ICPD AND HUMAN RIGHTS:

20 years of advancing reproductive rights through UN treaty bodies and legal reform

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International Conference on Population and Development Fact Sheets

In 1994, at the International Conference on Population and Development (ICPD), 179 countries came together and adopted a Programme of Action, in which they agreed that population policies must be aimed at empowering couples and individuals—especially women—to make decisions about the size of their families, providing them with the information and resources to make such decisions, and enabling them to exercise their reproductive rights. For the first time in an international consensus document, states agreed that reproductive rights are human rights that are already recognized in domestic and international law.

The ICPD Programme of Action recognizes that realizing the right to reproductive health is a critical element of guaranteeing reproductive rights. The ICPD Programme of Action broadly defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."[1] Reproductive health implies that people are able to have a safe and satisfying sex life; the ability to reproduce; and the right to decide if, when, and how frequently to reproduce.[2] Governments also recognized the inherent link between sustainable development, the eradication of poverty, and gender equality, and committed to address these issues in tandem. Furthermore, states agreed that coercive laws, policies, and practices that do not respect individuals' autonomy and decision making must be eliminated. In adopting the ICPD Programme of Action, states committed to take legal, policy, budgetary, and other measures to effectuate the principles and rights enshrined in the document.

Every five years since ICPD, states have come together to reaffirm this commitment, analyze the progress that has been made towards realizing sexual and reproductive health and reproductive rights, and decide upon further actions that should be taken. At the initial five-year review of ICPD (referred to as "ICPD+5"), states agreed to utilize benchmarks and indicators to monitor the realization of sexual health and reproductive rights.[3] The ICPD Programme of Action has helped shape the development and application of binding international human rights standards, including the rights protected under the Convention on the Elimination of Discrimination against Women; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the Convention on the Rights of the Child; and the Convention on the Rights of Persons with Disabilities and consensus documents such as the Beijing Declaration and Platform of Action, the Rio + 20 Declaration, and the United Nations (UN) Human Rights Council's resolutions on maternal mortality.[4] Reducing maternal mortality and increasing access to contraceptives were also incorporated into the Millennium Development Goals, an agreed-upon set of development targets adopted in 2001 and revised in 2007. To mark 20 years since ICPD, the United Nations Population Fund is spearheading a review of countries' progress toward the realization of the goals and rights enshrined in the ICPD Programme of Action.[5] This review process incorporates a review of laws and policies that have been adopted to identify achievements and challenges, and establish further plans for action.

These fact sheets highlight the progress states have made through their laws and policies to implement the ICPD Programme of Action and describe national and international human rights developments on a number of select issues related to sexual and reproductive health and rights. While the development of laws and policies are not the only measure of a state's commitment to and compliance with international human rights norms, it is an important component as it lays the foundation for the realization of rights and can ensure accountability when laws are violated or not implemented.

The specific sexual and reproductive health and rights issues and the respective human rights standards set out in these fact sheets are not exhaustive and were selected in order to depict how sexual and reproductive health and rights have come to be realized over the past two decades. Each fact sheet contains an overview of the issue, the framework set forth under ICPD to

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address the issue, the evolving human rights standards, and examples of laws, policies, and judicial decisions aimed to effectuate these particular rights. Finally, the fact sheets provide a select number of recommendations for overcoming barriers to realizing sexual and reproductive health and rights.

While many bodies contribute to the development of human rights standards, including the UN Human Rights Council, UN agencies, and specialized experts appointed by the UN, the human rights standards set forth in these fact sheets are those established by treaty monitoring bodies, as they are charged with providing authoritative interpretations of the rights enshrined in their respective treaties to which state parties are legally bound to comply. While regional human rights bodies and agreements have made tremendous contributions to the advancement of sexual and reproductive health and rights, they are not included in these fact sheets. International human rights standards are mutually reinforcing, as the different international treaty monitoring bodies and regional human rights systems influence and build upon one another. The examples in these fact sheets are intended to demonstrate how states have undertaken implementation of the ICPD Programme of Action by translating the agreements made therein into laws and policies designed to enhance sexual and reproductive health and reproductive rights. The last section of this series of fact sheets highlights implementation of these laws and policies as an imperative next step.

Treaty Monitoring Bodies

Each UN international human rights treaty has a corresponding treaty monitoring body, known as a committee, charged with overseeing the treaty's implementation by state parties. Utilizing a periodic reporting process, each committee assesses states' compliance with the treaty and issues concluding observations. Treaty monitoring bodies also develop "General Comments" or "General Recommendations" which provide overarching guidance on treaty implementation and authoritative interpretations of treaty provisions. Some committees also receive individual complaints of human rights violations, which they adjudicate to determine if a state has violated the treaty.

International Human Rights Principles

Recognizing that reproductive rights constitute internationally protected human rights, states must comply with international human rights standards and principles in fulfilling their obligation to take legislative, policy, and other measures to give effect to such rights.[6] States should develop legislation and public policies that explicitly include and protect these rights,[7] and create and implement comprehensive national strategies to protect sexual and reproductive health.[8]

States' obligation to respect, protect, and fulfill human rights should guide the development of laws and policies, as well as practices. The obligation to respect requires that states do not act in a way that interferes with individuals' enjoyment of their rights, either directly or indirectly.[9] As such, states should not limit access to contraceptives, withhold or misrepresent health-related information, or utilize coercive medical practices.[10] The obligation to protect demands that states take measures to prevent third parties from interfering with human rights and impose sanctions on those who violate others' human rights.[11] Treaty monitoring bodies have elucidated that in order to do so, states should adopt legislation to ensure equal access to health care, ensure that health services from private providers comply with human rights standards, and take measures to protect individuals from harmful traditional practices.[12] The obligation to fulfill requires states to adopt legislative, budgetary, administrative, and judicial measures towards the full realization of human rights.[13]

In respecting, protecting, and fulfilling human rights, states should apply a human rights-based approach to development policy and programming, in addition to enshrining human rights themselves into laws and policies. When human rights are specifically incorporated into laws and policies, they enhance both states' compliance with existing standards and states' accountability to their populations. Laws and policies aiming to respect, protect, and fulfill rights should also comply with the following international human rights principles.

Autonomy

Autonomy is a central component of the rights to life, privacy, and liberty, amongst others, and includes individuals' rights to make informed decisions about their bodies, to determine the number and spacing of their children, and to be free from coercion, discrimination and violence.[14] For example, a key component of the ICPD Programme of Action was the recognition that compelling individuals to carry out states' coercive population-based laws, policies, or practices constitutes a human rights violation and should be abolished. States also agreed to abolish laws, policies, and practices that interfere with individuals' rights to autonomous decision making and to ensure that third parties do not interfere with the right to autonomy. In order to fulfill this principle, states further agreed to provide individuals with access to information and services that enable them to exercise their autonomy.

Non-discrimination and Equality

The rights to non-discrimination and equality lie at the core of almost every international human rights treaty and are guaranteed protections in the exercise of all other rights. International human rights law expressly proscribes discrimination on the basis of, *inter alia*, sex, race, ethnicity, language, religion, disability, and economic status. Treaty monitoring bodies have recognized additional grounds of discrimination on the basis of age,[15] actual or perceived sexual orientation and gender identity,[16] marital status,[17] health status (including HIV status),[18] and pregnancy.[19] To effectuate the right to equality, states should take "all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men."[20] The gender dynamic that underlies sexual and reproductive health and rights demands that non-discrimination and equality are duly emphasized in the realization of these rights. Women who are also of a vulnerable or marginalized group may face multiple forms of discrimination, further imperiling their achievement of development outcomes and human rights, including the right to health.[21] The right to non-discrimination requires states to eradicate discriminatory policies and practices, and take affirmative measures to ensure that everyone is afforded the same rights in law and in practice.[22] In addition to eradicating formal discrimination in laws and policies, states must also eradicate substantive discrimination including by adopting measures to address the conditions and attitudes that perpetuate discrimination.[23] Policies and practices that place undue onus on women in order to access comprehensive reproductive health care, such as spousal authorizations, constitute discrimination and must be eradicated.[24] Furthermore, states must take measures to combat the social and cultural beliefs that contribute to the diminished status of women worldwide and that have a negative impact on their sexual and reproductive health.[25]

Accountability

The ICPD Programme of Action recognizes that enhanced accountability to all populations, particularly underserved and marginalized populations, is essential within reproductive health programming.[26] Accountability is critical for ensuring that policies and programs are properly implemented, preventing human rights violations, and providing remedies when violations occur. Measures to enhance accountability should be incorporated into laws and policies; such measures include ensuring

oversight, allocating appropriate budgets for initiatives, and clearly defining the roles of government ministries and the rights and duties of health care providers. Formal accountability mechanisms are essential in identifying individual and systematic human rights violations and ensuring access to justice for those who claim their rights have been violated. Examples of formal accountability mechanisms include a functioning judicial system with the authority to adjudicate sexual and reproductive rights violations, and national human rights institutions, including human rights ombudspersons. States also should ensure that their populations are aware of their rights. Through government-produced public awareness campaigns, people should learn of a state's obligation to protect those rights and thus be enabled to assert them.

Participation and Empowerment

The ICPD Programme of Action recognizes that the effective realization of sexual and reproductive health and reproductive rights requires empowering all sectors of society—including women, in particular—and incorporating their meaningful participation into the design of policies. The specific needs of women are better addressed by ensuring their meaningful participation in devising and implementing sexual and reproductive health programs and services. This participatory process also empowers individuals, including women, and civil society to assert their rights and report violations when they occur and enhances accountability for the implementation of laws and policies. Further measures to empower women must also be taken in order to elevate their social, economic and political status worldwide, such as guaranteeing their right to education and providing them with equal employment opportunities.[27] Such measures will empower women to exercise their sexual and reproductive health and rights and overcome the stigma attached to the exercise of these rights.

International Cooperation

In the ICPD Programme of Action, states agreed on the need for increased availability of and commitment to international cooperation and assistance.[28] Donor states have a responsibility to ensure that when their resources are utilized for sexual and reproductive health programs, they respect and advance human rights norms, and are not detrimental to women's exercise of their fundamental human rights, including their right to free and informed decision making.[29] Furthermore, donor states and recipient countries should aim to create long-term cooperation policies and development strategies that are consistent with national population and development priorities that respect and promote human rights.[30]

The Right to Health: Essential Elements - Availability, Accessibility, Acceptability, and Quality

The provision of reproductive health services must conform to the international human rights framework comprising the right to health— namely, the standards guaranteeing availability, accessibility, acceptability, and quality of health facilities, goods, and services.[31] These standards also apply to the underlying determinants of health, including access to sexuality education and information.

- **Availability**: States must ensure that there are an adequate number of functioning health care facilities, services, goods and programs to serve the population,[32] including essential medicines such as contraception and emergency contraception.[33]
- **Accessibility**: States must ensure that health facilities and services are accessible to their populations without discrimination, meaning that they must be accessible to all, in law and in practice, particularly the most vulnerable populations.[34] Health facilities and services must also be physically accessible, including for people with physical disabilities, and economically accessible, which entails affordability.[35] Payment assistance must be based on the principle of equity to ensure that impoverished families and individuals do not bear a disproportionate burden of health costs.[36] Finally, information must be accessible, meaning that individuals and groups must be able to seek, receive, and disseminate information and ideas on health issues.[37]
- **Acceptability**: Health facilities, services, and goods must be culturally appropriate and should take into account the interests and needs of minorities, indigenous populations, and different genders and age groups.[38]
- **Quality**: Reproductive health care must be of good quality, meaning that it is scientifically and medically appropriate and that service providers receive adequate training.[39]

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1 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 7.2, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].

2 *Id.*

3 *See Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development*, U.N. GAOR, 21st Special Sess., June 30-July 3, 1999, U.N. Doc. A/S-21/5/Add.1 (1999).

4 Other important advancements in regards to sexual and reproductive rights include the Amman Declaration and Programme of Action, the United Nations Declaration on the Rights of Indigenous Peoples, the 2012 Commission on Population and Development resolution on adolescents and youth, and the 2012 Commission on the Status of Women resolution on maternal health of rural women. *See Amman Declaration and Programme of Action,* Amman, Jordan, Nov. 5-7, 2012; United Nations Declaration on the Rights of Indigenous Peoples, U.N. Doc. A/61/L.67 (Sept. 12, 2007); Commission on Population and Development Res. 2012/1 Adolescents and youth, Rep. of the Commission on Population and Development, 45th Sess., Apr. 15 & Apr. 23-27, 2012, U.N. Doc. E/2012/25, E/CN.9/2012/8 (2012); Commission on the Status of Women, Agreed conclusions on access and participation of women and girls in education, training and science and technology, including for the promotion of women's equal access to full employment and decent work, Rep. of the Commission on the Status of Women, 55th Sess., Mar. 12., Feb. 22-Mar. 4 & Mar. 14, 2011, U.N. Doc. E/2011/27, E/CN.6/2011/12 (2011).

5 *See* GA Res. 65/234, U.N. Doc. A/RES/65/234 (Apr. 5, 2011).

6 *See, e.g.*, Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 3, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW] ("States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men."); International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 2(1), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR] ("Each State Party to the present Covenant 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."); International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, art. 2(2), G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR] ("Where not already provided for by existing legislative or other measures, each State Party to the present Covenant undertakes to take the necessary steps, in accordance with its constitutional processes and with the provisions of the present Covenant, to adopt such legislative or other measures as may be necessary to give effect to the rights recognized in the present Covenant.").

7 *See* Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Costa Rica,* para. 64(b), U.N. Doc. CRC/C/CRI/CO/4 (2011) (urging the state to "Design and implement an intersectoral public policy for health, sexual and reproductive rights aimed at adolescents within and outside the educational system and

taking into account sexual and reproductive rights, healthy sexuality, prevention of unplanned pregnancies, sexually transmitted diseases, HIV/AIDS, and the accessibility and use of condoms and other contraceptives."). Examples of legislation that explicitly incorporates sexual and reproductive rights include Bolivia's 2009 Constitution and Albania's 2002 Law on Reproductive Health. *See* Nueva Constitución Política del Estado [Constitution] Oct. 2008, arts. 14-15, 45, 48 & 66 (Bolivia) [hereinafter Bolivian Constitution]; Law No. 8876, Law on Reproductive Health (Apr. 4, 2002) (Albania).

8 Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 29, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

9 Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at para. 33, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*]; CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 8, para. 14.

10 ESCR Committee, *Gen. Comment No. 14*, *supra* note 9, para. 34.

11 *See id.* para. 33; CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 8, para. 15.

12 ESCR Committee, *Gen. Comment No. 14*, *supra* note 9, para. 35.

13 *Id.* para. 33; *see also* CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 8, para. 17 ("The duty to fulfill rights places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care.").

14 *See, e.g., ICPD Programme of Action*, *supra* note 1, para. 4.1; Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, arts. 3 & 25, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611 (*entered into force* May 3, 2008); CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 8, para. 31(e).

15 ESCR Committee, *General Comment No. 20: Non-discrimination in economic, social and cultural rights,* para. 29, U.N. Doc. E/C.12/GC/20 (2009) [hereinafter ESCR Committee, *Gen. Comment No. 20*].

16 *Id.* para. 32.

17 *Id.* para. 31.

18 *Id.* para. 33.

19 *See, e.g.,* C158 Termination of Employment Convention, 1982 (No. 158), *adopted* Jun. 22, 1982, art. 5, Geneva, 68th ILC Sess. (*entered into force Nov. 23, 1985*); C183 Maternity Protection Convention, 2000 (No. 183), *adopted* Jun. 15, 2000, Geneva, 88th ILC Sess. (*entered into force Feb. 7, 2002*); R191 Maternity Protection Recommendation, 2000 (No. 191), *adopted* Jun. 15, 2000, Geneva, 88th ILC Sess.

20 CEDAW, *supra* note 6, art. 3.

21 CEDAW Committee, *General Recommendation No. 28: Core Obligations of States parties under article 2 of the Convention on the Elimination of Discrimination against Women*, (47th Sess., 2010), para. 31, U.N. Doc. CEDAW/C/GC/28 (2010) [hereinafter CEDAW Committee, *Gen. Recommendation No. 28*].

22 *See generally* ESCR Committee, *General Comment No. 20, supra* note 15.

23 *Id.* para. 8(b).

24 CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 8, para. 14.

25 CEDAW, *supra* note 6, arts. 2(f) ("States Parties...undertake...[t]o take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women") & 5 ("States Parties shall take all appropriate measures: (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;"); Convention on the Rights of the Child, *adopted* Nov. 20, 1989, art. 24(3), G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter CRC] ("States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."); *See* CRC Committee, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, (33rd Sess., 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter Committee on the Rights of the Child, *Gen. Comment No. 4*] (incorporating sexual and reproductive health into the right to health).

26 *ICPD Programme of Action*, *supra* note 1, para. 13.8(a) & (c).

27 *See id.* Preamble, Principle 10 and para. 3.18.

28 *Id.* para. 14.10.

29 Office of the United Nations High Commissioner for Human Rights, *Technical guidance on the application of human rights-based approach to implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, para. 85, U.N. Doc. A/HRC/21/22 (July 2, 2012).

30 *ICPD Programme of Action*, *supra* note 1, para. 14.3.

31 *See* ESCR Committee, *Gen. Comment No. 14*, *supra* note 9, para. 12.

32 *Id.* para. 12(a).

33 *Id.*

34 *Id.* para. 12(b)(i).

35 *Id.* para. 12(b)(ii) and (iii).

36 *Id.* para. 12(b)(iii).

37 *Id.* para. 12(b)(iv).

38 *Id.* para. 12(c).

39 *Id.* para. 12(d).

I. MATERNAL MORTALITY AND MORBIDITY

During the 20 years since ICPD, important steps have been taken to reduce maternal mortality and morbidity. A fundamental shift has occurred in the international community's approach: whereas maternal mortality and morbidity were previously thought to be solely within the realm of health care, they are now recognized as human rights issues involving the right to nondiscrimination and other human rights deprivations, and the need for enhanced government accountability. It is widely accepted that maternal mortality is generally preventable and that states have an affirmative obligation to prevent it.[1] Alongside these changes, the annual number of maternal deaths decreased by 47 percent worldwide between 1990 and 2010.[2] Over 70 percent of maternal deaths worldwide result from severe bleeding, high blood pressure, infection, unsafe abortion, and prolonged or obstructed labor; these causes are generally preventable if they are identified and properly managed in a timely manner.[3]

Despite these advancements, many challenges remain in the effort to decrease maternal mortality and morbidity. Regional disparities in maternal mortality rates persist: developing countries are burdened with 99 percent of maternal deaths worldwide, with the majority occurring in sub-Saharan Africa and roughly one-third in South Asia.[4] Additionally, between 14 and 15 million adolescents give birth each year,[5] more than 90 percent of whom are in developing countries.[6] Adolescents between 15-19 years old face twice the risk of dying during pregnancy or childbirth as compared to women more than 20 years old, while adolescents under the age of 15 face five times the risk.[7]

Many women still face significant and often fatal obstacles in accessing maternal health care, including delays in seeking care, reaching health care facilities, and receiving treatment.[8] Human rights-based strategies to reduce maternal mortality promote increased access to comprehensive sexual and reproductive health information and services including contraception, pre-natal care, safe abortion, and post-abortion care, as well as ensure that women and girls who are in elevated situations of vulnerability or marginalization are given special consideration.

Maternal Mortality and Morbidity in the ICPD Programme of Action

The ICPD Programme of Action recognizes that women have the "right of access to appropriate health-care services that will enable [them] to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[9] The ICPD Programme of Action recognizes that a number of factors, including unsafe abortion, result in elevated maternal mortality rates[10] and that the majority of maternal deaths occur in developing countries.[11] It also recognizes that education, nutrition, prenatal care, emergency obstetric care, delivery assistance, post-natal care, and family planning are all critical components for reducing maternal mortality.[12] The ICPD Programme of Action's targets for the reduction of maternal mortality[13] were integrated into the Millennium Development Goals (MDGs), wherein countries agreed to reduce their 1990 maternal mortality rates by 75 percent by 2015. While countries have made progress, the reduction of maternal mortality is one of the MDGs that is least likely to be attained, as only 13 countries are poised to reach the targeted reductions by 2015.[14] In the ICPD Programme of Action, states agreed to reduce country-level disparities in maternal mortality based on geographic, socioeconomic, and ethnic differences.[15]

To reduce maternal deaths, states agreed that they should pay greater attention to preventing unwanted pregnancies and ensuring that diagnosis and treatment for complications of abortion are always available.[16] To this effect, states should integrate the provision of family planning information and services into maternal mortality reduction programs[17] and, where legal, abortion should always be safe.[18] States further agreed that women must always have access to humane, quality post-abortion care,[19] and committed to take measures to prevent, identify and manage high-risk pregnancies.[20] Additionally, states agreed that they should pay greater attention to the health needs of adolescents,[21] and provide them with "information, education and counseling to help them delay early family formation, premature sexual activity and first pregnancy."[22]

Human Rights Standards

The human rights framework that has been developed through international human rights treaties and their respective monitoring bodies recognizes that maternal mortality violates the rights to life,[23] health,[24] equality,[25] and non-discrimination.[26] The UN Human Rights Council has passed multiple resolutions declaring maternal mortality a human rights violation and urged states to renew their emphasis on its prevention.[27] Treaty monitoring bodies have consistently linked elevated rates of maternal mortality to lack of comprehensive reproductive health services,[28] restrictive abortion laws,[29] unsafe or illegal abortion,[30] adolescent childbearing,[31] child and forced marriage,[32] and inadequate access to contraceptives.[33] In the landmark case of *Alyne da Silva Pimentel v. Brazil*, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) ruled that states must provide adequate interventions to prevent maternal mortality, including appropriate maternal health services that meet the distinct needs of women[34] and are inclusive of marginalized sectors of society.[35] As the provision of maternal health care is recognized by human rights bodies as rising to the level of a core obligation, states must take steps to ensure safe pregnancy and childbirth, despite any economic challenges they may face.[36]

In addition to the ICPD Programme of Action's recognition of the need to ensure access to comprehensive reproductive health services and prevent unsafe abortions, UN treaty monitoring bodies require states to develop comprehensive policies and programs to reduce their maternal mortality rates,[37] and ensure access to birth assistance,[38] prenatal care,[39] emergency obstetric care,[40] and quality care for complications resulting from unsafe abortions.[41] Treaty monitoring bodies have urged states to remove barriers to reproductive health care, such as high costs,[42] and ensure that essential medicines for pregnancy-related complications are registered and available.[43] States must address the underlying determinants of healthy pregnancy, including potable water, adequate nutrition, education, sanitation, and transportation.[44] The CEDAW Committee has made clear that states must take measures to ensure that the life and health of the woman are prioritized over protection of the fetus.[45]

Treaty monitoring bodies have indicated that states should take targeted measures to address maternal mortality in especially vulnerable groups that have disproportionately elevated rates of maternal mortality and face additional obstacles in accessing reproductive health care, including young,[46] poor,[47] rural,[48] minority,[49] and indigenous women,[50] and migrant workers.[51]

Country Examples:

Armenia

Facing a maternal mortality rate much higher than the European average,[52] Armenia has taken targeted measures in order to reduce maternal mortality including promoting the maternal health of marginalized groups such as adolescents and rural women. In 2008, Armenia nearly doubled financing for perinatal services and launched an initiative guaranteeing women free birth-related services.[53] Furthermore, Armenia provided enhanced monetary incentives to service providers, which reduced informal payments by women.[54] Armenia also introduced traveling gynecologist teams and emergency obstetric care mobile teams to promote maternal health in inaccessible regions, including remote, rural, and impoverished areas.[55]

India

In 2008, the High Court of Delhi found failures in India's maternal health services to be in violation of the rights to life and health, as protected by national and international law, when two women were denied government-supported services. As a result, one woman was forced to give birth under a tree without a skilled birth attendant present and the other woman died in a preventable maternal death.[56] The court ordered the state to improve access to maternal health care,[57] including ensuring transportation to health facilities[58] and access to maternal health services for women who travel across state lines,[59] and enhancing monitoring of maternal health policies.[60] The court also ordered the government to pay reparations to the victims and their families.[61]

Nepal

Nepal reduced its 1990 maternal mortality rate by three-quarters by 2010.[62] Nepal's success in reducing maternal deaths can be attributed in large part to increasing access to skilled birth attendants. In 2006, only 19 percent of births were assisted by a skilled birth attendant; by 2011, the rate had nearly doubled to 36 percent.[63] Nepal's National Policy on Skilled Birth Attendants set forth short-, medium- and long-term training and deployment strategies for skilled birth attendants nationwide, including a licensing program to ensure they had the proper skills.[64] Additionally, Nepal's revision of its abortion law in 2002, which went from a total ban on abortion to permitting abortion without restriction as to reason during the first 12 weeks of a pregnancy and thereafter under certain circumstances, has contributed significantly to reducing maternal deaths from unsafe abortion.[65]

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1 *See* UN Department of Public Information, We Can End Poverty 2015 Millennium Development Goals: Goal 5: Improve Maternal Health (2010); Office of the United Nations High Commissioner for Human Rights, *Technical guidance on the application of human rights-based approach to implementation of policies and programmes to reduce preventable maternal morbidity and mortality,* U.N. Doc. A/HRC/21/22 (July 2, 2012).

2 World Health Organization (WHO), UNICEF, United Nations Population Fund (UNFPA) & The World Bank, Trends In Maternal Mortality: 1990 TO 2010, 1 (2012) [hereinafter Trends In Maternal Mortality]; *See also* Rafael Lozano et al., *Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis, 378 The Lancet 1139 (2011) [hereinafter Progress towards Millennium Development Goals 4 and 5].*

3 *Rep. of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights,* para. 6, U.N. Doc. A/HRC/14/39 (Apr. 16, 2010); WHO, Maternal Mortality: Fact Sheet No. 348 (2012).

4 WHO, Maternal Mortality: Fact Sheet No. 348 (2012).

5 WHO & UNFPA, Pregnant Adolescents: Delivering on Global Promises of Hope 4 (2006).

6 *Id.* at 8.

7 U.N. Secretary-General, *We the Children: End-decade review of the follow-up to the World Summit for Children,* para. 181, U.N. Doc. A/S-27/3 (May 4, 2001).

8 Paul Hunt & Judith Bueno de Mesquita, Human Rights Centre, University of Essex, Reducing Maternal Mortality: The Contribution of the right to the highest attainable standard of health (2010).

9 *Programme of Action of the International Conference on Population and Development,* Cairo, Egypt, Sept. 5-13, 1994, para. 7.2, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].

10 *Id.* para. 8.19.

11 *Id.* ("At the global level, it has been estimated that about half a million women die each year of pregnancy-related causes, 99 per cent of them in developing countries.").

12 *Id.* para. 8.22.

13 *Id.* para. 8.21.

14 *See Progress towards Millennium Development Goals 4 and 5*, *supra* note 2, at 1163.

15 *ICPD Programme of Action, supra* note 9, para. 8.21 ("Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed.").

16 *Id.* paras. 7.6, 7.24 & 8.19 ("Greater attention to the reproductive health needs of female adolescents and young women could prevent the major share of maternal morbidity and mortality through prevention of unwanted pregnancies and any subsequent poorly managed abortion.").

17 *Id.* para. 8.25 ("All Governments [should]… reduce the recourse to abortion through expanded and improved family-planning services.") & 8.26 ("Programmes to reduce maternal morbidity and mortality should include information and reproductive health services, including family-planning services. In order to reduce high-risk pregnancies, maternal health and safe motherhood programmes should include counselling and family-planning information.").

18 *Id.* para. 8.25.

19 Key Actions for Further Implementation of the Program of Action of the International Conference on Population and Development, U.N. GAOR, 21st Special Sess., June 30-July 3, 1999, para. 63, U.N. Doc. A/S-21/5/Add.1 (1999); *ICPD Programme of Action*, *supra* note 9, paras. 7.24 & 8.25.

20 *ICPD Programme of Action*, *supra* note 9, para. 8.23.

21 *Id.* para. 8.19.

22 *Id.* para. 8.24.

23 *See, e.g.,* Human Rights Committee (HRC), *Concluding Observations: Mali,* para. 14, U.N. Doc. CCPR/CO/77/MLI (2003).

24 Alyne da Silva Pimentel Teixeira v. Brazil, Committee on the Elimination of Discrimination against Women (CEDAW Committee), Commc'n No. 17/2008, paras. 7.5-7.6, U.N. Doc. CEDAW/C/49/D/17/2008 (2011) [hereinafter Alyne v. Brazil].

25 *See, e.g.,* HRC, *Concluding Observations: Mongolia,* para. 8(b), U.N. Doc. CCPR/C/79/Add.120 (2000); *Peru*, para. 20, U.N. Doc. CCPR/CO/70/PER (2000); *Trinidad and Tobago*, para. 18, U.N. Doc.CCPR/CO/70/TTO (2000).

26 Alyne v. Brazil, *supra* note 24, paras. 7.5-7.6.

27 *See* Human Rights Council Res. 11/8 Preventable maternal mortality and morbidity and human rights, Rep. of the Human Rights Council, 11th Sess., June 2-19, 2009, U.N. Doc. A/HRC/11/37, at 44 (Oct. 16, 2009).

28 CEDAW Committee, *Concluding Observations: Malawi,* para. 31, U.N. Doc. CEDAW/C/MWI/CO (2006); *Mexico*, para. 32, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); *Morocco, p*ara. 30, U.N. Doc. CEDAW/C/MAR/CO/4 (2008).

29 *See, e.g.,* HRC, *Concluding Observations: Chile*, para. 8, U.N. Doc. CCPR/C/CHL/CO/5 (2007); *Madagascar,* para. 14, U.N. Doc. CCPR/C/MDG/CO/3 (2007); *Panama,* para. 9, U.N. Doc. CCPR/C/PAN/CO/3 (2008).

30 *See, e.g.,* Committee in the Rights of the Child (CRC Committee), *Concluding Observations: Democratic People's Republic of Korea*, para. 50, U.N. Doc. CRC/C/15/Add.239 (2004); *Guatemala*, para. 40, U.N. Doc. CRC/C/15/Add.154 (2001); *Haiti*, para. 46, U.N. Doc. CRC/C/15/Add.202 (2003).

31 *See, e.g.,* CEDAW Committee, *Concluding Observations: Eritrea*, para. 22, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); *Mozambique*, para. 36, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007).

32 *See, e.g.,* CRC Committee, *Concluding Observations: Sudan,* para. 10, U.N. Doc. CRC/C/15/Add.10 (1993).

33 *See, e.g.,* CRC Committee, *Concluding Observations: Chile,* para. 41, U.N. Doc. CRC/S/15/Add.173 (2002).

34 Alyne v. Brazil, *supra* note 24, para.7.6.

35 *Id.* para. 7.7.

36 Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health* (Art. 12), (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at para. 44(a), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*] (noting that the provision of maternal health care arises to the level comparable to that of "core obligations" under human rights treaties).

37 *See, e.g.,* CRC Committee, *Concluding Observations: Côte d'Ivoire*, para. 39, U.N. Doc. CRC/C/15/Add.155 (2001); *Dominican Republic*, paras. 37–38, U.N. Doc. CRC/C/15/Add.150 (2001); *Lesotho*, para. 44, U.N. Doc.CRC/C/15/Add.147 (2001).

38 *See, e.g.,* ESCR Committee, *Concluding Observations: Korea*, para. 44, U.N. Doc. E/C.12/1/Add.95 (2003); *Nepal*, para. 46, U.N. Doc. E/C.12/NPL/CO/2 (2008).

39 CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 31(c), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); ESCR Committee, *Gen. Comment No. 14*, *supra* note 36, para. 14.

40 *See, e.g.,* CEDAW Committee, *Concluding Observations: Burundi*, para. 36, U.N. Doc. CEDAW/C/BDI/CO/4 (2008); *Malawi*, para. 32, U.N. Doc. CEDAW/C/MWICO (2006).

41 *See, e.g.,* CEDAW Committee, *Concluding Observations: Bolivia*, para. 43, U.N.Doc. CEDAW/C/BOL/CO/4 (2008); *Honduras*, para. 25, U.N. Doc. CEDAW/C/HON/CO/6 (2008); *Pakistan*, para. 41, U.N. Doc. CEDAW/C/PAK/CO/3 (2007).

42 *See, e.g.,* HRC, *Concluding Observations: Poland*, para. 11, U.N. Doc. CCPR/C/79/Add.110 (1999).

43 *See, e.g.,* ESCR Committee, *Gen. Comment No. 14*, *supra* note 36, para. 43(d); The WHO Model List of Essential Medicines includes misoprostol for obstetric purposes. WHO, WHO Model List of Essential Medicines 29 (17th List 2011).

44 *See, e.g.,* ESCR Committee, *Gen. Comment No. 14*, *supra* note 36, para. 12(a).

45 L.C. v. *Peru*, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

46 *See, e.g.,* HRC, *Concluding Observations: Ecuador*, para. 11, U.N. Doc. CCPR/C/79/Add.92 (1998).

47 *See, e.g.,* HRC, *Concluding Observations: Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000).

48 *Id.*

49 *See, e.g.,* HRC, *Concluding Observations: Ireland*, paras. 448-449, U.N. Doc. A/55/40 (2000).

50 CRC Committee, *Concluding Observations: Nicaragua,* para. 20(e), U.N. Doc. CRC/C/NIC/CO/4 (2010).

51 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, *adopted* Dec. 18, 1990, G.A. Res. 45/158, U.N. Doc. A/RES/45/158 (1990); CRC Committee, *Concluding Observations: Mexico,* para. 72, U.N. Doc. CRC/C/MEX/CO/3 (2006).

52 WHO, *Maternal and newborn health: Facts and figures,* World Health Organization: Regional Office for Europe, http://www.euro.who.int/en/what-we-do/health-topics/Life-stages/maternal-and-newborn-health/facts-and-figures (last visited May 8, 2013); *Safe Motherhood,* UNFPA: Armenia, http://unfpa.am/en/safe-motherhood (last visited May 8, 2013). Armenia has a maternal mortality rate of 28.5, while the European average is 16.

53 UNFPA, UNFPA submission to the Office of the High Commissioner for Human Rights on the topic of Preventable Maternal Morbidity and Mortality and Human Rights for inclusion into the thematic study on the subject requested by the Human Rights Council Resolution A/HRC/15/17, 8 [hereinafter UNFPA, Submission to OHCHR on Preventable Maternal Morbidity and Mortality] (on file at the Center for Reproductive Rights).

54 *Id.* at 8.

55 *Id.* at 8-9.

56 Consolidated Decision, *Laxmi Mandal v. Deen Dayal Harinagar Hospital &Others,* W.P. (C) No. 8853/2008 & *Jaitun v. Maternal Home MCD, Jangpura & Others,* W.P. (C) Nos. 8853 of 2008 & 10700 of 2009 (Delhi High Court, 2010), paras. 28-29 [hereinafter Consolidated Decision, *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Jaitun v. Maternal Home MCD*].

57 *Id.* para. 62(i)-(iii).

58 *Id.* para. 62(v).

59 *Id.* para. 62(viii).

60 *Id.* para. 62(vii).

61 *Id.* para. 51-61.

62 Trends in Maternal Mortality, *supra* note 2, at 25.

63 Government of Nepal, United Nations Country Team of *Nepal*, *Nepal* Millennium Development Goals: Progress Report 2010, 48 (2010); Population Division, Ministry of Health and Population, Government of Nepal et al., Nepal Demographic and Health Survey 2011, 128 (2012).

64 Government of Nepal, National Policy on Skilled Birth Attendants: Supplement to Safe Motherhood Policy 1998 (2006).

65 Guttmacher Institute, Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies 27, 30 (2012).

Over the past two decades, the percentage of women in developing regions ages 15-49 using contraceptives increased from 52 to 62 percent, while in developed regions, the percentage increased from 68 to 72 percent.[1] Despite these advancements, in developing countries across the globe, 222 million women who desire to avoid pregnancy are either not using any method of contraception or are utilizing traditional methods of contraception, which have high failure rates.[2]

This unmet need for modern methods of contraception prevents women from exercising their reproductive rights, including their rights to health and education.[3] Barriers to accessing contraceptives disproportionately impact vulnerable and marginalized populations, such as adolescents, minorities, indigenous communities, and persons with disabilities, as services are not designed to ensure accessibility for persons belonging to these groups.[4] In many countries, restrictive abortion laws mean that an unwanted pregnancy inevitably results in carrying the pregnancy to term or the woman risking her health and life to seek out an unsafe, clandestine abortion. Additionally, when women have access to contraception, they can space their pregnancies and childbirths, which studies demonstrate leads to healthier pregnancies.[5] Lack of access to condoms also leaves women unable to protect themselves against sexually transmitted infections, including HIV.[6]

Certain groups, such as unmarried women and adolescents, may face particular obstacles in accessing contraceptive information and services, based on the notion that they should not be sexually active. Furthermore, coercive policies and practices such as forced sterilization, which were prominent in the past and continue to be practiced today,[7] violate numerous human rights and disproportionately affect members of vulnerable groups such as the poor, people with disabilities, ethnic and racial minorities, and women living with HIV.[8]

Contraceptive Information and Services in the ICPD Programme of Action

The ICPD Programme of Action recognizes that "reproductive rights… rest on the recognition of the basic right 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."[9] To effectuate this, states agreed that individuals must have access to a variety of safe, quality, effective, affordable, convenient, and acceptable methods of family planning.[10] The ICPD Programme of Action recognizes the unmet need for contraceptives worldwide,[11] and states committed to providing universal access to a full a range of contraceptives by 2015.[12] Millennium Development Goal 5B aims to achieve universal access to reproductive health; contraceptive prevalence is one of the indicators for determining the attainment of this goal.[13]

States also committed to ensuring that family planning programs abide by human rights norms and ethical and professional standards.[14] To this end, the provision of contraceptive services must be free from coercion and discrimination,[15] ensure informed decision making,[16] respect privacy[17] and confidentiality,[18] and respect the dignity of all persons.[19] States should use all available means to ensure that voluntariness is at the foundation of all family planning programs.[20] The ICPD Programme of Action recognizes that government schemes designed as either incentives or disincentives to individuals and families about whether to have children have been ineffective and counterproductive[21] and that demographic goals, such as targets or quotas, should not be imposed on family planning providers.[22] Furthermore, states agreed to "identify and remove all the major remaining barriers to the utilization of family-planning services"[23] including "unnecessary legal, medical, clinical and regulatory barriers."[24]

Human Rights Standards

Treaty monitoring bodies have repeatedly recognized the correlation between unmet need for contraceptives and elevated rates of teenage pregnancy,[25] abortion,[26] and maternal mortality.[27] In accordance with human rights principles, a woman's right to decide on the number and spacing of her children incorporates the right to have the information and resources to do so,[28] including access to sexuality education and family planning services.[29] States must ensure access to medications on the

WHO Essential Medicines List, including hormonal contraception and emergency contraception.[30] States should implement programs to guarantee access to a full range of high-quality family planning services and contraceptives,[31] and long-term forms of contraception, such as sterilization.[32] Building upon the ICPD Programme of Action's recognition of the need to eliminate all obstacles to accessing contraception, treaty monitoring bodies have elucidated that such obstacles include high costs,[33] marital status requirements,[34] third-party authorization,[35] and parental consent.[36] Treaty monitoring bodies have framed such obstacles as potentially violating the rights to non-discrimination[37] and health.[38]

To comply with their human rights obligations, states should take measures to ensure vulnerable groups, such as adolescents and women and girls in rural and impoverished areas, can access contraception.[39] Confidential and child-sensitive counseling services should also be implemented,[40] and adolescents should have access to information and medical services without parental consent, in accordance with their maturity.[41]

Treaty monitoring bodies have made clear that states must take measures to ensure that the use of contraceptives is voluntary and fully informed.[42] Forced and coerced sterilization of women violates the rights to non-discrimination; health; determine the number and spacing of one's children; and be free from cruel, inhuman, and degrading treatment.[43] Instances of involuntary sterilization should be investigated and prosecuted,[44] and redress, including compensation, should be provided to people who are forcibly sterilized.[45] States should provide training on patients' rights in order to prevent involuntary sterilizations.[46] Preventative measures should be implemented in order to prevent involuntary sterilization of groups that have been targeted by involuntary sterilization, including women with disabilities, indigenous women, and ethnic minorities.[47] Treaty monitoring bodies have recognized that women in these groups may face multiple forms of discrimination and have advised states to adopt comprehensive strategies to address this.[48]

Country Examples:

Guatemala

In April 2006, Guatemala adopted the Law on Universal and Equitable Access to Family Planning Services,[49] which guarantees universal access to family planning services, including contraception, information, counseling, and sexual and reproductive health education.[50] The law establishes measures for service provision of contraception in both public and private health facilities, particularly aiming to ensure contraceptive access to adolescents, geographically isolated populations, underserved populations, and rural communities.[51] The law also requires voluntary, informed consent for contraception, requiring that its use should never be induced or coerced.[52] The legislation requires that national surveys be utilized in order to identify unmet need for family planning and to inform how the need will be met.[53] The law also establishes a strategy designed to expand services to adolescents and mandates sexuality and reproductive health education in both primary and secondary schools.[54]

Namibia

In 2012, the Namibian High Court decided the case of *L.M. and Others v. the Government of the Republic of Namibia*, wherein it ruled that medical practitioners in state-run hospitals involuntarily sterilized three women living with HIV.[55] While all three women in this case signed consent forms for sterilization, the court determined that they did so without the necessary information to make an informed decision, as they did not receive adequate counseling and one was told that medical treatment would be withheld if she did not sign the consent form.[56]

Philippines

In 2012, the Philippines passed the Responsible Parenthood and Reproductive Health Act of 2012, which guarantees the country's poorest women universal and free access to modern contraceptives at government health centers.[57] The law prohibits and includes sanctions for providers who knowingly withhold or restrict dissemination of information on

reproductive services and programs, as well as for those who intentionally disseminate incorrect information.[58] Furthermore, the law prohibits and sanctions providers who refuse to provide reproductive health care based on lack of spousal consent.[59]

United States

In 2010, the United States passed the Patient Protection and Affordable Care Act, which greatly expanded women's access to preventive health care, including contraceptives, without cost-sharing requirements such as co-payments or deductibles.[60] In accordance with the law, most employers are required to include contraception for their employees under their insurance schemes.[61] This provision ensures that women who are insured are able to afford contraceptives and, therefore, are better equipped to plan the number and spacing of their children.

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1 United Nations, The Millennium Development Goals Report 2012, 35 (2012) (These percentages reflect the increase from 1990-2010.).
2 Susheela Singh & Jacqueline E. Darroch, Guttmacher Institute, Adding It Up: Costs and Benefits of Contraceptive Services – Estimates for 2012, 1 (2012).
3 Human Rights Committee (HRC), *Concluding Observations: Hungary*, para. 11, U.N. Doc. CCPR/CO/74/HUN (2002) ("The State party should take steps to protect women's life and health, through more effective family planning and contraception (art. 6)."); Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Chile*, para. 28, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012) (expressing concern about pregnant adolescents being expelled from school); Dianne Hubbard, *Realising the right to education for all: School policy on learner pregnancy in Namibia, in* Children's Rights in Namibia, 223 (Oliver C Ruppel ed., 2009).
4 Center for Reproductive Rights, The Right to Contraceptive Information and Services for Women and Adolescents 10-11 (2010). *See* Individuals Belonging to Marginalized and Underserved Populations Fact Sheet for more information on the barriers faced by marginalized and underserved populations.
5 *See* Mayo Clinic Staff, *Family Planning: Get the facts about pregnancy spacing,* Mayo Clinic (May 27, 2011), http://www.mayoclinic.com/health/family-planning/MY01691.
6 *HIV/AIDS: Condoms for HIV prevention,* World Health Organization, http://www.who.int/hiv/topics/condoms/en/index.html (last visited May 8, 2013).
7 Coercive population policies and practices include measures that deprive women of their right to determine the number and spacing of their children in a voluntary and informed manner. This may include laws restricting the number of children a woman may have, sterilization campaigns targeting particular groups of women, and mandating or incentivizing reproductive health service providers to fulfill quotas for sterilizations, amongst others. *See, e.g.,* María Chávez v. *Peru*, Case 12.191, Inter-Am. Comm'n H.R., Report No. 71/03, OEA/Ser.L/V/II.118, doc. 70 rev. 2 (2003) [hereinafter María Chávez v. *Peru*]; Open Society Foundations, Against Her Will: Forced and Coerced Sterilization of Women Worldwide (2011) [hereinafter Against Her Will]; V.C. v. *Slovakia*, No. 18968/07 Eur. Ct. H.R. (2011) [hereinafter V.C. v. *Slovakia*].
8 *See* Against Her Will, *supra* note 7; María Chávez v. Peru, *supra* note 7; V.C. v. *Slovakia*, No. 18968/07 Eur. Ct. H.R. (2011); F.S. v. *Chile*, Inter-Am. C.H.R., pending admissibility (petition filed Feb. 3, 2009).
9 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 7.3 & Principle 8, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].
10 *Id.* paras. 7.2, 7.5(a), 7.12 & 7.14(c).
11 *Id.* para. 7.13.
12 *Id.* para. 7.16.
13 *Official list of MDG indicators,* Millennium Development Goals Indicators: The official United Nations site for the MDG Indicators (Jan. 15, 2008), http://mdgs.un.org/unsd/mdg/host.aspx?Content=indicators/officiallist.htm.
14 *ICPD Programme of Action*, *supra* note 9, para. 7.17.
15 *Id.* para. 7.3 & Principle 8.
16 *Id.* para. 7.12.
17 *Id.* para. 7.23(c).
18 *Id.* para. 7.14(c).
19 *Id.* para. 7.14(a).
20 *Id.* para. 7.15.
21 *Id.* para. 7.12.
22 *Id.*
23 *Id.* para. 7.19.
24 *Id.* para. 7.20.
25 CEDAW Committee, *Concluding Observations: Indonesia,* para. 37, U.N. Doc. CEDAW/C/IDN/CO/5 (2007) ("The Committee also recommends that measures be taken to guarantee effective access of women and girls to information and services regarding sexual and reproductive health and contraception in order to reduce the rate of unsafe abortions and teenage pregnancy.").
26 HRC, *Concluding Observations: Albania*, para. 14, U.N. Doc. CCPR/CO/82/ALB (2004); *Equatorial Guinea*, para. 9, U.N. Doc. CCPR/CO/79/GNQ (2004).
27 HRC, *Concluding Observations: Democratic Republic of Congo*, para. 14, U.N. Doc. CCPR/C/COD/CO/3 (2006); *Hungary*, para. 11, U.N. Doc. CCPR/CO/74/HUN (2002).
28 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, art. 16, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981).
29 CEDAW Committee, *General Recommendation No. 21: Equality in marriage and family relations*, (13th Sess., 1994), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at para. 22, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).
30 Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 12(a), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*]; World Health Organization, Model List of Essential Medicines, sec. 18.3 Contraceptives (17th List 2011).
31 ESCR Committee, *Gen. Comment No. 14*, *supra* note 30, para. 14.

32 *See* Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Costa Rica*, para. 64(e), U.N. Doc. CRC/C/CRI/CO/4 (2011) (recommending the State "Ensure that girls and adolescents have free and timely access to emergency contraception and raise awareness among women and girls about their right to emergency contraception, particularly in cases of rape."). *See also* Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover – Addendum – Mission to Poland*, para. 85(h), U.N. Doc. A/HRC/14/20/Add.3 (May 20, 2010) (urging the State to allocate sufficient public health funds for sterilization procedures and other modern methods of contraception).
33 *See, e.g.,* CEDAW Committee, *Concluding Observations: Hungary*, para. 254, U.N. Doc. A/51/38 (1996); *Slovakia*, para. 28, U.N. Doc. CEDAW/C/SVK/CO/4 (2008); *see also* HRC, *Concluding Observations: Poland*, para. 9, U.N. Doc. CCPR/CO/82/POL (2004).
34 *See* CEDAW Committee, *Concluding Observations: Mauritius*, para. 211, U.N. Doc. A/50/38 (1995).
35 CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 14, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].
36 *Id.* para. 14.
37 *See, e.g.,* HRC, *Concluding Observations: Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000); *Poland*, para. 11, U.N. Doc. CCPR/C/79/Add.110 (1999).
38 CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 35, para. 14.
39 CEDAW Committee, *Concluding Observations: Panama*, para. 43, U.N. Doc. CEDAW/C/PAN/CO/7 (2010) ("The Committee urges the State party to improve access to health services for all women and in particular for the most vulnerable groups of women, such as indigenous, Afro- and Asian-descendant women."); CRC Committee, *Concluding Observations: India*, para. 15, U.N. Doc. CRC/C/15/Add.115 (2000) ("The Committee recommends that the State party strengthen the existing National Reproductive and Child Health programme, targeting the most vulnerable groups of the population.").
40 *See* CRC Committee, *Concluding Observations: Oman*, para. 50, U.N. Doc. CRC/C/OMN/CO/2 (2006); *Russian Federation*, para. 56, U.N. Doc. CRC/C/RUS/CO/3 (2005).
41 CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 35, para. 14; CRC Committee, *Concluding Observations: Austria*, para. 15, U.N. Doc. CRC/C/15/Add.98 (1999); *Bangladesh*, para. 60, U.N. Doc. CRC/C/15/Add.221 (2003); *Barbados*, para. 25, U.N. Doc. CRC/C/15/Add.103 (1999).
42 *See* HRC, *Concluding Observations: Slovakia*, para. 12, U.N. Doc. CCPR/CO/78/SVK (2003); CEDAW Committee, *Concluding Observations: Chile*, para. 35(b), U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012).
43 *See* A.S. v. Hungary, CEDAW Committee, Commc'n No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (2006); HRC, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, (68th Sess., 2000), in Compilation of General Comments and Recommendations Adopted by Human Rights Treaty Bodies, at 228, para. 20, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); Committee against Torture (CAT Committee), *Concluding Observations: Czech Republic*, paras. 12-13, U.N. Doc CAT/C/CZE/CO/4-5 (2012).
44 CEDAW Committee, *Concluding Observations: China*, para. 32, U.N. Doc. CEDAW/C/CHN/CO/6 (2006); *Czech Republic*, para. 24, U.N. Doc. CEDAW/C/CZE/CO/3 (2006).
45 *See* CEDAW Committee, *Concluding Observations: Czech Republic*, para. 24, U.N. Doc. CEDAW/C/CZE/CO/3 (2006); HRC, *Concluding Observations: Japan*, para. 31, U.N. Doc. CCPR/C/79/Add.102 (1998); *Slovakia*, para. 12, U.N. Doc. CCPR/CO/78/SVK (2003).
46 CEDAW Committee, *Concluding Observations: Czech Republic*, para. 24, U.N. Doc. CEDAW/C/CZE/CO/3 (2006).
47 *See* CRC Committee, *General Comment 9: The Rights of Children with Disabilities*, (43rd Sess., 2006), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 60, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); ESCR Committee, *Concluding Observations: China (including Hong Kong and Macao)*, para. 36, U.N. Doc. E/C.12/1/Add/107 (2005).
48 CRC Committee, *Concluding Observations: Philippines,* para. 21, U.N. Doc. CRC/C/15/Add.259 (2005); *Singapore*, para. 30(b), U.N. Doc. CRC/C/SGP/CO/2-3 (2011).
49 *Decreto No. 87-2005, Ley de Acceso Universal y Equitativo de Servicios de Planificación Familiar y suintegración en el Programa Nacional de Salud Sexual y Reproductiva* [Law on Universal and Equal Access to Family Planning Services and its Integration into the National Program on Sexual and Reproductive Health], DIARIO DE CENTRO AMÉRICA, No. 17, Apr. 27, 2006 (Guat.).
50 *Id.* Preamble & art. 1.
51 *Id.* arts. 2-3, 5-6 & 9.
52 *Id.* art. 13.
53 *Id.* art. 5.
54 *Id.* art. 10.
55 L.M. and Others v. the Government of the Republic of Namibia,1603/2008, 3518/2008, 3007/2008 (High Court of Namibia, July 30, 2012), para. 80.
56 *Id.* para. 40.
57 Act Providing for a National Policy on Responsible Parenthood and Reproductive Health, Rep. Act No. 10354, § 2 (Dec. 21, 2012) (Phil.).
58 *Id.* §§ 23-24.
59 *Id.*
60 Guttmacher Institute, New Federal Protections Expand Coverage Without Cost-Sharing Of Contraceptives and Other Women's Preventive Services (2011).
61 *Id.*

III. ABORTION

Since the adoption of the ICPD Programme of Action, over 30 countries worldwide have liberalized their abortion laws, broadening the grounds under which women can access legal abortion and abolishing laws criminalizing women for having abortions.[1] Importantly, a number of these liberalizations have been in Latin America and Africa, two regions where highly restrictive abortion laws are pervasive.[2] As the World Health Organization (WHO) has recognized, restrictive abortion laws do not reduce the number of abortions—instead, they force women to seek out clandestine and unsafe abortions, which jeopardize their lives and their health.[3] Today, unsafe abortion still accounts for roughly 13 percent of maternal mortalities,[4] resulting in approximately 47,000 maternal deaths from unsafe abortion annually worldwide.[5] In some countries, the percentage of maternal deaths resulting from unsafe abortion is much higher, accounting for upwards of 30 percent.[6]

Globally, approximately 61 percent of the world's population lives in countries where abortion is permitted without restriction as to reason or on broad socioeconomic grounds. The remaining 39 percent of the global population lives in countries with restrictive abortion laws that either do not permit abortion at all or only permit abortion under limited circumstances, such as when the pregnancy poses a risk to the woman's life or health, or in instances of rape, incest, or fetal impairment. Notably, only a few countries have restricted their abortion laws to eliminate all exceptions to abortion, making abortion illegal even when the pregnancy poses a risk to the woman's life.

Even when abortion is legal, there remain barriers to women's access to safe abortion services. The WHO recognizes that laws and policies that require women to obtain parental or spousal consent, undergo mandatory delays or ultrasounds, or receive mandatory or directive counseling prior to undergoing an abortion are medically unnecessary and hinder women's access to safe abortion services.[7] The WHO has made clear that women must be provided complete, accurate, and understandable information about their pregnancies and safe abortion services, including prenatal diagnostic testing, to enable them to make informed, autonomous decisions about pregnancy.[8] Furthermore, the WHO also recognizes that the lack of legal clarity when a state permits abortion only under certain circumstances and the lack of implementation of abortion protocols further prevent women from accessing safe abortion services.[9] Finally, the WHO also notes that stigma surrounding abortion prevents women from accessing information about legal abortion and can deter women from seeking post-abortion care when they face complications arising from unsafe abortions.[10] All of these barriers inhibit women from exercising their right to reproductive autonomy and contribute to elevated levels of maternal mortality and morbidity.

Abortion in the ICPD Programme of Action

In the ICPD Programme of Action, states agreed that where abortion is legal, it should be safe and accessible through the primary health care system.[11] The ICPD Programme of Action recognizes that unsafe abortion is a leading cause of maternal mortality and morbidity, with harmful effects on women and their families.[12] States committed "to reduce greatly the number of deaths and morbidity from unsafe abortion,"[13] and to take measures to prevent unsafe abortion, such as by expanding and improving family planning services.[14] Particular attention should be paid to adolescents and young women in the provision of programs to prevent unwanted pregnancies and treat unsafe abortions.[15] Finally, under the ICPD Programme of Action, states agreed that "[i]n all cases, women should have access to quality services for the management of complications arising from abortion" and "[p]ost-abortion counselling, education and family-planning services should be offered promptly."[16]

Human Rights Standards

Since ICPD, the international human rights standards have substantially strengthened and expanded states' human rights obligations regarding abortion. Treaty monitoring bodies have clearly elucidated the connection between restrictive abortion laws and high rates of unsafe abortion and maternal mortality.[17] They have repeatedly condemned absolute bans on abortion as being incompatible with international human rights norms[18] and have urged states to eliminate punitive measures for women and girls who undergo abortions and for health care providers who deliver abortion services.[19]

III. ABORTION (continued)

Treaty monitoring bodies have called on states to decriminalize and ensure access to abortion, at a minimum, when the pregnancy poses a risk to the woman's life or health, when the pregnancy results from rape or incest, and when there is a severe fetal abnormality.[20] Human rights bodies have clearly indicated that denying women access to abortion in such instances violates the rights to health,[21] privacy,[22] and to be free from cruel, inhumane and degrading treatment.[23] The Human Rights Committee has indicated that these limited exceptions may be insufficient to guarantee women's human rights, urging a state with such exceptions to further liberalize its abortion law.[24] Treaty monitoring bodies have urged states to interpret exceptions to restrictive abortion laws broadly to incorporate, for example, mental health conditions as a threat to their health.[25]

Human rights bodies have noted that where abortion is legal, states must ensure that it is available, accessible (including affordable), acceptable, and of good quality.[26] They have also urged states to abolish barriers to accessing safe abortion services, such as third-party authorization requirements, including spousal authorization,[27] and to enact clear guidelines on the conditions under which abortion is legal.[28] Human rights standards dictate that states should ensure that women's access to and the availability of abortion is not hindered by conscientious objection[29] by monitoring its practice[30] and implementing mechanisms to ensure that women systematically receive timely referrals to another service provider.[31] States should also take measures to address the sociocultural factors which lead to son preferences and sex-selective abortion.[32] Despite the legal status of abortion, human rights bodies have made clear that states must ensure women receive confidential and adequate post-abortion care.[33] Post-abortion care must not be conditioned upon admissions by women that will be used to prosecute them for undergoing the procedure illegally, as this may amount to cruel, inhuman, and degrading treatment.[34]

Country Examples:

Colombia

In May 2006, the Colombian Constitutional Court issued a groundbreaking decision declaring that women have a right to terminate a pregnancy when it poses a risk to the woman's life or health; when the fetus suffers from severe impairment, causing it to be nonviable; and when the pregnancy results from rape, incest, or involuntary artificial insemination.[35] Prior to this decision, Colombia's abortion law banned abortion in all circumstances without any explicit exceptions.[36] The court stated that "a criminal law that prohibits abortion in all circumstances extinguishes the woman's fundamental rights, and thereby violates her dignity by reducing her to a mere receptacle for the fetus, without rights or interests of constitutional relevance worthy of protection."[37]

France

In 1988, France became the first country to license the use of medical abortions,[38] wherein women are administered medications to induce abortion instead of undergoing surgery.[39] Medical abortions have a number of advantages over surgical abortions, as they are less invasive, do not require anesthesia, and may be administered at home.[40] Studies indicate that many women view medical abortion at home as more confidential, comfortable, and convenient.[41] In 2001, France's Agence Nationale d'Accréditation et d'Évaluation en Santé (ANAES) issued guidelines establishing that medical abortions may be administered by women in their homes, or wherever they feel most comfortable, after receiving counseling and the medication from a physician.[42] The guidelines also recognize that when possible, women should be given the choice between medical or surgical abortion. Additionally, in 2013, the French health care system began covering the full cost of abortion—previously only 70 to 80 percent was covered[43]—noting that it deemed this step to be critical to ensure all women access to abortion services.[44]

South Africa

Prior to November 1996, South Africa permitted abortion only when there was a threat to a woman's life or in the cases of rape, incest, or fetal impairment. With the passage of the Choice on Termination of Pregnancy Act abortion became legal without restriction as to reason during the first 12 weeks of pregnancy.[45] From week 12 to 20, abortion is permissible if a

physician certifies that the pregnancy poses a risk to the woman's physical or mental health, in cases of severe fetal impairment, if the pregnancy results from rape or incest, or if continuing the pregnancy would significantly affect the woman's economic or social circumstances.[46] After the 20th week, abortion is available if two health care providers determine that the pregnancy threatens the woman's life, would result in a severe malformation of the fetus or would pose a risk of injury to the fetus.[47] The law also importantly grants minors the right to abortion without parental or guardian consent,[48] and requires that counseling on abortion be non-mandatory and non-directive.[49] A study on the impact of the Choice on Termination of Pregnancy Act found that abortion-related maternal deaths decreased by 91 percent following the law's implementation.[50]

Uruguay

In 2012, Uruguay approved a new law permitting abortion without restriction as to reason during the first 12 weeks of gestation, and thereafter up to week 14 of gestation when the pregnancy results from rape.[51] Previously, Uruguay permitted abortion only when the pregnancy posed a risk to the woman's life or health and in instances of rape. The change in Uruguay's abortion law was a significant departure from the norm in Latin America and the Caribbean, where abortion without restriction as to reason is only legal in a few countries. Uruguay's new law requires a woman to explain to a gynecologist any economic, social, or family hardship that she would experience if she carried her pregnancy to term and to appear before an interdisciplinary group to receive information about the law, the abortion process, risks of having an abortion, and alternatives to abortion.[52] These requirements are waived if the pregnancy poses a grave risk to the woman's life or health, if it results from rape, and in instances of fetal impairment incompatible with life.[53]

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1 *See* Center for Reproductive Rights, Abortion Worldwide: Seventeen Years of Reform (2011). Since the publication of this document, there have been further liberalizations of a number of abortion laws, including Argentina, Brazil, Lesotho, Luxemburg, Mauritius, Rwanda, and Uruguay. *See also The World's Abortion Laws 2012*, Center for Reproductive Rights (2012), http://worldabortionlaws.com/index.html.

2 *See* World Health Organization (WHO), Safe Abortion: Technical and Policy Guidance for Health Systems 25, Table 1.2 (2012) [hereinafter WHO, Safe Abortion Guidance]. *See also The World's Abortion Laws 2012*, Center for Reproductive Rights (2012), http://worldabortionlaws.com/index.html.

3 WHO, Safe Abortion Guidance, *supra* note 2, at 23; *See also* Guttmacher Institute, Facts on Induced Abortion Worldwide (2012).

4 WHO, Unsafe Abortion: Global and Regional Estimates of the incidence of unsafe abortion and associated mortality in 2008 1 (2011).

5 WHO, Safe Abortion Guidance, *supra* note 2, at 1.

6 Khalid S Khan, et al., *WHO analysis of causes of maternal death: a systematic review,* 367 The Lancet 1066, 1071 (2006).

7 WHO, Safe Abortion Guidance, *supra* note 2, at 34, 36, 78 & 95-97; *see also* Guttmacher Institute, The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review (2009).

8 WHO, Safe Abortion Guidance, *supra* note 2, at 36-37, 93 & 97; *see also* RR v. Poland, Eur. Ct. of Human Rights, App. No. 27617/04 (2011); Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, para. 47, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) (by Juan E. Méndez).

9 *See* WHO, Safe Abortion Guidance, *supra* note 2, at 95; *see also* Guttmacher Institute, Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies (2012) [hereinafter Making Abortion Services Accessible].

10 *See* WHO, Safe Abortion Guidance, *supra* note 2, at 23 & 95.

11 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, paras. 7.6, 8.19, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].

12 *Id*. para. 8.19.

13 *Id*. para. 8.20(a).

14 *Id*. para. 8.52.

15 *Id*. para. 8.19.

16 *Id*. para. 8.25.

17 *See, e.g.,* Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Paraguay*, para. 31(a), U.N. Doc. CEDAW/C/PRY/CO/6 (2011); *Chile*, para. 20, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); Committee on Economic, Social and Cultural Rights (ESCR Committee), *Concluding Observations: Philippines*, para. 31, U.N. Doc. E/C.12/PHL/CO/4 (2008); Human Rights Committee (HRC), *Concluding Observations: Zambia*, para. 18, U.N. Doc. CCPR/C/ZMB/CO/3 (2007).

18 *See, e.g.*, Committee Against Torture (CAT Committee), *Concluding Observations: Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009); HRC, *Concluding Observations: El Salvador*, para. 10, U.N. Doc. CCPR/C/SLV/CO/6 (2010); ESCR Committee, *Concluding Observations: Chile*, paras. 26, 53, U.N. Doc. E/C.12/1/Add.105 (2004).

19 *See, e.g.,* CEDAW Committee, *General Recommendation No. 24*: *Article 12 of the Convention (women and health),* para. 14, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 358 (2008); HRC, *Concluding Observations: Costa Rica*, para. 11, U.N. Doc. CCPR/C/79/Add.107 (1999); Committee on the Right of the Child (CRC Committee), *Concluding Observations: Nicaragua*, para. 59(b), U.N. Doc. CRC/C/NIC/CO/4 (2010); Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, paras. 21, 65(h), U.N. Doc. A/66/254 (2011) (by Anand Grover) [hereinafter Anand Grover 2011].

20 *See, e.g.,* L.C. v. *Peru*, CEDAW Committee, Commc'n No. 22/2009, para. 12(b), U.N. Doc. CEDAW/C/50/D/22/2009 (2011) [hereinafter L.C. v. *Peru*]; CRC Committee, *Concluding Observations: Chad*, para. 30, U.N. Doc. CRC/C/15/Add.107 (1999); *Chile*, para. 56, U.N. Doc. CRC/C/CHL/CO/3 (2007); *Costa Rica*, para. 64(c), U.N. Doc. CRC /C/CRI/CO/4 (2011); HRC, *Concluding Observations: Guatemala*, para. 20, U.N. Doc. CCPR/C/GTM/CO/3 (2012); ESCR Committee, *Concluding Observations: Dominican Republic*, para. 29, U.N. Doc. E/C.12/DOM/CO/3 (2010); *Chile*, para. 53, U.N. Doc. E/C.12/1/Add.105 (2004).

21 LC v. Peru, *supra* note 20, para. 8.15.

22 K.L. v. Peru, HRC, Commc'n No. 1153/2003, para. 7, U.N. Doc. CCPR/C/85/D/1153/2003 (2005) [hereinafter K.L. v. Peru].

23 *Id*. para. 7; L.M.R. v. Argentina, HRC, Commc'n No. 1608/2007, para. 10, U.N. Doc. CCPR/C/101/D/1608/2007 (2011) [hereinafter L.M.R. v. Argentina].

24 HRC, *Concluding Observations: Poland*, para. 8, U.N. Doc. CCPR/CO/82/POL (2004).

25 L.C. v. *Peru*, *supra* note 20, para. 9(b)(i).

26 *See, e.g.,* ESCR Committee, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12),* (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); K.L. v. Peru, *supra* note 22; L.M.R. v. Argentina, *supra* note 23; L.C. v. Peru, *supra* note 20.

27 CEDAW Committee, *Concluding Observations: Kuwait*, para. 43(b), U.N. Doc. CEDAW/C/KWT/CO/3-4 (2011).

28 *See, e.g.,* ESCR Committee, *Concluding Observations: Peru*, para. 21, U.N. Doc. E/C.12/PER/CO/2-4 (2012); CEDAW Committee, *Concluding Observations: Costa Rica*, paras. 32, 33(c), U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011); *Kuwait*, para. 42, 43, U.N. Doc. CEDAW/C/KWT/CO/3-4 (2011).

29 *See, e.g.,* CEDAW Committee, *Concluding Observations: Poland*, para. 25, U.N. Doc. CEDAW/C/POL/CO/6 (2007); Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover – Addendum – Mission to Poland, para. 50, U.N. Doc. A/HRC/14/20/Add.3 (May 20, 2010).

30 *See, e.g.*, CEDAW Committee, *Concluding Observations: Slovakia*, paras. 28, 29, U.N. Doc. CEDAW/C/SVK/CO/4 (2008).

31 *See, e.g., id. para. 29;* ESCR Committee, *Concluding Observations: Poland*, para. 28, U.N. Doc. E/C.12/POL/CO/5 (2009).

32 CRC Committee, *Concluding Observations: India*, paras. 32, 33 & 49, U.N. Doc. CRC/C/15/Add.115 (2000); CEDAW Committee, *Concluding Observations: Paraguay*, paras. 30, 31, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).

33 ESCR Committee, *Concluding Observations: Slovakia*, para. 24, U.N. Doc. E/C.12/SVK/CO/2 (2012); CEDAW Committee, *Concluding Observations: Chile*, para. 20, U.N. Doc. CEDAW/C/CHI/CO/4 (2006).

34 CAT Committee, *Concluding Observations: Chile*, para. 7(m), U.N. Doc. CAT/C/CR/32/5 (2004); *See also* Anand Grover 2011, *supra* note 19, para. 30.

35 Colombia Corte Constitucional [Colombia Constitutional Court], Sentencia C-355/2006 (2006) [hereinafter Sentencia C-355/2006].

36 Código Penal Colombiano (Ley 599 de 2000) [Colombian Penal Code (Law 599 of 2000)], art. 122.

37 Sentencia C-355/2006, *supra* note 35, para. 10.1 ("Ahora bien, una regulación penal que sancione el aborto en todos los supuestos, significa la anulación de los derechos fundamentales de la mujer, y en esa medida supone desconocer completamente su dignidad y reducirla a un mero receptáculo de la vida en gestación, carente de derechos o de intereses constitucionalmente relevantes que ameriten protección."). Translation provided by Women's Link Worldwide, C-355/2006, Excerpts of the Constitutional Court Ruling that Liberalized Abortion in Colombia 48, *available at* http://www.womenslinkworldwide.org/pdf_pubs/pub_c3552006.pdf.

38 Ipas, Medical Abortion – Implications for Africa 2 (2003).

39 Association of Reproductive Health Professionals, Health Matters, *Seeking* Early Abortion Services, *available at* http://www.arhp.org/Publications-and-Resources/Patient-Resources/Fact-Sheets/Early-Abortion.

40 *Id*.; Gynuity, Providing Medical Abortion in Low-resource Settings, An Introductory Guidebook 7 (2nd ed.) (2009).

41 *See Annotated Bibliography - Mifepristone Medical Abortion*, Gynuity Health Projects, http://gynuity.org/resources/read/annotated-bibliography-mifepristone-medical-abortion-en/ (last visited May 13, 2013).

42 Prise en Charge de l'Interruption Volontaire de Grossesse Jusqu'á 14 Semaines, mars 2001, Service des recommandations et références professionnelles, Section IV, *available at* http://www.ancic.asso.fr/textes/ressources/techniques_prise*en*charge.html.

43 Loi n° 2012-1404 du 17 décembre 2012 de financement de la sécurité sociale pour 2013 (1), art. 43. *See also* France 24, French State to Reimburse Abortions by 100%, http://www.france24.com/en/20121003-french-france-state-social-security-reimburse-abortions-100-percent-hospitals-women.

44 Financement de la sécurité sociale pour 2013, Portail du Gouvernement (Oct. 10, 2012), http://www.gouvernement.fr/gouvernement/financement-de-la-securite-sociale-pour-2013.

45 Choice on Termination of Pregnancy Act 1996, Section 2(a) (South Africa).

46 *Id*. Section 2(b).

47 *Id*. Section 2(c).

48 *Id*. Section 5(3).

49 *Id*. Section 4.

50 Making Abortion Services Accessible, *supra* note 9, at 11.

51 Interrupcíon Voluntaria del Embarazo, Ley Nº 18.987 [Voluntary Interruption of Pregnancy, Law No. 18.987], Publicada D.O. 30 oct/012 - Nº 28585, arts. 2 & 6(c) (Uruguay).

52 *Id*. art. 3.

53 *Id*. art. 6.

III. ABORTION (continued)

IV. SEXUAL AND REPRODUCTIVE HEALTH EDUCATION AND INFORMATION

Access to information and education on sexual and reproductive health is critical, enabling all individuals, including adolescents, to protect their health and exercise their sexual and reproductive health and rights. In regards to sexuality education, states often utilize formal school-based programs, although sexuality education should also be provided in different settings as well, since a significant population of adolescents in many areas are not enrolled in school. Sexual and reproductive health information encompasses information available to all individuals both in formal and informal settings.

Every year, adolescents account for 16 percent of all births in sub-Saharan Africa, 12 percent in South Central and Southeast Asia, and 18 percent in Latin America and the Caribbean.[1] Sexuality education enables adolescents and youth to prevent unwanted pregnancies,[2] thereby reducing the health risks associated with unsafe abortions and the negative impact of adolescent pregnancies in the enjoyment of other rights. For instance, adolescent pregnancies and childbirth pose serious health risks,[3] and also may compel girls to drop out of school or result in expulsion by school authorities.[4]

Studies demonstrate that sexuality education can also help adolescents to delay their sexual debut,[5] and prevent sexually transmitted infections (STIs), including HIV.[6] In accordance with the UN Educational, Scientific and Cultural Organization's International Technical Guidance on Sexuality Education, sexuality education should incorporate human rights principles;[7] employ participatory teaching methods; provide evidence-based, scientifically accurate information; address norms about use of condoms and other types of contraception; and cover a range of topics including human sexuality, sexual and reproductive health, human rights, and gender equality.[8] Sexuality education should not reinforce stereotypes or prejudice, and should not include discriminatory information on sexual minorities.[9]

Misinformation on sexual and reproductive health, such as intentionally exaggerated health risks associated with contraception or abortion, also poses a significant barrier to sexual and reproductive health, and may both deter and prevent individuals, including adolescents, from using reproductive health services.[10] Access to information and education on sexual and reproductive health remains hindered due to parental apprehension and resistance to sexuality education, the spread of misinformation and information that is not scientifically based, laws inhibiting access to information, and lack of political will. [11] Furthermore, several states have enacted or attempted to enact laws specifically designed to inhibit access to information on sexual and reproductive health and rights, including laws prohibiting or criminalizing dissemination of sexual and reproductive health information.[12] In addition to preventing individuals from accessing information, such laws stigmatize and may cause a chilling effect on the exercise of sexual and reproductive health and rights.

Sexual and Reproductive Health Education and Information in the ICPD Programme of Action

The ICPD Programme of Action identifies inadequate knowledge about human sexuality and poor-quality reproductive health information as barriers to attaining a state of reproductive health.[13] All couples and individuals have the right to the information and education necessary to make informed decisions about the number and spacing of their children.[14] States agreed that everyone has the right to education, which "should be designed to strengthen respect for human rights and fundamental freedoms, including those related to population and development."[15] Comprehensive reproductive health care includes information, counseling and education on reproductive health and sexuality.[16] Family planning programs should provide accessible, complete and accurate information about "the widest possible range of safe and effective family-planning methods."[17] Furthermore, states committed to remove unnecessary legal, medical and regulatory barriers to information.[18]

Recognizing the needs of adolescents,[19] under the ICPD Programme of Action states agreed to protect and promote adolescents' rights to reproductive health education and information[20] and to guarantee universal access to comprehensive and factual information on reproductive health.[21] The ICPD Programme of Action recognizes the connection between early marriage, adolescent childbearing, and elevated rates of adolescent maternal mortality, and highlights the critical role that education can play in preventing these harms.[22] The provision of information should enable adolescents to make responsible

decisions about their reproductive health, understand their sexuality, and prevent unwanted pregnancies.[23] States agreed to implement educational strategies to ensure that adolescents have access to information about responsible sexual behavior, family planning, reproductive health, and human sexuality.[24] Sexuality education should take place in a number of different settings, including within the family, community, the media, and in schools.[25]

Human Rights Standards

Since ICPD, treaty monitoring bodies have recognized that the right to health extends "to the underlying determinants of health, such as… access to health-related education and information, including on sexual and reproductive health,"[26] and protects the right to seek, receive, and disseminate information on health issues.[27] States must ensure women's access to health care information on an equal basis with men.[28] The right to health requires states to remove all barriers interfering with access to health education and information,[29] including barriers to sexuality education such as parental consent requirements.[30]

Treaty monitoring bodies have recognized that sexuality education contributes to the prevention of HIV/AIDS,[31] teenage pregnancy,[32] unwanted pregnancies,[33] abortions,[34] and maternal death.[35] Treaty monitoring bodies have made clear that states should ensure that all adolescents have access to information on sexual and reproductive health[36] and have reinforced the ICPD Programme of Action's recognition that states should implement sexuality education programs in all schools[37] and in other settings to reach adolescents who are not enrolled in schools.[38] Human rights bodies have noted that sexual and reproductive health information should be comprehensive, unbiased, and scientifically accurate.[39] Sexuality education programs should include information on preventing unwanted pregnancy,[40] sexual and reproductive health and rights,[41] risks of unsafe abortions,[42] the legality of abortion,[43] and preventing STIs, including HIV.[44] Sexuality education should also aim to transform cultural views about adolescents' need for contraception and other taboos regarding adolescent sexuality.[45]

Country Examples:

Colombia

In 2011, a lawsuit was filed against a number of Colombian public officials from the *Procuraduría General de la Nación* alleging violations of women's rights to information, health, and life, amongst others, following the government's distribution of official documents that contained false and misleading statements on sexual and reproductive health.[46] The public officials' statements included a number of falsehoods, such as stating that emergency contraception causes abortions, that health care providers and institutions are entitled to deny women access to legal reproductive health services based on religious or moral objections, and that there is no right to access safe abortion services in Colombia.[47] The Constitutional Court ruled that the officials' dissemination of misinformation violated women's right to access reproductive health services by denying them necessary information. The court noted that access to information is vital for the exercise of reproductive rights "because one of the mechanisms to perpetuate the historical discrimination suffered by women has been and continues to be, precisely, denying and creating obstacles to access to accurate and impartial information in this field."[48] Furthermore, the court found that these acts threatened women's rights to dignity, life, and physical and mental health.[49] The court ordered that the public officials rectify these statements by providing the public with true and accurate information on the various issues about which they had spread falsehoods.[50]

Estonia

In 1996, Estonia established a compulsory, national curriculum on human studies, which includes sexuality education. This educational program is provided in conjunction with youth counseling centers, which provide young people with free counseling on sexual and reproductive health, including safe sex, family planning and STI prevention.[51] The national curriculum and the youth counseling centers are credited with the reduction of HIV and STI rates and increased condom and

contraception use among adolescents.[52] The abortion rate among 15- to 19-year-olds decreased by 45 percent between 2001 and 2009, while the HIV infection rate among 15- to 19-year-olds decreased by 96 percent during the same time period.[53]

Iceland

In Iceland, the Ministry of Education establishes the sexuality education framework, which serves as a regulation which schools must follow in the provision of sexuality education.[54] The framework establishes that sexuality education should cover both biological and psychosocial considerations, including contraception, STIs, equality, gender identity and gender roles.[55] Sexuality education is mandatory, and as such, parents may not opt-out on behalf of their children.[56] In 2011, Iceland earmarked funding specifically for the incorporation of education on sexual assault in school curricula.[57] Under this initiative, students will learn about what constitutes sexual assault, consenting to sexual activity, and how to report sexual violence.[58]

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2 Guttmacher Institute, *Advancing Sexuality Education in Developing Countries: Evidence and Implications,* 14 Guttmacher Policy Review 17, 17 (2011) [hereinafter *Advancing Sexuality Education*] ("There is now clear evidence that sexuality education programs can help young people to delay sexual activity and improve their contraceptive use when they begin to have sex.").

3 Save the Children, Children Having Children: State of the World's Mother 2004, 4 (2004) (indicating that complications arising from pregnancy and child birth are the leading causes of death for 15- to 19-year-old girls in the developing world); United Nations Population Fund (UNFPA), State of the World Population 2004, 76 (2004) (indicating that adolescents between the ages of 15 and 19 have twice the risk of dying due to pregnancy-related complications compared to women in their twenties.).

4 Michelle J. Hindin & Adesegun O. Fatusi, *Adolescent Sexual and Reproductive Health in Developing Countries: In Overview of Trends and Interventions,* 35 International Perspectives on Sexual and Reproductive Health 58, 58 (2009).

5 *Advancing Sexuality Education*, *supra* note 2, at 17 ("There is now clear evidence that sexuality education programs can help young people to delay sexual activity and improve their contraceptive use when they begin to have sex.").

6 *See* World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS) & United Nations Educational, Scientific and Cultural Organization (UNESCO), WHO Information Series on School Health Document Six: Preventing HIV/AIDS/STI and Related Discrimination: An Important Responsibility of Health-Promoting Schools (1999).

7 UNESCO, International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers and health educators – Volume II Topics and learning objectives 17-20 (2009) [hereinafter UNESCO, Technical Guidance on Sexuality Education Volume II].

8 *See, e.g.,* UNESCO, International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers and health educators – Volume I The rationale for sexuality education 18-22 (2009); UNESCO, Levers of Success: Case studies of national sexuality education programmes 20-22 (2010); Commission on Population and Development Res. 2012/1 Adolescents and youth, Rep. of the Commission on Population and Development, 45th Sess., Apr. 15 & Apr. 23-27, 2012, para. 26, U.N. Doc. E/2012/25, E/CN.9/2012/8 (2012).

9 *See* INTERIGHTS v. Croatia, No. 45/2007 European Committee of Social Rights (2009).

10 *See Advancing Sexuality Education, supra* note 2; *see also* Center for Reproductive Rights, Fact Sheet: An International Human Right: Sexuality Education for Adolescents in Schools (2008).

11 For information on the criminalization of access to information *see, e.g.,* Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*, U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover) [hereinafter Anand Grover 2011].

12 *See, e.g., UN rights experts advise Russian Duma to scrap bill on 'homosexuality propaganda'*, United Nations Human Rights: Office of the High Commissioner for Human Rights (Feb. 1, 2013), http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=12964&LangID=E; *Ban on information about homosexuality reintroduced in Lithuanian law. President's draft returned for consideration once again*, ILGA Europe (Feb. 12, 2009), http://www.ilga-europe.org/home/guide/country_by_country/lithuania/lithuania_and_the_law_against_propaganda_of_homosexuality_and_bisexuality/ban_on_information_about_homosexuality_reintroduced_in_lithuanian_law_president_s_draft_returned_for_consideration_once_again.

13 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 7.3, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].

14 *Id.* Principle 8.

15 *Id.* Principle 10.

16 *Id.* para. 7.6.

17 *Id.* paras. 7.23(a) & 7.23 (b).

18 *Id.* para. 7.20.

19 *Id.* para. 7.47.

20 *Id.* para. 7.46.

21 *Id.* para. 7.5(a).

22 *Id.* paras. 6.7(c), 7.42.

23 *Id.* para. 7.41.

24 *Id.* paras. 7.41, 7.47, 6.4, & 7.37.

25 *Id.* para. 7.37.

26 Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*].

27 *Id.* para. 12(b)(iv).

28 Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 9-25, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

29 ESCR Committee, *Gen. Comment No. 14*, *supra* note 26, para. 21.

30 *See* Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Ireland*, para. 52, U.N. Doc. CRC/C/IRL/CO/2 (2006).

31 *See, e.g.,* CEDAW Committee, *Concluding Observations: Dominican Republic*, para. 349, U.N. Doc. A/53/38 (1998); *Togo*, para. 29, U.N. Doc. CEDAW/C/TOG/CO/5 (2006).

32 CEDAW Committee, *Concluding Observations: Chile*, paras. 226–227, U.N. Doc. A/54/38 (1999); *Togo*, para. 29, U.N. Doc. CEDAW/C/TOG/CO/5 (2006).

33 *See, e.g.,* CEDAW Committee, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (1999); *Nepal*, para. 148, U.N. Doc.A/54/38 (1999).

34 CEDAW Committee, *Concluding Observations: Burundi*, para. 62, U.N. Doc. A/56/38 (2001); *Cape Verde*, para. 29, U.N. Doc. CEDAW/C/CPV/CO/6 (2006).

35 *See, e.g.,* CEDAW Committee, *Concluding Observations: Cape Verde*, para. 29, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); *Togo*, para. 28, U.N. Doc. CEDAW/C/TOG/CO/5 (2006).

36 CRC Committee, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child* (33rd Sess., 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 26, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CRC Committee, *Gen. Comment No. 4*]; CRC Committee, *Concluding Observations: Australia*, para. 67, U.N. Doc. CRC/C/AUS/CO/4 (2012); ESCR Committee, *Concluding Observations: Russian Federation,* para. 30, U.N. Doc. E/C.12/RUS/CO/5 (2011).

37 CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 28, para. 23; *see also* CEDAW Committee, *Concluding Observations: Turkmenistan*, paras. 30–31, U.N. Doc. CEDAW/C/TKM/CO/2 (2006); CRC Committee, *Concluding Observations: Uruguay*, para. 52, U.N. Doc. CRC/C/URY/CO/2 (2007); ESCR Committee, *Concluding Observations: The Kingdom of the Netherlands*, para. 27, U.N. Doc. E/C.12/NDL/CO/4-5 (2010).

38 CRC Committee, *Gen. Comment No. 4*, *supra* note 36, para. 28.

39 *See, e.g.,* CEDAW Committee, *Concluding Observations: Eritrea*, para. 23, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); CRC Committee, *Concluding Observations: Antigua and Barbuda,* para. 54, U.N. Doc. CRC/C/15/Add.247 (2004); ESCR Committee, *Concluding Observations: Benin*, para. 42, U.N. Doc. E/C/12/1/Add.78 (2002); Anand Grover 2011, *supra* note 11, para. 65(l); *see also* Special Rapporteur on the right to education, *Rep. of the United Nations Special Rapporteur on the right to education*, U.N. Doc. A/65/162 (July 23, 2010).

40 CEDAW Committee, *Concluding Observations: Belize*, paras. 56–57, U.N. Doc. A/54/38 (1999); *Bosnia and Herzegovina*, para. 36, U.N. Doc. CEDAW/C/BIH/CO/3 (2006).

41 CEDAW Committee, *Concluding Observations: Jamaica*, para. 224, U.N. Doc. A/56/38 (2001); *Nicaragua*, para. 303, U.N. Doc. A/56/38 (2001).

42 CEDAW Committee, *Concluding Observations: Oman*, para. 41(b), U.N. Doc. CEDAW/C/OMN/CO/1 (2011).

43 *See, e.g.,* CEDAW Committee, *Concluding Observations: Benin*, para.158, U.N. Doc. A/60/38 (2005); CRC Committee, *Concluding Observations: Antigua and Barbuda,* para. 54, U.N. Doc. CRC/C/15/Add.247 (2004); ESCR Committee, *Concluding Observations: Bolivia*, para. 43, U.N. Doc. E/C.12/1/Add.60 (2001); Anand Grover 2011, *supra* note 11, para. 65(l).

44 CEDAW Committee, *Concluding Observations: Cape Verde*, para. 30, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); *Ghana*, para. 32, U.N. Doc. CEDAW/C/GHA/CO/5 (2006).

45 CRC Committee, *Gen. Comment No. 4*, *supra* note 36, para. 30.

46 Corte Constitucional [C.C.] [Constitutional Court], agosto 10, 2012, Sentencia T627/12 (Colomb.) at 1 [hereinafter Sentencia T627/12]; *see also Acción de Tutela sobre Derecho Fundamental a la Información*, Women's Link Worldwide (Oct. 15, 2012), http://www.womenslinkworldwide.org/wlw/new.php?modo=detalle_proyectos&dc=67.

47 Sentencia T627/12, *supra* note 46, para. 1.

48 *Id.* para. 65 ("porque uno de los mecanismos para perpetuar la discriminación histórica sufrida por las mujeres ha sido y continúa siendo, precisamente, negar u obstaculizar el acceso a información veraz e imparcial en este campo [de los derechos reproductivos] con el objetivo de negarles el control sobre este tipo de decisiones.").

49 *Id.* at *resuelve.*

50 *Id.* at *resuelve.*

51 UNESCO, School-Based Sexuality Education Programmes: A Cost and Cost-Effective Analysis in Six Countries, Executive Summary 26-27 (2011) [hereinafter School-Based Sexuality Education]; Estonian Ministry of Social Affairs, Estonia: A Country Report on National Response to HIV/AIDS Epidemic 15 (2007).

52 School-Based Sexuality Education, *supra* note 51, at 30.

53 *Id.*

54 The Safe Project, Sexuality Education in Europe: A Reference Guide to Policies and Practices 51 (2006).

55 *Id.* at 52.

56 *Id.* at 51.

57 Paul Fontaine, *Government Earmarks Millions for Sexual Violence Education,* The Reykjavík Grapevine, Dec. 21, 2011, http://www.grapevine.is/News/ReadArticle/Government-Earmarks-Millions-For-Sexual-Violence-Education.

58 *Id.*

IV. SEXUAL AND REPRODUCTIVE HEALTH EDUCATION AND INFORMATION (continued)

V. ADOLESCENTS AND YOUTH

In addition to inadequate access to reproductive health education and information, adolescents face a range of other unique barriers in accessing comprehensive sexual and reproductive health services. In the context of reproduction and health care, laws denying adolescents decision making capacity or requiring that they obtain parental consent undermines adolescents' autonomy; this lack of autonomy can prevent or deter them from receiving confidential reproductive health services which can in turn compromise their physical and mental health. In addition to their lack of autonomy, adolescents may also be deterred from accessing reproductive health services due to the stigma associated with adolescent sexuality and discrimination on the basis of marital status.[1] Adolescents also may be unable to access such services due to their lack of finances and inability to access or afford transportation.[2]

Adolescent girls are particularly vulnerable. Despite accounting for one fifth of all women of reproductive age, adolescents have been widely underserved by reproductive health services worldwide.[3] Every year, approximately 16 million adolescents between the ages of 15 and 19 give birth,[4] with potentially harmful health impacts; complications arising from pregnancy and child birth are the leading cause of death for 15- to 19-year-old girls in the developing world.[5] Adolescents between the ages of 15 and 19 have twice the risk of dying due to pregnancy-related complications compared to women in their twenties,[6] while girls under the age of 15 have five times the risk of pregnancy-related deaths worldwide.[7] Furthermore, adolescents who become pregnant are likely to have lower educational attainments,[8] in part due to policies in some countries permitting or mandating expulsion of pregnant students.[9]

Governments, policy-makers, and international organizations increasingly are recognizing that including adolescents in policies and programs and addressing their unique needs is crucial in improving their sexual and reproductive health. In this context, there has been a shift from viewing adolescents as a group that needs protection to viewing them as a group that should be empowered to make informed and responsible decisions regarding their sexual and reproductive health and rights.

Adolescents and Youth in the ICPD Programme of Action

The ICPD Programme of Action aims to "promote to the fullest extent the health, well-being and potential of all children, adolescents and youth."[10] Recognizing the special needs of adolescents and youth, and the unique barriers they face in accessing quality reproductive health services, the ICPD Programme of Action aims to overcome these barriers;[11] to this end, states agreed to remove regulatory, legal, and social barriers that inhibit adolescents' access to reproductive health information and services.[12] Recognizing that adolescents and youth have historically been neglected from the provision of reproductive health services,[13] states agreed that they should be active participants in the planning, implementation, and evaluation of programs affecting them, particularly programs surrounding reproductive and sexual health.[14]

States agreed to employ an approach that recognizes the "evolving capacities" of adolescents;[15] such an approach appreciates that as adolescents develop, they become increasingly more responsible and autonomous, enabling them greater decision-making capacity.[16] Adolescents should be provided with appropriate sexual and reproductive health services and counseling;[17] such services "must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs."[18]

Human Rights Standards

Under the international human rights standards established by human rights bodies, adolescents and youth are entitled to special measures of protection to ensure that they are able to exercise their human rights in accordance with their evolving capacities.[19] Recognizing the evolving capacities of adolescents to make decisions about their sexual and reproductive health, states should develop programs for the provision of sexual and reproductive health services for adolescents,[20] including family planning. States should also ensure adolescents access to sexuality education and information;[21] these standards are further elaborated upon in the Sexual and Reproductive Health Education and Information fact sheet. Furthermore, the Committee

on the Elimination of Discrimination against Women has urged states not to limit access to health facilities and information based on third-party consent requirements, such as spousal, parental or health authority consent,[22] and to eliminate laws criminalizing consensual sexual behavior between adolescents, as such laws hinder their access to sexual and reproductive health services.[23] Treaty monitoring bodies have urged states to ensure that individuals are not discriminated against based on their marital or family status,[24] particularly in the provision of reproductive health services. Adolescents and youth of all ages must also have access to confidential and child-sensitive services.[25] States should put in place measures to ensure that adolescents who become pregnant are able to remain in and return to school.[26]

States must take measures to eliminate harmful traditional practices that affect the right to health,[27] including child marriage and female genital mutilation; these standards are further detailed in the Harmful Traditional Practices: Female Genital Mutilation and Child Marriage fact sheet. Additionally, children and adolescents are at a heightened risk of being victimized by sexual violence in both public and private settings, such as in the home, in health care institutions, or in educational settings.[28] States should take measures to prevent sexual violence, provide rehabilitation and redress to victims of sexual violence, and prosecute offenders.[29]

Country Examples:

Panama

In 2002, Panama passed legislation guaranteeing pregnant adolescents comprehensive health care, education, and legal protections.[30] All pregnant adolescents have the right to be informed of available public and private health care centers, and to receive information about their particular rights and legal protections that are established by law.[31] Under this legislation, the Ministry of Education must ensure that the proper arrangements are made to enable pregnant adolescents to remain in school, including assigning a teacher to be responsible for the adolescent's academic advancement.[32] The law forbids discrimination against students based on pregnancy and calls for the Ministry of Education to provide the proper training for teachers on adolescent pregnancy in order to eradicate stigma and discrimination.[33] The legislation also establishes sanctions for the failure to inform pregnant students of their rights and to provide them with proper educational and health services.[34]

Uganda

In 2001, Uganda created the National Youth Policy in order to enhance awareness of the issues youth face and to provide a defined space for youth to participate in the nation's policies and development.[35] Recognizing that youth have historically been marginalized from policy creation and decision making, the National Youth Policy seeks to ensure their meaningful participation.[36] As a priority of focus, the policy seeks to improve access to health services for youth by removing barriers to such services and ensuring that they are youth-friendly.[37]

United Kingdom

In 2004, the United Kingdom's Department of Health issued best practice guidance to advise health care professionals about addressing the sexual and reproductive health needs of patients under the age of 16,[38] such as accessing contraception. The guidance identifies lack of confidentiality as one of the most prominent deterrents for young people to access sexual and reproductive health services, and emphasizes that health care professionals owe a duty of confidentiality to all patients, including those under the age of 16.[39] As such, all reproductive health services should guarantee individuals under the age of 16 the same right to confidentiality as adults.[40] Within health care facilities, effective trainings should be provided in order to effectuate employers' affirmative duty to ensure that their staff members maintain patients' confidentiality, and breaches of confidentiality should result in serious disciplinary matters.[41] Health service providers' personal beliefs should not interfere with their administration of care to minors; should such beliefs prevent the provision of care, the health professional must make alternative arrangements for another professional to fulfill the patient's needs.[42]

[1] Amanda Dennis et al., Guttmacher Institute, The Impact of Laws Requiring Parental Involvement for Abortion: A Literature Review (2009); *Parental Involvement Laws*, Center for Reproductive Rights (Jan. 1, 2009), http://reproductiverights.org/en/project/parental-involvement-laws; International Planned Parenthood Federation (IPPF), Understanding young people's right to decide: How can parents effectively support the autonomous decision-making of young people? 4 (2012); Center for Reproductive Rights, The Reproductive Rights of Adolescents: A Tool for Health and Empowerment 8 (2008); Ann E. Biddlecom et al., *Adolescents' view of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda,* 11 African Journal of Reproductive Health 99, 108 (2007); Dept. of Reproductive Health and Research, World Health Organization (WHO), From Evidence to Policy: Expanding Access to Family Planning 1 (2012).

[2] *See* Susheela Singh et al., Guttmacher Institute & United Nations Population Fund (UNFPA), Adding it Up: The Benefits of Investing in Sexual and Reproductive Healthcare 12 (2009); *Expanding Access to Youth-Friendly Services,* UNFPA, http://web.unfpa.org/adolescents/youthfriendly.htm (last visited May 12, 2013).

[3] *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 7.41, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].

[4] WHO & UNFPA, Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries: What the Evidence Says (2012).

[5] Save the Children, Children Having Children: State of the World's Mother 2004, 4 (2004).

[6] UNFPA, State of the World Population 2004, 76 (2004).

[7] UNFPA, Giving Birth Should Not Be A Matter of Life and Death 1.

[8] Daniel H. Klepinger et al., *Adolescent Fertility and the Educational Attainment of Young Women*, 27 Family Planning Perspectives 23 (1995).

[9] *See* Center for Reproductive Rights, *Supplementary information on the United Republic of Tanzania, Scheduled for Review by the Committee on Economic, Social, and Cultural Rights during its 49th Session* (Apr. 30, 2012), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_Tanzania_Shadow_Letter_2012.pdf; Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Tanzania*, para. 56(c), U.N. Doc. CRC/C/TZA/CO/2 (2006); Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Belize*, para. 23-24, U.N. Doc. CEDAW/C/BLZ/CO/4 (2007).

[10] *ICPD Programme of Action, supra* note 3, para. 6.7(a).

[11] *Id.* paras. 6.7(a), 6.15; Convention on the Rights of the Child, *adopted* Nov. 20, 1989, art. 24, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter CRC].

[12] *ICPD Programme of Action, supra* note 3, para. 7.45.

[13] *Id.* para. 7.41.

[14] *Id.* para. 6.15.

[15] *Id.* para. 7.45.

[16] Gerison Lansdown, Save the Children & UNICEF, The Evolving Capacities of the Child xi (2005) [hereinafter Evolving Capacities].

[17] *ICPD Programme of Action, supra* note 3, para. 7.44(a).

[18] *Id.* para. 7.45.

[19] CRC Committee, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, (33rd Sess., 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 1, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter Committee on the Rights of the Child, *Gen. Comment No. 4*]; *See also* Evolving Capacities, *supra* note 16.

[20] CRC Committee, *General Comment No. 4, supra* note 19, paras. 1, 31.

[21] CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health),* (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 23, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]; *see also* CEDAW Committee, *Concluding Observations: Turkmenistan*, paras. 30–31, U.N. Doc. CEDAW/C/TKM/CO/2 (2006).

[22] CEDAW Committee, *Gen. Recommendation No. 24, supra* note 21, para. 14.

[23] CRC Committee, *Concluding Observations: Benin*, para. 25, U.N. Doc. CRC/C/15/Add.106 (1999); Committee on Economic Social and Cultural Rights (ESCR Committee), *Concluding Observations: Peru*, para. 21, U.N. Doc. E/C.12/PER/CO/2-4 (2012).

[24] *See* ESCR Committee, *General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights),* para. 31, U.N. Doc. E/C.12/GC/20 (2009); *see also* CEDAW Committee, *Concluding Observations: Singapore*, para. 14, U.N. Doc. CEDAW/C/SGP/CO/3 (2007).

[25] *See* CRC Committee, *Concluding Observations: Oman*, U.N. Doc. CRC/C/OMN/CO/2 (2006); *Paraguay*, para. 42, U.N. Doc. CRC/C/15/Add.166 (2001).

[26] CRC Committee, *Concluding Observations: Senegal*, para. 54-55, U.N. Doc. CRC/C/SEN/CO/2 (2006); *Argentina*, para. 68, U.N. Doc. CRC/C/ARG/CO/3-4 (2010); CEDAW Committee, *Concluding Observations: Saint Lucia*, para. 28, U.N. Doc. CEDAW/C/LCA/CO/6 (2006).

[27] CRC, *supra* note 11, art. 24(3).

[28] CEDAW Committee, *Concluding Observations: South Africa*, paras. 31-32, U.N. Doc. CEDAW/C/ZAF/CO/4 (2011); CRC Committee, *Concluding Observations: Bhutan*, para. 41(b), U.N. Doc. CRC/C/15/Add.157 (2001). While rates of sexual violence are extremely difficult to gauge due to high rates of non-reporting and lack of routine statistics collection, a 2005 World Health Organization survey found that over 50 percent of women in some places were victimized by sexual violence during their lifetimes. WHO, Multi-country Study on Women's Health and Domestic Violence against Women 28, 44, tbls. 4.1 & 5.1, figs. 4.1 & 4.2 (2005).

[29] CRC Committee, *Concluding Observations: Lebanon*, para. 48(d), U.N. Doc. CRC/C/LBN/CO/3 (2006); CEDAW Committee, *Concluding Observations: Tanzania*, para. 24, U.N. Doc. CEDAW/C/TZA/CO/6 (2008); Committee against Torture (CAT Committee), *Concluding Observations: Costa Rica*, para. 19, U.N. Doc. CAT/C/CRI/CO/2 (2008).

[30] Asamblea Legislativa, Ley No. 29 Que Garantiza la salud y la Educacion de la Adoescente Embarazada [Law No. 29, Guarenteeing Health and Education for Pregnant Adolescents], art. 1 (Jun. 13, 2002) (*Panama*).

[31] *Id.* art. 4.

[32] *Id.* art. 5.

[33] *Id.* art. 7.

[34] *Id.* art. 10.

[35] Ministry of Gender, Labour and Social Development, Republic of Uganda, The National Youth Policy: A Vision for Youth in the 21st Century para. 4.0 (2001).

[36] *Id.* paras. 2.6, 5.5.

[37] *Id.* para. 8.4.

[38] Department of Health, United Kingdom Government, Best Practice Guidance for Doctors and other Health Professionals on the Provision of Advice and Treatment to Young People Under 16 on Contraception, Sexual and Reproductive Health: Gateway Reference Number 3382 (Jul. 29, 2004), *available at* http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4086914.pdf.

[39] *Id.* at 1.

[40] *Id.* at 2.

[41] *Id.* at 2-3.

[42] *Id.* at 3-4.

Individuals belonging to marginalized and underserved populations commonly face discrimination, in law or in practice, in accessing or in receiving reproductive health services. Persons belonging to indigenous populations; ethnic, religious, and linguistic minorities; older persons; persons with disabilities; people living with HIV; rural women; sex workers; lesbian, gay, bisexual and transgender (LGBT) persons; and persons with intersex conditions are particularly affected.[1] Adolescents are also a marginalized and underserved population; an in-depth discussion of their sexual and reproductive health and rights is available in the Adolescents and Youth fact sheet.

For marginalized and underserved populations, the right to non-discrimination is at the core of their right to access comprehensive reproductive health care, as reproductive health policies and programs have historically neglected their specific needs. For example, the distribution of health centers may inadequately address the needs of rural populations, or health facility staff members' own biases against members of particular groups may result in lower service quality or abusive treatment at health facilities. Cultural, geographic, and language barriers may also exclude many vulnerable individuals from the provision of social services. Furthermore, women belonging to marginalized and underserved populations may also face multiple forms of discrimination based on their status as a woman and their status as part of a marginalized group. The recent promotion of health systems that are sensitive to the needs of, for example, indigenous peoples, and ethnic, religious, and linguistic minorities in a number of countries across the globe has helped overcome some of these barriers.[2]

Persons belonging to these groups also require special attention for the realization of their sexual and reproductive health and rights due to human rights abuses within health care systems that have been and continue to be perpetrated against them. For example, a number of these groups have been or continue to be singled out under coercive or eugenic-based population policies aimed at depriving them of their reproductive capacities, such as persons with disabilities, transgendered people, and people living with HIV.[3] Furthermore, a number of states have enacted laws criminalizing the particular conduct or status of certain marginalized groups, such as laws criminalizing same-sex behavior, HIV-transmission, and undocumented immigrants. For example, 76 countries worldwide still have laws criminalizing people based on their sexual orientation or gender identity.[4] Such laws also deter individuals from accessing reproductive health services and exercising their sexual and reproductive health and rights out of fear of being deemed criminals. These laws also stigmatize members of vulnerable and marginalized groups. Even when discriminatory laws or policies have ended, individuals from these groups may be deterred from utilizing government-sponsored reproductive health programs due to prevailing discriminatory attitudes.

Marginalized and Underserved Populations in the ICPD Programme of Action

The ICPD Programme of Action recognizes the vulnerable position of migrants, adolescents, persons with disabilities, indigenous people, refugees, internally displaced persons, and elderly people. As such, states agreed to emphasize and prioritize the needs of vulnerable and underserved populations in the expansion of the provision of reproductive health services, including safe motherhood, prenatal care, delivery assistance, and family planning services.[5] Recognizing that vulnerable groups face discrimination which at times is institutionalized in laws and policies,[6] states committed to eliminate all forms of coercion,[7] discrimination, and violence.[8] States agreed that sexual and reproductive health programs and services should address vulnerable populations' specific needs[9] and should be socially and culturally appropriate.[10] The ICPD Programme of Action recognizes the importance of including vulnerable populations in the design, implementation, and monitoring of sexual and reproductive health programs.[11]

Additionally, states agreed to "ensure the realization of the rights of all persons with disabilities, and their participation in all aspects of social, economic and cultural life,"[12] including their reproductive health needs, such as their sexual health and their needs pertaining to family planning, access to information, education, and HIV/AIDS.[13] The ICPD Programme of Action recognizes that elderly people, especially impoverished elderly women, are particularly vulnerable.[14] The ICPD Programme of Action also recognizes that reproductive health includes the right of *all* people to have a satisfying and safe sex life, and the capability to reproduce.[15]

Human Rights Standards

Much attention has been paid to the rights of underserved and vulnerable populations since ICPD. In accordance with human rights principles, states must guarantee the right to non-discrimination in both health care services and the underlying determinants of health; this includes eradicating discrimination on the basis of race, sex, color, religion, language, physical or intellectual disability, health status (including HIV/AIDS), intersex or transgender status, and sexual orientation, among others.[16] In providing reproductive health care, human rights bodies have urged states to pay particular attention to vulnerable and marginalized groups to ensure that they are receiving adequate, appropriate, accessible, and quality care[17] that responds to their particular needs.[18] This requires making accommodations to ensure that the barriers faced by vulnerable groups in accessing health facilities can be overcome,[19] such as structural changes to make them accessible for people with physical disabilities and providing translation services for people who do not speak a state's dominant language. Strategies for the prevention and treatment of diseases, including HIV/AIDS, should also pay particular attention to vulnerable groups,[20] as they may face a higher risk of HIV infection and transmission due to social and economic factors, such as neglect within the formal health care system.

To comply with their international human rights obligations, states must take all appropriate measures to eliminate discrimination both in law and in practice.[21] This obligation is non-derogable and subject to immediate application; even in circumstances where states face extreme resource constraints, low-cost, targeted programs must be adopted in order to protect vulnerable members of society.[22] Measures should be taken to eradicate stereotypes and discrimination against these groups,[23] including through awareness-raising campaigns on diversity and tolerance;[24] and instituting disciplinary, administrative, and penal sanctions when violations occur.[25] Treaty monitoring bodies have advised states to adopt comprehensive strategies to address multiple discrimination against women belonging to marginalized groups.[26]

Country Examples:

Bolivia

In 2009, Bolivia adopted a new constitution that includes expansive protections for indigenous rights, women's rights, and sexual and reproductive rights. The constitution prohibits discrimination based on sexual orientation, gender identity, culture, disability, and marital status, amongst others.[27] It also protects indigenous populations' rights to cultural identity, practices and customs and universal health care that respects their traditional and cultural practices.[28] Furthermore, the constitution explicitly "guarantees women and men the right to exercise their sexual and reproductive rights."[29]

Canada

Canada's Human Rights Act protects individuals from discrimination based on "race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital status, family status, disability and conviction for which a pardon has been granted."[30] The prohibition of discrimination based on sex includes discrimination based on pregnancy and childbirth.[31] Following the adoption of the ICPD Programme of Action, the law was amended to protect certain indigenous groups from discrimination, such as Canada's First Nations, and to forbid discrimination on the basis sexual orientation.[32] Many members of First Nations live on reservations that are characterized as having lower levels of educational attainment, lower quality of housing, and lower incomes.[33] As a result of their inclusion in the Human Rights Act, these groups can now seek recourse for discriminatory practices.[34]

Republic of the Congo

In 2011, the Republic of the Congo became one of the few countries in Africa to inaugurate legislation specifically designed to protect the rights of indigenous populations. In addition to prohibiting discrimination against members of indigenous populations,[35] the law also enshrines the state's affirmative duty to ensure the meaningful participation of indigenous populations in the formulation and implementation of legislation and development programs.[36] The law also explicitly guarantees indigenous populations access to primary health care,[37] and protects the right to education, calling upon the state to take special measures to ensure non-discriminatory access to education for all indigenous children.[38]

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1 *See* Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights),* U.N. Doc. E/C.12/GC/20 (2009) [hereinafter ESCR Committee, *Gen. Comment No. 20*]; Committee against Torture (CAT Committee), *General Comment No. 2: Implementation of article 2 by States parties*, (39th Sess., 2007), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 19(d), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CAT Committee, *Gen. Comment No. 2*].

2 *See Intercultural Bilingual Education for the Amazona,* UNICEF (May 25, 2012), http://www.unicef.org/cbsc/index_55850.html.

3 Other groups include indigenous persons, ethnic minorities, and people with intersex conditions. *See, e.g.,* Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) (by Juan E. Méndez); Center for Reproductive Rights, Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities (2010); Center for Reproductive Rights, Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia (2003); Open Society Foundations, Against Her Will: Forced and Coerced Sterilization of Women Worldwide (2011).

4 U.N. High Commissioner for Human Rights, *Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity*, para. 40, U.N. Doc. A/HRC/19/41 (Nov. 17, 2011).

5 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, paras. 3.19, 7.16, 8.8 & 8.17, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].

6 *Id.* para. 6.22.

7 *Id.* para. 6.25 (referring to indigenous populations) & 6.30 ("Governments should eliminate specific forms of discrimination that persons with disabilities may face with regard to reproductive rights, household and family formation").

8 *Id.* para. 6.20 & 6.30.

9 *Id.* paras. 6.25, 6.7 (b), 6.30 & 7.11.

10 *Id.* para. 6.24(b).

11 *Id.* para. 6.24(a), 6.28 & 6.16.

12 *Id.* para. 6.29(a).

13 *Id.* para. 6.30.

14 *Id.* para. 6.16.

15 *Id.* para. 7.2 (emphasis added).

16 ESCR Committee, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 18, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*]; ESCR Committee, *Gen. Comment No.* 20, *supra* note 1.

17 *See* ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 12(b)(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"); Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Panama*, para. 43, U.N. Doc. CEDAW/C/PAN/CO/7 (2010); Committee on the Right of the Child (CRC Committee), *Concluding Observations: India*, para. 51, U.N. Doc. CRC/C/15/Add.115 (2000); ESCR Committee, *Concluding Observations: The Former Yugoslav Republic of Macedonia*, para. 46, U.N. Doc. E/C.12/MKD/CO/1 (2008).

18 Committee on the Right of the Child (CRC Committee), *Concluding Observations: Tajikistan*, para. 39, U.N. Doc. CRC/C/15/Add.136 (2000); ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 37.

19 *See* ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 12(b)(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"); CRC Committee, *Concluding Observations: Sri Lanka*, para. 39(a), U.N. Doc. CRC/C/15/Add.207 (2003); *Philippines*, para. 56(b), U.N. Doc. CRC/C/PHL/CO/3-4 (2009).

20 CEDAW Committee, *Concluding Observations: Ukraine*, para. 39, U.N. Doc. CEDAW/C/UKR/CO/7 (2010); CRC Committee, *Concluding Observations: Latvia*, para. 47(b), U.N. Doc. CRC/C/LVA/CO/2 (2006).

21 Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, arts. 1-2, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, art. 2 G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR]; International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 2(2), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR]; Convention on the Rights of the Child, *adopted* Nov. 20, 1989, art. 2, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter CRC].

22 ESCR Committee, *General Comment No. 3: The nature of States parties' obligations (Art. 2, para. 1)*, (5th Sess., 1990), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 18.

23 CEDAW Committee, *Concluding Observations: Ukraine*, para. 25, U.N. Doc. CEDAW/C/UKR/CO/7 (2010); CRC Committee, *Concluding Observations: Thailand*, paras. 62-63, U.N. Doc. CRC/C/THA/CO/3-4 (2012).

24 CRC Committee, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland*, para. 25(b), U.N. Doc. CRC/C/GBR/CO/4 (2008); Committee on the Elimination of Racial Discrimination, *Concluding Observations: Morocco*, para. 20, U.N. Doc. CERD/C/MAR/CO/17-18 (2010).

[25] CRC Committe, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland,* para. 25(c), U.N. Doc. CRC/C/GBR/CO/4 (2008).
[26] CRC Committee, *Concluding Observations: Philippines,* para. 21, U.N. Doc. CRC/C/15/Add.259 (2005); *Singapore,* para. 30(b), U.N. Doc. CRC/C/SGP/CO/2-3 (2011).
[27] Nueva Constitución Política del Estado [Constitution] Oct. 2008, art. 14(II) (Bolivia).
[28] *Id.* art. 30.
[29] *Id.* art. 66 ("Se garantiza a las mujeres y a los hombres el ejercicio de sus derechos sexuales y sus derechos reproductivos.").
[30] Canadian Human Rights Act, R.S.C., 1985, c. H-6, art. 3(1).
[31] *Id.* art. 3(2).
[32] Canadian Human Rights Commission, Human Rights Handbook for First Nations 51 (2011); Mary C. Hurley, *Sexual Orientation and Legal Rights: A Chronological Overview,* Parliament of Canada (Sept. 26, 2005), http://www.parl.gc.ca/Content/LOP/ResearchPublications/prb0413-e.htm#b1996txt.
[33] Indian and Northern Affairs Canada, First Nation and Inuit Community Well-Being: Describing Historical Trends (1981-2006) (2010).
[34] *See Aboriginal people file hundreds of human rights complaints,* CBC News Canada, Jun. 18, 2012, http://www.cbc.ca/news/canada/story/2012/06/18/aboriginal-human-rights-complaints.html.
[35] Act No. 5-2011 of 25 February 2011 On the Promotion and Protection of Indigenous Populations, art. 2 (2011) (Congo).
[36] *Id.* art. 3.
[37] *Id.* art. 22.
[38] *Id.* art. 17.

VII. HIV/AIDS

Since the start of the HIV/AIDS epidemic, almost 70 million people have contracted HIV and roughly 35 million people have died of AIDS.[1] In 2011, 34.2 million people were living with HIV, nearly 69 percent of whom are in sub-Saharan Africa.[2] Treatment of people living with HIV has been transformed in the 20 years since ICPD, even as the epidemic has continued to intensify worldwide. Where there is access to medication and treatment, HIV has changed from a death sentence to a chronic, manageable disease. Furthermore, with proper therapies, the risk of parent-to-child transmission of HIV can be reduced to less than 2 percent in non-breastfeeding populations.[3] Yet, the global and regional disparities worldwide mean that this is not the reality for millions of people living with HIV, as less than half of people living with HIV are receiving treatment,[4] and less than 50 percent of pregnant women living with HIV in developing countries receive the most effective treatment to prevent transmission to their children.[5] It is critical that disparities in treatment for HIV/AIDS are addressed in accordance with international human rights standards and intergovernmental resolutions on HIV/AIDS.[6] Additionally, people living with HIV have been targeted by coercive policies and practices, such as forced sterilization, stripping them of their reproductive capacity.[7]

The criminalization of HIV transmission in more than 60 countries worldwide contributes to the marginalization of people living with HIV.[8] Laws criminalizing HIV are ineffective at reducing transmission, as they deter individuals from undergoing HIV testing out of fear of prosecution.[9] Such laws compound the barriers to accessing adequate care for HIV/AIDS faced by vulnerable or marginalized groups that have an elevated risk of HIV infection, such as men who have sex with men, sex workers, transgender persons, intravenous drug users, prisoners, and migrants.[10] Women also bear an elevated risk of HIV infection due to social, cultural, and physiological reasons,[11] such as gender-based violence;[12] economic dependence, which limits their ability to control with whom they have sex;[13] and harmful cultural practices.[14] Women now account for over half of all people living with HIV, and the HIV prevalence rate among women ages 15-24 is twice that of young men in the same age range.[15]

HIV/AIDS in the ICPD Programme of Action

Under the ICPD Programme of Action, states agreed to "provide all means to reduce the spread and the rate of transmission of HIV/AIDS infection"[16] and provide treatment for HIV.[17] The ICPD Programme of Action aims to ensure people living with HIV receive adequate medical care and counseling.[18] States agreed that sexual and reproductive health programs should address HIV/AIDS[19] and committed to integrate identification of STIs into reproductive health programs.[20] The ICPD Programme of Action recognizes that women are particularly susceptible to HIV due to social and economic inequalities and the greater likelihood of transmission from men to women.[21] States committed to take a multi-sectoral approach to addressing HIV/AIDS that examines the socioeconomic factors influencing the spread of the disease.[22] The ICPD Programme of Action recognizes the need to eliminate discrimination against people living with HIV,[23] and states agreed to develop policies and guidelines to this effect. Additionally, HIV testing and other HIV-related programs must ensure confidentiality.[24]

Human Rights Standards

As the HIV/AIDS epidemic has continued to grow since ICPD, international human rights bodies have increasingly addressed the rights of people living with HIV, establishing that states must guarantee people living with HIV the equal enjoyment of their human rights.[25] In accordance with human rights standards, antiretroviral treatment should be available, affordable, and accessible to all in an equitable manner[26] and states should take measures to eradicate barriers in accessing antiretroviral treatment,[27] including the high cost.[28] States should implement prevention strategies such as promoting condom use and access to condoms (including female condoms),[29] ensuring access to contraceptives,[30] and conducting awareness-raising campaigns.[31] Human rights bodies have made clear that appropriate resources must be allocated to HIV/AIDS programs,[32] and the effectiveness of programs should be monitored and evaluated.[33]

States should also take effective measures to counter stigma and discrimination related to HIV/AIDS.[34] Treaty monitoring bodies have urged states to prohibit discrimination based on seropositive status[35] and to take steps to ensure that people living with HIV have non-discriminatory access to reproductive health services,[36] including treatments to reduce the risk of parent-to-child HIV transmission.[37] States should ensure that people living with HIV can make informed and voluntary decisions about reproduction[38] by eliminating policies that promote or permit the involuntary sterilization of people living with HIV[39] and ensuring that HIV testing and treatment is voluntary, confidential[40] and available without parental consent.[41] Treaty monitoring bodies have advised states that strategies to address HIV/AIDS should target high-risk groups,[42] such as young women,[43] people in rural areas, and ethnic minority groups,[44] as well as older persons.[45] In accordance with human rights standards, states should take a gender-sensitive approach to the HIV epidemic,[46] emphasizing the rights and needs of women.[47] Laws criminalizing consensual same-sex behavior and HIV transmission should also be repealed.[48]

Country Examples:

Nicaragua

In 1996, Nicaragua enacted legislation designed to enshrine human rights into the state's response to HIV/AIDS.[49] The law is based on the rights to life and health and the principles of non-discrimination, confidentiality, and autonomy.[50] The law guarantees all people living with HIV the right to receive reproductive health and family planning information, counseling, and services.[51] Furthermore, it guarantees the rights to work, education, and recreation for all people living with HIV.[52] It also creates an HIV/AIDS commission, a body made up of delegates from a number of ministries, including the ministries of health, education, work, and social security, charged with overseeing implementation of the law.[53]

Philippines

The Philippines' AIDS Prevention and Control Act of 1998 guarantees all people living with HIV the full protection of their civil liberties and human rights,[54] including basic health and social services.[55] The law requires written, informed consent for HIV testing and forbids compulsory HIV testing.[56] To this effect, HIV testing may not be required as a precondition for employment, educational opportunities, or the provision of services, including medical services.[57] Furthermore, the law forbids discrimination against people living with HIV and people perceived to have or suspected of having HIV.[58] Additionally, the state has an obligation to address issues which aggravate the spread of HIV, such as poverty, gender inequality and marginalization.[59]

Rwanda

Rwanda's 2009-2012 National Strategic Plan on HIV & AIDS[60] aims to universalize access to HIV prevention, treatment and care; reduce by one-half the incidence of HIV; significantly reduce morbidity and mortality of individuals living with HIV; and ensure equal opportunities for people living with HIV.[61] The plan identifies women's particular vulnerability to HIV and seeks to work in collaboration with women to diminish stereotypes that contribute to women's heightened vulnerability.[62] The plan seeks to ensure that women living with HIV are empowered to make informed reproductive health decisions[63] and to reduce mother-to-child transmission of HIV.[64] The plan identifies other vulnerable groups that are at an elevated risk of being infected with or transmitting HIV and identifies measures to reach these populations.[65]

South Africa

In 2002, the Constitutional Court of South Africa ruled that the government must remove restrictions on Nevirapine, a pharmaceutical which reduces the risk of mother-to-child transmission of HIV. Prior to this ruling, despite its affordability, Nevirapine was only being provided to women at a limited number of pilot sites, outside of which it was generally unavailable in public health facilities.[66] The court ordered the state to take positive measures to permit, facilitate, and expedite Nevirapine's use,[67] and to ensure the presence of appropriate staff at public hospitals to provide counseling on the use of Nevirapine.[68]

1 *Global Health Observatory: HIV/AIDS*, World Health Organization (WHO), http://www.who.int/gho/hiv/en/index.html (last visited May 9, 2013).
2 WHO & UNAIDS, Core Epidemiology Slides, slide 4 (2012) (indicating that 23.5 out of 34.2 million people living with HIV are in sub-Saharan Africa).
3 WHO, PMTCT Strategic Vision 2010-2015: Preventing Mother-to-Child Transmission of HIV to Reach the UNGASS and Millennium Development Goals 6 (2010); WHO, Dept. of HIV/AIDS, Prevention of Mother-to-Child Transmission (PMTCT): Briefing Note 3 (2007).
4 UNAIDS, Data Tables 5 (2011).
5 *Id.* at 7.
6 *See* Secretary-General, *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)*, U.N. Doc. A/HRC/16/69 (Dec. 20, 2010); UNAIDS & OHCHR, Handbook on HIV and Human Rights for National Human Rights Institutions (2007); UNAIDS, International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version (2006) [hereinafter International Guidelines on HIV/AIDS and Human Rights 2006].
7 *See, e.g.*, Center for Reproductive Rights, Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities (2010); Open Society Foundations, Against Her Will: Forced and Coerced Sterilization of Women Worldwide (2011).
8 Global Commission on HIV and the Law, Risks, Rights & Health 8 (2012).
9 *Id.*
10 *See generally id.*
11 UNFPA, State of the World Population 2005, ch. 4 (2005).
12 *See, e.g.,* Special Rapporteur on violence against women, its causes and consequences, *Integration of the Human Rights of Women and the Gender Perspective: Violence against Women – Intersections of violence against women and HIV/AIDS*, U.N. Doc. E/CN.4/2005/72/Corr. (Mar. 22, 2005) (by Yakin Ertürk); Amnesty International, Women, HIV/AIDS and Human Rights 4–8 (2004) [hereinafter Women, HIV/AIDS and Human Rights].
13 *Id.* at 9.
14 UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, HIV/AIDS, Gender and Violence Against Women; Women, HIV/AIDS and Human Rights, *supra* note 12, at 4–8.
15 *Statistics: Women and HIV/AIDS,* amfAR (Dec. 2012), http://www.amfar.org/about_hiv_and_aids/facts_and_stats/statistics__women_and_hiv_aids/.
16 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 7.33, U.N. Doc. A/CONF.171/13/Rev.1 (1995).
17 *Id.* para. 7.29.
18 *Id.* para. 8.29(b).
19 *Id.*
20 *Id.* para. 7.30.
21 *Id.* para. 7.28.
22 *Id.* para. 8.30.
23 *Id.* para. 8.29(b).
24 *Id.* para. 8.34 ("Services to detect HIV infection should be strengthened, making sure that they ensure confidentiality").
25 *See* Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Ethiopia*, para. 161, U.N. Doc. A/51/38 (1996).
26 *See* Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 12(b), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*]; ESCR Committee, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories,* para. 40, U.N. Doc. E/C.12/1/Add.79 (2002); Human Rights Committee (HRC), *Concluding Observations: Kenya*, para. 15, U.N. Doc. CCPR/CO/83/KEN (2005).
27 *See, e.g.,* ESCR Committee, *Concluding Observations: Honduras*, paras. 26, 47, U.N. Doc. E/C.12/1/Add.57 (2001); *Zambia*, para. 30, U.N. Doc. E/C.12/1/Add.106 (2005).
28 *See* ESCR Committee, *Concluding Observations: Sudan*, para. 27, U.N. Doc. E/C.12/1/Add.48 (2000); *see also* International Guidelines on HIV/AIDS and Human Rights 2006, *supra* note 6, at 18.
29 CEDAW Committee, *Concluding Observations: Burundi*, para. 60, U.N. Doc. A/56/38 (2001); *see also* International Guidelines on HIV/AIDS and Human Rights 2006, *supra* note 6, at 26.
30 Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Mali*, para. 57, U.N. Doc. CRC/C/MLI/CO/2 (2007).
31 CRC Committee, *Concluding Observations: Viet Nam*, para. 46, U.N. Doc. CRC/C/15/Add.200 (2003).
32 CRC Committee, *General Comment No. 3: HIV/AIDS and the rights of the child* (32nd Sess., 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 14, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CRC Committee, *Gen. Comment No. 3*].
33 CRC Committee, *Concluding Observations: Zambia*, para. 51(d), U.N. Doc. CRC/C/15/Add.206 (2003).
34 CRC Committee, *Concluding Observations: Bhutan*, para. 59(d), U.N. Doc. CRC/C/BTN/CO/2 (2008); *Kazakhstan*, para. 54(d), U.N. Doc. CRC/C/KAZ/CO/3 (2007).
35 CRC Committee, *Gen. Comment No. 3*, *supra note 32,* para. 9.
36 *See* ESCR Committee, *General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)*, para. 33, U.N. Doc. E/C.12/GC/20 (2009).
37 International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 12(c), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR]; ESCR Committee, *Gen. Comment No. 14, supra* note 26, para. 16; *see also* International Guidelines on HIV/AIDS and Human Rights 2006, *supra* note 6, at 38.
38 CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 22, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]
39 *Id.* para. 22.
40 CRC Committee, *Concluding Observations: Benin,* para. 58(f), U.N. Doc. CRC/C/BEN/CO/2 (2006).
41 CRC Committee, *Concluding Observations: Lesotho*, para. 46, U.N. Doc. CRC/C/15/Add.147 (2001); *Lithuania*, para. 40, U.N. Doc. CRC/C/15/Add.146 (2001).
42 *See, e.g.,* CEDAW Committee, *Concluding Observations: Republic of Moldova*, para. 31, U.N. Doc. CEDAW/C/MDA/CO/3 (2006); *Myanmar*, para. 96, U.N. Doc. A/55/38 (2000).
43 *See* Human Rights Committee (HRC), *Concluding Observations: Lithuania*, para. 12, U.N. Doc. CCPR/CO/80/LTU (2004).
44 *See* ESCR Committee, *Concluding Observations: People's Republic of China, Hong Kong and Macao*, para. 60, U.N. Doc. E/C.12/1/Add.107 (2005).
45 CEDAW Committee, *Concluding Observations: Zambia,* para. 36(a), U.N. Doc. CEDAW/C/ZMB/CO/5-6 (2011); *Uganda,* para. 46, U.N. Doc. CEDAW/C/UGA/CO/7 (2010).
46 *See* CEDAW Committee, *Concluding Observations: Antigua and Barbuda,* para. 261, U.N. Doc. A/52/38/Rev.1, Part II (1997).

[47] CEDAW Committee, *General Recommendation No. 15: Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS)*, (9th Sess., 1990), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, Recommendation (b), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).
[48] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, Anand Grover,* paras. 76(a), 76(c), U.N. Doc. A/HRC/14/20 (2010).
[49] Ley No. 238, 6 December 1996, Ley de Promoción, protección y Defensa de los Derechos Humanos ante el SIDA [Law for the Promotion, Protection and Defense of Human Rights in the face of AIDS] (Nicar.).
[50] *Id.* art. 1.
[51] *Id.* art. 26.
[52] *Id.* arts. 22, 24, & 25.
[53] *Id.* arts. 32-33.
[54] An Act Promulgating Policies and Prescribing Measures for the Prevention and Control of HIV/AIDS in the Philippines, Instituting a Nationwide HIV/AIDS Information and Educational Program, Establishing a Comprehensive HIV/AIDS Monitoring System, Strengthening the Philippine National AIDS Council, and for Other Purposes, Rep. Act 8504 § 2(b) (Feb. 13, 1998) (Phil.).
[55] *Id.* § 2(b).
[56] *Id.* § 15.
[57] *Id.* § 16.
[58] *Id.* § 2(b).
[59] *Id.* § 2(d).
[60] Office of the President, National AIDS Control Commission, Republic of Rwanda, National Strategic Plan on HIV & AIDS 2009-2012 (2012) [hereinafter National Strategic Plan on HIV & AIDS].
[61] *Id.* at 3.
[62] *Id.* at 54.
[63] *Id.* at 64.
[64] *Id.* at 62-63.
[65] *Id.* at 55-57.
[66] Constitutional Court of South Africa, Case CCT 8/02, para. 10-11 (Jul 5, 2002) (South Africa).
[67] *Id.* para. 135.
[68] *Id.*

VIII. Violence Against Women

One out of every three women across the globe will experience some kind of gender-based violence— violence directed toward women or girls causing, or likely to cause, physical, sexual, psychological, or economic harm or suffering.[1] Examples of violence against women include domestic violence, rape, sexual abuse of children, and female genital mutilation. While violence against women encompasses a broad range of forms, these forms share a number of commonalities: they reflect the inequalities between men and women in societies, which manifest themselves through patriarchal sentiments enabling males, as the dominant sex, to physically, verbally, and psychologically mistreat women.[2] In a cyclical manner, violence against women reinforces and perpetuates gender inequities, as women frequently feel unable to speak up about the violence due to social norms and/or fear of retribution. Furthermore, the threat of violence is heightened for refugees and women in conflict settings; for these groups and others, the harm associated with such violence may be exacerbated by lack of access to comprehensive reproductive health care.[3]

While some violence against women, particularly domestic violence, was historically understood as a "private" or "family" matter occurring outside the purview of the public system, it is now understood as a social problem symptomatic of greater social issues which manifest themselves in the form of violence against women. As such, addressing violence against women requires more than just criminal laws prohibiting physical violence against women; the underlying and root causes of gender-based violence must be addressed in order to eradicate the practice.

Violence against Women in the ICPD Programme of Action

In accordance with the ICPD Programme of Action, states agreed to take measures to eliminate all forms of violence against women, including enacting laws on sexual abuse and violence where they do not yet exist, strengthening existing laws, and enforcing all such laws.[4] States further agreed to take effective steps to address and eliminate sexual abuse of children[5] and to better provide assistance to individuals and families affected by domestic and sexual violence.[6] Migrants and displaced persons may be particularly vulnerable to sexual violence;[7] as such, services should be designed to address their specific reproductive health needs, including those resulting from sexual violence.[8] Educational programs at the national and community level should promote open discussion about the need to protect women, youth, and children from sexual abuse and violence.[9] States agreed to create conditions and implement procedures to encourage victims to report crimes[10] and take measures to rehabilitate victims of violence.[11]

Human Rights Standards

The human rights standards surrounding violence against women have increasingly strengthened since ICPD, and human rights bodies have also framed intimate-partner violence and violence based on sexual orientation or gender-identity as having similar underlying causes and consequences as violence against women. Human rights bodies recognize that violence against women constitutes a form of discrimination,[12] and as such, states must adopt adequate, comprehensive legislation and other measures, including sanctions where appropriate, to eradicate violence against women.[13] To this end, states should investigate, prosecute, and punish instances of gender-based violence,[14] and implement programs to train police, prosecutors and the judiciary about gender-based violence.[15] Treaty monitoring bodies have instructed states that programs addressing gender-based violence should take into account underserved and vulnerable groups, such as persons with disabilities, to ensure they have access to appropriate services and redress.[16] Furthermore, states should take steps to address violence based on sexual orientation or gender identity, including providing effective protection from violence and investigating all reports of violence.[17]

Human rights bodies have urged states to implement policies that protect victims from further abuse, such as social, psychological, and health services for victims.[18] Abortion should be decriminalized in instances of rape, and survivors of sexual violence should have access to emergency contraception.[19] Programs aimed at addressing gender-based violence should

incorporate efforts to combat gender-based stereotypes and other underlying causes of gender-based violence.[20] Such efforts should include campaigns to raise awareness about gender-based violence;[21] comprehensive training for relevant professionals, including teachers and health care workers; and education in schools about gender-based violence.[22]

Country Examples:

Argentina

In 2009, under the Law on the Comprehensive Protection to Prevent, Punish and Eradicate Violence against Women,[23] Argentina adopted an expansive definition of violence against women as including all conduct, acts, or omissions that are based on the unequal power relations between men and women and affect women's life; liberty; dignity; physical, psychological, sexual or economic integrity; or personal security.[24] The law explicitly recognizes violence against reproductive freedom, defining it as interfering with a woman's right to decide freely and responsibly on the number and spacing of her pregnancies and childbirths.[25] An example would be health care workers' failure to provide counseling about and access to contraception.[26] The law also recognizes obstetric violence as occurring when health care providers exert control over women's bodies and reproductive processes, treat women inhumanely, or abuse medical processes,[27] including inhumane or degrading treatment of patients in need of post-abortion care, irrespective of whether the abortion was legal or illegal.[28]

Kenya

In 2009, Kenya's Ministry of Health issued the National Guidelines for the Medical Management of Rape/Sexual Violence.[29] which explicitly recognizes that the ICPD Programme of Action and the Millennium Development Goals obligate the state to take measures to address sexual violence.[30] The guidelines highlight the importance of having emergency contraception readily available at all times and free of charge when treating a victim of sexual assault, and instructs that emergency contraception is not an abortifacient and will not harm an early pregnancy.[31] Survivors of sexual assault should be offered follow-up pregnancy tests and, if pregnant, should be informed that in these circumstances abortion is legal under Kenyan law.[32] If a survivor of sexual assault decides to terminate the pregnancy, the provider should treat her with compassion and refer her to an appropriate provider.[33] The guidelines include the administration of post-exposure prophylaxis (PEP) for HIV.[34] and highlight the importance of providing pre- and post-test counseling on HIV.[35] The guidelines also provide specific instructions for addressing instances of sexual violence against men.[36]

Spain

In 2004, Spain enacted the Law on Integrated Protection Measures against Gender Violence to address physical and psychological violence utilizing a holistic approach.[37] The law aims to strengthen public awareness about preventative measures; ensure victims' right to rapid, transparent, and effective access to services; improve the provision of information and integrated recovery services; guarantee victims of violence economic rights, including employment; and strengthen institutional protections.[38] It also emphasizes the educational systems' duty to prevent and address gender-based violence through educational programs and services.[39] The act also underlines the need to provide sensitization training to health professionals to be able to detect signs of gender-based violence and provide the necessary care for victims.[40] It also delineates the rights of victims of gender-based violence including the right to integrated social assistance and free legal counsel, employment rights and social security benefits, and institutional protection.[41]

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IX. Harmful Traditional Practices: Female Genital Mutilation and Child Marriage

Harmful traditional practices include, but are not limited to, female genital mutilation (FGM), child marriage, and other harmful practices stemming from societies' discrimination against women.[1] FGM, defined as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons,"[2] has been inflicted upon between 100 and 140 million women and girls,[3] and has been documented in 29 countries in Africa, Asia, the Middle East,[4] and Latin America.[5] At least 36 countries worldwide have enacted laws against FGM,[6] demonstrating that in many places it is no longer understood as an acceptable cultural practice, but instead as a harmful violation of women and girls' rights with horrific health consequences, including severe pain, hemorrhaging, sepsis and complications during childbirth.[7]

Similarly to FGM, countries have increasingly addressed child marriage, as at least 158 countries have set the minimum age for marriage without parental consent at 18 or older.[8] Nonetheless, child marriage persists, as 41 countries have rates of child marriage of 30 percent or more[9] and 52 countries allow children under the age of 15 to marry with parental consent.[10] Child marriage is most common in South Asia and West and Central Africa, where two in five girls marry before they reach 18.[11] Of the nearly 16 million girls between the ages of 15 and 19 who give birth annually in developing countries, nine out of ten are married.[12] Reducing child marriage can prevent adolescent pregnancy and resulting maternal mortalities.[13] Child marriage is also linked to increased risk of sexually transmitted diseases, including cervical cancer, resulting from human papillomavirus (HPV) infection, and HIV, and other diseases such as malaria, due to pregnancy's ability to suppress the immune system.[14] Despite critical advances in human rights standards on this issue, worldwide trends have been stagnant in the past ten years.[15] If current trends continue, 142 million girls will be married in the next decade.[16]

Harmful Traditional Practices in the ICPD Programme of Action

Under the ICPD Programme of Action, states agreed to take measures to eliminate harmful traditional practices. The ICPD Programme of Action recognizes that FGM "is a violation of [women's] basic rights and a major lifelong risk to women's health."[17] FGM should be prohibited[18] and states should urgently adopt and enforce measures to eliminate FGM.[19] In order to eliminate FGM, states should conduct community outreach with village and religious leaders,[20] provide education and counseling on the harmful impact of FGM,[21] and "vigorous[ly] support… efforts among non-governmental and community organizations and religious institutions to eliminate such practices."[22] Active discouragement of FGM should be an integral component of primary and reproductive health care programs,[23] and states should provide girls who have suffered FGM with appropriate treatment, rehabilitation, and counseling.[24]

The ICPD Programme of Action recognizes that "early marriage and early motherhood can severely curtail educational and employment opportunities and [are] likely to have a long-term, adverse impact on [young women's] and their children's quality of life."[25] As early marriage is connected to early childbearing, the ICPD Programme of Action recognizes the harmful effects of early childbearing, including increased risk of maternal mortality and morbidity and its impact as an impediment to improving women's educational, economic and social status.[26] States should strictly enforce laws designed to prevent forced marriage and should put in place educational and employment opportunities to enhance social support for such laws.[27]

Human Rights Standards

Under the international human rights framework, states have a positive obligation to protect adolescents from all harmful traditional practices, including FGM and child marriage.[28] Treaty monitoring bodies frame harmful traditional practices as violations of the rights to life,[29] equality,[30] non-discrimination,[31] and to be free from cruel, inhuman and degrading treatment.[32] Under the Convention on the Rights of the Child, states must "take measures to abolish traditional practices that are harmful to children's health,"[33] including by enacting and enforcing specific, effective legislative measures prohibiting such practices[34] and eradicating customary laws that encourage such practices.[35] States should also take measures to address traditional and cultural factors that contribute to such practices.[36] Such programs should involve and reach religious and community

leaders,[37] support practitioners of FGM to find alternative sources of income,[38] and include training for law enforcement and the judiciary.[39]

Treaty monitoring bodies have agreed that 18 is the appropriate minimum age for marriage for both men and women;[40] to this effect, states should enact legislation increasing the minimum age for marriage, with or without parental consent, to age 18.[41] Treaty monitoring bodies recognize that child, early, and forced marriage pose serious threats to the right to health,[42] as there is a connection between these practices and high maternal mortality rates,[43] elevated school dropout rates,[44] and an increased risk of sexual abuse.[45]

Country Examples:

Benin

In 2003, Benin adopted legislation banning all forms of female genital mutilation.[46] The law defines FGM as "any partial or total removal of the external genitalia of females and/or any other operations on these organs."[47] Anyone who is found to participate in FGM faces six months to three years in prison.[48] Should the girl or woman die as a result of the procedure, the person may be imprisoned between five and 20 years.[49] Accomplices, including those who help during, assist in, provide means for or solicit the procedure, face the same penalties as the principal actor.[50] In instances of repeat offenders, the maximum penalty shall be imposed.[51] The law also places an affirmative obligation on individuals to report instances of FGM to the police or prosecutor; those who know of an impending FGM procedure who do not report it or take action to prevent it can be penalized by a fine of up to 100,000 francs.[52] Finally, the legislation requires that health facilities treat victims of FGM and report instances of FGM to the police or prosecutor.[53]

Ethiopia

Despite Ethiopia's legal restrictions prohibiting marriage before age 18, 50 percent of girls are married by age 15 in Ethiopia's rural Amhara region, and 80 percent of girls are married by age 18.[54] In 2004, Ethiopia began implementing a program called Berhane Hewan to protect girls at risk of child marriage and to support married adolescent girls.[55] The program seeks to reduce early marriage by addressing the economic and social factors that contribute to its occurrence through the provision of support for girls to remain in the education system and cash incentives for families to keep unmarried girls in school.[56] It also organizes information sessions, led by adult female mentors, for girls to learn about reproductive health, family planning services, and livelihood skills.[57] An evaluation of the program conducted in 2006 found a substantial improvement in school attendance and literacy levels among girls, increased educational attainment, and delays in the age of marriage among young girls.[58]

Senegal

In 2008, as a participant in the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting, a non-formal education program entitled the Community Empowerment Programme (CEP) was implemented in Senegal.[59] The three-year program focused on education and dialogue on issues such as democracy, human rights, health and education, amongst others. In learning about human rights and health, students began questioning the impact of FGM on women, girls, and the community.[60] They came to the conclusion that FGM should not be practiced and publicly declared their support for ending FGM.[61] Villages participating in this program demonstrated a marked reduction in reports of girls who were subjected to FGM – with only 30 percent of women reporting that at least one daughter was subjected to FGM compared to 69 percent of women in villages where the program was not present.[62]

Turkey

In 2001, Turkey reformed its Civil Code in order to recognize the equality of the rights of spouses in marriage. The Civil Code sets the minimum age for marriage at 18, while previously it was 17 for males and 15 for females.[63] Spouses have equal rights

under the code, and are both equally entitled to rights over the family's home and property acquired during the marriage.[64] Should the woman be coerced into the marriage, she can later file for an annulment based on these grounds.[65] Prior to these reforms, the Turkish Civil Code established the supremacy of men and the subordination of women.[66] In 2001, the constitution was also amended to state that "the family is the foundation of Turkish society and is based on equality between the spouses."[67]

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X. Advancing Sexual and Reproductive Health and Rights after ICPD+20

Enshrining Human Rights Standards into National-level Laws and Policies

In the nearly 20 years since ICPD, the international human rights system has advanced substantially to incorporate rights and obligations that were explicitly included in the ICPD Programme of Action and that further advance states' responsibilities to guarantee sexual and reproductive health and rights. As the interpretation of international human rights standards and norms continues to develop, it is critical that states take measures to ensure that their domestic laws and policies are in line with these evolving standards. States must also ensure that their laws and policies protect the core pillars of sexual and reproductive health and rights, including autonomy, non-discrimination, and equality.

- **States must guarantee the rights to autonomy and to be free from discrimination by taking measures such as:**
  - implementing laws and policies prohibiting discrimination in the provision of reproductive health services and reviewing laws to ensure that they are not discriminatory, on their face or in practice. For example, lack of or a ban on government funding for reproductive health services may appear to be gender-neutral, but would likely disproportionately affect women, as they generally have greater reproductive health needs than men;
  - developing laws that address the sexual and reproductive health and rights of all people, taking into consideration the specific needs of marginalized populations;
  - ensuring women have access to the full range of maternal health services, including safe abortion services, both in law and in practice, including at a minimum in cases where the pregnancy threatens the life or health of the pregnant woman and in cases of rape, incest, or fetal impairment incompatible with life, as defined in the jurisprudence of UN treaty monitoring bodies;
  - reviewing national laws and administrative regulations to ensure compliance with human rights standards, such as those governing sexual and reproductive health, including laws which are discriminatory or criminalize access to sexual and reproductive health services that only women need;
  - removing barriers to accessing contraception, including laws criminalizing or policies restricting emergency contraception; and
  - abolishing laws criminalizing consensual sexual conduct amongst adults, such as same-sex behavior, sexual conduct outside of marriage, and sexual conduct by people living with HIV.
- **States must eliminate coercion in reproductive health care, including by:**
  - reforming laws to ensure that policies and practices on reproductive health care respect the right to informed decision making;
  - ensuring that laws and policies guarantee individuals the right to informed consent, especially for vulnerable and marginalized populations, with particular safeguards such as, for instance, measures to prevent involuntary sterilization and forced abortion. For consent to be considered informed, it must be given freely and voluntarily; following the provision of evidence-based and accurate information on the risks, benefits and alternatives of the procedure or medication in a manner understandable to the patient; and cannot be obtained during a time of duress or fatigue; and
  - establishing mechanisms to identify coercive practices, hold health care providers accountable for such violations, and ensure victims of coercion access to remedies and compensation.

- **States must ensure sexual and reproductive health information and services are available, accessible, acceptable, and of good quality by:**
  - guaranteeing comprehensive reproductive health care is affordable, geographically accessible and administered without discrimination, stigma, or maltreatment;
  - ensuring that services are monitored and regulated to guarantee high quality;
  - removing legal restrictions that create barriers to and delay women's access to sexual and reproductive health services, such as third-party authorization requirements, biased counseling, mandatory ultrasounds, and mandatory waiting periods;
  - guaranteeing adolescents the right to full and accurate information on sexual and reproductive health and rights, including formal sexuality education;
  - monitoring and regulating conscientious objection to ensure its invocation does not prevent women from accessing comprehensive reproductive health care;
  - developing and implementing intercultural health models, which are culturally sensitive to the world views and needs of indigenous women as well as ethnic, linguistic, and cultural minorities;
  - ensuring all survivors/victims of gender-based violence have immediate access to critical services, such as psychosocial and mental health support, treatment for injuries, and post-rape care including emergency contraception and safe abortion services;
  - systematically integrating responses to gender-based violence into all sexual and reproductive health programs and services; and
  - meeting the reproductive health service, information and education needs of young people with full respect for their privacy and confidentiality, free of discrimination, and providing them with evidence-based comprehensive education on human sexuality, sexual and reproductive health, human rights and gender equality, to enable them to deal in a positive and responsible way with their sexuality.

Implementation and Monitoring of Laws and Policies

While many countries have enacted laws aiming to ensure access to sexual and reproductive health services and laws punishing gender-based violence and other harmful practices, lack of implementation frequently results in frameworks which do not effectively fulfill individuals' sexual and reproductive health and rights. By incorporating accountability mechanisms during the crafting and implementation of laws and policies, states can better ensure that laws and policies will be effectively implemented.

- **To enhance accountability and ensure laws are fully implemented, states should:**
  - clearly identify rights-holders and duty-bearers within laws and policies and specify the responsibilities of the parties charged with implementation, such as government ministries and health care providers, and incorporate sanctions for non-compliance while ensuring full respect for the rights of health workers;
  - ensure there are adequate budgetary allocations to the maximum extent of available resources for the full implementation of laws and policies furthering the progressive achievement of the right to sexual and reproductive health;
  - utilize inclusive and broad-based participatory processes involving key stakeholders in the formulation, implementation and monitoring of laws, including relevant government bodies and ministries, and external stakeholders such as civil society and the vulnerable groups being impacted;

- ensure transparency and access to public information for civil society and users of sexual and reproductive health services, including by creating awareness-raising campaigns about reproductive health care services, and implement mechanisms to engage civil society and users of sexual and reproductive health services in policy monitoring and evaluation;
- devise comprehensive strategies to effectuate existing legislation on sexual and reproductive health and rights. This requires the adoption of a national strategy to ensure to all the enjoyment of sexual and reproductive health and rights, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding indicators and benchmarks. The national health strategy should also identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources; and
- formalize and distribute guidelines and provide training on laws and policies to ensure that the appropriate actors, including government ministries and, importantly, health care providers, are informed of their obligations to ensure the provision of lawful services.

- **To ensure that laws and policies being implemented are attaining their desired aims, states should consistently monitor and evaluate laws and policies by:**
  - collecting disaggregated data on access to and use of sexual and reproductive health services. States should use this data to ensure laws and policies do not have a discriminatory impact and that they appropriately address national needs and unmet demand for services from all segments of the population, especially marginalized groups;
  - putting in place rigorous mechanisms to ensure that programs are being effectively implemented and are reaching their target populations, and take targeted measures to adjust programs to respond to identified gaps in their execution; and
  - ensuring through legislative and other measures that regulatory, legal, and social barriers, including conscientious objection, mandatory waiting periods, and requirements for third-party authorization, do not prevent access to comprehensive reproductive health services.

Guaranteeing Access to Remedies for Human Rights Violations

To comply with their national and international legal obligations, states must ensure that individuals harmed by human rights violations have access to appropriate and adequate remedies and take measures to prevent human rights violations from recurring. To this end, states should:

- develop effective and responsive mechanisms for reporting and filing claims about human rights violations that address the sensitive nature of sexual and reproductive rights violations and make these mechanisms known and accessible to users;
- conduct thorough, fair, and impartial investigations into allegations of sexual and reproductive rights violations;
- enable national human rights institutions and ombudspersons to inquire broadly into sexual and reproductive health and rights issues; investigate individual complaints; make recommendations directly to governments on alleged human rights violations; conduct public awareness campaigns; and review national laws and administrative regulations relating to reproductive rights, including laws which are discriminatory or criminalize access to sexual and reproductive health services;
- ensure that judicial, national human rights institution and ombudsperson proceedings are transparent, accessible, and effective;

- implement recommendations from UN treaty monitoring bodies and other international and regional human rights institutions in order to address and remediate potential human rights violations;
- provide appropriate redress to victims when violations have occurred; sanction perpetrators with appropriate civil, penal, or administrative decisions; and implement measures to prevent future violations and mechanisms to monitor for such violations;
- restore the liberty and dignity of individuals who have been deemed criminals based on laws criminalizing reproductive health services and provide them with appropriate, adequate reparations;
- train health care workers, judges, prosecutors, police, and ombudspersons to prevent, recognize, and respond to sexual and reproductive rights violations; and
- revise laws that exonerate perpetrators of violence against women and girls, including provisions that allow them to evade punishment if they marry the victim, or are the partners or husbands of the victim, and eliminate sexual violence from post-conflict amnesty provisions.