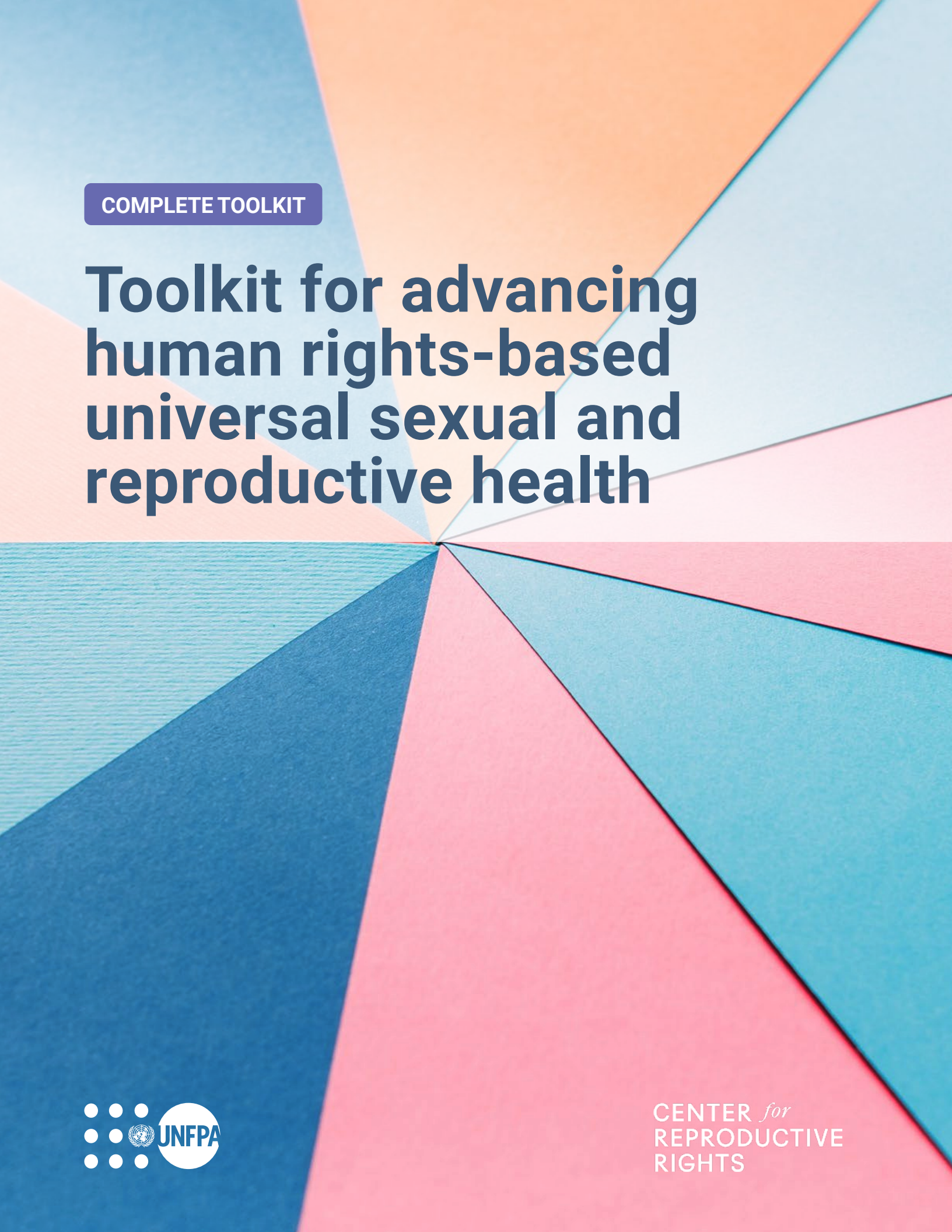
COMPLETE TOOLKIT

Toolkit for advancing human rights-based universal sexual and reproductive health



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Acknowledgments

This toolkit is a publication of the United Nations Population Fund (UNFPA)[1] and the Center for Reproductive Rights (CRR). It was conceptualized by Rebecca Brown, Senior Director of Global Advocacy at CRR, and Emilie Filmer-Wilson, Human Rights Advisor at UNFPA. The toolkit was drafted by Payal Shah, CRR consultant, and Violeta Canaves, Human Rights Analyst at UNFPA. Research and drafting support was also provided by Emily Walsh, CRR Fellow. The toolkit was reviewed and edited by Rebecca Brown; Emilie Filmer-Wilson; the UNFPA reference group (Gabriela Alvarezminte, Gunilla Backman, Maria Bakaroudis, Elizabeth Benomar, Catherine Breen Kamkong, Nafissatou Diop, Jennie Greaney, Anneka Knutsson, Geeta Lal, Alexandra Robinson, Tim Sladden, Jyoti Tewari, Francelle Toedtli, Irem Tumer, and Ilya Zhukov); Christina Zampas, Associate Director of Global Advocacy at CRR; and Alejandra Cardenas, Director of Global Legal Strategies at CRR. This toolkit benefited from the invaluable feedback provided via pilot testing by UNFPA country offices in Malawi, Rwanda, and Zambia, the UNFPA East and Southern Africa Regional Office, the Swedish Embassy in Rwanda, AfriYAN Rwanda, the Health Development Initiative (Rwanda), IntraHealth International (Rwanda), and Ministry of Health officials in Malawi and Zambia. The pilot testing was facilitated by UNFPA's Regional Office for Eastern and Southern Africa. Emma Chessen, Program Coordinator at CRR, supported the toolkit's publication and dissemination process.

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List of Acronyms

CEDAW	Committee on the Elimination of Discrimination against Women
CEFM	Child, early, and forced marriage
CRR	Center for Reproductive Rights
CSE	Comprehensive sexuality education
FGM	Female genital mutilation
ICPD	International Conference on Population and Development
OHCHR	Office of the United Nations High Commissioner for Human Rights
SDG	Sustainable development goal
SOGIESC	Sexual orientations, gender identities, gender expressions, and sex characteristics
SRHR	Sexual and reproductive health and rights
STIs	Sexually transmitted infections
UHC	Universal health coverage
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization

User's Manual

What is this toolkit?
This toolkit provides practical guidance for those seeking to incorporate a human rights-based approach to sexual and reproductive health in the context of universal health coverage (UHC).

Through seven thematic modules—(1) maternal health, (2) contraceptive information and services, (3) sexuality education, (4) abortion care, (5) HIV and other sexually transmitted infections, (6) gender-based violence, and (7) harmful practices—the toolkit outlines key questions that users can ask themselves as they analyze the human rights compliance of their countries' health systems. It provides relevant resources, case studies, and practical examples of what "good" implementation of a rights-based approach to universal health care (UHC) looks like.

By translating international human rights standards on sexual and reproductive health and rights into an operational format, the toolkit provides a practical framework for people wishing to assess and improve their health system's compliance with international human rights obligations.

Who can use it?

Government officials, health professionals, civil society, human rights advocates, United Nations staff, and anyone else committed to ensuring a rights-based approach to sexual and reproductive health and rights (SRHR) in UHC.

How can it be used?

This toolkit is meant to guide efforts to shape, inform and review the extent to which international human rights obligations to SRHR have been supported and implemented as part of UHC policies and programs. Among other things, the toolkit can be used to:

- monitor health facilities' compliance with human rights
- identify gaps in the implementation of sexual and reproductive health and rights
- guide discussions on practices and policies to ensure rights-based outcomes
- encourage data collection and research at the national and local level
- provide a practical framework for supporting human rights-based accountability
- spot issues that merit further attention
- provide an entry point for health teams to discuss human rights obligations
- facilitate discussions on sexual and reproductive health and rights obligations with national partners, including governments and civil society.

Key Questions “Traffic lights”

Each “key question” is followed by a column with “traffic lights”—standing for always, often, sometimes, rarely and never—intended to help users answer each question based on their country context.

ALWAYS	OFTEN	SOMETIMES	RARELY	NEVER

INTRODUCTION

Universal health coverage (UHC) is essential to fulfilling a range of human rights, starting with right to enjoyment of the highest attainable standard of health.

To ensure that all people – especially women, girls, and adolescents – can enjoy their right to health, with dignity and without discrimination, coercion, or violence, work to achieve UHC needs to integrate sexual and reproductive health and rights (SRHR). To remain anchored in human rights, these efforts must keep the focus on equality and nondiscrimination, quality of services, accountability, and bodily autonomy.

Fulfilling SRHR and providing UHC are both core components of states' human rights obligations. Providing UHC is a central to states' obligation to respect, protect, and fulfill the right to health, while the international human rights framework requires states to ensure that sexual and reproductive health care is available, accessible, acceptable, of good quality, and free from discrimination, coercion, and violence; to address the root causes of human rights violations, such as gender inequality; and to ensure accountability for the effective implementation of SRHR.

Achieving UHC that includes SRHR is critical to implementing the 2030 Agenda for Sustainable Development. In 2019, world leaders made a political declaration recommitting to achieving UHC by 2030, reinforcing the commitments made in the Sustainable Development Goals (SDGs). The SDGs explicitly recognize sexual and reproductive health as essential to health, development, and gender equality. Sexual and reproductive health is referenced under SDGs 3 and 5. SDG 3 includes a target to "ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes".

In the Programme of Action adopted during the 1994 International Conference on Population and Development (ICPD), states agreed that human rights were the cornerstone to addressing development and population concerns, including the need to eliminate gender-based discrimination and harmful traditional practices; to protect individuals' ability to make free and informed decisions about their sexual and reproductive health; to ensure access to voluntary family planning, contraception, and safe abortion; and to ensure safe pregnancy and childbirth. The ICPD Programme of Action also called on states to ensure that reproductive health care is available through the primary health care system by 2015.

While states are obligated to comply with the international human rights framework in implementing UHC, there is little guidance available on how to integrate a rights-based approach to sexual and reproductive health in national UHC policies and programs. This toolkit provides a practical guide, to support government officials, civil society organizations, human rights institutions, health professionals, United Nations (UN) staff and other key stakeholders working on SRHR in ensuring a rights-based approach to sexual and reproductive health in developing policies and programs for UHC.

Drawing on international human rights standards, the toolkit aims to support advocacy, policy, and other relevant work on SRHR to ensure that all people—particularly those furthest behind—have the means, information, and services available to make free and informed decisions related to sexuality and reproduction. In this sense, it aims to support the broader goal of building strong, sustainable, and rights-supporting Universal Health Care, particularly as it concerns SRHR.

The toolkit offers seven thematic modules, exploring key human rights-based elements as they relate to seven thematic areas of sexual and reproductive health:[2]

- maternal health
- contraceptive information and services
- comprehensive sexuality education
- comprehensive abortion care
- HIV and sexually transmitted infections
- gender-based violence
- harmful practices.

Each module provides a questionnaire, with key questions drawing on international human rights standards and principles, along with practical examples and helpful resources. The questionnaires are meant to support the analysis of current programs and policies, and the resources offer ideas for strengthening a rights-based approach.

The challenges unleashed by the COVID-19 pandemic have highlighted the urgency of guaranteeing UHC and SRHR and ensuring that the recovery puts people and their human rights front and center. This toolkit aims to provide both inspiration and direction for elevating the centrality of rights and choices in efforts toward UHC.

Module 1

Human Rights Standards on

Maternal Health

More than 800 women die daily from preventable causes related to pregnancy and childbirth –largely the result of gender inequality, discrimination, health inequities, and a failure to guarantee human rights.[3]

Over 70% of maternal deaths worldwide result from severe bleeding, high blood pressure, infection, complications from unsafe abortion, and prolonged or obstructed labor. Most of these emergencies are preventable, if identified and managed in a timely manner.[4] Reducing the global maternal mortality ratio to 70 per 100,000 live births by 2030 is a key SRHR and UHC target in the SDGs.

Upholding human rights goes beyond simply preventing death during pregnancy and childbirth. The right to safe pregnancy and childbirth includes the right to access the full range of services in connection with pregnancy and the postnatal period, without being subjected to discrimination, coercion, or violence.[5]

Health systems must guarantee that sexual and reproductive health services are available, accessible, acceptable, and of good quality.[6] States must address the denial of women's autonomy in decision-making that occurs across maternal health care contexts, including during prenatal care, labor, and childbirth – including violations of the right to informed consent and abuses of the doctrine of medical necessity.[7] Examples include forced sterilization immediately following childbirth, over-medicalized and unconsented-to procedures during and immediately after childbirth, and breaches of privacy and confidentiality prior to and during a woman's stay in a health care facility.[8]

Such abuses violate women's rights to physical integrity and autonomy, can cause lasting harm to their health and well-being, and have grave impacts on public health and human rights, as recognized by the World Health Organization (WHO).[9] They disproportionately affect women, adolescents,

and people of diverse sexual orientations, gender identities, gender expressions, and sex characteristics (SOGIESC), as well as those from marginalized groups or with intersectional identities.

Addressing maternal health from a human rights perspective requires developing laws, policies, and practices to guarantee individuals' health, well-being, and freedom from violence throughout pregnancy, delivery, and the postpartum period—including by creating an enabling environment for well-trained and well-supported health professionals. A human rights-based approach to maternal health also addresses the power dynamics that perpetuate inequalities, through strategic interventions such as reallocating resources, strengthening accountability mechanisms within health systems, and taking steps to dismantle negative social and cultural norms.[10] Because providing maternal health care is a "core obligation" under international human rights law, states must ensure safe pregnancy and childbirth even in the context of economic or other challenges.[11]

Key Questions

for Monitoring Health System Compliance with Human Rights Obligations

The questionnaire below provides a tool for assessing your health system's compliance with human rights obligations regarding maternal health care.

There are many dimensions to ensuring safe pregnancy and childbirth. A human rights-based approach to maternal health care requires action across sectors, coordinated through dedicated and comprehensive policies, programs,[12] strategic plans and campaigns[13] that guarantee access to birth assistance,[14] prenatal care,[15] emergency obstetric care,[16] and quality post-abortion care.[17] Maternal health care should be provided in a manner that is respectful and ensures women's autonomy in decision-making[18]

1. Is quality maternal health care at functional health care facilities available as needed, physically accessible and affordable to all, including in remote areas?[19]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

2. Are communities accessing these services?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

EXAMPLES OF IMPLEMENTATION

Engage with the drug regulation authority to ensure that all essential medicines for treating pregnancy-related complications (e.g., misoprostol to treat postpartum hemorrhage or incomplete abortion) are legally permitted, registered for obstetric use, and available in practice.[20]

Work with local health officials and health facilities to ensure that maternal health care is physically available by providing transportation, modifying buildings to ensure access for people with disabilities, and adequately staffing health centers, even in remote areas.

Engage national health officials to adopt policies guaranteeing free access to maternal health care and to allocate adequate budgets to implement this guarantee.

Ensure that facilities are well equipped with medicines and equipment and that personnel are available and adequately trained to provide quality, respectful, and nondiscriminatory maternity care.

Conduct participatory research with community members to identify social, geographic, economic or other barriers preventing them from accessing quality maternal health care.

KEY RESOURCES

UNFPA, AMDD, and University of Geneva, Implementation Manual for Developing a National Network of Maternity Units and Improving Emergency Obstetric and Newborn Care

OHCHR, Information Series on Sexual and Reproductive Health and Rights: Maternal Mortality and Morbidity

OHCHR, UNFPA, FXB Center, PMNCH, and WHO, Summary Reflection Guide on a Human Rights-Based Approach to Health: Application to Sexual and Reproductive Health, Maternal Health and Under-5 Child Health—Health Policy Makers, p. 20

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 35

3. Is information on sexual and reproductive health and maternal health accessible and understandable to all (considering age, language, age, ability, etc.)?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

4. Is comprehensive sexuality education accessible and available?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

EXAMPLES OF IMPLEMENTATION

Develop and disseminate information and education materials on maternal health and rights in the most common local languages, Braille, and adolescent-friendly formats.

Work with national and subnational health officials to develop and implement a curriculum on comprehensive sexuality education that includes maternal health.

Develop culturally appropriate communication campaigns in collaboration with communities, faith-based organizations, and civil society organizations to raise awareness around stigmatized aspects of maternal health (such as abortion, mental health, and forms of maternal morbidity such as obstetric fistula and uterine prolapse) and where to seek treatment.

KEY RESOURCES

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 34

See also questionnaire on "Comprehensive Sexuality Education"

5. Is the quality of maternal health services being maintained, including by ensuring skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, and respectful care?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

EXAMPLES OF IMPLEMENTATION

Support local health offices in developing oversight and monitoring programs for maternal health care, including how to follow standardized protocols for managing inventories of drugs and equipment, patient records, and patient care.

Ensure that health care providers are properly trained and their competencies are maintained through supportive supervision and mentoring to provide quality, respectful care to all patients.

Ensure the proper recording of maternal and newborn deaths and stillbirths, health worker training on how to conduct maternal death reviews, and feedback mechanisms for quality-related improvements in health facilities. Conduct patient satisfaction surveys.

Work with national health officials and medical schools to develop and implement national guidelines on respectful maternal health care, and integrate these guidelines into the medical school training curriculum.

Engage with national health officials and civil society organizations to ensure adherence to guidelines on the prevention of disrespect and abuse in maternal health care (such as regulations prohibiting the shackling of incarcerated people in labor, or detention in hospitals postpartum due to inability to pay medical fees). Ensure that redress mechanisms for complaints are clearly established and guarantee confidentially.

KEY RESOURCES

OHCHR, UNFPA, FXB Center, PMNCH, and WHO, Summary Reflection Guide on a Human Rights-Based Approach to Health: Application to Sexual and Reproductive Health, Maternal Health and Under-5 Child Health—Health Policy Makers, p. 20

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 35

5. Is maternal health care provided in a manner that is culturally appropriate?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

6. Are confidentiality and privacy guaranteed in the provision of maternal health care?[21]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

EXAMPLES OF IMPLEMENTATION

Facilitate participatory inclusion audits or reviews of maternal and adolescent health policies and action plans to gather views on how well these instruments meet the needs of indigenous women, women of African descent, women with disabilities, people with actual or perceived diverse SOGIESC, and adolescent girls.

Support national and subnational health officials in designing health facilities that include private spaces for confidential counseling, examination, and treatment, and in implementing policies that clarify that counseling sessions and examinations should include only the patient, unless they request the presence of a spouse or another person.

Work with national law and justice officials to ensure that laws on mandatory reporting (including as they relate to sexual violence and abortion) comply with human rights standards on confidentiality and privacy.

KEY RESOURCES

UNFPA, UNICEF, and UN Women, Fact Sheet on Indigenous Women's Maternal Health

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 34

7. Do legal and professional regulations respect service users' autonomy and support informed consent, including by providing counseling?[22]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

EXAMPLES OF IMPLEMENTATION

Partner with legal experts on sexual and reproductive rights to review restrictions on the disclosure of health-related information to pregnant individuals, such as provisions that prohibit informing pregnant individuals about conditions that may pose a risk to their lives or health, or laws that place restrictions on maternity care based on marital status. Facilitate consultations on these findings with law and justice officials.

Engage with professional societies of obstetricians and gynecologists to adopt ethical guidance concerning informed consent in maternal health care, including to prevent unnecessary cesarean sections and forced or coercive sterilization or intrauterine device insertion after childbirth.

KEY RESOURCES

UNFPA, Ensure Universal Access to Sexual and Reproductive Health and Reproductive Rights: Measuring SDG Target 5.6, p. 20

8. Has the state taken steps to ensure that goods and services essential to maternal health, as defined in the WHO Model List of Essential Medicines (such as misoprostol and comprehensive abortion care), are legally available and accessible to all?[23]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

EXAMPLES OF IMPLEMENTATION

Work with national law and justice officials and regulatory authorities to review laws and policies to modify or eliminate legal barriers to accessing uterotonic drugs (including the failure to register misoprostol as an essential medicine for multiple obstetric uses).

Work with national law and justice officials and women's legal associations to review laws and policies related to comprehensive abortion care and to develop strategies to modify or eliminate legal barriers to accessing care, including the criminalization of abortion.

Host capacity-building programs with legislators, government officials (including public health officials and health care providers), and the judiciary concerning human rights standards and state obligations relating to the provision of abortion care.

Engage with national and local health officials to adopt policies and programs guaranteeing legal access to humane, dignified post-abortion care, even where abortion is illegal or restricted, and to remove any policies requiring that individuals suspected of having an abortion be reported or requiring that individuals attest to having an abortion before being able to receive care.

Work with training institutions, medical schools, and medical professional associations to strengthen pre-service and in-service education on comprehensive abortion care to build health care providers' capacities to deliver such care.

KEY RESOURCES

UNFPA, Ensure Universal Access to Sexual and Reproductive Health and Reproductive Rights: Measuring SDG Target 5.6, p. 20

WHO, Safe Abortion: Technical and Policy Guidance for Health Systems—Legal and Policy Considerations

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 35

See also questionnaire on "Comprehensive Abortion Care"

9. Are the underlying determinants of healthy pregnancy (including adequate nutrition, potable water, education, sanitation, and transportation) guaranteed to pregnant and postpartum individuals?[24]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

EXAMPLES OF IMPLEMENTATION

Engage with government officials overseeing social welfare programs to ensure that pregnant and postpartum individuals are guaranteed access to nutrition benefits, shelter homes, transportation and potable water.

Work with the Ministry of Education to develop policy guidance to ensure that pregnant students are not expelled from schools and that accommodations are made to allow them to continue their education.

Work with the Ministries of Health and Water and Sanitation to ensure that all health care facilities have a safe and accessible water supply, adequate sanitation, handwashing facilities at points of care and at toilets, and appropriate waste disposal systems.

KEY RESOURCES

CRR, From Risk to Rights: Realizing States' Obligations to Prevent and Address Maternal Mortality, p. 8

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 35

10. Are targeted measures in place to address maternal health among marginalized groups that have disproportionately elevated rates of maternal mortality and face additional obstacles in accessing reproductive health care, including adolescents, poor women, indigenous women, women from discriminated-against racial or ethnic groups, rural women, migrant women, and women with disabilities?[25]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

EXAMPLES OF IMPLEMENTATION

Partner with district-level health offices to collect disaggregated data on maternal mortality among individuals experiencing intersectional discrimination that can hinder access to maternal health care services, such as adolescents, women from ethnic and racial groups facing discrimination, displaced and conflict-affected women, and women living in underserved areas.

Engage with the Ministry of Health and medical schools to develop and implement health education modules to address the linkages between discriminatory stereotyping by health providers (by gender and other factors) and negative maternal health outcomes. These modules should be mainstreamed in pre-service education and imparted through in-service training.

Explore options for addressing attitudinal biases against marginalized groups through mass media and special targeted programs that aim to educate and expose health care workers to the views, perspectives and rights of these groups.

Support national and local health officials in the introduction of a system of maternal death audits (a nonjudicial review that goes beyond medical reasons to identify the social, economic and cultural reasons that led or contributed to a maternal death).[26]

KEY RESOURCES

UNFPA, UNICEF, and UN Women, Fact Sheet on Indigenous Women's Maternal Health

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 34

11. Are confidential and unbiased accountability processes to address and provide remedies for complaints of violence, disrespect, and abuse in maternal health care in place and accessible to all in a timely manner?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

EXAMPLES OF IMPLEMENTATION

Support local health officials and civil society organizations in developing facility- or district-level mechanisms that allow individuals to file complaints and have grievances redressed after experiencing violence, disrespect, or abuse. Provide the necessary information and resources (including free legal assistance where appropriate) to help individuals seek redress for violations.

Work with national judicial academies and national human rights institutions to develop and implement capacity-building programs on maternal health as a human rights concern.

Provide free legal assistance as needed to women whose rights are violated. Support social accountability mechanisms such as citizen score cards.

KEY RESOURCES

OHCHR, UNFPA, FXB Center, PMNCH, and WHO, Summary Reflection Guide on a Human Rights-Based Approach to Health: Application to Sexual and Reproductive Health, Maternal Health and Under-5 Child Health—National Human Rights Institutions

OHCHR, UNFPA, FXB Center, PMNCH, and WHO, Summary Reflection Guide on a Human Rights-Based Approach to Health: Application to Sexual and Reproductive Health, Maternal Health and Under-5 Child Health—Judiciary

CRR, From Risk to Rights: Realizing States' Obligations to Prevent and Address Maternal Mortality, p. 28

CASE STUDIES

Expanding Quality Care for Young Indigenous Mothers in the Republic of Congo

In the Republic of Congo, UNFPA partnered with Médecins d'Afrique to increase access to sexual and reproductive health services for indigenous Baka women in the department of Sangha.

The "First Time Young Mother" initiative piloted a series of interventions from April to June 2017,[27] including:

- hosting workshops for health providers on the specific needs of indigenous women
- training community volunteers to liaise with pregnant women to inform them of their rights to maternal health services and encourage them to go to health clinics
- training traditional birth attendants on biomedical practices to enable them to practice in medical institutions, and
- distributing kits with clothing and soap to pregnant indigenous women prior to their antenatal visits, so that they were able to arrive washed and wearing clean clothes and did not feel embarrassed when visiting the clinics.[28]

As a result of these interventions, the number of women receiving antenatal care and giving birth in health clinics and hospitals in the district increased dramatically. In the first quarter of 2017, 10 women received antenatal care and 11 women gave birth in a medical facility. In the third quarter, 112 women received antenatal care and 38 gave birth in a medical facility.[29]

Holding Maternal Health Providers Accountable for Abuse in Kenya

In 2013, Josephine Oundo Ongwen gave birth in Bungoma County Hospital in Nairobi, Kenya – and suffered severe physical and verbal abuse by hospital staff.

The hospital forced Josephine to purchase the medicine needed to induce her labor, which should have been given free of charge. Nurses told her that if she needed attention once her labor was induced, she would have to walk from the labor ward to the delivery room herself. She did so, only to find no available beds.

Josephine delivered her baby on the floor, with no medical assistance.[30] Finding her unconscious, the nurses physically and verbally assaulted her for dirtying the floor. When she regained consciousness, they made her walk unassisted to the delivery room for examination.[31]

Josephine suffered severe emotional trauma as a result of this maltreatment.[32] Her ordeal was witnessed and documented by another patient, leading to widespread media coverage of her case.[33]

The court that heard Josephine's case found that the hospital had violated her right to dignity and subjected her to cruel, inhumane, and degrading treatment.[34] Its ruling, issued in 2018, clarified that Kenyan law guarantees every person the right to the highest attainable standard of health, including reproductive health; guarantees free maternal health care in public facilities; and establishes that these services must be accessible and safe.[35]

Josephine's case highlights the need for maternity services everywhere to be delivered in a respectful manner that honors each woman's dignity.[36] Since 2018, the government of Kenya has prioritized UHC as one of the key pillars of its Big Four Agenda.[37] Access to free maternal health services is a key component of UHC through the Ministry of Health's Linda Mama program, rolled out by the National Health Insurance Fund in 2017[38] to advance universal access to maternal and child health services and contribute to the country's progress toward UHC.[39]

Module 2

Human Rights Standards on

Contraceptive information and services

The scale of unmet need for contraceptives is vast. In developing regions, 214 million women and girls of reproductive age want to avoid pregnancy but are not using a modern contraceptive method, according to 2017 estimates.[40]

Under human rights law, every person has the right to determine the number and spacing of their children, and to access the information and means to do so, including sexuality education and family planning services.[41]

Unmet need for contraceptives can result in violations of the rights to privacy, health, life, education, nondiscrimination and equality.[42] Human rights law recognizes that high unmet need for contraceptives is linked to numerous harms, including unsafe abortion;[43] maternal mortality and morbidity from higher-risk unplanned or closely timed pregnancies;[44] increased risk of sexually transmitted infections (STIs), including HIV; and infertility arising from STIs.[45] For survivors of rape and other forms of sexual abuse, the failure to ensure legal and accessible emergency contraception is linked to physical and mental suffering, which may amount to ill-treatment.[46]

Barriers to contraceptive information and services may be particularly acute for people from marginalized or vulnerable groups, such as people with disabilities, adolescents, ethnic and racial groups subjected to discrimination, people living with HIV/AIDS, and people living in low-income households or humanitarian settings. People from these groups are also disproportionately affected by coercive or forced contraceptive policies and practices,[47] such as involuntary sterilization,[48] and by harm from poor-quality contraceptive and sterilization procedures. Such practices violate numerous human rights and may rise to the level of torture or cruel, inhuman, or degrading treatment.[49]

Gendered and other stereotypes about who "should" and "should not" reproduce may shape access to contraceptive information and services and affect the risk of coercion. For example, contraceptive-

related policies and programs may exclude single women and adolescents, based on a presumption that they should not be sexually active, or women with disabilities, often stereotyped as asexual. Intersex children may be sterilized early in life due to misconceptions about their fertility and sexuality.

Human rights law and the ICPD Programme of Action recognize states' obligations to ensure that the full range[50] of good-quality, modern, and effective contraceptives are available and accessible to everyone.[51] Human rights law specifically establishes that emergency contraception, which can prevent pregnancy following unprotected sexual intercourse, should be available without a prescription and[52] free for victims of violence, including adolescents,[53] and that special measures should be taken to ensure that it is available in conflict and post-conflict zones.[54]

States are obligated to ensure that the use of contraceptives is voluntary, fully informed, and free from coercion and discrimination, and they should pay particular attention to groups who have historically been subject to coercive family planning practices, such as Roma, people with disabilities, and women living with HIV.[55]

States must also guarantee the right to seek, receive, and disseminate contraceptive-related information. This includes providing access to unbiased, comprehensive, and evidence-based information and services for family planning and contraception, without discrimination and including to adolescents and youth.[56]

Key Questions

for Monitoring Health System Compliance with Human Rights Obligations

The questionnaire below provides a tool for assessing your health system's compliance with human rights obligations regarding contraceptive information and services.

A comprehensive, human rights-based approach to contraceptive information and services programming includes capacity development for health workers, advocacy, adequate data, targeted interventions for marginalized groups, attention toward gender inequality, and strong accountability mechanisms. To support the further assessment and design of programming embracing a human rights-based approach to contraceptive information and services, see the support tool developed by UNFPA.[57]

1. Are contraceptive-related facilities, goods, information, and services available as needed, accessible and affordable, including in remote areas?[58]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support health officials and civil society organizations in ensuring that the full range of contraceptive methods is readily available in public and private clinics (e.g., by supporting procurement and training of health workers, task-sharing where appropriate, and modifying facilities to ensure accessibility for all).

Engage with the Ministry of Health to support the integration of contraceptive information and services into primary health care and sexual and reproductive health care, including postpartum and post-abortion care.

Engage with the drug regulation authority to ensure that all essential medicines for contraception (as recognized in the WHO Model List of Essential Medicines), including emergency contraception, are legally permitted and available in practice.[59]

Examine logistics and procurement policies to ensure the availability of goods and conduct regular monitoring of contraceptive distribution and stocks, with attention to stockouts and method mix at all levels of service delivery.

Review public insurance plans and budgeting processes to ensure the affordability of contraceptive services, including their inclusion in public health insurance schemes and their subsidization.[60]

KEY RESOURCES

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 32

WHO, Ensuring Human Rights in the Provision of Contraceptive Information and Services

UNFPA and WHO, Ensuring Human Rights within Contraceptive Services Delivery: An Implementation Guide, p. 15

2. Are contraception-related facilities, goods, and services provided in a manner that is respectful of medical ethics and culturally acceptable to all, including by being respectful of the cultures of individuals belonging to ethnic and religious minorities and Indigenous Peoples, and sensitive to gender and life-cycle requirements?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

In partnership with affected communities, provide training to health care providers to improve the accessibility of services to all individuals and cultures, including by raising awareness around the needs and cultures of marginalized groups and addressing dominant discriminatory stereotypes and norms that may undermine care.

Ensure that civil society and other stakeholders play a central role in the development and monitoring of laws, policies, and programs on contraceptive information and services.

KEY RESOURCES

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 32

WHO, Ensuring Human Rights in the Provision of Contraceptive Information and Services

UNFPA and WHO, Ensuring Human Rights within Contraceptive Services Delivery: An Implementation Guide, p. 21

UNFPA, Social and Cultural Determinants on Sexual and Reproductive Health: Studies from Asia and Latin America

3. Do all people have access to comprehensive, unbiased, and scientifically accurate[61] information on sexual and reproductive health that covers the full range of contraceptives (including through comprehensive sexuality education and public health campaigns), provided in a manner that is understandable to all (considering age, language, ability, etc.)?[62]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Develop and disseminate information and education materials on contraceptive information and services and related rights in the most common local languages, Braille, and adolescent-friendly formats.

Work with education officials to develop a national curriculum on comprehensive sexuality education that reflects the input of young people and includes contraceptive information and services.

Develop communication campaigns, targeting providers and the public, to destigmatize contraceptive use and dispel misconceptions and misinformation that create barriers to accessing contraceptives and related services.[63]

KEY RESOURCES

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 31

WHO, Ensuring Human Rights in the Provision of Contraceptive Information and Services

UNFPA and WHO, Ensuring Human Rights within Contraceptive Services Delivery: An Implementation Guide, pp. 28, 37

4. Are sufficient numbers of health care providers adequately trained to provide information and counseling on the full range of contraceptive methods, including emergency contraceptives?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

5. Does the state ensure that access to contraception is not impeded based on conscience by health care providers or pharmacists?[64]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Provide ongoing competency-based training to health care providers to ensure their capacity to provide counseling and services around the full range of contraceptives, including recent advancements and emergency contraception.

Support the development and execution of quality-assurance processes in health care facilities to identify barriers to access, including refusal to provide contraceptive information and services based on conscience.

KEY RESOURCES

WHO, Ensuring Human Rights in the Provision of Contraceptive Information and Services

UNFPA and WHO, Ensuring Human Rights within Contraceptive Services Delivery: An Implementation Guide, p. 32

UNFPA and CRR, The Right to Contraceptive Information and Services, p. 21

See also questionnaire on "Comprehensive Abortion Care"

6. Are state policies, programs, and practices regarding contraceptive goods and services evidence-based and scientifically and medically appropriate, and in line with recent technological advances and innovations?[65]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support national and local health officials in the review of contraception-related policies and programs to ensure the quality of the information presented and the inclusion of recent technological advances and innovations.

KEY RESOURCES

WHO, Ensuring Human Rights in the Provision of Contraceptive Information and Services

UNFPA and WHO, Ensuring Human Rights within Contraceptive Services Delivery: An Implementation Guide, p. 32

7. Have legal and professional regulations been adopted to guarantee the confidentiality and privacy of individuals seeking contraceptive information and services? [66]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support national and local health offices in designing health facilities that include private spaces for confidential counseling, examination, and treatment and in implementing policies that clarify that counseling sessions and examinations should include only the patient, unless they request the presence of a spouse or another person.

KEY RESOURCES

UNFPA and CRR, The Right to Contraceptive Information and Services, p. 17

8. Do legal and professional regulations respect autonomy and support informed consent, including by: providing counseling; removing all third-party authorization requirements (such as parental, spousal, or partner consent);[67] and eliminating non-medical conditions for access to contraceptives (such as restricting access to contraception on the basis of age, marital status or minimum number of children)?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Partner with civil society to provide capacity-building and sensitization programs for health officials, judges, and legislators to raise awareness of human rights standards concerning third-party consent for contraceptive information and services, including for adolescents.

Engage national and local health officials to develop robust protocols for informed consent, including tools to ensure comprehensive counseling and consent forms in multiple languages and formats (e.g., Braille and audio).

Support law and health officials in removing non-medical conditions for access to contraceptives and ensuring that laws and policies on contraceptive information and services and other health care adopt a clear definition of meaningful, free, full, and informed consent.

KEY RESOURCES

UNFPA, Danish Institute for Human Rights, and UNCHR, Reproductive Rights Are Human Rights: A Handbook for National Human Rights Institutions

9. Has the state taken effective measures to prevent or eliminate laws, practices and policies that promote involuntary, coercive, or forced contraception?[68]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Conduct a review of laws, policies, and programs to strengthen commitments to identify if and where such measures may directly or indirectly perpetuate coercion, including through incentives schemes for sterilization, quota policies for providers to perform sterilization, or surgery or sterilization requirements for the legal recognition of one's gender identity or for access to health services such as HIV treatment, obstetric care, gender-affirming surgery, or abortion.[69]

In partnership with affected communities, identify and advocate for procedural safeguards protecting the rights of those who are at high risk of being subjected to medical interventions without informed consent.

Engage medical professional associations to review, develop, implement, and monitor ethical and professional standards for the prohibition of discrimination and stereotyping on all grounds in connection with sterilization, in conformity with international human rights law and ethical standards.

Work with national and local health officials to review contraception-related programming and policies to ensure that access to quality, accessible, acceptable, and voluntary sterilization remains available alongside the full range of short- and long-term contraceptive methods.

KEY RESOURCES

OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, and WHO, Eliminating Forced, Coerced and Otherwise Involuntary Sterilization: An Interagency Statement

10. Are special measures being taken to ensure that contraceptive information and services are provided in compliance with the human rights of marginalized groups, including adolescents, people with disabilities, sex workers, and people living in remote areas or humanitarian settings?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support civil society organizations in advocating for and monitoring the delivery of quality contraceptive information and services and facilitating discussions between service providers and users (particularly those from marginalized groups).

Ensure that recent, reliable, disaggregated contraception-related data is accessible to local advocates, and support them in using data to foster accountability.

Work with national judicial academies and national human rights institutions to develop and implement capacity-building programs on contraceptive information and services as a human rights concern.

KEY RESOURCES

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 31

UNFPA and CRR, The Right to Contraceptive Information and Services, p. 10

11. Has the state ensured administrative or judicial safeguards in instances where an individual is impermissibly denied access to a particular contraceptive method (including emergency contraceptives) or experiences violations of informed consent or other abuses around contraceptive access and use?[70]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Create awareness-raising campaigns and legal aid programs to provide individuals affected by forced, coercive or involuntary sterilization with information on seeking administrative and judicial redress.

Support the establishment of monitoring mechanisms to prevent and document forced, coercive, and otherwise involuntary sterilization and adopt corrective measures.

KEY RESOURCES

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, p. 33

OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, and WHO, Eliminating Forced, Coerced and Otherwise Involuntary Sterilization: An Interagency Statement

CASE STUDIES

Hairdressers Promote Family Planning in Mali[71]

In rural Mali, girls and women often fear that they will be stigmatized when they visit health facilities for services related to family planning or gender-based violence. The distance to health facilities and the cost of transportation present additional challenges.

To dismantle such barriers, UNFPA supports innovative approaches that empower women to access sexual and reproductive health services locally. One such approach involves training beauticians from hairdressing salons serving women and girls to provide family planning counseling and information on gender-based violence and to refer women, when needed, to clinical services or for long-term contraceptives. The trained hairdressers are provided with short-term contraceptives and awareness-raising materials and are supported through regular supervision.

Piloted with 10 salons in 2020, the project has since scaled up to 700 salons. During 2020 and the first three months of 2021, it provided contraceptive methods to 96,181 women.[72]

Investigating the Barriers to Reproductive Health and Rights in the Philippines

In 2012, the Philippines enacted a groundbreaking law—the Responsible Parenthood and Reproductive Health (RPRH) Act—recognizing Filipinos' sexual and reproductive rights. Giving priority to women and those living in poverty or crisis situations, the law guarantees universal, free access to contraception, as well as expanded sexual and reproductive health education, including for adolescents. It also recognizes women's right to post-abortion care.

In the years following the law's enactment, progress in implementation was extremely slow – in a country with one of the highest maternal mortality rates in the Asia-Pacific region, as well as high rates of unmet need for family planning.[73] Women's organizations and reproductive health advocates called on the Commission on Human Rights to act, prompting the creation of a national inquiry on reproductive health and rights with the support of UNFPA.[74] Carried out in 2016, the inquiry included regional consultations, fact-finding missions and public hearings, and consulted 1,263 individuals.

The findings highlighted the uneven delivery of reproductive health services across regions and social strata, primarily because of fragmented health service delivery resulting from decentralization and the autonomy of local governments units. It also found that most people were not aware of their rights and entitlements under the RPRH Act. Furthermore:

- The law was not uniformly supported by local governments. For example, Manila City prohibited public funding from going to contraceptives, and Sorsogon City – whose mayor sponsored a radio show that spread misinformation on contraceptives, claiming that they caused cancer – refused to implement the law.
- Poor women were often treated with disrespect at health facilities, causing them to avoid seeking health services.
- Health care providers often discriminated against people with diverse SOGIESC and those living with HIV, often refusing to provide them with counselling and services.
- Young people, because they needed parental consent to access sexual and reproductive health services, were not accessing modern methods of family planning or being tested for HIV. They had little information on how to prevent pregnancies, leading to an increase in teenage pregnancies.

As a result of the national inquiry, the Department of Health began changing policies and practices that were hindering access to reproductive health services among women, adolescents, and people with diverse SOGIESC. Civil society and the United Nations have leveraged the inquiry's findings to engage with international human rights mechanisms, including the Committee on the Elimination of Discrimination against Women and the Universal Periodic Review of the Human Rights Council, which made recommendations to the Philippine government to strengthen its implementation of the RPRH Act and guarantee women's access to effective methods of family planning. In 2017, the president of the Philippines signed an executive order directing various government agencies to intensify efforts to achieve zero unmet need for modern family planning, in accordance with the RPRH Act.[75]

Module 3

Human Rights Standards on

Comprehensive Sexuality Education

The right to comprehensive sexuality education (CSE) is grounded in universal human rights, including the rights to education, information, and health.[76] Human rights law requires states to take steps to ensure the ability of all individuals to seek, receive, and impart information on sexual and reproductive health.[77]

CSE is a process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. It aims to equip individuals, particularly children and young people, with knowledge, skills, attitudes, and values that empower them to:

- realize their health, well-being, and dignity
- develop respectful social and sexual relationships
- make informed decisions around sexuality and reproduction, and consider how their choices affect their own and others' well-being
- protect themselves and their partners from early and unintended pregnancy, unsafe abortion, HIV and other STIs, and infertility
- identify and seek accountability for gender-based violence and harmful practices, and
- understand and protect their rights throughout their lives.[78]

A human rights-based approach to CSE aims to educate and encourage all individuals, including young people in all their diversity, to recognize their own rights, acknowledge and respect the rights of others, and advocate for those whose rights are violated.[79] It builds awareness of how harmful gender and other stereotypes can perpetuate inequality, and how these inequalities can affect the overall health and well-being of children and young people, including by impeding efforts to prevent STIs, early and unintended pregnancies, and gender-based violence.[80]

To be effective, CSE must be scientifically accurate, incremental, age- and developmentally appropriate, based on human rights and gender equality, culturally relevant and context-appropriate. CSE is proven

to promote a range of positive reproductive and sexual health outcomes, and can help people achieve educational and other development goals. It does not lead to earlier or increased sexual activity.81 Providing CSE during adolescence is particularly critical, as it helps adolescents develop life skills and achieve well-being.

Treaty monitoring bodies have called on states to provide access to CSE in and out of schools,[82] online and in person, irrespective of age and without the consent of parents or guardians.[83] States have an obligation to ensure that the information provided is scientifically accurate and objective, age-appropriate, inclusive, and free of prejudice and discrimination.[84] This includes an obligation to refrain from censoring or withholding information or disseminating biased or factually incorrect information.[85]

The SDGs call for CSE to be recognized as a mandatory component of national school curricula. Indicators under SDG 5.6.2 specify that CSE curricula should include eight key topics: relationships; values, rights, culture, and sexuality; understanding gender; violence and staying safe; skills for health and well-being; the human body and development; sexuality and sexual behavior; and sexual and reproductive health as outlined in international standards.

Key Questions

for Monitoring Health System Compliance with Human Rights Obligations

The questionnaire below provides a tool for assessing your health system's compliance with human rights obligations regarding CSE.

States have an obligation to develop laws, policies, and practices to ensure access to comprehensive, scientifically accurate sexuality information and education consistent with the evolving capacities of children and adolescents.[86] A human rights-based approach calls for the meaningful participation and inclusion of adolescents and youth—including those from marginalized groups—in the development of laws, policies, programs, and other interventions around CSE.

1. Is CSE part of the mandatory or standard school curriculum and accessible to all adolescents, including those with diverse learning needs, in an age-appropriate manner?[87]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Review school curricula in various settings and regions to analyze whether and how CSE is taught, as well as whether such programs are mandatory, presented in a format that is accessible to students with different needs (in local languages, Braille, etc.),[88] and available in age-appropriate forms.[89]

Where CSE is not mandatory or part of the standard curriculum, play a leadership role in advocating for its inclusion, including by increasing national and local health and education officials' familiarity with evidence-based rationales for a gender-focused, rights-based, comprehensive approach.

Partner with young people and foster youth leadership and participation in matters that affect their lives and their communities. Facilitate dialogues between youth networks and advocates, communities, and health and education officials to understand and address concerns about the inclusion of CSE in the school curriculum.

KEY RESOURCES

UNFPA, UNESCO, UNAIDS, UNICEF, UN Women, and WHO, International Technical Guidance on Sexuality Education: An Evidence-Informed Approach, pp. 81, 89

UNFPA, Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender, p. 19

UNESCO, Sexuality Education Review and Assessment Tool (SERAT)

2. Are CSE programs available and accessible through out-of-school initiatives (e.g., through community-based organizations), in order to reach individuals excluded from the educational system?[90]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

In cooperation with key partners, including youth and parents, conduct an assessment of policies on sexuality education and other relevant themes (such as gender mainstreaming in education) at the national and subnational levels, and collect data on the impact of such policies.

Identify whether and how CSE programming outside of schools reaches marginalized groups, such as LGBTIQ youth, youth living with HIV, youth with disabilities, youth who use drugs, and youth who engage in sex for money. Draw on this assessment to develop priorities for action.

Work with civil society and local government officials to map opportunities to link CSE programming with existing programs, including initiatives on gender equality or violence prevention, programs that engage boys and young men on gender equality or sexual and reproductive health issues, and campaigns to end child marriage, prevent transmission of HIV, promote girls' education, promote puberty education or traditional rites of passage, or strengthen laws on gender-based violence.

Partner with national and local health officials to develop public education campaigns and programs to raise awareness about sexual and reproductive health issues, such as the risks of early pregnancy and the prevention of STIs, through the media and other alternative forums.[91]

KEY RESOURCES

UNFPA, UNESCO, WHO, UNICEF, and UNAIDS, International Technical and Programmatic Guidance on Out-of-School Comprehensive Sexuality Education: An Evidence-Informed Approach for Non-Formal, Out-of-School Programs, p. 11

3. Has the state ensured that CSE is taught by trained teachers and peer educators in a safe learning environment, in which individuals are able to participate free from discrimination, harassment, and violence?[92]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Partner with national education officials and youth coalitions to develop materials and include instruction on CSE in teacher training programs to ensure that instructors are adequately trained to provide comprehensive information in a safe learning environment[93] and to ensure respect for confidentiality and privacy.

Work with local youth advocates to identify obstacles that impede individuals' access to CSE and develop advocacy initiatives to counter such opposition.

Work with civil society and other experts to develop trauma-informed CSE programming that teaches about sexuality in a way that does not re-traumatize participants by arousing feelings or memories associated with a traumatic experience (known as triggering).

Support initiatives to develop safe spaces for out-of-school CSE programs, including physical venues and online platforms.

Advocate for the state to take special measures to reach adolescents who face multiple or intersecting barriers to SRHR,[94] including adolescent girls; young people with disabilities; those living with HIV/AIDS, in detention, or in humanitarian contexts; young people selling sex; and adolescents of diverse SOGIESC.

KEY RESOURCES

UNFPA, UNESCO, UNAIDS, UNICEF, UN Women, and WHO, International Technical Guidance on Sexuality Education: An Evidence-Informed Approach

RAND, Support for Students Exposed to Trauma: The SSET Programme, Group Leader Training Manual, Lesson Plans, and Lesson Materials and Worksheets

CARDEA, Guide to Trauma-Informed Sex Education

UNFPA, UNESCO, WHO, UNICEF, and UNAIDS, International Technical and Programmatic Guidance on Out-of-School Comprehensive Sexuality Education: An Evidence-Informed Approach for Non-Formal, Out-of-School Programs, p. 18

UNESCO, Global Guidance on Addressing School-Related Gender-Based Violence

4. Has the state developed a quality CSE curriculum that is scientifically accurate, unbiased, nondiscriminatory, rights-based, and inclusive of and responsive to sexual and gender diversity?[95]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support national education and health officials in developing CSE materials and ensuring they are up to date, scientifically accurate, free of gender and other harmful stereotypes or social norms,[96] and inclusive, including by facilitating expert reviews of such materials and inputs for improvement by young people and other key stakeholders.

Convene and support a diverse coalition of young people, including those from marginalized groups, to conduct annual reviews of CSE curricula to identify gaps or areas for strengthening, including revisions to address harmful and discriminatory stereotypes,[97] address unequal power dynamics and patriarchal or heteronormative norms,[98] and integrate a gender perspective that respects diversity.[99]

Develop young people's capacity for advocacy by involving youth leaders as stakeholders in policy actions and by including lessons on advocacy and rights—especially advocacy around sexuality education and human rights and diversity—as part of CSE curricula.

Facilitate partnerships between local governments and civil society organizations that are experienced in developing and implementing gender-transformative programs to conduct CSE programs. Ensure that such efforts reach out to youth who are not in school, and prioritize vulnerable girls, including those who are married.

KEY RESOURCES

UNFPA, UNESCO, UNAIDS, UNICEF, UN Women, and WHO, International Technical Guidance on Sexuality Education: An Evidence-Informed Approach, p. 84

UNFPA ESARO, Regional Comprehensive Sexuality Education Resource Package for Out of School Young People

UNFPA, Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender

See also questionnaires on "Contraceptive Information and Services," "HIV and Other STIs," "Gender-Based Violence," and "Harmful Practices"

5. Does the CSE curriculum raise awareness of gender-based violence and harmful practices, with the aim of providing participants with tools to prevent, identify, and report gender-based violence and harmful practices?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support coordinators of CSE programs in linking to initiatives in other sectors that have overlapping goals (e.g., national programs and campaigns to end child marriage, prevent transmission of HIV, promote girls' education, and strengthen anti-rape laws).

Ensure that CSE programs discuss how gender-based violence and harmful practices link to human rights, and provide tools to recognize such practices, understand how to seek support, and advocate for their elimination.

KEY RESOURCES

UNFPA, UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender

See also questionnaires on "Gender-Based Violence" and "Harmful Practices"

6. Has the state taken steps to repeal laws, policies, and regulations restricting access to CSE and information on sexual and reproductive health, including laws requiring parental authorization for participation in such programs or contradictory provisions in plural legal systems?[100]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

With national legal experts and national child rights' mechanisms, conduct a review of laws, policies, and regulations to identify provisions that may hinder access to information on sexual and reproductive health (e.g., parental consent requirements for CSE; parental consent requirements for sexual and reproductive health care; laws mandating the reporting of children's sexual activity; and laws criminalizing adolescents for consensual sexual activity, marriage below legal minimum ages, or drug use).

KEY RESOURCES

UNFPA APRO, Rights Versus Protection. Marriage, Sexual Consent and Medical Treatment

UNFPA ESARO, Harmonizing the Legal Environment for Adolescent Sexual and Reproductive Health and Rights

UNFPA ESARO, Technical Brief on Criminalization of Consensual Sexual Acts among Adolescents

CRR, Capacity and Consent: Empowering Adolescents to Exercise their Reproductive Rights

See also questionnaires on "Contraceptive Information and Services," "HIV and Other STIs," and "Harmful Practices"

7. Has the state enacted administrative or judicial safeguards to provide remedy and redress regarding violations of human rights related to CSE and sexual and reproductive health information (e.g., improper requirement of parental consent; information promoting heteronormative stereotypes; and non-evidence-based information or curricula that adopt an abstinence-only approach[101]**)?**

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Build capacity among officials from the judiciary and human rights institutions concerning evidence-based rationales for CSE and relevant international and regional human rights standards.

Raise awareness among the public, including among young people and adolescents, of their rights to CSE and sexual and reproductive health information, and how to access such services inside and outside of school.

CASE STUDY

Bringing Comprehensive Sexuality Education to Out-of-School Adolescents and Youth in Iran

In Iran, evidence has shown that out-of-school adolescents are more likely to become infected with HIV than their peers. In order to reach and protect adolescent girls and boys at risk of HIV with comprehensive sexuality education, Iran's Centre for Communicable Diseases Control adapted two modules from UNFPA's International Technical Guidance on Sexuality Education (ITGSE).[102]

The modules – on sexual and reproductive health and relationships – were developed in a participatory manner by national and international experts, with inputs from adolescents, young people, and staff from Adolescent Well-being Centres. The process provided an opportunity to build the reproductive health education capacities of national experts and Centre for Communicable Diseases Control staff.[103]

Three preliminary workshops took place to prepare the training curricula, including a training of trainers for staff of the Adolescent Well-being Centres on how to conduct focus group discussions,[104] an introduction to the Comprehensive Prevention Programme for Ministry of Health and Medical Education staff, and a participatory session with adolescents and youth to make sure that the training modules reflected their needs.[105] Packages of training materials were subsequently developed through 10 focus group discussions involving adolescent girls and boys at risk of HIV.[106] Their parents, along with staff from the Adolescent Well-being Centres, were included in the discussions to identify and respond to the needs of adolescents and youth.[107]

The training packages included a curriculum for adolescents and youth, and a training guide for service providers on STIs, puberty, and communication between parents and adolescents.[108] Each package was developed separately for boys and girls to ensure gender-responsiveness.[109]

Module 4

Human Rights Standards on

Comprehensive Abortion Care

Access to legal and safe abortion services is essential to the attainment of the right to health, as recognized by WHO. Comprehensive abortion care includes information, goods, services, and facilities for safe abortion – which can be completed through medication or surgery – and the provision of post-abortion care. Medical abortion plays a critical role in expanding access to care, particularly in early pregnancy, because it can be supported on an outpatient basis, can be administered by a range of providers, including family physicians, internists, nurse practitioners and certified midwives, and allows individuals a greater role in managing their abortion care.[110]

In 2010–2014, approximately 45 percent of all abortions worldwide were estimated to be unsafe.[111] Human rights law has long recognized the connection between restrictive abortion laws, high rates of unsafe abortion, and maternal mortality.[112] Human rights bodies have found that restrictive abortion laws violate a range of human rights, including the rights to health, life, privacy, freedom from gender discrimination and gender stereotyping, and freedom from ill-treatment.[113] The criminalization of abortion, denial or delay of safe abortion and post-abortion care, and forced continuation of pregnancy are recognized as forms of gender discrimination and gender-based violence.[114]

Legal, regulatory, and practical barriers, both in countries with more restrictive abortion regimes and in those with more liberal ones, can effectively deny women access to safe abortion services. Restrictive abortion laws, criminal laws that punish women or providers for helping women undergo abortion, mandatory waiting periods and biased counseling requirements, refusals to perform legal abortions based on conscience, the absence of public funding, a lack of availability of commodities and supplies, and a lack of confidentiality and respectful care are but a few barriers that women face across the globe.[115]

The ability to decide whether, when, and how to terminate a pregnancy is shaped not only by barriers to health information and services, but also by unequal power dynamics and discriminatory gender norms, stereotypes and practices. Human rights bodies have repeatedly highlighted how women and girls may be deprived of reproductive autonomy due to laws and practices grounded in patriarchal norms and stereotypes according to which women's value lies in their capacity to be mothers, who should be self-sacrificing,[116] and who lack the mental capacity to make decisions about their own bodies.[117] These discriminatory gender stereotypes and practices compound health system barriers to comprehensive abortion care, including a lack of regulations allowing non-physicians to provide care, refusal to perform abortion based on conscience, a lack of availability of commodities and supplies, and a lack of confidentiality and respectful care.

Evidence demonstrates that legal restrictions on abortion do not reduce the number of induced abortions – rather, they contribute to higher rates of unsafe abortion.[118] Further, criminal laws on abortion can lead to harassment and even prosecution of individuals seeking care for obstetric emergencies due to suspicion of induced abortion.

Human rights law requires states to decriminalize access in all circumstances and to ensure available, accessible, affordable, acceptable, and good-quality services, at a minimum, to save the life or health of the pregnant person, in cases of rape or incest, and in cases of fetal diagnosis incompatible with life.[119] Human rights law also requires that states address legal barriers to comprehensive abortion care, as outlined in detail in the questionnaire below. States have specific obligations to ensure that individuals facing multiple and intersecting forms of discrimination—including adolescents, women with disabilities, and rural women—have full and equal access to sexual and reproductive health services.[120] Importantly, states must prevent the stigmatization of individuals who seek, complete, or facilitate an abortion.[121]

Key Questions

for Monitoring Health System Compliance with Human Rights Obligations

The questionnaire below provides a tool for assessing your health system's compliance with human rights obligations regarding comprehensive abortion care. Throughout efforts to support rights-based comprehensive abortion care, it is critical to ensure the participation of women and girls, including those from marginalized groups who face intersectional discrimination.

1. Are abortion-related facilities, goods, information, and services in the country available, physically accessible and affordable, including, at a minimum, in cases where the pregnancy threatens the life or health of the pregnant person and in cases of rape, incest, or fetal impairment incompatible with life, as defined in the standards of UN treaty monitoring bodies?[122]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support health officials at all levels in ensuring that abortion services are readily available in public and private clinics (e.g., by supporting procurement and training of health workers, task-sharing where appropriate, telehealth services, and modification of facilities to ensure accessibility for all).

Engage with the drug regulation authority to ensure that all essential medicines for abortion (as recognized in the WHO Model List of Essential Medicines) – including misoprostol and mifepristone, as well as the combination regimen of misoprostol and mifepristone – are legally permitted, registered for abortion, and available in practice.[123]

Review public insurance plans and budget processes to ensure the affordability of services, including the inclusion of safe abortion and post-abortion care in public health insurance schemes and their subsidization.[124]

Support national health officials in recognizing abortion as an essential health service (including its role in preventing maternal mortality and morbidity) and in implementing measures to ensure continued access to abortion in line with international human rights standards, including in times of emergency or crisis.

Conduct values clarification and attitude transformation programs with health sector actors, including health care providers and health officials, to address stigma and misconceptions around abortion.

Build the capacity of national health officials concerning the safety and practical implementation of self-care interventions for abortion, in line with WHO standards and public health evidence.

KEY RESOURCES

WHO, Abortion Care Guideline

WHO, Safe Abortion: Technical and Policy Guidance for Health Systems—Legal and Policy Considerations

WHO, Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception

WHO, Medical Management of Abortion

WHO, WHO Consolidated Guideline on Self-Care Interventions for Health: SRHR, p. 67

2. Where states allow health care providers to exercise conscientious objection, do they ensure that access to abortion and post-abortion care is not impeded?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Engage with national health officials to raise awareness of human rights standards on conscientious refusal of care and to monitor compliance to guarantee that such refusals do not impede access to abortion at institutions that could otherwise provide the service, that refusals are never permitted in life-threatening conditions or emergencies, and that referrals are always provided.

Support local health officials in implementing patient feedback mechanisms, including concerning reasons for delays or denials of comprehensive abortion care, whether referrals were made, whether care was ultimately received, and whether quality of care was maintained.

KEY RESOURCES

WHO, Safe Abortion: Technical and Policy Guidance for Health Systems—Legal and Policy Considerations

CRR, Law and Policy Guide: Conscientious Objection

3. Are individuals seeking services able to make informed, autonomous, and confidential[125] decisions about abortion, without spousal, parental, or other third-party consent?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support youth networks and groups in the generation of evidence on the impact of laws on abortion access (e.g., laws on parental consent or mandatory reporting of sexual activity below the minimum legal age for consent to sex), and share findings with relevant government officials. Facilitate youth participation in shaping abortion-related programming, laws, and policies.

Collaborate with civil society to provide capacity-building and sensitization programs for health officials, judges, and legislators to raise awareness of human rights standards on third-party consent for abortion, including recommendations by human rights bodies of a presumption of capacity to consent for adolescents seeking sexual and reproductive health services.

Support national health officials in developing training curricula for health care workers to raise awareness about the harm of third-party consent requirements and to dispel stereotypes and social norms that may lead to requests for third-party consent, even where legally not required (e.g., stereotypes that women cannot make decisions about their health independently or that decisions about pregnancy belong to a woman's partner or family).

Support national and local health offices in creating private spaces for confidential counseling, examination, and treatment and in implementing policies that clarify that examinations should include only the patient, unless they request the presence of a spouse or another person.

KEY RESOURCES

WHO, Safe Abortion: Technical and Policy Guidance for Health Systems—Legal and Policy Considerations

Ipas, Young Women and Abortion: Avoiding Legal and Policy Barriers

4. Has the state ensured the availability of comprehensive, unbiased, scientifically accurate[126] information on abortion, including its legal status and how to access safe services,[127] in a manner that is understandable to all (considering age, language, ability, etc.)? [128]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Develop communication campaigns targeting providers and the public to destigmatize abortion and dispel misconceptions and misinformation concerning abortion and its legal status that create barriers in accessing services.[129]

Partner with and train journalists on issues related to comprehensive abortion care, build champions who can support the dissemination of evidence-based information, and build awareness of issues around access.

Support health officials and civil society organizations in developing know-your-rights materials regarding abortion for pregnant individuals in a variety of formats (e.g., Braille, audio, and local languages).

Facilitate collaboration between health officials and civil society organizations to establish local accompaniment models to support individuals seeking abortions, establish and sustain hotlines to respond to questions regarding abortion confidentially, and refer individuals to skilled providers.

KEY RESOURCES

IPPF, How to Educate about Abortion: A Guide for Peer Educators, Teachers and Trainers

5. Has the state taken steps to guarantee quality, respectful post-abortion care, irrespective of the legal status of abortion, including by removing any policies or practices requiring health care workers to report individuals suspected of having an abortion or requiring individuals seeking post-abortion care to provide a confession of undergoing an illegal abortion?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Engage with national and local health officials to adopt policies and programs guaranteeing legal access to humane, dignified post-abortion care, even where abortion is restricted, and to remove any policies requiring that individuals suspected of having an abortion be reported or requiring them to attest to having an abortion before being able to receive care. Ensure the participation of women's rights groups, including groups from marginalized communities, in such processes.

Partner with professional networks of health providers, including medical professional associations, to ensure that ethical rules concerning post-abortion care align with human rights standards and to build their capacity as advocates to champion human rights standards around comprehensive abortion care.

Partner with local health facilities to provide training on skills necessary to provide post-abortion care, confirm the legality of provision of such care, and utilize tools such as values clarification to destigmatize abortion.

Provide capacity building to law enforcement officials and the judiciary to avoid unnecessary arrests and prosecutions of individuals for abortion-related crimes.

KEY RESOURCES

WHO, Safe Abortion: Technical and Policy Guidance for Health Systems—Legal and Policy Considerations

CRR and Ipas, Improving Access to Abortion in Crisis Settings: A Legal Risk Management Tool for Organizations and Providers

6. Has the state repealed laws, policies, or regulations that criminalize abortion (in all circumstances),[130] including by eliminating criminalization for health care providers who provide abortion services safely and with pregnant individuals' voluntary and informed consent?[131]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Host capacity-building programs with legislators, government officials, and the judiciary concerning human rights standards on abortion criminalization and the impact of criminalization on health and rights.

Support civil society organizations in mapping and presenting evidence to public officials regarding how criminal laws impact access to abortion and human rights (e.g., laws criminalizing abortion either entirely or outside of limited exceptions; laws criminalizing self-managed abortions; and laws criminalizing certain populations, such as sex workers).

Support national human rights institutions in conducting inquiries into the impact of criminalization of abortion on rights, with a focus on marginalized populations.

KEY RESOURCES

WHO, Safe Abortion: Technical and Policy Guidance for Health Systems—Legal and Policy Considerations

CRR and Ipas, Medical Abortion and Self-Managed Abortion: Frequently Asked Questions on Health and Human Rights

CRR, Abortion Law and Policy Guide: Criminality

7. Are the state's laws aligned with international human rights standards, ensuring, at a minimum, that abortion is legal:

- **where the pregnant person's life is at risk,**
- **where the pregnant person's health is at risk, and**
- **where carrying a pregnancy to term would cause the pregnant person substantial pain or suffering, such as where the pregnancy is the result of rape or incest and in cases of severe or fatal fetal impairments?[132]**

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Work with national health officials to develop tools that offer health care providers guidance from human rights law on the scope and nature of exceptions (e.g., by clarifying that health exceptions should be interpreted in line with WHO's definition of health).

Engage with national and local health officials to ensure that clinical standards, guidelines, and related documents are aligned with human rights standards.

Convene expert briefings with national health and judicial officials to clarify local laws in the context of international human rights law and to ensure coherence across laws, policies, and regulations on abortion.

KEY RESOURCES

WHO, Safe Abortion: Technical and Policy Guidance for Health Systems—Legal and Policy Considerations

CRR and Ipas, Improving Access to Abortion in Crisis Settings: A Legal Risk Management Tool for Organizations and Providers

8. Has the state removed non-evidence-based requirements for access to abortion, including mandatory waiting periods, consent to postpartum contraception, requirements of multiple providers' approval for abortion, and biased counseling requirements?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Convene expert briefings with national health officials to debunk misconceptions on the necessity of such requirements and raise awareness of the impact of these preconditions on access to care, especially for marginalized groups.

9. Has the state taken measures to address discriminatory gender and other stereotypes, as well as abortion-related stigma,[133] that may hinder access to services and decision-making?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support government officials, including law and justice officials, in addressing wrongful gender stereotyping in laws, policies, and cases by lower courts.

Engage with medical schools to provide training to medical students and facility-based health workers on how to recognize and dismantle discriminatory stereotypes.

Engage with women's rights associations and legal champions for gender equality to integrate SRHR into broader legal movements for women's rights and gender equality.

Together with women's rights associations and broader civil society organizations, create public awareness campaigns that seek to address and dismantle discriminatory stereotypes that impede comprehensive abortion care.

Strengthen the capacity of judicial sector actors to recognize discriminatory stereotypes in the context of abortion, and raise awareness of state obligations to address them.

KEY RESOURCES

UNFPA, State of the World's Population 2020, p. 118

OHCHR, Background Paper on the Role of the Judiciary in Addressing the Harmful Gender Stereotypes related to Sexual and Reproductive Health and Rights: Review of Case Law

Ipas, Youth Act for Safe Abortion: A Training Guide for Future Health Professionals

10. Are special measures being taken to ensure that comprehensive abortion care is provided to marginalized groups, including adolescents, people with disabilities, and people in remote areas and humanitarian settings, to the full extent of the law?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support civil society organizations in advocating for and monitoring the delivery of quality comprehensive abortion care, and facilitate discussions among users (particularly those from marginalized groups), service providers, and government officials.

KEY RESOURCES

Ipas, Abortion Care for Young Women: A Training Toolkit

11. Has the state ensured administrative or judicial safeguards in instances where an individual is improperly denied comprehensive abortion care or faces delays or abuse while seeking care, including at the facility, district, and community level and through the courts?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Create awareness-raising campaigns and legal aid programs to provide individuals who face violations of their rights around comprehensive abortion care with information on the possibility of seeking administrative and judicial redress.

Support the creation of confidential and timely facility-based appeals mechanisms for individuals who face denials of their rights around comprehensive abortion care. Publish materials to raise awareness of where remedies can be sought. Engage civil society movements to guide the development of such mechanisms.

Work with national judicial academies and national human rights institutions to develop and implement capacity-building programs for judges and human rights officials on comprehensive abortion care as a human rights concern (including international and regional human rights standards, comparative perspectives, and public health standards from WHO).

KEY RESOURCES

UNFPA, Danish Institute for Human Rights, and OHCHR, Reproductive Rights Are Human Rights: A Handbook for National Human Rights Institutions

CASE STUDIES

Dismantling Barriers to Comprehensive Abortion Care in Nepal

Nepal's 2002 abortion law permits abortion on most grounds, while its Interim 2007 Constitution enshrines reproductive health as a fundamental right. Still, as of the early 2000s, widespread barriers to abortion hindered access for many women.[134] These included prohibitive costs, with an abortion in a public health facility costing more than the average monthly salary, and a lack of available information, with 80% of rural women unaware that abortion was legal.[135]

Lakshmi Dhikta was forced to continue an unintended pregnancy, because she could not afford a legal abortion in a public hospital.[136] In 2007, together with local activists, she filed a lawsuit citing the government's failure to implement the country's abortion law, which resulted in the obstacles she faced.[137]

In its ruling, handed down in 2009, the Supreme Court of Nepal required the government to create a comprehensive abortion law enabling all women and girls unhindered access to safe and affordable abortion services.138 It noted that such a law should:

- create a national fund to cover abortion expenses for poor and rural women
- enhance the protection of women's privacy rights
- disseminate information on the comprehensive abortion law to inform the public at large
- facilitate access to abortion services for all, and
- allocate affordable and good-quality resources to meet the demand for abortion services.[139]

The Court found that the unavailability of abortion violated the rights to life, health, equality, living with dignity and freedom, personal liberty, privacy, and self-determination. It asserted that "the right to reproductive health is considered as an integral part of woman's human rights, and the right to abortion holds an important place in that."[140]

In response, the Nepalese government took a number of steps. In 2016, it implemented free abortion services in all public health facilities, while expanding safe medical abortion services and training health providers in community-level health facilities.[141] In 2018, the Safe Motherhood and Reproductive Health Rights Act recognized women's right to abortion as a reproductive right, and the Safe Motherhood and Reproductive Health Rights Regulation was adopted in 2020.[142] The Act addresses safe motherhood, family planning, reproductive health-related morbidity, and safe abortion. It prohibits discrimination in the provision of reproductive health care services and requires services to be adolescent- and disability-friendly. It also makes all reproductive services free at public health facilities and requires all levels of government—federal, provincial, and local—to allocate a specific budget for reproductive services.[143]

Repealing the Ban on Abortion in Ireland

Until 2018, Ireland had one of the world's most restrictive abortion laws. In the 19th century, abortion was fully criminalized and subject to severe criminal penalties. The legislative ban was strengthened in 1983, when a new constitutional provision – the 8th amendment, instituted through a public referendum – enshrined a prenatal right to life and equated the "right to life of the unborn" with the right to life of a pregnant woman. As the Irish constitution can only be changed through public referenda, this provision prevented the future reform of Irish law on abortion through ordinary legislative means. Changing the law would require another vote of the electorate.

The impact of Ireland's abortion ban had untold consequences on the lives, health and well-being of generations of women and girls in Ireland. Every year, thousands travelled out of Ireland to obtain abortion care in neighboring countries. Yet for decades following the 8th amendment's adoption, the Irish social and political landscape was dominated by extreme social stigma surrounding abortion. In this hostile environment, the prospect of legal reform to loosen the ban was inconceivable.

Beginning in 2010, a series of external events, tragic occurrences and individual cases began to mobilize a new generation of activists and generate new recognition of the need for change. Intensive grassroots mobilization, civil society organizing and political engagement in support of fundamental legal change mobilization intensified rapidly, while a number of women who had been denied access to abortion care in Ireland filed individual complaints with regional and international human rights mechanisms, contributing to reform efforts.

In 2016 and 2017, the United Nations Human Rights Committee issued ground-breaking rulings against Ireland in the cases of Mellet v. Ireland and Whelan v. Ireland, confirming that Ireland's obligations under international treaties required the removal of the ban on abortion. These cases concerned women who had travelled out of Ireland to obtain abortion care following diagnoses of fatal fetal impairment. The Committee held that both women had been subject to cruel, inhumane and degrading treatment as a result of Ireland's legal ban on abortion, and it instructed the state to reform its laws on abortion, including its constitution, in order to legalize access.

The decisions drew lasting public attention and galvanized political will in favor of reform. In addition to issuing apologies to both women, in 2016 and 2017, respectively, Ireland implemented a series of remedial steps to provide reparations.

In 2018, as a result of decades of efforts and a series of highly strategic interventions by many stakeholders, and following an intensive three-month public referendum campaign led by the civil society coalition, 'Together for Yes', transformative legal change occurred when two-thirds of the Irish electorate voted to repeal the 8th Amendment on 25 May 2018. Later that year, the Irish parliament enacted new legislation legalizing abortion on request in early pregnancy, and thereafter in cases of risk to the life or health of the pregnant woman, or of fatal fetal impairment.

Now, for the first time, abortion care is available and accessible for many women and girls in Ireland, and is provided free of charge in primary care settings, sexual and reproductive health clinics and hospitals. Still, some challenges remain in implementation, and stakeholders are advocating for the removal of all remaining legal and policy barriers and for the full decriminalization of abortion in Ireland.

Module 5

Human Rights Standards on

HIV and other Sexually Transmitted Infections

Worldwide, over 37.6 million people are living with HIV, and each year 1.5 million more acquire an HIV infection.[144] Meanwhile, more than 1 million people acquire other sexually transmitted infections (STIs) every day.[145] Untreated, STIs can lead to issues such as infertility, pelvic inflammatory disease, cervical cancer, and poor pregnancy and neonatal outcomes.[146]

HIV and STI case management—delivered via sexual health, reproductive health, and broader primary health care services—includes the detection and treatment of STIs, follow-up, risk assessment, and behavior-change counseling, including providing condoms, lubricants and voluntary HIV testing. Human rights law recognizes that accurate information, goods, and services for the prevention and treatment of HIV and other STIs, as well as for ensuring good sexual health and well-being, are part of the comprehensive package of SRHR, and that sexual health services need to be available, accessible, acceptable, of high quality, and provided without coercion or discrimination.[147]

The importance of addressing STIs through a human rights-based approach has been most clearly articulated in the context of HIV. All individuals have a human right to the best possible attainable health, which includes the prevention, treatment, and care of HIV.[148] People have the right to access information and education on HIV;[149] preventive interventions (including male and female condoms, lubricants, the management of other STIs, and CSE);[150] voluntary and confidential counseling and testing for HIV;[151] nondiscriminatory health care;[152] and accessible and affordable antiretroviral therapy.[153]

Human rights bodies have specifically recognized states' obligation to address barriers to an effective HIV response, including by countering stigma and discrimination, inequality, gender-based violence, the denial of SRHR, the misuse of criminal law and punitive approaches, and mandatory procedures such as HIV testing and sterilization or abortion for women living with HIV.[154] Reducing inequalities is critical for ending the HIV epidemic.[155] Key populations – groups that are particularly vulnerable to HIV, including gay men and other men who have sex with men,

transgender people, people who inject drugs, and incarcerated people – often lack adequate access to services for prevention and treatment.

Where individuals and communities are able to realize their rights—to education, free association, information, and, most importantly, nondiscrimination—the harmful impact of HIV and other STIs is reduced. With information and access to sexual and reproductive health care, as well as respect for bodily autonomy, people are better able to minimize risk factors for HIV and other STIs. People are more likely to seek testing in environments that are open and supportive, protect them from discrimination, treat them with dignity, and provide them with access to treatment, care, and support, and where criminal laws relating to HIV transmission and key populations[156] are repealed to reduce discrimination and exclusion, including in health care settings. In such environments, people living with and at risk of HIV may be better able to reduce HIV-related impact by seeking and receiving treatment and psychosocial support and by taking measures to prevent HIV infection or transmission to others.[157]

The SDGs seek to end the HIV epidemic by 2030 and to leave no one behind, which requires addressing human rights-related barriers that make people vulnerable to HIV and hinder their access to HIV prevention, treatment, care, and support services.[158]

Key Questions

for Monitoring Health System Compliance with Human Rights Obligations

The questionnaire below provides a tool for assessing your health system's compliance with human rights obligations regarding STIs, including HIV. Under human rights law, the participation of people living with HIV and other STIs, key populations, and other at-risk populations in the development of policies and programmes that affect them is critical to ensure that all interventions are grounded in lived realities and respect rights.

1. Has the state developed and implemented national strategies or plans to address the sexual health and well-being of the population that integrate plans or strategies aimed at the prevention, treatment, and management of HIV and other STIs?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Facilitate multisectoral discussions—inclusive of people living with HIV, key populations, and other populations at risk of HIV—aimed at developing or strengthening national and subnational strategies and plans concerning sexual health and well-being, HIV, and other STIs, including ensuring access to testing, prevention, and treatment programs (including programs to reduce both sexual and vertical parent-to-child transmission) [159] and addressing stigma and discrimination against people living with HIV and key populations.[160]

Support reviews of state resource allocations to implement such strategies or plans, including budgetary, human, and administrative resources. Put in place governance and oversight structures that include community representation to develop, implement, and monitor the delivery of sexual health services, including for HIV and other STIs.

KEY RESOURCES

UNAIDS, Checklist and Reference List for Developing and Reviewing a National Strategic Plan for HIV

UNAIDS and OHCHR, International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version, p. 21

OHCHR and UNAIDS, Handbook on HIV and Human Rights for National Human Rights Institutions

2. Are quality goods, services, information, and facilities for preventing and treating HIV and other STIs available and accessible to all as needed?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Partner with government and nongovernment providers, including private practitioners, to ensure universal access to sexual health services, particularly tailored, people-centered, and community-led services for people living with HIV, key populations, and other marginalized populations at risk of HIV (e.g., people with disabilities). Integrate or link HIV and sexual health services with contraceptive care, antenatal and cancer screening services, and broader primary health care.

Ensure that science-based combination HIV prevention is centralized in HIV service provision and includes the following evidence-based interventions: male and female condoms and lubricants, treatment as prevention, pre-exposure prophylaxis, post-exposure prophylaxis, voluntary medical male circumcision, harm reduction (including needle-syringe programs and opioid substitution treatment), CSE in and out of school, screening and treatment of STIs, and blood safety.[161]

Work with local health officials, key populations, youth, and civil society organizations to ensure comprehensive condom programming, including the promotion of male and female condoms and lubricants. Ensure that condoms are accessible without discrimination,[162] including to adolescents, and promoted within family planning programming.

Support the procurement of pre- and post-exposure prophylaxis for HIV, and train health care providers regarding their use, especially for key populations, women and girls in high-HIV-prevalence settings, and survivors of sexual and gender-based violence.

Partner with local health officials to increase the accessibility of STI prevention and case management, such as by guaranteeing adolescents access to free, confidential, adolescent-responsive, and nondiscriminatory counseling and services.[163]

Ensure universal HIV, syphilis, and hepatitis B virus testing and treatment in all antenatal settings. Refer and follow up with pregnant women diagnosed with HIV. Develop STI case management services for provision via emergency obstetrics and newborn care facilities. Test and follow up on infants who can become infected during pregnancy, childbirth, or breastfeeding. Include services for infants at highest risk of HIV acquisition, as well as treatment for those who sero-convert.[164]

Ensure universal access, particularly for poor and marginalized adolescents of diverse SOGIESC, to vaccines for human papillomavirus, which can lead to cervical, oral, and anal cancer.

Encourage government partnerships with and support for civil society organizations led by people living with HIV, key populations, young people, and other marginalized populations. Support the civil society provision of community-led services (including mobile outreach, community development, peer education, and support) to reduce risks of HIV and STI acquisition or transmission and encourage uptake of sexual health services. Support these services in the inclusion of key population peer navigators to encourage sexual health service utilization.

KEY RESOURCES

UNAIDS, End Inequalities. End AIDS. Global AIDS Strategy 2021-2026

WHO, HIV Prevention, Diagnosis, Treatment and Care for Key Populations

WHO, Actions for Improved Clinical and Prevention Services and Choices: Preventing HIV and Other Sexually Transmitted Infections among Women and Girls Using Contraceptive Services in Contexts with High HIV Incidence

UNITAID, UNAIDS, and WHO, Building Capacity for the Roll-Out of PrEP and HIV Testing Innovations in Asia and Pacific

GNP+, ICW, Young Positives, EngenderHealth, and IPPF, Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: A Guidance Note

UNAIDS and OHCHR, International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version, p. 37

UNFPA, Sexually Transmitted Infections: Breaking the Cycle of Transmission

WHO, Guidelines for the Prevention and Control of Cervical Cancer

UNICEF, UNICEF 2021 World AIDS Day Report: Stolen Childhood, Lost Adolescence

See also questionnaires on “Contraceptive Information and Services” and “Comprehensive Sexuality Education”

3. Do all people have access to comprehensive, unbiased, scientifically accurate165 information regarding HIV and STI prevention, diagnosis, and treatment in a manner that is understandable to all (considering age, language, ability, etc.)?[166]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Work with affected communities to design scientifically accurate public education campaigns on HIV and other STIs in local languages to raise awareness (including on methods of STI transmission and prevention) and reduce stigma against, and promote the rights of, people living with HIV.[167]

Partner with education officials to develop inclusive CSE programs as part of the mandatory school curriculum, with a focus on HIV and other STIs.[168]

Develop and fund out-of-school CSE programs, especially for young key populations.

Conduct assessments of sexuality education programming to ensure that such programs raise awareness of safer sex practices (including combination HIV prevention), highlight the importance of seeking care for STIs to prevent longer-term health harms, provide tools to understand, prevent, and report gender-based violence, and challenge discriminatory gender stereotypes.

Conduct social and mass media behavior-change communication campaigns to raise awareness of STIs and promote safe sex behaviors.

KEY RESOURCES

UNESCO, UNFPA, UNAIDS, UNICEF, WHO, and UN WOMEN, International Technical Guidance on Sexuality Education: An Evidence-Informed Approach

UNFPA, UNESCO, WHO, UNICEF, and UNAIDS, International Technical and Programmatic Guidance on Out-of-School Comprehensive Sexuality Education: An Evidence-Informed Approach for Non-Formal, Out-of-School Programs, p. 11

See also questionnaires on “Contraceptive Information and Services” and “Comprehensive Sexuality Education”

4. Has the state developed tailored measures to address HIV among key populations and other high-risk groups, including through community-led responses?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Commit to implement the Greater Involvement of People Living with HIV/AIDS principle[169] and engage with national health officials and civil society networks of individuals living with HIV, key populations, and other high-risk communities to develop national guidelines and strategies to address HIV and other STIs in target high-risk groups,[170] such as men who have sex with men, people who inject drugs, sex workers, transgender people, young women,[171] people with disabilities, people in rural areas, migrants and displaced people, indigenous people and other marginalized ethnic groups,[172] and older people.[173]

Support national health officials in tailoring HIV-related service delivery to meet the needs of key populations and other high-risk populations and to address inequalities in health care, including among individuals without legal status, criminalized populations, individuals in humanitarian settings, and adolescents.

Strengthen the availability and use of strategic data on HIV, particularly data on young key populations.

Establish epidemiological, behavioral, programmatic, community-led, and participatory monitoring and evaluation systems that generate, collect, and use the disaggregated data needed to reach, support, and empower key populations and other populations affected by HIV.[174]

Support civil society monitoring and assessments of the impact of parental and guardian consent requirements and mandatory reporting of child sexual offenses on access to HIV care.

KEY RESOURCES

Global HIV Prevention Coalition, Implementation of the HIV Prevention 2020 Road Map, p. 10

UNFPA, UNAIDS, WHO, and OHCHR, Translating Community Research into Global Policy Reform for National Action

UNAIDS and OHCHR, International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version, p. 24

5. Has the state addressed social, cultural, and structural factors that may exacerbate the transmission of HIV and other STIs, including poverty, criminalization of key populations, stigma and discrimination, gender-based violence, gender stereotyping, lack of or inadequate sexuality education, and child, early, and forced marriage?[175]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Engage with national officials on gender to map social and cultural factors that compound the risk of contracting HIV and other STIs, and host consultations to identify possible policy responses.

Provide values clarification and attitudinal change training to health care providers and community leaders in order to sensitize them and reduce stigma and discrimination around HIV, other STIs, and sexuality (including diverse SOGIESC, sex work, and the sexual behavior of adolescents and young people).

Provide professional, quality, and people-centered sexual health services to all sexually active people to manage the risk of acquiring HIV and other STIs (including support for individuals who are exposed to intimate partner or family violence; child, early and forced marriage; or other gender-based violence).

Support the formation of multisectoral coalitions—inclusive of people living with HIV, key populations, and other populations affected by HIV—to integrate government programming on HIV and other STIs, gender-based violence, and SRHR.

KEY RESOURCES

WHO, UNFPA, OHCHR, and UNAIDS, Consolidated Guideline on Sexual and Reproductive Health and Rights of Women Living with HIV

UNFPA, UNAIDS, WHO, and OHCHR, Translating Community Research into Global Policy Reform for National Action, p. 10

UNAIDS and OHCHR, International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version, p. 56

UNFPA, Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage

See also questionnaires on "Harmful Practices," "Gender-Based Violence," and "Comprehensive Sexuality Education"

6. Has the state removed legal barriers that hinder its HIV response, including requirements of parental or guardian consent for information and education on STIs (including HIV),[176]

- **laws that criminalize unintentional HIV transmission and exposure,[177] and**
- **criminalization of key populations at high risk of HIV (including men who have sex with men, sex workers, people who inject drugs, and transgender people)?[178]**

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Partner with civil society to provide capacity-building and sensitization programs for health officials, judges, and legislators to raise awareness of human rights standards on adolescents' sexual and reproductive health, CSE, and the criminalization of HIV transmission.

Support law and health officials in reviewing and reforming laws and policies related to HIV to eliminate legal barriers that undermine the HIV response and access to justice (including the criminalization of HIV transmission and key populations).

Facilitate engagement by civil society (including women's movements, youth movements, LGBTIQ movements, sex worker movements, and other key population-led organizations) in international treaty body reviews and Universal Periodic Reviews.

Contribute to HIV-related reporting before international treaty bodies, and support states in implementing treaty bodies' recommendations.

Contribute to states' implementation of the 2021 Political Declaration on HIV and AIDS and the UNAIDS Global AIDS Strategy 2021–2026.[179]

KEY RESOURCES

UNAIDS and OHCHR, International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version, pp. 26-31

UNFPA, SDG 5.6.2: Country level data on laws that restrict access to HIV testing and care, pp. 30-32

UNDP and UNAIDS, Legal and Policy Trends Impacting People Living with HIV and Key Populations in Asia and the Pacific 2014–2019

7. Has the state enacted legislative or regulatory protections to eliminate HIV-related discrimination, ensure confidentiality in testing and treatment, and ensure the rights of individuals living with or at risk of HIV to give informed and voluntary consent to health goods and services, including HIV testing?[180]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Engage with legislators to raise awareness of the need to eliminate involuntary or punitive measures in HIV testing, prevention, and treatment programs, such as the involuntary HIV testing of pregnant women and girls.[181]

Work with health officials to develop protocols for the respectful treatment of patients with HIV, including on how to ensure informed consent and confidentiality, as well as patients' access to their medical records.

KEY RESOURCES

UNAIDS and OHCHR, International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version, pp. 26-31

8. Does the state guarantee that individuals living with HIV have the same right to sexual and reproductive health as HIV-negative individuals, including the freedom to decide whether and when to reproduce[182] and the freedom to have a safe and satisfying sex life?[183]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Work with local health officials to develop facility-level protocols to ensure that individuals living with HIV have access to respectful, quality sexual and reproductive health care, including contraceptive information and services, safe abortion services, perinatal care, skilled attendance during birth, emergency obstetric care, and medicines and technology essential to sexual and reproductive health.[184]

Support national health officials and legislators in eliminating policies and programs that promote or condone involuntary sterilization or abortion for people living with HIV.[185]

Develop information campaigns to address discriminatory stereotypes and misconceptions that women living with HIV should not reproduce, which often lead to involuntary sterilization and abortion.

Partner with national medical professional associations to strengthen and align ethical guidance on the treatment of patients with HIV with human rights standards, with the aim of eliminating discrimination and increasing respect for bodily autonomy and integrity.

KEY RESOURCES

UNAIDS, Evidence for Eliminating HIV-Related Stigma and Discrimination

WHO, UNFPA, OHCHR, and UNAIDS, Consolidated Guideline on Sexual and Reproductive Health and Rights of Women Living with HIV

UNAIDS and OHCHR, International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version, p. 59

See also questionnaires on "Comprehensive Abortion Care," "Maternal Health," and "Contraceptive Information and Services"

9. Has the state enacted administrative or judicial safeguards to provide remedy and redress regarding violations of human rights related to HIV and other STIs, including where an individual living with HIV or member of a key population has been denied essential health care on the basis of their HIV status or has received abusive or discriminatory treatment in health care settings?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support accountability for HIV-related human rights violations by increasing meaningful access to justice for people living with and affected by HIV, in particular key populations, by increasing collaboration among key stakeholders, supporting legal literacy programs, increasing access to legal support and representation, and supporting community monitoring.[186]

Develop programming tools that promote awareness of rights among key populations and other groups vulnerable to HIV, UN staff, service providers, and communities.

Support initiatives to promote free legal services for individuals facing HIV-related discrimination, abuse, or denial of essential health care.

Support local health officials in strengthening accountability mechanisms within health facilities to respond to complaints of discrimination, abuse, and denial of essential health care.

Build capacity among judges, law enforcement officials, ombudspersons, health complaint units, and national human rights institutions to address HIV-related violations of human rights.

Support national human rights institutions in conducting hearings or inquiries on the HIV response for key populations and other high-risk groups from a human rights perspective.

KEY RESOURCES

UNAIDS and OHCHR, International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version, pp. 48, 60

UNFPA, Guide in Support of National Human Rights Institutions: Country Assessments and National Inquiries on Human Rights in the Context of Sexual and Reproductive Health and Well-Being

CASE STUDIES

Ending Abuse and Discrimination against Women Living with HIV in Chile

In Chile, women living with HIV are subjected to widespread abuse and discrimination in health care facilities, including forced sterilization.[187]

In 2002, F.S., a 27-year-old Chilean woman living with HIV, was surgically sterilized without her knowledge by her doctor, who was aware of her HIV status, while giving birth via cesarean section.[188] She suffered significant physical and psychological harms due to her inability to have more children.[189] F.S. filed a criminal case against her doctor, but a Chilean court dismissed it based on a false claim that she had verbally consented to the sterilization – adding to the harms she had already experienced.

Chile is a party to international human rights treaties that protect the right to full and informed consent to contraception and sterilization,[190] and Chilean domestic law requires the patient's written consent before sterilization can occur. In practice, however, women living with HIV are frequently sterilized without their doctors obtaining written or verbal consent.

A report conducted by human rights organizations analyzed systematic abuses against women living with HIV in Chilean health facilities and made several recommendations for actions that should be taken by the Chilean government to prevent future violations, including:

- Allocating adequate space and time in health facilities to ensure that women living with HIV receive comprehensive and medically accurate counseling and information on family planning, pregnancy, motherhood, and HIV;
- Incorporating CSE into school curricula to ensure access to evidence-based sexuality education to provide adolescents with the information they need to protect themselves from HIV transmission; and
- Disseminating information on laws on informed consent and the rights of people living with HIV/AIDS to ensure that all health care faculties, both public and private, are implementing current laws and policies.[191]

Civil society, donor communities, and human rights bodies can increase demand for government accountability and improve health care access by facilitating data collection on intersectional discrimination (such as discrimination involving gender and HIV) and on violence against women and HIV, and by monitoring reproductive health, family planning and HIV/AIDS programs to ensure that they are efficient, of good quality and respect women's rights.[192]

After years of negotiation, the Chilean government and F.S. reached an agreement in 2021. Chile agreed to provide reparations to F.S. for the harms she suffered due to her forced sterilization.[193] The government committed to take measures to ensure informed and free (uncoerced) consent for sterilization procedures, including unique protections for people living with HIV. The agreement establishes a compliance-monitoring mechanism to ensure that Chile fulfills its commitments. Cases of noncompliance will revert back to the Inter-American Commission on Human Rights.[194]

Ensuring Care for Incarcerated People Living with HIV in Namibia

In Namibia, as is the case globally, HIV prevalence in prisons is higher than in the general population, and is currently estimated at 11.5 percent. Incarcerated people commonly experience denial of access to antiretroviral therapy, along with infrequent meals and lack of adequate nutrition.

The Office of the Ombudsman in Namibia has played a critical role in ensuring access to antiretroviral therapy and adequate nutrition for people living with HIV in places of detention. Its staff visited a number of police holding cells and correctional facilities from 2012 to 2019 to verify detainees' complaints. The Office then convened a stakeholders' meeting concerning the conditions in police holding cells in February 2019, at which the police agreed to keep a record of detainees living with HIV on antiretroviral therapy, including dates for follow-up medical examinations and receipt of medication, and to make these records available for inspection by complaints investigators from the Office of the Ombudsman.

The police also undertook to ensure that detainees would be provided with regular meals of adequate nutritional value. The issue of inadequate nutrition in prisons was addressed with the Namibia Correctional Service, which consulted a dietitian and developed a new menu catering to all medical conditions. This menu was implemented in all prisons in February 2020.[195]

Gender-based violence is any harmful act that is perpetrated against a person's will and is based on socially ascribed differences between biological sexes – that is, on gender differences. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty.[196]

Gender-based violence is a human rights violation and a form of discrimination that can be committed against any person as a result of their actual or perceived sex, sex characteristics, or socially constructed gender roles. It most often targets women, girls, and people of actual or perceived diverse SOGIESC.[197] Cisgendered and gender-conforming men and boys can also be victims of gender-based violence, including sexual violence stemming from socially determined roles and expectations.[198]

Approaching gender-based violence from a human rights perspective brings about an important conceptual shift: this kind of violence does not occur by happenstance or because of an inborn vulnerability. It is the result of structural, deep-rooted discrimination and social and gendered stereotypes, which states have a legal obligation to address.

Gender-based violence against women and girls, including those who are same-sex attracted, transgender, or gender nonconforming, is persistent and pervasive. WHO estimates that across their lifetime, one in three women are subjected to physical or sexual violence by an intimate partner or sexual violence from a non-partner.[199] This number has remained largely unchanged for over a decade. Women often begin to experience gender-based violence before they reach their mid-twenties.[200]

Module 6

Human Rights Standards on

Gender-Based Violence

Forms of gender-based violence include femicide; rape; murder; sexual, physical, and psychological violence; harmful practices like female genital mutilation and child marriage; forced sterilization; the criminalization of abortion; the denial or delay of safe abortion; the forced continuation of pregnancy; and the mistreatment of women and girls seeking sexual and reproductive health services.[201] Gender-based violence is associated with increased risk of injuries, depression, anxiety disorders, unplanned pregnancies, STIs, and many other health problems.[202]

States must ensure that perpetrators of gender-based violence are held accountable, across all spheres of human interaction.[203] Under the due diligence principle of human rights law, states have positive obligations regarding gender-based violence, even when committed by private actors. States are responsible should they fail to take all appropriate measures to prevent—and investigate, prosecute, punish, and provide reparations for—acts or omissions that result in gender-based violence, including those by nonstate actors.[204] This obligation includes ensuring effective protection against violence and investigating reports of violence on the basis of actual or perceived SOGIESC.[205]

Breaking the cycle of gender-based violence requires tackling its underlying causes, by addressing systemic economic and social inequalities, ensuring access to education and safe work, and changing discriminatory gender norms and institutions. To meet their obligation to address sexual and gender-based violence, states must ensure that essential services are available and accessible to survivors, challenge discriminatory gender stereotypes, address stigma, reform discriminatory laws, and strengthen legal responses, among other measures. The CEDAW Committee has highlighted legislative and other preventive measures including education, awareness-raising programs involving the media, capacity building for the judiciary, and making public spaces safe and accessible to all women and girls.

Key Questions

for Monitoring Health System Compliance with Human Rights Obligations

The questionnaire below provides a tool for assessing your health system's compliance with human rights obligations regarding gender-based violence and its integration as part of the essential service package for Universal Health Coverage.

Human rights-based approaches provide a clear framework for comprehensive and multisectoral responses, as well as primary, secondary, and tertiary prevention (preventing disorders from developing, providing early detection and treatment, and managing chronic conditions, respectively). The questions are formulated to support the integration of concerns related to gender-based violence into UHC, to improve outcomes for women and adolescents in all their diversity. For this reason, the questionnaire does not reference all sectors of the response, which also involves the security and justice sectors.

1. Has the state developed and implemented national strategies and plans aimed at preventing, punishing, and eradicating all forms of gender-based violence?[206]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Facilitate discussions among diverse stakeholders (e.g., government, civil society, and private sector) and sectors (e.g., health, gender, etc.) aimed at developing or strengthening national strategies and plans concerning gender-based violence, particularly in light of the updated General Recommendation 35 by the CEDAW Committee on gender-based violence against women.

Support reviews of state resource allocations to implement such strategies or plans, including budgetary, human, and administrative resources.

KEY RESOURCES

UN Women, Handbook for National Action Plans on Violence against Women

UNODC, Gender-Based Violence against Women

WHO, UN Women, UNFPA, UNDP, and UNODC, Essential Services Package for Women and Girls Subject to Violence

WHO, UNFPA, UN Women, UNDP, and UNODC, RESPECT Women: Preventing Violence against Women

2. Has the state taken sufficient steps to repeal laws and policies that directly or indirectly excuse, condone, or facilitate violence, including laws that allow for medical procedures on women with disabilities without their informed consent or that criminalize abortion, sex work, or being lesbian, bisexual, or transgender?[207]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support civil society organizations and national human rights institutions in documenting the sexual and reproductive health impact of laws that criminalize abortion, sex work, and being lesbian, bisexual, or transgender, with the aim of informing law reform processes.

Assess how national laws and policies may promote gender stereotypes that sustain gender-based violence.

Support states in their efforts to repeal laws and policies that indirectly excuse, condone, or facilitate violence.

KEY RESOURCES

UNFPA, A Guide in Support of National Human Rights Institutions

3. Has the state taken steps to eliminate gender-based violence in health care settings, such as forced sterilization and disrespect and abuse in maternal health care?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Engage with professional societies of obstetricians and gynecologists to develop ethical guidance to prevent gender-based violence in health care settings, including forced sterilization and mistreatment of pregnant or postpartum individuals.

Develop and implement campaigns to increase awareness among women, girls, and others of their rights in health care settings and how to access complaints mechanisms.

Partner with national human rights institutions to investigate and outline recommendations in response to reports of incidence of such violence.

Provide pre- and in-service training for health workers on gendered and social norms to ensure that health service responses serve as intervention strategies to prevent gender-based violence.

Ensure that laws and policies, as well as health-specific guidelines and standard operating procedures, effectively prohibit all forms of gender-based violence in health care settings and provide adequate remedies where violations occur.

KEY RESOURCES

WHO, UN Women, UNFPA, UNDP, and UNODC, Essential Services Package for Women and Girls Subject to Violence

UNFPA, A Guide in Support of National Human Rights Institutions

4. Are sexual and reproductive health care services for survivors of gender-based violence—including emergency contraception, post-exposure prophylaxis, and safe abortion— available, accessible, affordable (or free where needed), acceptable, and of good quality, in line with international human rights law?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Work with national and local health officials to provide training, procure commodities, and strengthen rules, regulations, and guidelines to ensure survivors' access to free emergency contraception without a prescription,[208] post-exposure prophylaxis,[209] and safe abortion services in line with international human rights law.[210]

Engage with national and local health officials to conduct audits of medico-legal services to ensure the availability, acceptability, accessibility, and quality of gender-based-violence-related medical services for diverse groups of women, girls, and people of diverse SOGIESC, including identifying any procedural barriers (e.g., reporting of violence to police as a precondition for abortion access) that may hinder access to care.

Partner with national and local health officials to provide training to health care providers on the health needs and rights of survivors of gender-based violence, including to strengthen clinical skills, confront discriminatory stereotypes and social norms that undermine care, outline ethical and legal obligations, and facilitate gender-sensitive and compassionate care.

KEY RESOURCES

WHO, Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence

WHO, Clinical Management of Rape in Humanitarian Settings

UNFPA, Minimum Initial Services Package

Global Protection Cluster, Tip Sheet: Addressing Gender-Based Violence (GBV) in Health Assessments and Initial Programme Design

WHO, Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-Care Providers

5. Does the state provide social and legal support services for survivors of gender-based violence, including psychosocial and counseling services, education, affordable housing, employment opportunities, and high-quality legal aid?[211]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support government officials in providing legal aid programs, free 24-hour helplines, and sufficient numbers of safe and adequately equipped crisis, support, and referral centers and shelters for survivors, their children, and other family members.

Engage with education officials to increase opportunities for training and education for survivors of gender-based violence, including pregnant individuals and new parents.

KEY RESOURCES

WHO, UN Women, UNFPA, UNDP, and UNODC, Essential Services Package for Women and Girls Subject to Violence

6. Has the state adopted specific measures in consultation with affected groups to respond to gender-based violence experienced by individuals who face intersectional discrimination, including women with disabilities and adolescents?[212]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Work with national and local health officials to disaggregate data by type of violence and to ensure that data capture the intersecting forms of discrimination and other relevant sociodemographic characteristics.

Support or lead consultative processes aimed at facilitating women's and affected individuals' participation in the design, implementation, monitoring, and provision of services to address gender-based violence.

Partner with civil society organizations and women- and adolescent-led organizations to strengthen referral and access mechanisms and to ensure that services are appropriate and comprehensive.

7. Are programs, strategies, or campaigns in place to support social norms change to eliminate prejudices, patriarchal attitudes, and discriminatory stereotypes, including among the public?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Develop and implement awareness-raising campaigns on gender-based violence, including to promote zero tolerance for violence, address stigma, counter discriminatory gender and intersectional stereotypes, and address other underlying causes of gender-based violence.[213]

Engage with customary, traditional, and religious leaders who ascribe to human rights and gender equality to reach underserved populations with whom they often have contact (e.g., elderly people, women with disabilities, immigrants, and marginalized ethnic groups).

Invest in and support feminist organizations to facilitate their participation in national development processes.

KEY RESOURCES

UNFPA, Women, Faith and Human Rights

UNFPA, Technical Brief: How Changing Social Norms Is Crucial in Achieving Gender Equality

8. Does the state ensure that accountability mechanisms are available to survivors of violence and their families where appropriate; investigate promptly, impartially, and seriously investigations all allegations of violence against women and girls; and bring offenders to justice?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support law, justice and health officials in developing and adopting mandatory, recurrent, and effective capacity-building and education programs for judges, lawyers, law enforcement officials, legislators, and health professionals on the linkages between gender-based violence and discriminatory gender stereotypes[214] and the importance of access to sexual and reproductive health services, in particular STI and HIV prevention and treatment services.[215]

Partner with civil society organizations to conduct legal rights training for women and girls so that they are aware of their right to be free from violence and how to claim it.

Support states in their efforts to establish accountability mechanisms to ensure access to justice and redress for victims of violence that are responsive to the specific obstacles that survivors of gender-based violence face when seeking justice.

KEY RESOURCES

WHO, UN Women, UNFPA, UNDP, and UNODC, Essential Services Package for Women and Girls Subject to Violence

UNODC, Gender-Based Violence against Women

CASE STUDY

Protecting Public School Students from Sexual Violence in Ecuador

Paola Guzmán Albarracín, a 16-year-old high school student in Ecuador, was repeatedly sexually abused by her school's vice principal. When she became pregnant as a result of the abuse, he pressured her to have an abortion.[216] Following this sexual trauma, Paola committed suicide.[217] Though school authorities became aware that she ingested lethal white phosphorus as a suicide attempt, they did not intervene to save Paola's life by taking her to a hospital or notifying her family.[218]

The Ecuadorian government did not conduct a proper investigation into the vice principal's sexual misconduct, thus failing to provide her family with justice.[219]

Paola's case was brought before the Inter-American Court of Human Rights, which determined that by failing to protect Paola, the Ecuadorian government violated her rights to life, personal integrity, private life, dignity, special protection from the state as a child, equality and nondiscrimination, education, and a life free from gender violence and discrimination.[220] Ecuador paid monetary reparations to Paola's family and issued a public apology acknowledging its role in failing to protect Paola and recognizing her as a victim of sexual assault in a school environment.[221]

Paola's case established clear human rights standards to protect public school students from sexual violence and harassment and served as an example for many other states.[222] The Inter-American Court of Human Rights outlined legally required protocols to safeguard the rights of young people to be free from sexual violence and harassment in Latin American and Caribbean schools. These mechanisms include structural measures to address sexual violence, policies mandating sexual and reproductive education as a component of school curricula, acknowledgment of adolescent girls' autonomy (including sexual freedom and control of their bodies), and recognition of consent as central to sexual and reproductive rights.[223]

Module 7

Human Rights Standards on

Harmful Practices

Harmful practices are violations of the rights of women and girls that are deeply rooted in gender discrimination.[224] They take many forms, including child and forced marriage and female genital mutilation (FGM),[225] which have an especially significant impact on the enjoyment of sexual and reproductive health.[226]

Harmful practices constitute a form of gender-based violence and may amount to torture or cruel, inhuman, or degrading treatment.[227] They often involve violence and cause physical or psychological harm or suffering, including through immediate or long-term consequences for the survivor's dignity, physical, psychosocial and moral integrity and development, participation, health, education, and socioeconomic status.[228] The UN Committee against Torture has repeatedly said that practices such as FGM violate the physical integrity and human dignity of girls and women.[229] Many harmful practices place women's and adolescents' sexual and reproductive health and rights (SRHR) at great risk.

A core element of harmful practices is that they are imposed by family members, community members, or society at large, regardless of whether the victim provides, or is able to provide, full, free, and informed consent.[230] These practices are deeply rooted in discrimination, including on the basis of sex, gender, and age.[231] A human rights-based approach recognizes that they stem from societal attitudes and gender stereotypes that regard women and girls to be "irrational" or "weak" and that assign more power, value, and voice to men.

Despite progress in reducing certain harmful practices through targeted efforts, growing populations mean that a larger number of women and girls than ever before are anticipated to face these practices in the coming decades.[232] People facing

intersecting forms of discrimination, including women and girls with disabilities and women and girls in rural areas, are at particular risk of experiencing harmful practices.[233] Situations of crisis, including conflicts and other humanitarian emergencies, can increase the incidence of some harmful practices, including child, early, and forced marriage (CEFM)[234] and FGM.[235] UN agencies estimate that the COVID-19 pandemic may result in two million cases of FGM and ten million child marriages that would otherwise have been averted.[236]

Human rights treaties include both general and specific obligations to address harmful practices.[237] States must eliminate practices that discriminate against women or are prejudicial to the health of children.[238]

A human rights-based approach to harmful practices recognizes that state responses to end such practices should actively seek to transform the discriminatory gender stereotypes at their root, and to ensure respect for bodily autonomy and integrity. Addressing power imbalances and dynamics—including sexism, racism, adultism, classism, ableism, and heterosexism[239]—and empowering women and girls and other oppressed groups are critical to the effectiveness of efforts to address harmful practices. For example, anti-FGM focusing solely on physical harms, rather than implications for bodily autonomy, may inadvertently lead to the medicalization of the practice rather than its eradication.[240] Similarly, initiatives aimed at ending child marriage that address only the legal need to set a minimum age – but do not provide access to opportunities, agency, and services for girls – may be insufficient to put an end to the practice and may lead to unintended consequences, such as increases in informal unions or unregistered marriages.[241]

Key Questions

for Monitoring Health System Compliance with Human Rights Obligations

The questionnaire below provides a tool for assessing your health system's compliance with human rights obligations regarding harmful practices. Because of the particular impact that CEFM and FGM have on sexual and reproductive health, it focuses on these two harmful practices.

Effectively addressing harmful practices is a core obligation of states, meaning that states cannot make reservations to limit or qualify this responsibility.[242] At a minimum, states must collect, update, and disseminate data on the incidence and prevalence of harmful practices; develop and apply appropriate laws and regulations with the participation of affected communities; and implement prevention and response efforts to establish rights-based social, gender, and cultural norms, empower women and communities through education and economic opportunities, raise awareness, and ensure that protective measures, responsive services, and remedies are available to the women and girls most vulnerable to harmful practices.

1. Has the state established a well-defined, rights-based, and locally relevant holistic strategy or plan to address harmful practices, including CEFM and FGM?[243]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Raise awareness among diverse stakeholders (e.g., civil society, government, and the private sector) and among sectors (e.g., health, education, and social protection) concerning what human rights-based approaches to harmful practices entail, as well as the scope and nature of human rights-related legal obligations concerning such practices.

Facilitate discussions with diverse stakeholders aimed at developing or strengthening national strategies and plans concerning harmful practices, guided by the Joint General Recommendation 31/General Comment 18 of the CEDAW Committee and the Committee on the Rights of the Child.

Support reviews of state resource allocations to implement such strategies or plans, including budgetary, human, and administrative resources.

Engage with national health officials, national statistics offices, and other public officials to develop and implement tools to collect disaggregated data on harmful practices, in order to document trends and the girls and women who are most at risk; inform state action; and monitor the effectiveness of laws, policies, and programs.

KEY RESOURCES

UNFPA, State of the World's Population 2020, p. 120

UNFPA, Costing the Three Transformative Results, pp. 23-33

Girls Not Brides, A Checklist for National Strategies to End Child Marriage

UNFPA, Enabling Environments for Eliminating Female Genital Mutilation, p. 10

UNFPA and UNICEF, Global Theory of Change Phase II

UNFPA and UNICEF, Seven Steps to Strengthening Legislation, Policy and Public Financing to End Child Marriage

2. Has the state utilized law or policy to prevent harmful practices, including CEFM and FGM, and ensure remedies for survivors?[244]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Raise awareness among legislators of human rights standards concerning harmful practices and the appropriate legal responses, including the need to center women's and girls' bodily autonomy and to ensure that laws do not have a negative impact on the populations they seek to empower.[245]

Partner with UN entities at the country level, including UNFPA, UNICEF, UN Women, and the Office of the UN High Commissioner for Human Rights, to assess how national laws and policies may promote gender stereotypes that are linked to harmful practices and what legal reforms are needed to comply with human rights standards.

KEY RESOURCES

UNFPA, State of the World's Population 2020, p. 119

UNFPA-UNICEF Global Programme to End Child Marriage, Child Marriage and the Law: Technical Note for the Global Programme to End Child Marriage

UNFPA APRO, Rights Versus Protection: Marriage, Sexual Consent and Medical Treatment

Kathmandu Call for Action to End Child Marriage in South Asia

SADC, GNB, and UNFPA, A Guide to Using the SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage

3. Is the process of lawmaking, dissemination, and implementation related to CEFM and FGM inclusive and participatory of affected populations, including adolescents?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Convene national dialogues with engagement from civil society and populations impacted by CEFM and FGM, including adolescents, on how laws can be useful in preventing harmful practices, supporting survivors, and achieving accountability.

Support women's rights groups and youth advocates in coming together to develop recommendations on legal reforms necessary to address harmful practices, including through assessment of the effectiveness of existing legal frameworks, such as criminalization, and how best to address religion-based personal status laws[246] that may permit such practices.

4. Has the state invested in proactive measures to promote the empowerment of girls and women, including challenging patriarchal and other harmful gender norms and stereotyping?[247]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Engage with health and education officials to ensure that school curricula include mandatory comprehensive sexuality education and that out-of-school programs provide accurate information relating to harmful practices[248] and contain information on human rights (including those of women and children), gender equality, gender stereotypes, gender-based violence, and the need to foster an environment of nondiscrimination.[249]

Develop long-term awareness-raising informational and educational campaigns aimed at community and religious leaders, families, and men and boys, as well as specific interventions to empower women and girls and discourage harmful practices (e.g., through awareness-raising about the impact of FGM on girls' and women's health and lives).

KEY RESOURCES

UNFPA, How Changing Social Norms Is Crucial in Achieving Gender Equality

UNICEF, Gender Transformative Approaches for the Elimination of Female Genital Mutilation

UNFPA and UNICEF, Technical Note on Gender-Transformative Approaches: A summary for practitioners

UNFPA and UNICEF, Technical Note on Life Skills Programmes for Empowering Adolescent Girls: Notes for Practitioners on What Works

See also questionnaire on "Gender-Based Violence"

5. Has the state implemented measures in humanitarian contexts and crises for prevention of CEFM and FGM and support for survivors?[250]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Review existing quantitative and qualitative data on child and forced marriage, FGM, and other prevalent harmful practices and use this for advocacy to ensure that the issues are included in response planning for protection, education, and health.

At the onset of or during crises, seek feedback from girls and families, in accordance with ethical principles, on whether the services or interventions to prevent harmful practices are accessible and appropriate and respond to their needs.

Map the types and capacity of existing formal and informal service providers that currently provide adolescent-responsive and survivor-centered services (e.g., girls' safe spaces, adolescent-centered services, and other entry points where child survivors may seek support) and develop a referral pathway between these services.

KEY RESOURCES

UNFPA, Addressing Child Marriage in Humanitarian Settings

UNICEF, Technical Note on COVID-19 and Harmful Practices

UNFPA ESARO, A Guidance Note on Alternative Rites of Passage and Cultural Practices for Adolescents and Young People in East and Southern Africa

6. Has the state taken measures to address root causes of harmful practices, including poverty and lack of access to education for women and girls, which are proven to protect girls from harmful practices such as child marriage?[251]

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Build the capacity of legislators and national education officials on the link between poverty, education, and harmful practices, including the critical role of efforts such as universal, free, and compulsory primary school; abolishing school fees for secondary school; policies to encourage regular attendance; and efforts to eliminate gender disparities and support attendance for the most marginalized girls.

Advocate with legislators, government officials and the private sector to build a commitment to investing in economic empowerment, access to cash transfers, and economic opportunities for women and girls as a way to redistribute resources and prevent harmful practices.

Engage local education officials and civil society to ensure that adolescent girls subjected to harmful practices are able to continue attending school even if they are married or pregnant. Support girls who are unable to return to school through out-of-school nonformal education, including on life skills and entrepreneurship training.[252]

Partner with local education officials to develop and implement programming to makes schools and their surroundings safe and friendly to girls.[253]

KEY RESOURCES

UNFPA, Marrying Too Young, p. 50

UNFPA, State of the World's Population 2020, p. 118

UNICEF, How to Make 'Cash Plus' Work, Linking Cash Transfers to Services and Sectors

UNFPA and UNICEF, Global Programme to End Child Marriage: Phase II Programme Document: 2020-2023

UNFPA and UNICEF, Technical Note Leaving No One Behind: Technical Note of the Global Programme to End Child Marriage

7. Has the state guaranteed access to sexual and reproductive health information and services for individuals who have been, or are at risk of, being subjected to harmful practices?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Engage survivors' networks and adolescent and youth networks to identify barriers to decision-making and autonomy concerning sexual and reproductive health for those impacted by harmful practices (including spousal and parental consent requirements and lack of adolescent-responsive health services), and conduct advocacy to remove such barriers.

Partner with local health and education officials and religious and community leaders to provide training programs for educators and health care providers on how to convey accurate, science-based information and education on sexual and reproductive health, which contributes to empowering individuals, including adolescents, to make informed decisions and claim their rights.

Supply commodities and engage health officials to provide sexual and reproductive health care to survivors of harmful practices, including, where necessary, access to emergency contraception, abortion, and prophylactic antiretroviral treatment for survivors of sexual violence.[254]

KEY RESOURCES

UNFPA, State of the World's Population 2020, p. 118

OHCHR, Information Series on Sexual and Reproductive Health and Rights: Harmful Practices

WHO, Female Genital Mutilation: Evidence Brief

UNFPA ESARO, The Impact of Rites of Passage and Cultural Practices on Adolescents' and Young People's Sexual and Reproductive Health in East and Southern Africa

UNFPA ESARO, A Guidance Note on Alternative Rites of Passage and Cultural Practices for Adolescents and Young People in East and Southern Africa

UNFPA and UNICEF, Technical Note on Adolescent Girl-Responsive Systems

See also questionnaires on "Comprehensive Sexuality Education" and "Gender-Based Violence"

8. Does the state have programs established to ensure that individuals seeking to avoid being subjected to harmful practices have access to social protection and services (such as shelters)?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support the establishment of voluntary shelters and relocation services outside of immediate communities for individuals fleeing their homes to avoid harmful practices.[255]

Promote in-kind support to girls and women to keep them in school, as well as cash transfers or food vouchers to alleviate poverty.

Promote gender-transformative "cash plus" models (which combine cash transfers with complementary programs, such as life skills, mentoring, savings, parenting support, community conversations, and mass media approaches for normative change).256 For example, engage with national and local education officials to implement measures such as economic incentives to support pregnant girls and adolescent mothers in completing secondary school and to establish nondiscriminatory return policies.[257]

9. Does the state have effective law enforcement regarding harmful practices, with legal processes to ensure that cases are promptly, impartially, and independently investigated, as well as provision of effective remedies for survivors?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Serve as a leading voice advocating to ensure that national human rights institutions are mandated to consider individual complaints and petitions and carry out public inquiries and investigations of cases of CEFM and FGM, including those submitted on behalf of or directly by women and children, in a confidential, gender-sensitive, and child-friendly manner.

Develop long-term capacity-building partnerships with national human rights institutions to operationalize human rights norms to address harmful practices, including through awareness-raising campaigns, country assessments, inquiries, and public hearings with survivors.

Support national officials in developing and implementing systems of birth and marriage registration to ensure documentation that may be necessary under local laws to seek accountability for CEFM.

KEY RESOURCES

UNFPA-UNICEF Global Programme to End Child Marriage, Child Marriage and the Law: Technical Note for the Global Programme to End Child Marriage

UNFPA, Conducting Public Inquiries to Eliminate Female Genital Mutilation

UNFPA, Elevating Rights and Choices for All: Guidance Note for Applying a Human Rights Based Approach to Programming, pp. 25-26

UNFPA, A Guide in Support of National Human Rights Institutions

10. Has the state ensured that individuals who have experienced harmful practices have access to justice, including by addressing legal and practical barriers?

ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER

Examples of Implementation

Support civil society coalitions in identifying and advocating for reform of legal and practical barriers to justice, including short statutes of limitations.

Support local governments officials in providing legal aid programs and know-your-rights programs.

Partner with gender equality experts to sensitize the judiciary on gender stereotypes and address the role of these stereotypes in undermining access to justice.

KEY RESOURCES

OHCHR, Gender Stereotyping and the Judiciary: A Workshop Guide

CASE STUDY

Eliminating FGM through Youth Advocacy and Male Engagement in Senegal

In Senegal, 23% of women between the ages of 15 and 49 report having undergone FGM.[258]

Youth organizations and networks have made decisive contributions to the campaign to eliminate FGM, through combined strategies that include the development of tools to support community organizations in advocating against FGM, advocacy messaging to promote social norms change around the practice, and a mobilization campaign through the hashtag #TouchePasAMaSœur (don't touch my sister).[259]

The Movement 99-05 youth advocacy initiative calls on judicial authorities to implement Law 99-05 prohibiting FGM, and to end the practice.[260] The campaign targets young people by engaging popular Senegalese musicians to perform music with social commentary on FGM, laying bare its harmful consequences.[261] It has reached a wide audience via social media platforms, inspiring boys and girls and men and women alike to get involved.

The UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation encouraged young people's participation in the movement by training them in advocacy techniques and communication tools.[262] The young people drafted a memorandum for state authorities with recommendations for eliminating FGM.

The Joint Programme supports families and communities in shifting attitudes so that FGM is no longer a "women's issue." It engages men and boys as allies who can catalyze change by helping to expand choices for girls and women and by amplifying their voices.[263] The community-wide approach that engaged men and boys in Senegal has had a transformative impact on gender relations, social and gender norms, and systems that sustain gender inequalities.[264]

To ensure that FGM is understood as a human rights issue, the Joint Programme also works with Senegal's judiciary, police, and policymakers to ensure that the anti-FGM law is implemented.

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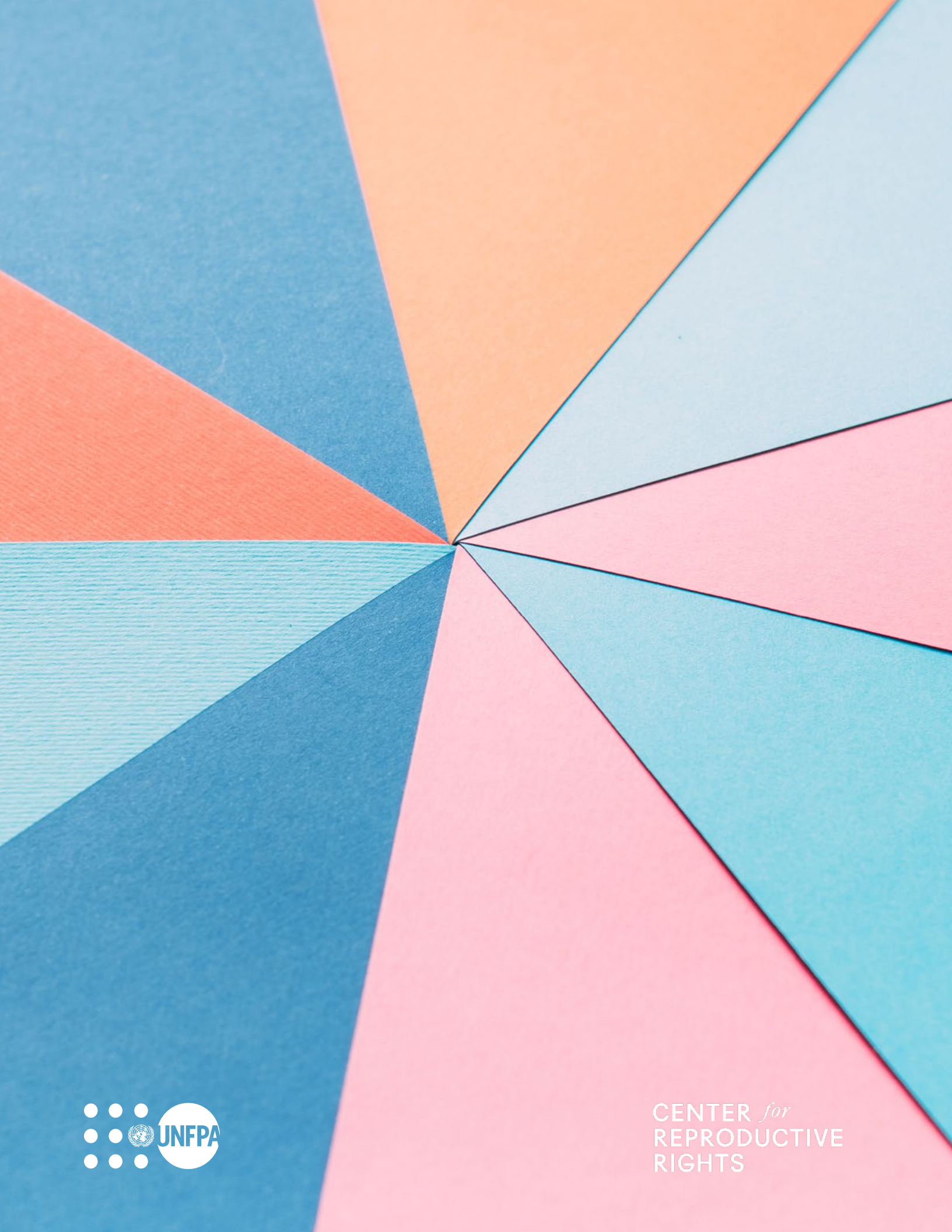
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