reproductive rights is the subject of Article 14. According to this Article, the sexual and reproductive health of women shall be *"respected and promoted"*, including *"(a) the right to control their fertility; (b) the right to decide whether to have children, the number ... and spacing of children; (c) the right to choose any method of contraception; (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; (e) the right to be informed on one's health status, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognized standards and best practices; (f) the right to have family planning education"*. Furthermore, states shall provide health services, accessible also in rural areas and including information and education; shall secure pre-natal, delivery and post-natal health and nutritional service during pregnancy and breast-feeding; and shall authorize 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"*. In Article 24 on women in distress, it is stated that pregnant and nursing women shall be provided with an environment suitable to their condition and treated with dignity.

The **African Charter on the Rights and Welfare of the Child** was adopted in 1990. It defines a child as anyone under 18 years of age, cf. Article 2. According to Article

5 the child's right to life includes "to the maximum extent possible, the survival, protection and development of the child". Not doing enough to prevent infant and child mortality may be considered contrary to this provision. The privacy of a child, under reasonable supervision by parents or legal guardians, is protected by Article 10; this is relevant when considering an adolescent's access to confidential reproductive health services. Article 14 specifies children's right to the best attainable state of physical, mental and spiritual health and obliges states to take measures to reduce infant and child mortality, to ensure appropriate care for expectant and nursing mothers, and to ensure the knowledge by all sectors of society of, among other things, the advantages of breastfeeding. Article 18 deals with protection of the family, Article 19 specifies the rights by children to parental care and protection, and Article 20 sets out the responsibilities of parents while also obliging the state to assist parents, including with respect to child care facilities for working parents. Furthermore, Article 27 protects against sexual exploitation and abuse.

Similar to the Protocol on the Rights of Women in Africa, the Child Charter includes a provision on harmful social and cultural practices, in this case Article 21. According to this, states shall take all appropriate measures to eliminate such practices, in particular those affecting the health and life of children and those that are discriminatory, for example on the basis of gender. Article 21 prohibits marriage and betrothal of boys and girls and mandates a minimum age of marriage of 18 years. Article 30 sets out specific protection for expectant mothers and mothers of infants and young children with respect to imprisonment.

In 2006 the AU adopted the **African Youth Charter**, concerning persons between 15 and 35 years of age, cf. the definitions prior to Article 1. Article 7 protects the right of young persons to privacy from "arbitrary or unlawful interference". According to Article 8 on the protection of the family, marriage shall only be entered into on the basis of free consent and both parties shall be treated equally. The education of young persons shall include issues such as HIV/AIDS, reproductive health and cultural practices harmful to young girls and women, and the state shall ensure that girls and young women becoming pregnant before completing their education can continue and that culturally appropriate, age specific sexual and parenthood education is available, cf. Article 13. The right to an adequate standard of living and sustainable livelihoods are also guaranteed in Articles 14 and 15.

Article 16 deals with health and starts by repeating the phrase on the "best attainable state of physical, mental and spiritual health". It further specifies the right for youths to be involved in identifying their reproductive and health needs; the obligation to secure health services in poor areas and to vulnerable and disadvantaged youths; the right to access youth friendly reproductive health services including contraceptives and ante- and post-natal care; and the obligation to take steps to prevent unsafe abortions. Article 16 contains several provisions on HIV/AIDS, including the obligation to instigate programmes to prevent transmission; to make testing and counselling available; to provide food security for people living with HIV/AIDS; and to provide access to treatment, in particular to prevent mother to child transmissions.

The rights of girls and young women are the subject of Article 23. Among the various stipulations, the states are to provide education that does not impede the participation of pregnant women; protects girls and young women from violence, incest, rape, sexual abuse and female genital mutilation; and secures young women the right to maternity leave. Articles 20 and 25 oblige the states to take all steps to eliminate harmful social and cultural practices.

THE AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS

The African Charter on Human and Peoples' Rights establishes the African Commission on Human and Peoples' Rights, cf. Articles 30-63 of the African Charter. Among its tasks is to consider state reports from the states having ratified the African Charter (53 of the 54 AU member states), somewhat similar to what is done at the United Nations human rights committees. This means that also civil society and NHRIs are invited to provide information directly to the Commission. The states coming up for examination can normally be found on the website of the Commission. States are supposed to report both on the rights set out in the African Charter and, provided they are parties to the Protocol on the Rights of Women, on the rights set out in this Protocol. In the guidelines for reporting on the Protocol, adopted by the Commission in May 2010, the following issues are mentioned among issues to be reported on: protection of women from violence, harmful practices (including female genital mutilation), female stereotypes, marriage (including minimum age), and health and reproductive rights (including access to services, reduction of maternal mortality, abortion, HIV/AIDS and sex education).

The African Commission prepares **concluding observations** following examinations. Regrettably, the publication of these is sporadic but some can be found on the website of the Commission. In the concluding observations concerning **Uganda**, adopted in May 2009, Uganda was commended for establishing HIV/AIDS Health Centres in every sub-district and for putting in place an HIV/AIDS National Policy. Among the concerns mentioned were the prevalence of harmful cultural practices like the ritual sacrifice of children, female genital mutilation and early marriages. The Commission also recommended that Uganda ratify the Protocol on the Rights of Women.

Another example is the concluding observation concerning Botswana, adopted in November 2009. The Commission commended **Botswana** for its effort to contain the spread of HIV/AIDS, including by making anti-retroviral drugs and prevention of mother to child transmission programmes available and for carrying out awareness campaigns, while also raising concern that the requirement that parents accompany minors for HIV testing may discourage testing, thus potentially contribute to the spread of HIV/AIDS.

In 2010, the Commission adopted concluding observations on **Cameroon**, which included a recommendation to reinforce efforts in relation to reproductive health *"in order to raise the level of access by women and adolescents to family planning and to accessible and good quality health services and to reduce maternal and infant mortality rates."*

In addition to examining state reports, the African Commission makes decision with respect to individual complaints. So far,

however, none of these have dealt with issues relating to reproductive rights.

Furthermore, the Commission issues resolutions. In 2001, it issued a **resolution on the HIV/AIDS Pandemic**, confirming that this is indeed a human rights issue, calling upon states to allocate the necessary resources, ensure human rights protection of persons living with HIV/AIDS, provide support for families caring for the dying, devise health-care programmes of education, carry out awareness-raising campaigns and take necessary medical interventions. The Commission also called upon the international pharmaceutical industry and international donors to do their share.

In 2004 the African Commission adopted the so-called **Pretoria Declaration on Economic, Social and Cultural Rights in Africa**. This Declaration had originally been adopted at a meeting in Pretoria with representatives of the Commission, 12 African states, NHRIs and NGOs. In the Declaration the participants attempted to flesh out the economic, social and cultural rights contained in the African Charter. With respect to health, Article 16 of the African Charter, it is stated that this entails, among other things, accessible and affordable health care for all; access to reproductive, maternal and child health care; and education, prevention and treatment of HIV/AIDS.

The Pretoria Declaration contains individual recommendations to the various actors, including to NHRIs. NHRIs are recommended to work on economic, social and cultural rights, including undertaking studies, monitoring and reporting; scrutinizing laws and other acts; publicizing reports; raising awareness; examining complaints and

filing court cases; and carrying out follow-up activities on recommendations from international bodies.

In 2008 the African Commission adopted a **Resolution on Maternal Mortality in Africa**. In it the African Commission refers, among other things, to the ICPD Programme of Action, the Beijing Declaration and the MDGs. The Commission goes on to declare that preventable maternal mortality is a violation of the rights to life, health and dignity of women in Africa, enshrined in both the African Charter and the Protocol on the Rights of Women, and calls upon the African governments to address this issue in accordance with the recommendations attached to the resolution. Among the recommendations are allocating 15% of national budgets to the health sector and to adopt Human Rights Based Approaches to reduce maternal mortality, including ensuring that poor and rural women have access to health services; ensuring “*as much as practicable*” free, accessible and available antenatal and obstetric services; ensuring women and civil society participation in formulating, implementing, monitoring and evaluating policies to secure maternal health; providing maternity centres in rural areas; securing skilled health personal and birth attendants in rural and semi-urban areas; training health workers in emergency obstetric care; developing emergency transport systems; and developing training curricula for educating women and girls on reproductive rights.

The Commission has also adopted a **General Comment** on Article 14(1)(d) and (e) of the Protocol on Women’s Rights, pertaining to the right to be protected against sexually transmitted infections, including HIV, and

the right to be informed of one's health status. This General Comment provides more detailed guidance on States' obligations in this context.

Similar to the United Nations human rights system, the African Commission has established a number of special procedures in the form of special rapporteurs and working groups. None of them directly targets the issue of reproductive health but there is a **Special Rapporteur on the Rights of Women in Africa**, and in 2010 the Commission established a Committee on the Protection of PLHIV [People Living with HIV] and Those at Risk. The Special Rapporteur on Women has been dealing with the issue of reproductive rights, see for instance her Inter-session Report from May 2009 where she recommends states to take more steps against violence against women, including sensitization campaigns, law reform, and access to justice etc. This Report also recommends states to ensure women access to health, including reproductive health, such as securing access to quality health care and to reproductive health especially in the rural areas; offering more comprehensive health services in the area of sexuality and contraception with a view to avoiding illegal abortions among adolescents; and promoting sex education for boys and girls, primarily to prevent early pregnancies and combat sexually transmitted diseases and HIV Aids, cf. Paragraphs 72-74.

POLICY DOCUMENTS

Over the years, the AU (and prior to that the OAU) and the African countries have made various declarations, statements and action plans dealing with issues relating to sexual and reproductive health. The most

comprehensive document is the **2005 Continental Policy Framework on Sexual and Reproductive Health and Rights**, developed by the African Union Commission in collaboration with, among others, UNFPA. This was adopted by the African Ministers of Health meeting in October 2005 and endorsed by the AU Executive Council in January 2006.¹ In its endorsement the AU Executive Council specifically recognizes the role of Sexual and Reproductive Health and Rights in the attainment of the Millennium Development Goals (MDGs) and urges the member states to mainstream these rights in their national health programmes by developing linkages between sexual and reproductive health and rights, HIV/AIDS and other primary health care programmes and to draw inspiration from the Continental Policy Framework. On this basis, the Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010 was prepared and adopted by the Ministers of Health in September 2006.

The Continental Policy Framework is a very extensive document that basically advocates for mainstreaming sexual and reproductive health and rights in primary health care to accelerate the achievement of the health-related MDGs; addresses the most common causes of maternal and new born child morbidity and mortality and identifies the implementation of the Roadmap for the Acceleration of the Reduction of Maternal and Newborn Child morbidity and mortality as the strategy for improving reproductive health; calls for a strengthening of the health sector component, sexual and reproductive

¹ Albeit with reservations by Algeria, Djibouti, Egypt, Libya, Somalia, the Sudan and Tunisia.

health and rights in particular, in Poverty Reduction Strategy Papers; calls for mainstreaming gender issues in socio-economic development programmes by facilitating improved women's health thereby increasing their participation in national economic development; and calls for including sexual and reproductive health related medicine in the Essential Drug Lists. The annexed policy framework lists and explains eleven priorities, being:

1. Sexual and reproductive health legislation into primary health care;
2. Integration of sexual and reproductive health services;
3. Sexual and reproductive health communication;
4. Budgeting of sexual and reproductive health activities;
5. Mainstreaming gender in development programmes;
6. Youth sexual and reproductive health;
7. Mid-life concerns of both men and women;
8. The fight against the HIV/AIDS pandemic;
9. Strengthening of sexual and reproductive health programme of the AU;
10. Establishment of an African maternal and infant mortality advocacy day; and
11. Establishment of an African adolescent and youth health day.

The annexed Operational Plan focuses on ten strategic areas, being

1. Increase resources to sexual and reproductive health and rights programmes;
2. Translate ICPD commitments into national legislation;
3. Reduce maternal mortality;
4. Reduce infant and child mortality;
5. Young people's sexual and reproductive health and rights;
6. Combat HIV/AIDS;
7. Expand contraceptive use;
8. Reduce levels of unsafe abortion,
9. Female genital mutilation
10. Gender-based violence

As set out in Paragraph 16, an overarching goal of the Maputo Plan of Action is to achieve universal access to sexual and reproductive health in all African countries by 2015.

Another important recent initiative is **CARMMA, the Campaign on Accelerated Reduction of Maternal Mortality in Africa**. This is an initiative of the AU Commission, supported by the member states (it was launched at a meeting of the African Ministers of Health in May 2009) and various United Nations agencies (WHO, UNICEF, the Food and Agriculture Organization of the United Nations, UNAIDS, UN Women and UNFPA) as well as bilateral donors and civil

society organizations. The main purpose of CARMMA is to promote and advocate for renewed and intensified implementation of the Maputo Plan of Action. CARMMA has so far been launched in more than 20 African countries. As an example Sierra Leone used the CARMMA initiative to introduce free treatment and medicines for pregnant women, lactating mothers and children under five at all government health facilities.

The theme of the AU Summit of Heads of State and Government in July 2010 in Uganda was *“Maternal, Infant and Child Health and Development in Africa”*. In its **Declaration on Action on Maternal, New-born and Child Health and Development in Africa by 2015**, the Heads of State and Government among other things undertook to launch CARMMA in their respective countries, involve all key stakeholders, such as civil society organizations, religious and community leaders, media, etc. and institutionalize an annual CARMMA week each year until 2015; strengthen the health care system to provide comprehensive maternal, new born and child health care services and reposition family planning including reproductive health commodities security; provide sustainable funding, e.g. by reducing out-of-pocket payments; and institute a strong monitoring and evaluation framework at country level. NHRIs could conceivably play a role in such monitoring and evaluation.

In December 1992 the African governments adopted the **Dakar/Ngor Declaration on Population, Family and Sustainable Development**. According to this document, the African governments must set fertility and family planning targets; implement legal measures to improve the status of women

and their reproductive health; establish strong maternal and child health programmes; address unmet family planning needs of adolescent and others; promote the education of men and women on joint responsible parenthood; assure availability and promote the use of contraception and fertility regulation methods to double the contraceptive prevalence rate from about 10 to about 20% by 2000 and to 40% by 2010; and promote research into human reproduction, cf. Paragraph 3. The Declaration also recommends giving priority to combating infant, child and maternal morbidity and mortality, aiming for an infant mortality rate of less than 50 per 1000 live births and for a reduction of maternal mortality by at least 50% from 1990 levels by 2000 with some of the means being quality family planning services and studies to reduce unsafe abortions, cf. Paragraph 4. The Declaration also mentions the need to establish and strengthen programmes to combat HIV/AIDS, cf. Paragraph 4, and the need to strengthen women’s status within the family, cf. Paragraph 7.

The Dakar/Ngor Declaration on Population, Family and Sustainable Development, adopted by the relevant ministers, was endorsed by the Heads of State and Government in the **OUA Declaration on Population and Development in Africa**, adopted in June 1994. In this Declaration, the interplay between population, environment and sustainable development is acknowledged and the Heads of State and Government, among other things, commit themselves to empower women and eliminate all forms of discrimination.

2001 saw the adoption of several relevant documents. In the **Abuja Declaration on**

HIV/AIDS, Tuberculosis and other related Infectious Diseases, the African Heads of State and Government acknowledged the seriousness of HIV/AIDS. They pledged to prioritize the fight against HIV/AIDS in national development plans, to do this together with all other relevant actors and to allocate at least 15% of the annual budgets to the improvement of the health sector. The **Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa** from May 2006 heads of State and Government reiterated, among other things, the commitments made in 2001 and further stressed their commitment to prevention. Included was commitment to information services and universal access to female and male condoms. Additionally, States committed to integrate HIV/AIDS issues into reproductive health issues and vice-versa.

The **Declaration and Plan of Action of the First Pan-African Forum for Children, Africa fit for Children**, adopted in Cairo in 2001 and later taken note of by the OAU Heads of State and Government in July 2001, contains various targets and obligations for child mortality rates, mother to child transmission, HIV prevalence in 14-25 year olds, HIV/AIDS prevention and information services to youths, breastfeeding, and effective family planning programmes. The Plan of Action contains specific activities to be undertaken by the African governments, including integrating reproductive health services, safe delivery units and ante- and post natal care into primary healthcare; improving access to reproductive health information; counselling and voluntary testing services for HIV/AIDS; involving children and youth in development and implementation of programmes, and introducing

sexuality education in school curricula; and eliminating all harmful practices detrimental to girls' and women's rights and health, including female genital mutilation and early marriage.

This was followed by the second Pan-African Forum that took place in 2007 and led to the adoption of the **Call for Accelerated Action on the Implementation of the 2001 Plan of Action (2008-2012)**. Among the commitments are to establish national observatories or ombudspersons on child rights to include child members, to strengthen maternal health and child health services, and to scale up HIV/AIDS prevention, treatment, care and support. This could be an inspiration to include children in the work of NHRIs. In the **Declaration on Promotion of Maternal, Infant and Child Health and Development** of January 2008 the African Heads of State and Government took note of the Call for Accelerated Action, recognising the negative impact of poor maternal, infant and child health on development and urging the member states to effectively implement all commitments with respect to women, infants and children.

In 2005, the African Ministers of Health adopted the **Gaborone Declaration on a Roadmap towards Universal Access to Prevention, Treatment and Care, of HIV/AIDS, malaria, tuberculosis and other communicable diseases**. In it the ministers, among other things, expressed their commitment to achieving the MDGs and realising the goals and objectives of ICPD, e.g. by adopting the Sexual and Reproductive Health Policy Framework mentioned above.

In the 2006 **Brazzaville Commitment on Scaling up towards Universal Access,**

concerning HIV/AIDS, the states among other things confirmed that basic medicines and other commodities are a human right that should be available and accessible to all who need them.

The African Ministers of Health adopted the **African Health Strategy 2007-2015** in Johannesburg in 2007; this was endorsed by the AU Executive Council in July 2007. According to Section 95, health systems shall prioritise maternal mortality, emphasize gender in health policy, and seek to eliminate all forms of violence against women while promoting helpful traditional practices and eliminating harmful practices, linked to fistula, and female genital mutilation. Paragraph 96 advocates broader women's health

programmes to include family planning, care of sexually transmitted infections, screening and treatment of reproductive cancers and managing infertility and menopause. In light of the morbidity and mortality from unsafe abortions, it advises the inclusion of safe termination of pregnancy and post-abortion services as far as legal in the country in question. Countries should have a gender and sexuality education programme and youth and women friendly services with a specific focus on reducing teenage pregnancies and sexually related infections. The role of men should be developed. Paragraph 97 stresses the need to focus on neo-natal care to decrease child mortality as up to 40% of under-five deaths occur in the first month of life and about 26% in the first week.

THE AMERICAS

The Inter-American system of Human Rights was one of the first regional systems to come into existence. The American Declaration on the Rights and Duties of Man was adopted before the Universal Declaration of Human Rights. However, as an operating legal system, it has only been operating from the late 1970's.

Much has been done within the Inter-American system to protect and promote sexual and reproductive health and rights. The Inter-American system has the necessary tools to apply international principles and standards when national governments fail to do so. Legislation is in place, as well as procedural norms (both from the Commission and from the Court) that can contribute to the application of human rights in the field of sexual and reproductive health.

CONVENTIONS

The **American Declaration on the Rights and Duties of Man** was approved at the ninth International American Conference in Bogotá, Colombia in April 1948 where the Organization of American States (OAS) was also created.

Due to its nature, the Declaration is not legally binding but it is nevertheless a persuasive and important legal document. The **American Convention on Human Rights** is the first legally binding document of the Inter-American System. It was signed in 1969 and came into force in 1978. The Convention formalizes the structures, functions and proceedings of the Inter-American Commission on Human Rights and creates the Inter-American Court on Human Rights.

Another important document is the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social, and Cultural Rights (more commonly known as **Protocol of San Salvador**). The Protocol was signed on 17 November 1988 and came into force in 1999. This Protocol has provisions on labour rights, social security, health, the environment, education, culture, family rights as well as the rights of elderly people. Relevant for reproductive rights is Article 10 that establishes the right to the highest attainable standard of health.

Of major importance when reproductive rights are concerned is the **Belém do Pará Convention** or the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women ratified in 1994. The Convention came to force in 1995. Violence against women is very broadly defined, women's rights are recognized, and states' obligations to prevent, investigate and punish violence against women are set forth. Moreover, the Convention includes state obligations connected to legislative measures to be taken in the area of violence against women.

THE INTER-AMERICAN COMMISSION ON HUMAN RIGHTS

The Inter-American Commission on Human Rights (IACHR) was created within the Organization of American States in 1959² as an answer to the political crisis faced at the time, especially by Caribbean countries, to create mechanisms to protect human rights. In the beginning the Commission's man-

2 Resolution VIII from the 5th Consultation Meeting of Foreign Affairs Ministers. The OAS Council approved the Statute of the Inter-American Commission on Human Rights on 25 May 1960.

date was very vague, and its responsibility was only to promote human rights. In 1965 the Commission's mandate was expanded to receive petitions of violations of rights within the American Declaration. Only with the coming into force of the American Convention on Human Rights in 1978 could the Commission rely on a legally binding document. The Commission is composed of experts that act in their individual capacities while being elected by the member states.

The principal function of the IACHR is promoting the observance and the defence of human rights. In carrying out its mandate, the IACHR³ among other things:

- a) Receives, analyses and investigates individual petitions which allege human rights violations;
- b) Observes the general human rights situation in the member states and publishes special reports regarding the situation in a specific state, when it considers it appropriate;
- c) Carries out on-site visits to countries to engage in more in-depth analysis of the general situation and/or to investigate a specific situation. These visits usually result in the preparation of a report regarding the human rights situation observed which is published and sent to the General Assembly.

The Commission works as a "filter" for the cases that go to the Inter-American Court on Human Rights. Not all states parties to the Declaration are parties to the

3 The Inter-American Commission on Human Rights. Available from: <http://www.cidh.oas.org/what.htm>

Convention; when the state in question is not a party to the Convention, the Commission applies the Declaration. Any person or organization (NGO) can present a petition to the Commission, acting either on its own behalf or on the behalf of other persons. These petitions have to be presented within six months from the final decision taken in the national sphere after all internal remedies have been exhausted.

Some of the decisions of the Commission are of crucial importance for the protection and promotion of reproductive rights. One such case is the case of **MCG vs. Chile**.⁴ A public school expelled a young girl who was pregnant. The Commission found a case for discrimination and found Chile to have violated the girl's right to the protection of honour and dignity and her right to equality before the law. As a part of the amicable settlement, Chile was obliged to provide her with a scholarship to return to school.

The Commission is composed of seven Commissioners, who also serve as Rapporteurs on particular topics. In 1994, the **Office of the Rapporteurship on the Rights of Women** was created. This office undertakes thematic research, advises on individual cases, and carries out country missions, in order to examine issues related to women's human rights in the region.

THE INTER-AMERICAN COURT OF HUMAN RIGHTS

The Court was created by the American Convention to supplement the function

4 "Informe Anual de la Comisión Interamericana de Derechos Humanos 2002", Informe N° 32/02, Caso 12.046, Chile, 12 de marzo de 2002, (<http://www.cidh.oas.org/annualrep/2002sp/Chile12046.htm>)

of the Commission when supervising the enforcement of the American Convention on Human Rights. Its fundamental functions are to:

1. Decide on the individual cases submitted to it by the Commission; and
2. Emit Advisory Opinions on the interpretation of the Convention and other human rights treaties in force in the American states.⁵

The Court can only be accessed by the Commission and by States. The Court has not emitted any Advisory Opinions connected to reproductive rights and sexual health. Most of the opinions concern the interpretation of both Inter-American documents and other treaties that have an effect in the Americas.

On 21 December 2012, the Inter-American Court found **Costa Rica** in breach of the American Convention on Human Rights, ruling that the State's ban on In Vitro Fertilization (IVF) violated the right to privacy, the right to liberty, the right to personal integrity, and the right to form a family, in conjunction with the right to be free from discrimination. The Court ordered Costa Rica to legalize in vitro fertilization and provide compensation for the victims in this case. It also ordered the State to conduct trainings on reproductive rights for judicial officials throughout the country. The Court referred to Article 16 (e) of the Convention on the Elimination of All Forms of Discrimination against Women according to which women enjoy the same right as men "to decide freely and responsibly on the number and spacing of their children and

5 American Conventions, Articles 61 and 64.

to have access to the information, education and means to enable them to exercise these rights” as well as to various recommendations of United Nations Treaty Bodies and policy documents such as the ICPD and Beijing Programmes of Action. The Court further established links between personal autonomy, reproductive freedom and physical and psychological integrity. It also highlighted the different and disproportionate impact that laws banning access to reproductive health and services have on women.

More recently, on 29 May 2013, the Inter-American Court intervened in a case of a woman in **El Salvador** who suffered from lupus and was pregnant with an anencephalic foetus, a condition incompatible with life outside the womb. Referring to her own deteriorating health, and the certain death of the foetus she was carrying, the claimant requested and was denied an abortion, which is banned in all circumstances in El Salvador. The Inter-American Court requested the State to enable the medical professionals working with the claimant to take measures to protect her health and to “avoid any damage that could be irreparable to the rights to the life, personal integrity and health.”

The “*Campo Algodonero*”⁶ case decided by the Court in 2009 is also relevant to reproductive rights. The case involved three minors who were found dead at *Campo Algodonero* in Ciudad Juárez in **Mexico**. The Court found violation of the right to freedom from discrimination, as it found a pattern of discrimination against women in that area (which also affected their sexual and repro-

6 Inter-American Court of Human Rights. *Caso González y otras (“Campo Algodonero”) Vs. México*. Decision of 16 November 2009, Series C, No. 205.

ductive health and rights) and used the Convention of Belém do Pará to refer to violence against women as a form of discrimination and structural violence that limits women’s freedoms.

REPORTS

In 2010, the Inter-American Commission published the report **Access to Maternal Health Services from a Human Rights Perspective**. In this report, the Commission focused on the importance of guaranteeing women access to health without any form of discrimination. The Report explained how many women still die due to complications connected to pregnancy and how most of these deaths are preventable. The Report also showed that poor women, women of Afro-Descent or indigenous women who live in rural areas are more likely to lose their lives due to complications related to pregnancy and birth than other women.

The Report identified a series of obligations of Member States in the OAS that require immediate attention from states. These obligations are as follows:

- Identification and allocation of human and material resources to work toward eliminating barriers in access to services;
- Implementation of measures to reduce preventable deaths due to pregnancy or childbirth, particularly to ensure that women have effective access to emergency obstetrical services and to care before and after delivery;
- Incorporation of the gender perspective and elimination of de facto and de jure forms of discrimination that impede

women's access to maternal health services;

- Prioritization of efforts and resources in order to guarantee access to maternal health services for women that may be at greater risk because they have been subject to various forms of discrimination such as indigenous, AfroDESCendant, and adolescent women, women living in poverty, and women living in rural areas;
- Education for users regarding health services, as well as services to provide information on their rights as patients and on their health, including family planning;
- Design and implementation of maternal health policies, plans, and programmes on a participatory basis; and
- Timely access to effective judicial remedies to ensure that women who allege that the State has not met its obligations in this area have access to effective judicial remedies

The Report emphasized issues of equality and non-discrimination and the link between discrimination and violence in order to establish member states' obligations to promote maternal health. In order to achieve the proposed change, the Report made recommendations connected to improvements in the health system, more gender equality, better judicial, legislative and executive measures in the area of maternal health, and training to health professionals in order to better respond to women's needs.

In 2011, the Commission issued **three additional reports** of particular significance: Access to Information on Reproductive Health from a Human Rights Perspective, Legal Standards Related to Gender Equality and Women's Rights in the Inter-American Human Rights System: Development and Application, and Access to Justice for Women Victims of Sexual Violence: Education and Health.⁷

⁷ These reports are available from: <http://www.oas.org/en/iachr/women/>

EUROPE

For the purposes of this Handbook Europe is defined as all the countries that have ratified the European Convention on Human Rights, meaning all the 47 member states of the Council of Europe. As indicated above, the global number of maternal and child deaths caused by deficiencies in the reproductive rights and health systems remains very high, with Europe as a whole having far fewer deaths due to pregnancy complications

than other continents. However, it should be noted that even in Europe there are disparities between countries, and the numbers of maternal mortality and morbidity for some European countries remain high.

In many countries in the Central and East European (CEE) region, due to limited contraceptive services and information, abortion is used as the primary method of fertility

control. Many women are still denied access to modern contraceptive methods because of financial inaccessibility, lack of information, or because they receive misleading information. Accurate and scientifically based sexuality education and access to reproductive health services is also limited due to the growing influence of conservative forces, including but not limited to certain churches. Moreover, sexually transmitted infections (STIs), including HIV/AIDS, have risen dramatically, especially amongst adolescents and women, in some countries of the region, and experts predict that this crisis is likely to spread to other CEE countries if strong rights-based prevention programmes are not put in place.⁸

CONVENTIONS

The most important human rights document on the European Continent is the **European Convention on Human Rights** (formally known as Convention for the Protection of Human Rights and Fundamental Freedoms). It was drafted in 1950 and entered into force in 1953. The Convention establishes the European Court of Human Rights and focuses on civil and political rights. The Convention offers a judicial approach to the protection of the fundamental rights and freedoms.

The **European Social Charter** is Europe's economic and social rights document. It was adopted in 1961 and revised in 1996. The most relevant article of the Charter relating to reproductive rights is Article 11, which guarantees the highest attainable standard of health to all persons.

8 Astra Network, 2006. "Sexual and Reproductive Health and Rights in Europe", Report to the European Union, January 2006

The **European Convention to Prevent and Combat all forms of Violence against Women** is a new treaty of the Council of Europe that opened for ratification on 11 May 2011. The Convention is a legally binding document that establishes a comprehensive legal framework to protect women against all forms of violence, and prevent, prosecute and eliminate violence against women and domestic violence. The Convention also establishes an international mechanism to monitor its implementation at the national level.

THE EUROPEAN COURT OF HUMAN RIGHTS

The Court was created to "ensure the observance of the engagements undertaken by the High Contracting Parties".⁹ It is a judicial body responsible for the application and interpretation of the norms of the European Convention on Human Rights (ECHR). Any individual or group of persons who are victims of a human rights violation can, following the legal procedures established in the ECHR, lodge an application to the Court.

Most of the cases relating to reproductive and sexual health and rights fall within the scope of Article 8 of the Convention, one of the most open-ended provisions of the Convention. Article 8 reads:

1. *Everyone has the right to respect for his private and family life, his home and his correspondence.*
2. *There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the*

9 Former Article 19 of the ECHR.

law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The innovative character of Article 8 (similar to Articles 9-11) is that not only must states refrain from violating a person's right to family life, privacy, home and correspondence, states must also take positive actions to guarantee that no one else violates those rights. As Jacobs and White¹⁰ explain it, *"Positive obligations under Article 8 can arise in two types of situations. The first is where the state must take action to secure respect for the rights included in the article, as distinct from simply refraining from interfering with the rights protected. (...) The second type of situation is where a duty arises for the state to protect an individual from interferences by other individuals"*.

There are several cases decided by the European Court of Human Rights that relate to respect for and protection of reproductive rights. An example illustrating how the Court influences policies and practices of member states is **Typical v. Poland**, Application No. 5410/03, Judgment, 20 March 2007.¹¹

This case involved a pregnant Polish woman who had severe myopia. She was told that her eyesight would become worse if she

¹⁰ Jacobs, White & Ovey, *"the European Convention on Human Rights"*. Oxford University Press, 4th edition, 2010, p. 243.

¹¹ Centre for Reproductive Rights, available from <http://reproductiverights.org/en/case/tysiac-v-poland-european-court-of-human-rights>.

did not terminate the pregnancy. Numerous doctors concluded that the pregnancy and delivery posed a serious health risk but refused to issue a certificate for the pregnancy to be terminated. After finally obtaining a certificate authorizing the abortion, the applicant went to a public hospital in Warsaw to have the procedure, only to have her request refused again. At this point, the applicant had no choice but to carry her pregnancy to term. After the delivery, the applicant's eyesight badly deteriorated due to haemorrhages in her retina. The applicant was at risk of losing her eyesight.

The Court issued its ruling in March 2007. It held that the Polish government had failed to fulfil its positive obligation under Article 8 of the European Convention on Human Rights to ensure the applicant's right to respect for her private life. The finding of a violation is specifically based on the government's failure to establish an effective procedure through which the applicant could have appealed her doctors' refusal to grant her request for an abortion. The Court prescribed some of the key components of such a procedure: It should guarantee to a pregnant woman the right to be heard in person and have her views considered; the body reviewing her appeal should issue written grounds for its decision; and, recognizing that *"the time factor is of critical importance"* in decisions involving abortion, the procedure should ensure that such decisions are timely. The Court awarded the applicant EUR 25,000 for pain and suffering and EUR 14,000 for legal fees.

Another important case decided by the European Court of Human Rights was **A, B and C vs. Ireland**, (Application no. 25579/05), Judgement 16 December 2010.

In this case, three women lodged a complaint against Ireland since they were forced to travel outside the country in order to obtain an abortion, as abortion was illegal in Ireland except to save the health of the woman. Importantly, with respect to the third complainant, who suffered cancer and was undergoing chemotherapy, the court found that although abortion is legal in Ireland in certain instances, the Government had not adequately legislated to provide for clear procedures about when an abortion could be performed legally.

POLICIES

The **European strategy for the promotion of sexual and reproductive health and rights**, Parliamentary Assembly Recommendation 1675 (2004) and Resolution 1399 (2004) supported by the Committee of Ministers, recognises the importance of working in this area. In this context,

the Committee recognises the strong link between “*sexual and reproductive health and rights*” and HIV/AIDS and supports all initiatives in member states to promote and protect sexual and reproductive health and rights.

The Directorate of Youth and Sport of the Council of Europe has elaborated a **Charter on Sexual and Reproductive Health and Rights of Young People**.¹² This Charter tries, in a simplified and youth-friendly way, to explain the relationship between reproductive rights and human rights. The Charter was produced after a study session in 2008 and is an instrument used by the Directorate to promote sexual and reproductive health and rights and other connected issues, such as gender equality, gender violence, and LGBT rights.

12 “*European Youth Charter on Sexual and Reproductive Health and Rights*”, adopted in July 2008 by the Directorate for Youth and Sport

ANNEX 3: NHRI EXPERIENCES WITH REPRODUCTIVE RIGHTS¹

AFGHANISTAN

In Afghanistan, violence against women is a major obstacle to the effective realization of reproductive rights. The Afghan Independent Human Rights Commission has prioritized this issue. In 2008, the Commission worked closely with the government in drafting a new law on violence against women. The law has been finalized and is now in force. A new department dealing with violence against women has been established in the Office of the Attorney-General and is now operating in several provinces.¹

The Afghan Commission has noted that because of serious weaknesses in public administration, even the most egregious violations of reproductive rights occurring in that country often remain unresolved. In attempting to respond to these challenges, the Commission has had some success with mediating cases involving violations of reproductive rights. Particularly when such cases involve close family members (e.g. a dispute over child marriage or a forced marriage), the Commission is able to provide a confidential and safe environment for a discussion that can lead to resolution of the problem.

¹ Information gathered by Asia-Pacific Forum for their work with UNFPA on reproductive rights was used as the basis for Asia-Pacific. For all other areas, letters were sent to all NHRIs. Additional information was gathered during the workshop in Kuala Lumpur and the validation workshop in New York, mentioned above. All information was provided in 2011-2012.

For a multitude of reasons, including lack of resources, the Afghan Human Rights Commission considers itself unable to rely on criminal justice agencies (the police and the prosecutors) to pursue serious violations of human rights including reproductive rights. In order to make progress in this area the Commission must develop strategic alliances with those who are in a position to provide support. Recently, the Commission has begun to work closely with the newly formed family units within the Afghan National Police. These units include a significant proportion of female officers who are proving to be strong allies in the Commission's fight against practices such as forced marriage, wife-beating and self-immolation.

Issues related to personal freedom and familial, social and political pressure mean that many violations of reproductive rights are never reported to the Afghan Commission. The Commission has sought to address this problem by expanding its monitoring scope to include hospitals, where many women go after being burned or beaten. Close monitoring of hospitals has improved the Commission's understanding of the nature of reproductive rights violations as well as the challenges to an effective response.

AUSTRALIA

In 2001 the Australian Human Rights Commission issued Pregnancy Guidelines, which sets out the rights of employees and the obligations of employers in relation to pregnancy. The Guidelines, which were prepared after consultation with unions and employers, cover issues of pregnancy discrimination through all aspects of the employment relationship, including recruitment, employment and dismissal. They also address the overlap between discrimination and industrial and occupational health and safety obligations. The Guidelines use basic principles and case studies to illustrate rights and responsibilities and to provide practical advice.

The Australian Human Rights Commission has worked to prevent sterilizing procedures performed on persons with disabilities, particularly girls and young women. In a series of court cases, the Commission argued for improved legal scrutiny of decisions to perform sterilizing medical or surgical procedures. The Commission subsequently monitored the implementation of the important

legal principles that emerged from this case, publishing major research papers in 1997 and 2001. The research analysed the reasons commonly given in support of the sterilization of girls and young women, and identified alternative and less invasive procedures might achieve similar outcomes. The Commission has continued to argue for improvement in the legal framework that applies to decision-making in respect of sterilization of children. Its research provided commentary on the distinction between therapeutic and non-therapeutic sterilization and the key principles of the best interests of the child and the procedure of 'last resort'.

More than one in five complaints received by the Australian Human Rights Commission relate to pregnancy-based discrimination (2008-2009 figures). In addition, the Commission has highlighted the issue of pregnancy-related discrimination in its Gender Equality Blueprint 2010, which makes specific recommendations for legislative and policy reform.

BOLIVARIAN REPUBLIC OF VENEZUELA

The Ombudsman's Office of the Bolivarian Republic of Venezuela, has been working with reproductive rights since 2002. With the support of UNFPA, the NHRI conducted a training course on the subject of reproductive rights for staff working in the Office of the Defensoría. In 2005, the Office conducted an educational programme directed at young people in areas where sexual and reproductive health and rights are not

respected. The programme was directed at youth aged between 13 and 23.

In 2006 the Office conducted a study to analyse the knowledge of reproductive rights among young people. After the report was published 5,000 leaflets were produced and distributed among young people aged between 13 and 23 that did not have information on the issue.

In November 2008 the Office participated in a symposium organized by UNFPA and the Ministry of Health on how to diminish the number of teenage pregnancies. The following are some decisions taken during the aforementioned symposium:

1. The consequences of early pregnancies should be considered a public health issue and attention should be directed towards its prevention;
2. Multi- and intersectional strategies on sexuality education and the promotion of sexual and reproductive health should be implemented;
3. The involvement of the family, the community and adolescents is crucial for the prevention of early pregnancies and the promotion of sexual and reproductive health.

The Office has been involved in municipal work in the Caracas municipality to work

on the prevention of teenage pregnancies. It has also been involved in work related to prevention of sexual abuse of children and adolescents which in many cases have reproductive consequences. It has further been involved in a national initiative connecting several state institutions to work on diminishing maternal mortality and morbidity, in close relation to the Millennium Development Goal no. 3 on gender equality. Another initiative by the Office has been to improve its monitoring functions related to complaints on issues of obstetric violence.

Experiences from the project were used to develop a 44-hour course for children and adolescents in schools to educate young people on sexual and reproductive health and rights. The programme is based on participatory approaches and builds on participants' previous knowledge. More importantly, the course involves many actors already in the young people's lives, such as teachers, parents and the school board.

EL SALVADOR

The Ombudsman's Office for the Defence of Human Rights, has worked on reproductive rights in its department that deals with women's and family rights. The department has deepened knowledge regarding reproductive rights in the country and has worked to promote these in the Salvadorian society.

The NHRI has promoted campaigns in order to promote and educate the citizenry on women's rights focusing on the reporting

of any kind of violence committed against women. These campaigns have included the promotion of reproductive rights.

Another activity of the NHRI has been to make recommendations to the relevant state institutions on what to do when it comes to sexual violence against the girl-child and adolescent girls. Adolescent girls' rights have also been addressed in El Salvador, as one of the issues related to reproductive rights is the high rate of early pregnancies.

The NHRI has conducted a study on the issue in order to inform the government of which measures to take to promote the reproductive rights of adolescent girls and prevent early pregnancies.

THE NHRI has also coordinated an initiative involving several state institutions (the police, national development state institutions, women institutions, among others) to address violence against women in El Salvador. The main goal of this project is to coordinate the initiatives of different state institutions to address cases of violence against women, guaranteeing the rights of the victims.

Moreover, THE NHRI has a department directed at working on HIV/AIDS and reproductive rights, established in October 2010. The main focus of the department is to

enhance the rights of people living with HIV. Nonetheless, it also works on reproductive rights not connected to such persons.

THE NHRI has conducted a comprehensive study on the situation of HIV in the country. Among its findings is that of the lack of reproductive health assistance to HIV infected adolescent girls, which often results in unwanted pregnancies. The study also shows the need for sexual and reproductive education in schools, as it is not part of the Salvadorian school curricula.

The Juvenile Units project, started in 2008 and now a part of the 2009-2014 Platform for Children and Youth, consists of educating youth to conduct peer-to-peer education on reproductive rights. The project involves youth from rural and urban areas.

INDIA

In 1996-1997, the National Human Rights Commission of India identified maternal anaemia as a violation of the right to life and the right to health. Easily avoidable iron and iodine deficiencies were causing serious health problems among pregnant women as well as death and mental disabilities in infants. Over the following years, the Commission worked with government ministries and other partners to deal with the problem. In the year 2000, it organized a workshop on Health and Human Rights in India with Special Reference to Maternal Anaemia. This workshop made valuable recommendations and contributed to a wider recognition of the right to health. It also resulted in some important changes in national health

practice including national distribution of supplements to pregnant women, nutrition education, and improved mother and child health services in rural areas.

During 1999-2000, the Indian Commission examined the observations and recommendations issued by the Committee on the Elimination of All Forms of Discrimination against Women in response to the first State party report submitted by the Government of India, and recommended several steps that the Indian Government should take to reduce maternal anaemia. It recommended, in particular, the gender sensitization of health workers, and a specifically targeted healthcare campaign to combat

discrimination against girls and women with regard to access to nutrition to effectively combat maternal anaemia. It also recommended the strengthening of the National Reproductive and Child Health Programme and called for concerted efforts to upscale the National Nutritional Anaemia Control Programme to bring down maternal mortality and low birth weight amongst children.

In 2003, the Commission, in collaboration with UNFPA and the Ministry of Health and Family Welfare, organized a Colloquium on Population Policy – Development and Human Rights. The Colloquium adopted a Declaration and recommended that discriminatory and coercive measures be excluded from population policies. The Declaration acknowledged that reproductive rights encompass several aspects such as the right to informed decision-making, free from fear of discrimination; the right to regular accessible, affordable, good quality and reliable healthcare; the right to medical assistance and counselling for the choice of birth control methods appropriate for the individual couple; and the right to sexual and reproductive security, free from gender-based violence. In 2006 the Commission established a Working Group to examine State Population Policies in light of the National Population Policy. Its report called for adopting a rights-based approach to population stabilization based on the principles of choice, equity and quality of care.

The National Human Rights Commission of India took up the issues of prenatal sex selection and female infanticide in 2004 during regional and national consultations on “Public Health and Human Rights”. In 2008, the Commission undertook a collaborative research project with UNFPA to

review the cases registered by the States/ Union Territories under the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act and identify the hurdles in filing of such cases and the final orders passed on these cases, thus focusing on the impediments to the implementation of the Act.

In October 2010, the Commission organized a one day Conference on Prenatal Sex Selection in India: Issues, Concerns and Actions in collaboration with the National Commission for Women. The main objective of the Conference was to critically analyse the existing problem of prenatal sex selection in India. The Commission hoped to create awareness to this issue that it recognizes as an unacceptable form of gender discrimination and a violation of human rights of surviving girls and women. Prior to this, the Commission had recommended that a vigorous and comprehensive national campaign be undertaken as a matter requiring urgent and utmost concern by the federal and state Governments. Among the recommendations coming out of the conference was to review the (lack of) implementation of the existing act and hold the relevant ministry accountable; to work with the Medical Councils to ensure proper implementation of the existing act and strict consequences for violations by medical practitioners; to push for improved registration of births so that availability of birth data can enable tracking of sex ratio at birth trends on a periodic basis; to advocate for more control of registered clinics under the existing act; to collaborate with medical colleges and teacher education programmes to ensure that gender issues are included in their curricula; and to sensitize the judiciary and other

stakeholders about the existing act and its implementation.

The Commission has also worked extensively to combat sexual harassment. After the Supreme Court prescribed norms and guidelines on preventing and combating sexual harassment of women at the workplace, known as the Vishaka Guidelines, the Commission was instrumental in ensuring that all the States and Union Territories established complaints mechanisms and made the required amendments in the Conduct Rules for their employees. In addition, the Commission brought out a booklet on the subject in English, Hindi and other regional languages and organized a one-day Workshop for Chairpersons and Members of Complaints Committees constituted in various Government Ministries/Departments/Offices in Delhi sensitizing them on the issue of sexual harassment and the manner in which complaints about sexual harassment need to be dealt with. Finally, the Commission worked in close collaboration with the Ministry of Railways and non-governmental organizations to prevent and combat sexual harassment of

female passengers in trains; this included developing a new course for training railway personnel.

In 2002, the Commission examined the provisions of the Protection from Domestic Violence Bill and provided suggestions, which it then lobbied to have incorporated. All the suggestions ended up being incorporated in the Protection of Women from Domestic Violence Act, 2005. Additionally, the Commission recommended a number of amendments to the recasting of the Child Marriage Restraint Act, 1929 so as to provide for higher penalty for violations of the provisions of this Act and also to make the offence cognizable and non-bailable. In pursuance of these recommendations, the Government of India introduced The Prevention of Child Marriage Bill which became The Prohibition of Child Marriage Act, 2006. It incorporated all the Commission's recommendations. The Commission has additionally, after a review, recommended amendments in the Immoral Traffic (Prevention) Act, 1956 to the Government of India.

JORDAN

The Jordanian National Centre for Human Rights was involved in a comprehensive review of that country's personal status law (dealing with marriage, family, etc.). The Centre was able to promote a rights-based analysis of a number of key issues. It also lobbied strongly for the new law to include an explicit prohibition on child marriage with an exception made in the case of pregnant

girls. That recommendation was accepted and the revised law is currently being considered for adoption.

The National Centre has adopted a flexible approach to handling complaints that appears to be well suited to addressing some violations of reproductive rights. In responding to a complaint involving family

relations (e.g. a husband's insistence on a certain number of children over the wishes of his wife) the Centre will seek to contact the husband directly in order to informally mediate the complaint. If a complaint concerns a lack of access to essential services, e.g. with respect to premature infants, the Centre will try to intervene directly with the service provider. In addition to resolving the particular case, the Centre will also seek to address underlying causes by contacting the relevant ministry.

In 2010, the Centre organized a workshop at the University of Jordan on the issue of abortion in cases of foetal deformity/disability. The workshop focused specifically on whether national law and international conventions would allow abortion in such circumstances. The Centre ensured that

the debate included a cleric who was able to pronounce on the religious law aspects. The workshop came up with detailed recommendations that were widely shared. The event received much publicity and, in the view of the organizers and participants, succeeded in raising awareness and discussion on one potentially controversial aspect of reproductive rights.

In collaboration with UNDP, the National Centre carried out a training session on the right to health 16-18 October 2011. The participants were 20 physicians. The training session included one session allocated to reproductive rights and one session dealing with the rights to health for women and children. Case studies and working groups on the subject of reproductive rights also took place.

KENYA

The Kenya National Commission on Human Rights (KNCHR) received a complaint from FIDA-Kenya (Federation of Women Lawyers) and CRR (Centre for Reproductive Rights) alleging violations in public health facilities, specifically at Pumwani Maternity Hospital in Nairobi. This was supported by a research report highlighting inadequate access to health care, including

- High user fees;
- Delays in the provision of reproductive healthcare;
- Women detained in health facilities for inability to pay bills;

- Negligence and mistreatment of women during delivery;
- Acute shortage of staff and supplies; and
- Violations in the context of HIV/AIDS, such as lack of consent for testing and discrimination.

Preliminary investigations by KNCHR revealed widespread violations and deteriorating standards in government and non-government health facilities across the country. On this basis, KNCHR decided to carry out a national inquiry on sexual and reproductive health and rights with the purpose of:

1. Establishing the legal and policy framework governing the implementation of sexual and reproductive health rights in Kenya and its effectiveness;
2. Assessing compliance of sexual and reproductive health rights in Kenya;
3. Determining the awareness and usage of sexual and reproductive health in Kenya; and
4. Identifying and documenting cases of violations of sexual and reproductive health and rights in Kenya.

The inquiry started in 2011. It included a comprehensive desk review of statistics, laws, policy documents, budgets, etc., missions to six regions (visits to health facilities, focus group discussions and interviews) and six public hearings, each of which was preceded by community forums, and an experts' forum to digest the information gathered. As part of the preparation of the inquiry, two stakeholder consultations were held, the first to get input on how to carry out the inquiry and its purpose, the second to discuss how stakeholders could assist in providing support to the inquiry, including mobilizing victims.

The conclusions of the inquiry are reflected in a report containing the findings as well as recommendations for policy change in the reproductive health sector published in April 2012. Some of the findings are as follows:

1. Despite the key role that family planning plays in sexual and reproductive health, the unmet need still remains high. The inquiry determined that most Kenyans who desire to plan their families still

do not have access to family planning services.

2. Findings of the Inquiry point to a number of barriers that inhibit the realization of maternal health rights in Kenya:
 - a. Unavailability of maternal health services, including antenatal care, delivery care, postpartum care and abortion care, at all levels of health care;
 - b. The long distance covered to access maternal health services, especially in the far flung areas such as the Northern and North Eastern regions;
 - c. Poor quality of maternal health services occasioned by lack of supplies and equipment, understaffing and inadequate training and supervision, negligence and unethical practices, and weak referral systems;
 - d. High cost of maternal health care, making the use of skilled health attendants out of reach for many Kenyans;
 - e. Failure to tailor maternal health care services to respond to the cultural norms and practices of particular communities such as those who do not allow a pregnant woman to be attended to by a male healthcare provider;
 - f. Failure to integrate traditional birth attendants into the broader health care system with a view to regulate their operations in order to make them safe for women who seek their services.

3. During the Inquiry, witnesses reported incidences of sexual violence in the form of rape, defilement, female genital mutilation, early/forced marriages, among others across the country as well as the long-term effects, including unwanted pregnancies, infection with STIs including HIV/AIDS, numerous gynaecological complications, stigma, abandonment by their spouses and psychosocial trauma.

The Inquiry is providing recommendations on all of the above mentioned issues in addition to recommendations relating to adolescents, the rights of sexual minorities, persons with disabilities, persons living with HIV/AIDS, IDPs and refugees, and minority groups.

The report is accessible on http://www.knchr.org/Portals/O/Reports/Reproductive_health_report.pdf.

MALAYSIA

The Human Rights Commission of Malaysia conducts regular sessions with school students to raise awareness about human rights issues. The revised curriculum will enable it to use these sessions to discuss issues related to reproductive rights that are of great concern to young people.

The Human Rights Commission was involved in consultations for the development of a national policy on reproductive and social health. Not all the Commission's recommendations were accepted but its involvement helped to strengthen the link between reproductive issues and human rights. The Commission also identified several matters as issues of concern that should be reflected in the population policy. These included the stigma around

unwed motherhood leading to procurement of unsafe abortions by adolescents and abandonment of babies. The Commission subsequently provided recommendations to the Government on how these problems could be effectively addressed in a way that respects human rights.

The Malaysian Human Rights Commission plays an important role in bringing the Government and civil society together to bridge differences of opinion in relation to reproductive rights issues. It has organized meetings between NGOs and the Government on certain sensitive issues related to reproductive rights. The Government seems more amenable to dialogue with civil society when this is facilitated by the Commission.

MONGOLIA

The National Human Rights Commission of Mongolia uses the MDGs (especially as they relate to child and maternal mortality)

as one of its benchmarks when monitoring or advocating for reproductive rights. The MDGs have universal support and are well

understood by the Commission's partners, particularly within government where much important data is generated. In monitoring reproductive rights, the Commission works

closely with the health ministry. This relationship ensures that its own information is positioned more strongly, thereby enabling effective policy development and follow-up.

NAMIBIA

It is envisaged that the right to health and the health sector will be targeted in the National Human Rights Action Plan. This will allow the Office of the Ombudsman in

Namibia to monitor progress in terms of reproductive and other human rights relating to health.

NEPAL

In December 2009, the National Human Rights Commission of Nepal opened a baby care centre (crèche) that provides care for the infants and babies of staff. This initiative found its authority in various provisions under the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against

Women and sought to address unsatisfactory maternity leave entitlements that affect all Government employees. The Commission's operating budget funds the centre. The intention of this initiative is to facilitate the opening of similar childcare centres in other Government and private offices.

NEW ZEALAND

In 2008, the Human Rights Commission of New Zealand was involved in bringing together community activists and leaders to discuss the sensitive areas of sexuality, gender and human rights. Four main themes emerged in the course of the discussion, being human rights; gender and power; culture and identities; and advocacy relationships. In addition to its substantive discussion on sexuality, gender and rights, the dialogue and its report reflected upon the important place of dialogue as an

opportunity for shared conscious reflection and collaborative learning. It was observed that while human rights issues are constantly present, they risk being overlooked and watered down without conscious reflection, and that reference to a human rights framework provides opportunities for progress.

The Human Rights Commission of New Zealand issues an annual report on the State of Human Rights. From 2011 the Report will

include a section on sexual and reproductive health and rights. This section will be largely descriptive, seeking to document and describe the conversation around sexual

and reproductive health and rights rather than advocating a particular position on the issues.

PALESTINE

In September 2011, the Palestinian Independent Commission for Human Rights (ACHR) developed a sensitization session on reproductive rights with the assistance of UNFPA. The purpose was to raise the awareness of ACHR on the principles and concepts of reproductive rights. The workshop emphasized the need to integrate reproductive rights into the work of the ICHR, in addition to its work on gender equality and equity and women's empowerment.

In October 2011, ACHR organized a workshop entitled Violence Confrontation against Women. The aim of the workshop was to highlight the phenomenon of violence against women in Palestine and discuss the governmental and non-governmental efforts to protect women from violence. Speakers at the workshop emphasized the necessity to enhance the reality of reproductive rights in Palestine by showing them to be a reality to the men and women there.

PHILIPPINES

The Commission on Human Rights of the Philippines provided the national government with a written advisory opinion on the legality of a local government ordinance restricting access to birth control. Prior to drafting the opinion, the Chair of the Commission held a dialogue with relevant non-governmental organizations and other stakeholders. The advisory opinion evaluated the ordinance in light of the obligations of the Philippines under international human rights law, particularly the Convention on the Elimination of All Forms of Discrimination against Women, to conclude that the law breached those obligations. The Commission has further called for a public inquiry into the issue.

The Commission noted the importance of involving religious authorities in discussions about reproductive rights, citing its work on sexuality as an example of the value of such an approach in building common ground. The Commission intends to involve leaders and members of faith-based groups to participate in discussions on a future strategy for reproductive health rights.

The Commission has decided to develop a reproductive rights programme. In developing this programme the Commission will begin by holding discussions at the village level, using its 15 provincial offices to coordinate these events. The discussions will feed into the Commission's human rights education programme by providing initial

awareness-raising about reproductive rights. They will also enable the Commission to gain an insight into the situation of reproductive rights. In addition to their monitoring

value, such insights will help to clarify needs and priorities as well as to identify obstacles to the effective realization of reproductive rights.

PORTUGAL

The Portuguese Ombudsman, Provedor de Justiça, is a NHRI that mostly works through complaints handling. In the past few years there have been some complaints regarding “family rights” which, in many cases, comprise of reproductive rights (parental social rights, maternal and infant health care, etc.).

Probably as a reflection of the legislative evolution in these issues, the most recent complaints include novel matters such as access to fertility treatments:

1. A recent example (dated from 2009) relates to the procedures adopted by an institution integrated within the National Health Service regarding medically assisted reproduction.²

Medically assisted reproduction is recognized and regulated by Law 32/2006 of 26 July, and has been gradually included in the medical services provided by public hospital facilities.

The Portuguese healthcare system is based on a National Health System (NHS) orientated by the constitutional principles of universal access and free healthcare, in this case applied to medical assistance in reproduction.

The complaint was presented by a woman who had been accepted and included on the waiting list for a certain fertility treatment, who ended-up being excluded after some months, allegedly for the reason that in the intervening period she had become too old to benefit from it.

The Provedor de Justiça has recommended the adoption of transparent criteria for the selection of the couples admitted for treatment, emphasizing the importance of the prior publication of the conditions required (age limit, clinical condition, etc.), selection criteria and further procedures applicable.

2. Maternity (parental) social protection has been handled in other cases.

In one of these cases, the Provedor de Justiça aimed at a reorientation in the interpretation of the existing law on maternity leave, recommending that the period of maternity leave should also apply to cases of premature death of the newborn. The recommendation was based on the principle that maternity leave not only pursues the interest of the child but also that of the mother.³

2 Proc. R-5803/2009 (A6).

3 Proc. R-4988/00, in “Provedor de Justiça – Relatório à Assembleia da República 2003”, pp. 628-630.

The Provedor de Justiça also intervened on a right to breast-feed case, defending before a public employer the case that breast-feeding time should accrue to (and not exclude) the monthly leave of absence recognized for that employee, according to her working regime.⁴

3. Concerning maternal and infant mortality during childbirth, this Provedor receives fairly regular complaints, most of them related to inadequate medical assistance when giving birth, with negative health consequences to the mother and/or child. As the comprehension of medical malpractice requires in-depth technical analysis, which the Provedor de Justiça does not feel able to perform, his/her role has been to adequately redirect the citizens to the competent public

bodies and to control the fulfilment of the right to a quick and adequate reply.

4. The Provedor carry out inspections to prisons and has in this respect addressed the special needs of pregnant prisoners and the question of the presence of young children in prisons, in general with satisfactory results. As an example the Provedor de Justiça suggested the legal age limit of 3 years old for children to be allowed to stay with their mothers be increased to 5 years old. This recommendation was accepted.
5. The introduction of voluntary termination of pregnancy at the woman's request until the tenth week of gestation by Law 16/2007 of 17 April (issued after a National Referendum) motivated some complaints and consequent legal assessment by the Provedor de Justiça. However, the Provedor decided that no intervention be made.

4 "Provedor de Justiça - Relatório à Assembleia da República 2007", Vol.I, p. 647.

QATAR

In February 2011, the National Human Rights Committee of Qatar conducted a community survey on reproductive rights. The survey involved the production and distribution of a questionnaire to 1,000 women. Five hundred of the respondents lived in remote communities, identified by the Committee as a group in situation of particular vulnerability with respect to reproductive rights. The purpose of the survey was to assess the situation (nature, size and

scope of the problem); to identify the priorities of women in relation to reproductive rights; and to gauge community reaction to a proposed engagement by the Committee in this area. On the basis of those results the Committee expects to develop training courses, seminars/roundtables and other events aimed at raising awareness about reproductive rights and addressing issues of concern that have been identified.

REPUBLIC OF KOREA

The Human Rights Commission of Korea has recently received complaints from some human rights groups related to the current abortion law. As part of its investigation into these complaints the Commission will convene community discussions on the current situation and options for legal and policy reform.

The Commission recently dealt with two complaints in a way that has already led to important policy changes within government. The first complaint related to the right of incarcerated women to keep their infants

with them in detention and the availability of facilities to make this possible. The second complaint related to the exclusion of a girl from school on the basis of her pregnancy. Both cases were resolved in favour of the complainant. In the school exclusion case, a submission by the Commission to the relevant government department resulted in substantial policy changes that have since been fully implemented. In the detention case, the Commission's recommendation to the government is currently under consideration.

SENEGAL

The Human Rights Committee of Senegal is involved in a project to address the reproductive health of adolescents, not least the scourge of sexual violence in schools. This project is managed by the Ministry of Education with the Human Rights Committee being responsible for the human rights aspects, including issues of reproductive rights. As part of this project, separate guides/manuals have been prepared for trainers, teachers and pupils, and so far the administrative staff of 14 schools have been trained. As part of the project, a group of teachers and pupils will be trained to sensitise all the pupils at the said schools and to prevent and manage eventual cases

of sexual violence and abuse. The overall purpose is to promote gender equality and make the new generation aware of the issues of sexual health, gender, human rights and the negative consequences of sexual violence and abuse.

In addition to this specific project, the Senegalese Human Rights Committee has prioritised the establishment of human rights clubs at schools. In that connection all issues relevant to young persons, including issues of reproductive rights, are considered by the Committee and analysed from a human rights angle.

SOUTH AFRICA

The practice of ukuthwala traditionally permitted parents to arrange their children's marriage but was said to have been abandoned in the 1960's. It is evident that the practice has been revived and is still being performed, mainly in villages in the Eastern Cape Province of South Africa. In 2008, the South African Human Rights Commission (SAHRC) carried out research in conjunction with various government departments into the prevalence of ukuthwala and conducted education and awareness raising activities. The research confirmed that ukuthwala was still in practice and that it affected girls as young as 13 years of age. Further, the SAHRC noted that ukuthwala had a detrimental impact on all girls within the regions where it was in practice as many lived in fear of being abducted and forced to enter marriage.

Section 12 of the South African Children's Act emphasises a child's right not to be subjected to social, cultural and religious practices that are detrimental to his or her well-being. Certain practices are prohibited (female genital mutilation and forced marriages) while others are limited to children over the age of 16 and regulated to prevent abuse (virginity testing and male circumcision for cultural reasons). A virginity test is the practice and process of traditional examiners inspecting the genitalia of girls and women to determine if they are sexually chaste. During the past 20 years there has been the re-emergence of mass based virginity testing particularly amongst the Zulu people. The re-emergence of this cultural practice has led to concerns being raised about the potential invasion and violation of guaranteed constitutional rights

of the young women who are tested. It is the view of the Commission that allowing virginity testing to take place, even in accordance with the Children's Act, is a violation of South Africa's international obligations and the South African Constitution. During the process leading to the adoption of the Children's Act, the Commission drew parliament's attention to this but to no avail.

Spurred on numerous complaints with regards to poor health care service delivery throughout all of South Africa, in 2007 SAHRC initiated public hearings on the right to health care access. This served to highlight the lamentable state of maternal health care in South Africa. Starting May 2007, SAHRC embarked on visits to approximately 100 facilities across the country, investigating complaints relating to general healthcare access and inviting the public to make public submissions. This culminated in public hearings in 2009. A report containing recommendations was prepared, tabled in Parliament and presented to the relevant government departments with a request for response to the recommendations. Among the issues highlighted was the discriminatory attitude of healthcare staff towards vulnerable groups such as women, children, rape survivors, the elderly, refugees, persons with disabilities, and gays and lesbians, which in many cases affects these groups' rights to healthcare. The Department of Health has indicated that it will take the recommendations into consideration. The fate of the recommendations will be monitored.

SAHRC participates in the parliamentary processes, ranging from making submissions on draft legislation and participating

in parliamentary public hearings on draft legislation to briefing portfolio committees on particular issues of concern. In many cases, this has concerned maternal mortality, and SAHRC has been able to influence parliament, including in giving more women access to safe legal abortions (the Choice of Termination of Pregnancy Act 1996) which led to a substantial (90%) reduction in abortion related deaths.

As part of its constitutional duties, the SAHRC annually monitors the implementation of economic and social rights. The 2010 report focused on the attainment of the MDGs, including MDG 5 on maternal mortality. SAHRC concluded that maternal

mortality actually seemed to be on the increase in South Africa and repeated its calls for the Department of Health to investigate child and maternal mortality. In 2011 SAHRC will establish a database to monitor and evaluate the impact of its recommendations.

Currently, SAHRC is investigating the deaths of premature babies in a number of hospitals in South Africa. From January-April 2010 181 babies died at one hospital in South Africa and six at another hospital in May 2010. This has led SAHRC to carry out investigations and engage the Minister of Health. This remains on-going.

THAILAND

In 2007, the National Human Rights Commission of Thailand issued a guide to reproductive rights, directed mainly to government officials, NGOs and those providing legal and social services to women and girls.

The guide sets out the nature and scope of reproductive rights and explains how these rights are protected under international and national law.

TIMOR LESTE

In Timor Leste, the Provedor de Direitos Humanos e Justiça was involved in the development of legislation relating to domestic violence, an issue with direct implications for a range of reproductive rights in that country.

The Provedor was involved in national discussions regarding the criminalization of abortion, where together with civil society members and the Government it undertook a concerted effort to bring the provisions of the draft criminal code in line with the Convention on the Elimination of All Forms of Discrimination against Women.

UGANDA

The Uganda Human Rights Commission is an example of a NHRI that integrates reproductive rights into its work. Consequently, the NHRI investigates allegations of violations of reproductive rights, carries out human rights education on reproductive rights, monitors and documents the state of reproductive and sexual health and advises government on its compliance with established human rights standards, for example on proposed legislation and policies that affect reproductive rights issues, such as the review of the Anti-Homosexuality Bill, the HIV and AIDS Bill and the Domestic Relations Bill.

One of the most controversial pieces of legislation to come before the Ugandan Parliament in recent years is the Anti-Homosexuality Bill. The bill, introduced as a private member's bill on 14 October 2009, increases the penalty for homosexual acts to life imprisonment in certain cases. It also criminalizes the promotion of homosexuality, including publishing of most material and views on homosexuality as well as the failure to report known homosexual activities.

The bill immediately sparked off protests especially from the international community, while it acquired support from many Ugandans including some religious leaders, based on tradition, religion and moral values.

The Uganda Human Rights Commission, as part of its mandate to analyse and review bills before Parliament to ensure compliance with human rights standards, subjected the bill to a detailed analysis, drawing from human rights standards set out in the Ugandan Constitution, treaties and the

practice of relevant United Nations human rights bodies. The conclusion, based entirely on legal arguments, was that the Anti-Homosexuality Bill contradicted international human rights standards, including the right to privacy, equality and non-discrimination, as well as the freedoms of speech, expression, association and assembly. The 12th Annual Report 2009 of the Ugandan Human Rights Commission presented the analysis.

Despite the advocacy efforts of the Uganda Human Rights Commission and other national and international actors, the President of Uganda promulgated a slightly altered version of the bill in February 2014, impacting in the rights, personal security and wellbeing of lesbian, gay, bisexual and transgender persons in Uganda.

To enhance monitoring the Commission has established the Vulnerable Persons Unit, which handles issues of women's rights, rights of persons living with disabilities and the rights of persons living with HIV/AIDS among other groups. A specific unit, also under the Directorate of Monitoring and Inspections, has been established to focus on the right to health; this unit monitors the situation on the right to health in general. Both these units are involved with issues of reproductive rights.

The Ugandan Human Rights Commission encountered the following challenges in monitoring reproductive rights: (i) a general lack of awareness of reproductive rights; (ii) high poverty levels making it impossible for most people to afford health care services and thus effectively enjoy sexual and

reproductive health and rights; (iii) the clash between cultural and traditional values and human rights which is especially apparent with respect to sexual and reproductive

health and rights; and (iv) the common desire of complainants to keep their issues private and confidential which complicates investigation and resolution of complaints.

UZBEKISTAN

The Parliamentary Ombudsman in Uzbekistan has been involved in various activities within the field of reproductive rights. In 2002 it monitored the observance of women's reproductive rights in the Djizak region. This kind of monitoring normally entails analysing complaints and applications addressed to the Ombudsman and awareness-raising activities and is ordinarily carried out jointly with the regional representatives of the Ombudsman, NGOs, legal scholars, social scientists, journalists and

officials at all levels. The monitoring is then summarized in analytical reports setting out the reasons and conditions for human rights violations and containing specific recommendations for how to address the causes. The reports are discussed at regional gatherings of deputies, at panel discussions in ministries and departments and in the press. The idea is that the recommendations of the Ombudsman are presented to state authorities that are then expected to take the necessary steps.

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