REPRODUCTIVE RIGHTS:

A Tool for Monitoring State Obligations

CENTER FOR REPRODUCTIVE RIGHTS

UNFPA

What is the Monitoring Tool?*

The Monitoring Tool provides a means for human rights experts responsible for overseeing compliance with international legal standards on human rights to monitor the implementation of specific State obligations in the field of reproductive rights.

The tool outlines State obligations under international and regional human rights law on a range of reproductive rights issues—**freedom from discrimination**, **contraceptive information and services**, **safe pregnancy and childbirth**, **abortion and post-abortion care**, **comprehensive sexuality education**, **freedom from violence against women**, and **HIV/AIDS**. The tool then identifies key questions that human rights experts and monitoring bodies can use to assess to what extent a State is in compliance with its obligations.

International standards on reproductive rights are grounded in core human rights treaties and are continuously evolving. International treaty bodies and regional human rights mechanisms play an essential role in ensuring the continued consolidation and elaboration of these standards. In identifying State obligations, the tool relies on international legal standards on these issues as they currently stand, based on authoritative interpretations of major United Nations treaties through General Comments, individual complaints, and concluding observations, as well as standards developed through reports by Special Procedures and regional human rights bodies. This tool is designed to facilitate monitoring of State compliance with these obligations and to support this continued consolidation; it is not intended to be an exhaustive account of these obligations.

In evaluating States' compliance with their international human rights obligations, experts and monitoring bodies should draw from governmental and non-governmental sources to build up a complete picture: this should include both qualitative and quantitative information. The questions set out in the tool are designed to guide the analysis of this information in line with international standards on reproductive rights, and to enable experts and monitoring bodies to draw specific conclusions and make concrete recommendations for action.

Reproductive Rights are Human Rights

Reproductive rights are grounded in a range of fundamental human rights guarantees, protected in both foundational human rights instruments as well as international and regional human rights treaties.

As the United Nations 1994 International Conference on Population and Development (ICPD) explains: "[R]eproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence."[1]

The ICPD Programme of Action defines **reproductive health** as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and

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the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[2]

Sexual health, in turn, is defined as "a state of physical, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."[3]

Twelve Human Rights Key to Reproductive Rights

Reproductive rights arise out of established human rights protections; they are also essential to the realization of a wide range of fundamental rights. In particular, the following rights cannot be protected without ensuring that women and adolescents can determine when and whether to bear children, control their bodies and sexuality, access essential sexual and reproductive health information and services, and live lives free from violence.

- The Right to Life
- The Right to Liberty and Security of the Person
- The Right to Health
- The Right to Decide the Number and Spacing of Children
- The Right to Consent to Marriage and Equality in Marriage
- The Right to Privacy
- The Right to Equality and Non-Discrimination
- The Right to be Free from Practices that Harm Women and Girls
- The Right to be Free from Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment
- The Right to be Free from Sexual and Gender-Based Violence
- The Rights to Education and Information
- The Right to Enjoy the Benefits of Scientific Progress

State Obligations under International Law

Through ratifying human rights treaties, States consent to be bound by these treaties and must comply with their provisions in good faith.[4] Domestic laws that conflict with treaty provisions cannot be used to justify noncompliance.[5]

States have specific legal obligations to **respect**, **protect**, and **fulfill** the rights protected in these human rights treaties. These obligations include both limitations on the actions that States may take (negative obligations) and proactive measures that States must take (positive obligations). States must take steps towards fulfilling their obligations by all appropriate means, including particularly the adoption of legislative measures, and should report on these measures and the basis on which they have been considered the most "appropriate" under the circumstances.[6] Some State obligations, including civil and political rights obligations and core economic, social and cultural rights obligations, are of immediate effect while others are subject to progressive realization.

- The duty to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of reproductive rights.
- The duty to *protect* requires States to prevent third parties from infringing on reproductive rights and to take steps to investigate and punish such violations when they occur.
- The duty to *fulfill* requires that States adopt whatever measures necessary—legislative, budgetary, judicial, and/or administrative—to achieve the full realization of reproductive rights.

As part of their obligations, States must ensure that reproductive health information, goods, and services are **available**, **accessible**, **acceptable,** and of good **quality (AAAQ)** in order for States to meet their obligations to respect, protect, and fulfill reproductive rights.[7] Specifically, such information, goods, and services must be:

- *Available* in sufficient quantity within the State. This includes the underlying determinants of health, such as safe and potable drinking water; adequate sanitation facilities, hospitals, clinics and other health-related buildings; trained medical and professional personnel; and essential drugs, as defined by the WHO Model List of Essential Medicines.
- *Accessible* to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any prohibited grounds. This includes:
    - Physical accessibility (within safe physical reach for all sections of the population, and adequate access to buildings for persons with disabilities),
    - Economic accessibility (affordable for all, whether publicly or privately provided services), and
    - Information accessibility (ability to seek, receive, and impart information concerning reproductive health issues).
- *Acceptable*, requiring that they are respectful of medical ethics, respectful of the culture of individuals, sensitive to gender and life-cycle requirements, and designed to respect confidentiality.
- Of good *quality.* This means that they must be scientifically and medically appropriate, which requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

The tool relies on the AAAQ framework when identifying State obligations with respect to reproductive health information, goods, and services.

Key Concepts

There are a number of key concepts that are relevant to each of the thematic issues addressed in this tool. These should be considered in conjunction with the information and obligations identified in each thematic section.

Accountability: Accountability is central to ensuring that States are meeting their human rights obligations. International and regional human rights bodies play an essential role in holding States accountable, by monitoring compliance with their obligations under human rights treaties to which they are bound. When a State is not meeting its obligations to respect, protect, and fulfill reproductive rights, accountability mechanisms provide an opportunity to expose the barriers to reproductive rights and to offer appropriate redress. Moreover, such mechanisms help States identify the gaps and failures in existing policies and programs and give them an opportunity to improve them, with a view to ensuring the full realization of sexual and reproductive rights for women and adolescents

- The degree to which States have established effective, accessible and independent mechanisms that ensure accountability for reproductive rights, and the extent to which these mechanisms respond in practice to specific obstacles women and girls face in exercising their reproductive rights, should be considered when assessing State compliance with their obligations.

Monitoring and Evaluation: Monitoring and evaluation are crucial in ensuring that reproductive health policies and programs promote and protect women's and adolescents' sexual and reproductive rights. Ongoing monitoring and evaluation provide governments with the information necessary to determine which areas to focus on to meet their human rights obligations. In addition, monitoring provides rights-holders with information necessary to hold governments accountable when human rights obligations have not been fulfilled. Effective monitoring and evaluation requires identification of relevant benchmarks and indicators for gauging the effectiveness of reproductive health policies and programs, and that data collected on key issues be disaggregated.

- The degree to which States have developed and implemented mechanisms for effective monitoring and evaluation of sexual and reproductive health policies and programs should be considered when assessing compliance with their reproductive rights obligations.

Indicators: Quantitative and qualitative indicators can be useful markers of health status, service provision, or resource allocation, and can play an important role in monitoring progress toward the realization of reproductive rights. Indicators can also help hold States accountable for their obligations, for instance by exposing persistent problems or areas requiring greater attention. It is important to keep in mind, however, that indicators do not present a complete picture of the realization of reproductive rights in a State, given the lack of reliable and appropriately disaggregated data collected for health system indicators. The tool identifies several illustrative indicators for each of the thematic issues that are addressed herein. These are identified with reference to a conceptual and methodological framework developed by the United Nations Office of the High Commissioner for Human Rights, which recommends the development of structural, process, and outcome indicators. This configuration of indicators is designed to help assess the steps taken by States in addressing their obligations, from commitments and acceptance of international human rights standards (*structural* indicators) to efforts being made to meet the obligations that flow from the standards (*process* indicators) and on to the results of those efforts (*outcome* indicators).[8] The indicators listed are indicative rather than exhaustive.

- States should collect, analyze, and disseminate data disaggregated by sex, race, ethnicity, age, disability, rural/urban, and socioeconomic status, at a minimum, for each of the thematic issues addressed in the tool. The degree to which States have collected disaggregated data should be considered when assessing State compliance with their reproductive rights obligations.

Informed Consent: Informed consent is a process of communication between health care providers and patients to ensure that consent for a medical procedure is given voluntarily, without threats or inducements, after the patient has been fully counseled on the risks and benefits of the procedure, as well as possible alternatives, in a language and form that is understandable to the patient. While the process of obtaining informed consent may be difficult and time-consuming, such difficulties do not absolve health care providers from meeting these criteria.[9]

- Laws, policies, and practices relating to informed consent for reproductive health goods and services should be evaluated in all relevant areas to assess State compliance with reproductive rights obligations.

International Assistance and Cooperation: State obligations under some human rights treaties[10] extend beyond their national borders to include international assistance and cooperation to achieve the full realization of human rights. International assistance and cooperation includes both financial assistance and technical cooperation. Donor States must prioritize helping

low-income countries realize their core obligations,[11] and take concrete and deliberate steps toward supporting the progressive realization of reproductive rights. Donor States must refrain from supporting or proposing activities that could jeopardize these rights.

- The degree to which donor States meet their obligation to provide international assistance and cooperation, and the adherence of the programs they are implementing and supporting to human rights, is a cross-cutting issue and should be considered when assessing donor States' compliance with their reproductive rights obligations.

Participation: The voices of key stakeholders must contribute to all stages of decision making, from development and implementation of policies and programs to monitoring and evaluation. Participation of key stakeholders—particularly marginalized populations who face significant barriers to accessing reproductive health services—ensures that the needs and priorities of those who are most affected by reproductive health policies inform the delivery of such services.

- The degree to which States ensure participation of affected populations is a cross-cutting issue, and should be considered when assessing State compliance with their reproductive rights obligations.

Remedy and Redress: States have an obligation to ensure that victims have access to timely and independent redress in the event of violations of their reproductive rights, which includes the obligation to remove legal and practical barriers to accessing justice.

- The degree to which States ensure access to effective redress mechanisms where reproductive rights violations occur is a cross-cutting issue, and should be considered when assessing State compliance with their reproductive rights obligations.

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1 *Programme of Action of the International Conference on Population and Development*, ¶ 7.3, Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev.1, (1995) [hereinafter *ICPD Programme of Action*].
2 *ICPD Programme of Action*, *supra* note 1, ¶ 7.2.
3 World Health Organization (WHO), Defining Sexual Health 5 (2006).
4 Vienna Convention on the Law of Treaties, art. 26, 1155 u.n.t.s. 331 (1980) [hereinafter Vienna Convention].
5 Vienna Convention, *supra* note 4, at art. 27.
6 Committee on Economic, Social and Cultural Rights, *General Comment No. 3: The nature of States parties' obligations (Art. 2*, para. 1), ¶¶ 2-4 (1990), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. 1), at 7 (2008).
7 Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health*, ¶ 12 (2000), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I), at 78 (2008) [hereinafter ESCR Committee, *General Comment No. 14*].
8 Rep. of the United Nations High Commissioner for Human Rights, Substantive sess. of 2011, July 4-29, 2011, ¶12, U.N. Doc. E/2011/90 (Apr. 26, 2011); Rep. on Indicators for Monitoring Compliance with International Human Rights Instruments, 18th meeting of chairpersons of the human rights treaty bodies, June 22-23, 2006, 5th inter-committee meeting of the human rights treaty bodies, June 19-21, 2006, U.N. Doc. HRI/MC/2006/7 (May 11, 2006).
9 *See, e.g., FIGO, Guidelines Regarding Informed Consent 2007*, in Ethical Issues in Obstet. & Gynec.,13-14 (2009).
10 The International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, and the Convention on the Rights of Persons with Disabilities are among those treaties which include obligations to respect, protect and fulfil human rights through international assistance and cooperation.
11 ESCR Committee, *General Comment No. 14, supra* note 7, ¶ 45.

INDIVIDUALS OR GROUPS REQUIRING SPECIAL CONSIDERATION

When evaluating States' compliance with their international human rights obligations, special consideration should be given to women and girls who are in an elevated situation of vulnerability or marginalization, as these individuals may encounter significant barriers to realizing their sexual and reproductive rights. This includes, but is not limited to, women and girls who are members of the following groups.

Adolescents: Adolescence is a critical stage of development marked by both rapid biological and emotional change. Adolescents' specific rights under international law are enshrined in the Convention on the Rights of the Child, which recognizes the "evolving capacities" of adolescents to make decisions in matters affecting their lives.[1] Adolescents encounter additional legal and practical obstacles—including low social status, lack of autonomy, stigmatization of adolescent sexuality, and laws and policies that discriminate on the basis of age or mandate parental consent for reproductive health services—which constitute serious hurdles for the exercise of their reproductive rights. Young people often lack access to both comprehensive sexuality education and confidentiality in accessing health services, encounter barriers to contraceptive access, and may be subjected to harmful practices, such as early marriage or female genital mutilation.

Migrant Women[2]: A number of legal and practical barriers, including language, cost of services, and lack of access to transportation, pose significant obstacles to migrant women's access to reproductive health services in their country of destination. For instance, migrant women may not be eligible for coverage under national health insurance schemes, which can make the cost of reproductive health services prohibitive. Migrant women may also be subjected to discriminatory practices, including mandatory pregnancy tests or mandatory HIV testing, which can result in job loss or deportation when positive. Pregnant migrant women may also encounter coercive abortion, lack of access to safe and affordable maternal health care, and inadequate or absent maternity leave and benefits. Migrant women may also face a heightened risk of sexual abuse, sexual harassment, and physical violence. Undocumented migrants may avoid interacting with formal health systems, fearing deportation and family separation if their immigration status is disclosed, and thus face greater risk of inadequate or poor quality reproductive health care.

Minorities, Indigenous Peoples and Afro-descendants: Minorities,[3] indigenous peoples and Afro-descendants may encounter significant barriers to accessing health care services, which often translate into a lower health status than that of the overall population.[4] As a result of persistent discrimination and marginalization, these communities often have limited access to reproductive health services.[5] Discrimination in health care settings may take different forms, including outright refusal of care or the provision of inferior care—both of which perpetuate mistrust and fear of the health establishment among indigenous or minority women.[6] Language and cultural differences—and in remote areas, geography—can present additional barriers to accessing reproductive health services.[7] Discrimination in health care settings has also led to the implementation of involuntary practices, such as forced sterilization,[8] that violate fundamental rights and fuel mistrust of public health institutions.

Older Persons: Older persons can encounter significant barriers to realizing their sexual and reproductive health, and their specific needs are frequently overlooked. Older persons may be excluded from sexual and reproductive health services entirely—often based on misconceptions that they are not sexually active.[9] Comprehensive sexual health information and services for older persons should therefore be responsive to changing sexual health needs as a result of age-related physical or pathological changes.[10] Older persons are often excluded from programs to prevent and treat sexually-transmitted infections including HIV.

Persons with Disabilities: The Convention on the Rights of Persons with Disabilities explicitly recognizes the obligation of States to "[p]rovide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes,"[11] and recognizes the rights of individuals with disabilities to "decide freely and responsibly on the number and

spacing of their children, and to have access to age-appropriate information, reproductive and family planning education."[12] However, women and girls with disabilities—which includes women and girls with long-term physical, mental, intellectual, or sensory impairments—are often subject to double discrimination based on their disabilities and their gender.[13] Reproductive health services are largely unavailable to individuals with disabilities due to barriers to physical access, the absence of alternative formats of information and communication, lack of disability-related technical and human support, stigma, and discrimination.[14] Despite the fact that individuals with disabilities are equally as likely to be sexually active as persons without disabilities, misconceptions that they are asexual or incompetent to raise children are widespread.[15] These discriminatory views contribute to barriers to accessing contraceptive information and services because of the inaccurate perception that individuals with disabilities do not require such information and services. These individuals may also be subjected to involuntary medical procedures, such as forced or coerced sterilization or abortion, all of which often are facilitated through the use of substituted decision-making mechanisms such as guardianship.[16]

Women and Adolescents in Conflict and Post Conflict Zones: Women and children account for more than 75 percent of the refugees and persons displaced by war, famine, and natural disasters around the world.[17] Displaced women and adolescents often have limited access to reproductive health care,[18] and also are particularly vulnerable to sexual coercion and gender-based violence.[19] These factors contribute to high rates of unintended pregnancies, which in turn can lead to high rates of maternal mortality and unsafe abortion.[20] Accordingly, access to sexual and reproductive health information, goods, and services is crucial in the context of internal displacement or refugee settings.

Women in Institutional Settings: Women in institutional settings, such as those who are incarcerated and those who are being treated in healthcare facilities, are vulnerable to human rights violations at the hands of detention facility personnel and medical personnel who hold clear positions of authority and often exercise significant control over women in these contexts. Reproductive rights violations in prisons may include shackling of pregnant women during medical care including during labor, delivery, and the post-delivery recovery period for hours or even days, despite the presence of armed guards.[21] Women may also be subjected to other reproductive rights violations in health facilities such as involuntary sterilization[22] and denial of sexual or reproductive health services, such as prenatal diagnostic care,[23] abortion and post-abortion care.[24]

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1 Convention on the Rights of the Child, art. 5, 12(1), G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) [hereinafter CRC].
2 *See, e.g.*, Committee on the Elimination of Discrimination against Women, *General Recommendation No. 26: Women migrant workers*, U.N. Doc. CEDAW/C/2009/WP.1/R (2008).
3 Minorities include individuals of shared racial, ethnic, national, religious, linguistic, or cultural origins. *See, e.g.*, Minority Rights Group International, *Who are minorities?* (last visited Aug. 14, 2012), http://www.minorityrights.org/566/who-are-minorities/who-are-minorities.html.
4 *See, e.g.*, Clive Nettleton et al., *An overview of current knowledge of the social determinants of indigenous health* (Commission on Social Determinants of Health, WHO, Working Paper, 2007).
5 *See, e.g.*, United States Department of State, *2009 Country Reports on Human Rights Practices: Australia* (Mar. 11, 2010).
6 *See, e.g.*, Pan American Health Organization/WHO, Services Delivery in Areas Inhabited by Indigenous Peoples 10 (2009).
7 *See* Anne Terbough et al., *Family Planning Among Indigenous Populations in Latin America*, 21 Int'l Fam. Plan. Persp. 143, 143-44 (1995).
8 *See, e.g.*, Open Society Foundations, *Against Her Will: Forced and Coerced Sterilization of Women Worldwide* (2011).
9 *See, e.g.*, Meredith Wallace, *Assessment of Sexual Health in Older Adults*, in 108 American J. of Nursing 52, 54 (2008) [hereinafter *Assessment of Sexual Health in Older Adults]*.
10 *See Assessment of Sexual Health in Older Adults*, *supra* note 9, at 54.
11 Convention on the Rights of Persons with Disabilities, art, 25, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611 (2008) [hereinafter CRPD].
12 CRPD, *supra* note 11, art. 23(1)(b).
13 *See,* Peter Blanck et al., *Defying Double Discrimination*, 8 Georgetown J. Int'l Aff. 95, 95-96 (2007).
14 *See* WHO and UNFPA, Promoting Sexual and Reproductive Health for Persons with Disabilities: WHO/UNFPA Guidance Note 6-7 (2009) [hereinafter WHO/UNFPA Guidance Note].
15 WHO/UNFPA Guidance Note, *supra* note 14, at 3.
16 *See, e.g.*, Open Society Foundations, *Sterilization of Women and Girls with Disabilities* (2011).
17 UNFPA, *Fact Sheet: Responding to Emergencies: Ignoring Women Imperils the Effort* (2009).

[18] *See*, Center for Reproductive Rights, *Displaced and Disregarded: Refugees and their Reproductive Rights* 4-5 (2001) [hereinafter *Displaced and Disregarded*].
[19] *See, e.g.*, UN Secretary-General, *In depth study on all forms of violence against women, Rep. of the Secretary-General*, ¶¶ 143-146, 157-165, U.N. Doc A/61/122/Add.1 (2006).
[20] *See Displaced and Disregarded*, *supra* note 18, at 4.
[21] The Rebecca Project for Human Rights and National Women's Law Center, *Mothers Behind Bars:A state-by-state report card and analysis of federal policies on conditions of confinement for pregnant and parenting women and the effect on their children* (2010).
[22] *See, e.g.*, Center for Reproductive Rights, *Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities* (2010); *Against Her Will, supra* note 8.
[23] *See, e.g.,* R.R. v. Poland, No. 27617/04, Eur. Ct. H.R. (2011).
[24] *See, e.g.*, Center for Reproductive Rights, *In Harm's Way: The Impact of Kenya's Restrictive Abortion Law* (2010).

Tackling discrimination is an essential component of a comprehensive strategy to guaranteeing the full realization of women's and adolescents' fundamental human rights. International human rights law proscribes discrimination on the basis of, *inter alia*, sex, race, ethnicity, language, religion, ability, and economic status. Standards have also evolved to recognize the right to be free from discrimination on the basis of age,[1] real or perceived sexual orientation or gender identity,[2] marital status,[3] health status (including HIV status),[4] and pregnancy status[5]

Discrimination can be both a cause and consequence of sexual and reproductive health-related concerns. Women and individuals and groups with an historic experience of exclusion—including individuals or groups requiring special consideration mentioned above, as well as low-income women, women living in rural areas, unmarried women, women living with HIV, and women in detention—are often more likely to encounter discrimination in the enjoyment of their sexual and reproductive rights. Individuals may also encounter discrimination on multiple and intersecting grounds. Discrimination in the context of sexual and reproductive health can contribute to unequal access to health services, delays in or denials of sexual and reproductive health care, or abusive treatment in the provision of sexual and reproductive health services. Temporary special measures may be necessary to remedy historical patterns of exclusion.[6] States must achieve both formal and substantive equality for women by ensuring the provision both in law and in practice of distinct reproductive health services that attend to specific needs, such as those required by women during and after pregnancy.[7]

Components of State Obligations

States have an obligation to develop laws, policies, and practices to ensure equal treatment and freedom from discrimination in the context of sexual and reproductive health and rights, with immediate effect. This requires that:

- Sexual and reproductive health information, goods, and services be accessible to all in law and practice without discrimination. This includes the obligation to:
    - Eliminate direct and indirect discrimination and take measures to ensure both formal and substantive equality in laws, regulations, policies, and practices with respect to sexual and reproductive health information, goods, and services.[8]
    - Ensure that reproductive health information, goods, and services that only women require are available, accessible, acceptable, and of good quality.[9]
    - Refrain from restricting access to reproductive health information, goods, and services for certain individuals or groups, such as adolescents or unmarried women.[10]
- States adopt measures to achieve equality and eliminate discrimination with respect to sexual and reproductive health for all.[11] This includes the obligation to:
    - Ensure that the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights[12] to combat stigma and discrimination amongst health care professionals.
    - Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent, and choice.[13]
    - Ensure adequate allocation of funding to policy implementation across regions to eliminate disparities in availability, accessibility, acceptability, and quality of sexual and reproductive health services.[14]
    - Adopt necessary measures to prevent discrimination in the private sphere, such as termination of employment or expulsion from school of pregnant women or girls.[15]

Assessing State Compliance

- To what extent has the State developed and implemented measures to eliminate discrimination in the field of sexual and reproductive health through policy?
- What steps has the State taken to ensure that reproductive health services that only women need, such as services related to pregnancy, pregnancy-related complications, and abortion, are available, accessible, acceptable, and of good quality both in law and in practice?
- What steps has the State taken to eliminate laws or policies that require third party (e.g., parental, spousal, or judicial) authorization for access to reproductive health information and services[16]?
- What steps has the State taken to decriminalize specific forms of consensual sexual activity, such as same-sex or extra-marital sexual activity?
- What measures has the State taken to prevent or eliminate discriminatory policies or practices in both the public and private spheres, such as mandatory pregnancy testing or policies or practices that target ethnic or racial minorities and groups, women living with HIV, or women with disabilities for involuntary surgical sterilization?
- How does the State ensure affordable access, such as through free or subsidized care, for low-income women or those who may face heightened barriers to seeking reproductive health care?
- What steps has the State taken to integrate gender and sexuality perspectives into their policies, plans, and programs on sexual and reproductive health, such as involving women in the planning, implementation, and monitoring of such policies, plans, and programs[17]?
- What type of judicial or administrative safeguards has the State enacted in instances where an individual is discriminated against in accessing sexual and reproductive health information, goods and services?
- What steps has the State taken to ensure that such administrative and safeguards are accessible and timely?
- What specific measures has the State taken to increase access to quality sexual and reproductive health services by marginalized and excluded groups?

Relevant indicators

Relevant indicators include, but are not confined to:

- Proportion of health care professionals handling requests from potential patients in a non-discriminatory manner (source: discrimination testing survey) (process indicator)
- Mortality rates disaggregated by targeted population groups (outcome indicator)

Additional Resources from the Center for Reproductive Rights

Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom
Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities
At Risk: Rights Violations of HIV-Positive Women in Kenyan Health Facilities
Litigation Briefing Series: Alyne da Silva Pimentel v. Brazil
A.S. v. Hungary: Informed Consent: A Signature is Not Enough

[1] Committee on Economic, Social and Cultural Rights, *General Comment No. 20: Non-discrimination in economic, social and cultural rights,* ¶ 29 U.N. Doc. E/C.12/GC/20 (2009) [hereinafter ESCR Committee, *General Comment No. 20*].
[2] ESCR Committee, *General Comment No. 20, supra* note 1, ¶ 32.
[3] ESCR Committee, *General Comment No. 20, supra* note 1, ¶ 31.
[4] ESCR Committee, *General Comment No. 20, supra* note 1, ¶ 33.
[5] *See, e.g.,* ILO Conventions C158 Termination of Employment Convention, 1982 (No. 158), art. 5; C183 Maternity Protection Convention, 2000 (No. 183); R191 Maternity Protection Recommendation, 2000 (No. 191).
[6] *See, e.g.*, Committee on the Elimination of Discrimination against Women, *General Recommendation No. 25: Article 4, paragraph 1 of the Convention (Temporary special measures),* (2004), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 365 (2008) [hereinafter CEDAW Committee, *General Recommendation No. 25].*
[7] Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (women and health),* ¶¶ 8, 20 (1999), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 358 (2008) [hereinafter CEDAW Committee, *General Recommendation No. 24*].
[8] Convention on the Elimination of All Forms of Discrimination against Women, art. 10(h), 12, 16(1)(e), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1981) [hereinafter CEDAW]; ESCR Committee, *General Comment No. 20, supra* note 1; Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (2011) [hereinafter Alyne da Silva Pimentel v. Brazil].
[9] CEDAW Committee, *General Recommendation No. 24, supra* note 7; Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health,* (2000), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I), at 78 (2008) [hereinafter ESCR Committee, *General Comment No. 14].*
[10] See, e.g., CEDAW Committee, *General Recommendation No. 24, supra* note 7, ¶14; Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, ¶ 31 (2003), U.N. Doc. HIR/GEN/1/Rev.9 (Vol. II), at 410 (2008) [hereinafter CRC, *General Comment No. 4*].
[11] CEDAW Committee, *General Recommendation No. 25, supra* note 6.
[12] CEDAW Committee, *General Recommendation No. 24, supra* note 7, ¶ 31(f).
[13] CEDAW Committee, *General Recommendation No. 24, supra* note 7, ¶ 31(e).
[14] Alyne da Silva Pimentel v. Brazil, *supra* note 8.
[15] CEDAW, *supra* note 8, art. 11(2).
[16] CEDAW Committee, *General Recommendation No. 24, supra* note 7, ¶ 14; CRC, *General Comment No. 4, supra* note 10, ¶ 28.
[17] CEDAW Committee, *General Recommendation No. 24, supra* note 7, ¶ 31(a).

Women's and adolescents' ability to make autonomous decisions about whether and when to have children through access to available, acceptable, and good quality contraceptive information and services is critical for achieving gender equality and ensuring that they can participate as full members of society. Yet, despite desires to avoid or delay pregnancy, roughly 222 million women in developing countries rely on either traditional methods—periodic abstinence or withdrawal—which have high failure rates, or do not use any contraceptive method at all.[1] In other instances, marginalized women may be subjected to coercive or forced contraceptive policies, such as involuntary sterilization.[2]

Components of State Obligations

States have an obligation to develop laws, policies, and practices to ensure access to contraceptive information and services free from discrimination, coercion, or violence both in law and in practice. This requires that:

- States take steps to ensure that all individuals have access to comprehensive, scientifically accurate,[3] unbiased information regarding contraceptive methods.[4] This includes the obligation to ensure that health care providers are trained to provide scientifically accurate information and counseling on a full range of contraceptive methods, and that information is available in a language and format that is understandable.
- States take steps to ensure a full range of contraceptive methods[5] are available, accessible, acceptable, and of good quality.[6] This includes the obligation to ensure:
    - That public and private health facilities offer a full range of contraceptive methods that are responsive to the needs of different women and that such methods are regularly available.[7]
    - That contraceptive services are made affordable,[8] either by subsidizing contraceptives so they are free or low-cost or covering them through public health insurance schemes;
    - That disparities in access to contraceptive information and services among certain groups of women and adolescents who may face additional barriers to access are eliminated.[9]
- States take steps to ensure that all individuals are able to make informed and voluntary decisions about the contraceptive method that is suitable for them, both in law and in practice. This includes the obligation to ensure that all women and adolescents, including marginalized women, have given their free and fully informed consent regarding contraceptive use.
- States develop public education campaigns and programs to raise awareness about the importance of contraceptive use through the media and other alternative forums.[10]
- States collect, analyze, and disseminate disaggregated data to better understand and monitor unmet need for modern contraceptive methods, contraceptive use, and primary barriers to accessing contraceptive information and services.[11]

Assessing State Compliance

- To what extent has the State developed and implemented a national strategy or plan that includes measures to ensure access to contraceptive information and services[12]?
- To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans?
- What measures has the State taken to ensure that a full range of contraceptive methods, including emergency contraception, are available, accessible, acceptable, and of good quality, both in law and in practice?

- What measures has the State taken to make scientifically accurate information on a full range of contraceptive methods available, accessible, acceptable, and of good quality (e.g., through comprehensive sexuality education or public education campaigns)?
- What steps has the State taken to eliminate third-party authorization (e.g., parental, spousal, or judicial) for particular contraceptive methods?
- What steps has the State taken to eliminate other conditions on access to contraceptives, such as requiring a minimum number of children before allowing a woman to undergo surgical sterilization or restricting access to contraceptives on the basis of age or marital status?
- What steps has the State taken to ensure the affordability of contraceptives, for instance by ensuring that a full range of contraceptive services are covered by public health insurance or available at no or low cost in public health facilities?
- What measures has the State taken to prevent or eliminate involuntary practices or policies (e.g., involuntary sterilization)?
- To what extent does the State ensure that access to contraceptive information and services is not impeded by the exercise of conscientious objection by a health care provider or pharmacist[13]?
- What types of administrative or judicial safeguards has the State enacted in instances where a woman is impermissibly denied access to a particular contraceptive method?
- What steps has the State taken to ensure that such administrative or judicial safeguards are accessible and timely?

Relevant Indicators

Relevant indicators include, but are not confined to:

- Time frame and coverage of national policy on sexual and reproductive health (structure indicator)
- Increase in proportion of women of reproductive age using, or whose partner is using, contraception (contraceptive prevalence rate) (process indicator)
- Unmet need for modern contraceptive methods (process indicator)
- Adolescent birth rate (outcome indicator)

Additional Resources from the Center for Reproductive Rights

Bringing Rights to Bear: Family Planning is a Human Right
The Right to Contraceptive Information and Services for Women and Adolescents
Calculated Injustice: The Slovak Republic's Failure to Ensure Access to Contraceptives
Imposing Misery: The Impact of Manila's Contraception Ban on Women and Families
Litigation Briefing Series: Lourdes Osil v. Mayor of Manila
A.S. v. Hungary: Informed Consent: A Signature is Not Enough

[1] Susheela Singh & Jacqueline E. Darroch, Adding It Up: Costs and Benefits of Contraceptive Services: Estimates for 2012 4 (2012).
[2] *See, e.g.*, Open Society Foundations, *Against Her Will: Forced and Coerced Sterilization of Women Worldwide* (2011).
[3] The scientific accuracy of sexual and reproductive health information, as referred to throughout the tool, relies on objective international standards, as determined by established authorities in the field of sexual and reproductive health, such as the World Health Organization.
[4] *See, e.g.*, Committee on the Elimination of Discrimination against Women, *General Recommendation No. 21: Equality in marriage and family relations* ¶ 22 (1994), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 337 (2008); Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, ¶ 28 (2003), U.N. Doc. HIR/GEN/1/Rev.9 (Vol. II), at 410 (2008); Special Rapporteur on the right to education, *Report of the United Nations Special Rapporteur on the right to education*, ¶¶ 19, 24-37, U.N. Doc. A/65/162 (2010).
[5] A full range of modern contraceptives includes condoms, vaginal barrier methods, oral hormonal contraceptives, implants, injectables, intrauterine devices, male and female voluntary sterilization, and emergency contraception. *See, e.g.*, World Health Organization (WHO), Family Planning: A Global Handbook for Providers 2011 Update (2011).
[6] *See, e.g.*, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* ¶ 65(d), U.N. Doc A/66/254 (2011).
[7] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health*, ¶ 43(d) (2000), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I), at 78 (2008) [hereinafter ESCR Committee, *General Comment No. 14*] (explaining that the provision of essential drugs, as defined by the WHO, constitutes a core obligation of States parties in satisfying the right to health). The WHO Model List of Essential Medicines includes a full range of modern contraceptives. World Health Organization, WHO Model List of Essential Medicines 26 (2011).
[8] *See, e.g.*, ESCR Committee, *General Comment No. 14*, *supra* note 7, at ¶ 12(b)(iii); CEDAW Committee, *Concluding Observations: Hungary*, ¶ 254, U.N. Doc. A/51/38 (1996); *Kazakhstan*, ¶ 106, U.N. Doc. A/56/38 (2001); *Slovakia*, ¶¶ 42-43, U.N. Doc. CEDAW/C/SVK/CO/4 (2008); Human Rights Committee, *Concluding Observations: Poland*, ¶ 9, U.N. Doc. CCPR/CO/82/POL (2004).
[9] For example, individuals or groups requiring special consideration mentioned above, as well as low-income women, women living in rural areas, unmarried women, women living with HIV, women in detention, and sex workers, may be more likely to encounter difficulties in accessing contraceptive information and services. *See, e.g.*, ESCR Committee, *General Comment No. 14*, *supra* note 7, at ¶ 12(b)(i).
[10] *See, e.g.*, Human Rights Committee, *Concluding Observations: Guatemala*, ¶ 20, U.N. Doc. CCPR/C/GTM/CO/3 (2012); *Dominican Republic*, ¶ 15, U.N. Doc. CCPR/C/DOM/CO/5 (2012).
[11] *See, e.g.*, Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, ¶ 9 (1999), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 358 (2008) [hereinafter CEDAW Committee, *General Recommendation No. 24*]; CEDAW Committee, *Concluding Observations: Georgia*, ¶ 29, U.N. Doc. CEDAW/C/GEO/CO/3 (2006); CEDAW Committee, *Concluding Observations: Jamaica*, ¶ 35, U.N. Doc. CEDAW/C/JAM/CO/5 (2006).
[12] *See, e.g.*, *Rep. of the Special Rapporteur on the right to health*, *supra* note 6, ¶ 65(b) (2011).
[13] *See, e.g.*, CEDAW Committee, *General Recommendation No. 24*, *supra* note 11, ¶11; Pichon and Sajous v. France, No. 49853/99, Eur. Ct. H.R. (2001) (holding that pharmacists cannot invoke personal religious beliefs as a justification for refusing to sell legal contraceptives).

Many women and girls experience complications during pregnancy, delivery, or after giving birth, which in turn can lead to death or disability. The primary causes of maternal mortality and morbidity are severe bleeding (the risk of which increases when a woman is anemic), infection, hypertensive disorders, and unsafe abortion. Access to key interventions—including contraceptive information and services to prevent unwanted pregnancy, skilled attendance at birth, emergency obstetric care, and safe abortion services—can prevent the vast majority of maternal deaths and disabilities. A number of effective interventions are available at a low cost, and States can and should take immediate steps to reduce preventable maternal mortality and morbidity.

Components of State Obligations

States have an obligation to develop laws, policies, and practices to ensure women's and girls' health and well-being throughout pregnancy, delivery, and the post-partum period. This requires that:

- States take steps to ensure availability of and access to the underlying determinants for a healthy pregnancy, including adequate nutrition, potable water, education, transportation, and sanitation.[1]
- States take steps to ensure that reproductive health information, goods and services—including access to perinatal care, skilled attendance during birth, emergency obstetric care, and medicines and technology essential to sexual and reproductive health—are available, accessible, acceptable, and of good quality. This includes the obligation to:
    - Ensure registration and availability of essential medicines for treating pregnancy-related complications (e.g., misoprostol to treat post-partum hemorrhage and incomplete abortion).[2]
    - Provide free services in connection with pregnancy, childbirth, and the post-natal period, as necessary.[3]
    - Provide adequate training and distribution of health care providers to ensure access to essential maternal health services for all women and girls, including those in rural areas.[4]
    - Regulate conscientious objection by health care providers to ensure that women and girls have access to the information and services they need to make informed decisions regarding their pregnancies and reproductive health.[5]
- States take steps to ensure access to good quality maternal and reproductive health care. This includes the obligation to:
    - Ensure that clear legal and professional regulations exist to ensure the quality of care.[6]
    - Prevent and eliminate abusive treatment of women and girls seeking reproductive health services.[7]
- States take steps to ensure access to special care and assistance during pregnancy and for a period following childbirth.[8]
- States collect, analyze, and disseminate disaggregated data necessary to evaluating and responding to primary causes—both direct and indirect—of maternal mortality and morbidity.[9]

Assessing State Compliance

- To what extent has the State developed and implemented a national strategy or plan to ensure access to maternal and reproductive health information, goods, and services and the reduction of maternal mortality and morbidity?
- To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans?

- What steps has the State taken to ensure that reproductive health goods or services essential to maternal health—such as uterotonic drugs (e.g., misoprostol) to stop hemorrhaging or safe abortion services when the pregnant woman's life or health is at risk—are legally available and, in the case of drugs, registered for obstetric use?
- What measures has the State taken to eliminate any laws, policies or practices that prioritize the fetus over life- or health-saving medical care for pregnant woman and girls[10]?
- What measures has the State taken to eliminate harmful practices that can contribute to high-risk pregnancies, such as female genital mutilation or early or forced marriages?
- What efforts has the State taken to exercise due diligence to prevent and eliminate abusive treatment, including by health providers, against women and girls seeking pregnancy-related health care?
- What steps has the State taken to ensure that women and girls are not exposed to preventable health risk by reason of pregnancy?
- What steps has the State taken to combat early or unwanted pregnancy by ensuring access to comprehensive sexuality education and access to contraceptive information and services, including for adolescents and youth?
- What types of administrative or judicial safeguards has the State enacted to provide remedy and redress where women's rights to access quality pregnancy-related care are violated?
- What steps has the State taken to ensure that such administrative or judicial safeguards are accessible and timely?

Relevant Indicators

Relevant indicators include, but are not confined to:

- Time frame and coverage of national policy on sexual and reproductive health (structure indicator)
- Estimated proportions of births and deaths recorded through vital registration system (process indicator)
- Proportion of births attended by skilled providers (process indicator)
- Availability and use of basic essential obstetric care (process indicator)
- Availability and use of comprehensive essential obstetric care (process indicator)
- Proportion of women with obstetric complications using these facilities (process indicator)
- Prevalence of anemia in women (outcome indicator)
- Lifetime risk of maternal death (outcome indicator)

Additional Resources from the Center for Reproductive Rights

Bringing Rights to Bear: Preventing Maternal Mortality and Ensuring Safe Pregnancy
Surviving Pregnancy and Childbirth: An International Human Right
Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change
Broken Promises: Human Rights, Accountability, and Maternal Death in Nigeria
Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities
Litigation Briefing Series: Alyne da Silva Pimentel v. Brazil

[1] *See, e.g.*, Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health*, ¶ 12(a) (2000), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I), at 78 (2008) [hereinafter ESCR Committee, *General Comment No. 14*].

[2] *See, e.g.*, ESCR Committee, *General Comment No. 14*, *supra* note 1, ¶ 43(d). The WHO Model List of Essential Medicines includes misoprostol for obstetric purposes. WHO, WHO Model List of Essential Medicines 29 (2011).

[3] *See, e.g.*, Convention on the Elimination of All Forms of Discrimination against Women, art. 12(2), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1981) [hereinafter CEDAW].

[4] *See, e.g.*, CEDAW, *supra* note 3, art. 14(2)(b); Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, No. 17/2008, ¶¶ 7.6, 8(2), U.N. Doc. CEDAW/C/49/D/17/2008 (2011) [hereinafter Alyne da Silva Pimentel v. Brazil]; ESCR Committee, *General Comment No. 14*, *supra* note 1, ¶ 12(b).

[5] R.R. v. Poland, No. 27617/04 Eur. Ct. H. R. (2011).

[6] *See, e.g.*, Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, ¶ 22 (1999), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 358 (2008) [hereinafter CEDAW Committee, *General Recommendation No. 24*].

[7] *See, e.g.*, CEDAW Committee, *General Recommendation No. 24,supra* note 6, ¶ 15(c); CEDAW Committee, *Concluding Observations: Kenya*, ¶¶ 37-38, U.N. Doc. CEDAW/C/KEN/CO/6 (2007).

[8] *See, e.g.*, International Covenant on Economic, Social and Cultural Rights, art. 10(2), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966).

[9] *See, e.g.*, CEDAW, *General Recommendation No. 24*, *supra* note 6, ¶ 9.

[10] L.C. v. Peru, CEDAW Committee, No. 22/2009, ¶ 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011); Inter-Am. Comm'n H.R., Precautionary Measures 43-10, "Amelia," Nicaragua (2010).

Legal, regulatory, and practical barriers can effectively deny women and girls access to safe abortion services. These include criminal laws that punish providers or those seeking abortions, lack of clarity on the legal status of abortion, an absence of public funding for legal abortion, mandatory waiting periods, and providers' refusals to perform legal abortions. Evidence demonstrates that legal restrictions on abortion do not reduce the number of induced abortions in practice; rather they contribute to higher rates of unsafe abortion.[1] While complications from abortion are rare when performed by a skilled health care provider in sanitary conditions, unsafe abortions result in high rates of complications.[2] Roughly 13% of all maternal deaths worldwide are due to unsafe abortion.[3] Timely post-abortion care is essential to minimize the harmful effects of spontaneous or unsafe induced abortions, and should be available throughout the health system as part of a minimum standard of care,[4] irrespective of the legality of abortion. Post-abortion care for unsafe abortion cannot replace the protection of women's health and their human rights afforded by safe, legal induced abortion.[5]

In 1994, governments at the International Conference on Population and Development recognized that where legal, abortion should be safe and accessible.[6] Since then, human rights bodies have strengthened and broadened this consensus, identifying absolute bans on abortion as incompatible with international human rights law[7] and calling for the provision of access to abortion at a minimum in cases where continued pregnancy poses a risk to the life or health of the pregnant woman, or in cases of severe fetal abnormality, or of rape or incest.[8] The World Health Organization calls for all abortion laws to be interpreted and implemented in such a way that women's physical and mental health can be promoted and protected.[9]

Components of State Obligations

International human rights bodies have indicated that States have an obligation to develop laws, policies, and practices to reduce the risk of unsafe abortion and ensure access to safe abortion and post-abortion care. This requires that:

- States take steps to reduce the number of unsafe abortions and the risks to women's and girls' health and lives. This includes the obligation to:
    - Ensure access to unbiased, comprehensive, and scientifically accurate information on sexual and reproductive health, including information necessary to prevent unwanted pregnancy and reduce unsafe abortions and information regarding the legal availability of abortion.[10]
    - Ensure access to abortion both in law and in practice in certain instances, including at a minimum in cases where the pregnancy threatens the life or health of the pregnant woman and in cases of rape, incest, or fetal impairment incompatible with life.[11]
    - Review laws that criminalize abortion, with a view to eliminating punitive measures for women and girls seeking, and health care providers performing voluntary abortion services.[12]
    - Ensure access to essential medicines and services that make legal abortion services safer and easier to access, especially in rural settings.[13]
    - Ensure the availability, accessibility (including affordability), acceptability, and quality of safe abortion services where legal.[14]
- States take steps to ensure access to post-abortion care for all women and girls, free from discrimination, violence, or coercion. This includes the obligation to:
    - Ensure adequate training, support, and supplies to ensure that abortion-related complications can be treated, irrespective of the legality of abortion.[15]

- Ensure patient confidentiality for women and girls accessing post-abortion care,[16] and ensure that procedures are in place to investigate and impose sanctions on those who violate women's confidentiality.[17]
- Ensure that post-abortion care is not conditioned upon statements made by women and girls seeking post-abortion care, and that these statements are not subsequently used to prosecute them.[18]
- Eliminate requirements that health care providers report patients who have undergone or are suspected of having undergone an illegal abortion.[19]

Assessing State Compliance

- To what extent has the State developed and implemented measures to reduce the risks of unsafe or clandestine abortions?
- To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans?
- What efforts has the State taken to repeal laws, policies or regulations that criminalize abortion?
- What measures has the State taken to clarify its legal or regulatory framework to ensure effective access to abortion where legal[20]?
- To what extent has the State eliminated or refrained from imposing other restrictions on access to legal abortion services, such as laws requiring third-party authorization (e.g., parental, spousal, or judicial) to access abortion services?
- What measures has the State taken to eliminate practical barriers to accessing legal abortion, such as long distances to health facilities, lack of accessible transportation, and formal or informal user fees, in particular for low-income women and adolescents?
- What steps has the State taken to guarantee the confidentiality of women and girls seeking abortions or post-abortion care, for instance by eliminating requirements for physicians to report individuals who have had abortions or who seek treatment for abortion-related complications or prohibiting the release of medical records of women who have undergone abortions?
- When providing financial assistance, has the State refrained from imposing restrictions on the provision of abortion-related information and services by aid recipients?
- What efforts has the State taken to ensure effective access to quality, respectful post-abortion care, irrespective of the legal status of abortion?
- What measures has the State taken to regulate conscientious objection by health care providers to ensure that women and girls have access to legal abortion and post-abortion care[21]?
- Has the State refrained from imposing or eliminated policies or practices conditioning access to post-abortion care on confessing to having undergone an illegal abortion or denouncing the abortion provider?
- What steps has the State taken to eliminate and punish abusive treatment of women and girls seeking legal abortion services or post-abortion care?
- What types of administrative or judicial safeguards has the State enacted to provide remedy and redress where a woman has been impermissibly denied access to a legal abortion or post-abortion care, or when her confidentiality has been breached?

- What steps has the State taken to ensure that such administrative or judicial safeguards are accessible and timely?

Relevant Indicators

Relevant indicators include, but are not confined to:

- Number of unsafe abortions per 1,000 women of reproductive age (process indicator)
- Number of legal abortions performed (process indicator)
- Percentage of obstetric and gynecological admissions owing to abortion-related complications (process indicator)
- Number of health care providers, including mid-level providers, trained on providing abortion-related services (process indicator)
- Percentage of maternal deaths due to unsafe abortion (outcome indicator)

Additional Resources from the Center for Reproductive Rights

Bringing Rights to Bear: Abortion and Human Rights
Safe and Legal Abortion is a Woman's Human Right
Forsaken Lives: The Harmful Impact of the Philippine Criminal Abortion Ban
In Harm's Way: The Impact of Kenya's Restrictive Abortion Law
Litigation Briefing Series: Lakshmi Dhikta v. Nepal
Litigation Briefing Series: RR v. Poland, S&T v. Poland, and Z v. Poland

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1 WHO, Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008 6 (2011) [hereinafter Unsafe Abortion]. *See also*, UN Women, 2011-2012 Progress of the World's Women: In Pursuit of Justice 43 (2011).

2 Complications from unsafe abortion include incomplete abortion, failed abortion, hemorrhage, infection, and uterine perforation or rupture. WHO, Safe Abortion: Technical and Policy Guidance for Health Systems 47-49 (2012) [hereinafter Safe Abortion Guidance].

3 Unsafe Abortion, *supra* note 2, at 1.

4 The WHO has established that "every service-delivery site at each level of the health system should be equipped and have personnel trained to recognize abortion complications and to provide, or refer women for, prompt care," which includes the training and supplies necessary to complete evacuation of uterine contents through either vacuum aspiration or dilation and evacuation, as well as essential medicines, such as antibiotics to treat infection and uterotonic drugs to stop hemorrhaging (e.g., misoprostol). Safe Abortion Guidance, *supra* note 2, at 47-49.

5 Safe Abortion Guidance, *supra* note 2, at 64.

6 *Programme of Action of the International Conference on Population and Development*, ¶¶ 7.6, 8.25, 13.14(b), Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].

7 Committee against Torture, *Concluding Observations: Nicaragua,* ¶ 16, U.N. Doc. CAT/C/NIC/CO/1 (2009); Human Rights Committee, *Concluding Observations: El Salvador*, ¶ 10, U.N. Doc. CCPR/C/SLV/CO/6 (2010); ESCR Committee, *Concluding Observations: Chile*, ¶¶ 26, 53 U.N. Doc. E/C.12/1/Add.105 (2004).

8 Safe Abortion Guidance, *supra* note 2, at 91-93; L.C. v. Peru, CEDAW Committee, No. 22/2009, ¶ 12(b)(i), U.N. Doc. CEDAW/C/50/D/22/2009 (2011) [hereinafter L.C. v. Peru]; CEDAW Committee, *Concluding Observations: Sri Lanka*, ¶ 283, U.N. Doc. A/57/38, Part I (2002).

9 Safe Abortion Guidance, *supra* note 2, at 87.

10 *See, e.g.*, Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, ¶ 10 (2000), U.N. Doc. HIR/GEN/1/Rev.9 (Vol. I), at 168 (2008); CEDAW Committee, *Concluding Observations: Benin*, ¶158, U.N. Doc. A/60/38 (2005); *Bosnia and Herzegovina*, ¶ 36, U.N. Doc. CEDAW/C/BIH/CO/3 (2006); *Burkina Faso*, ¶ 350, U.N. Doc. A/60/38 (2005); *Cape Verde*, ¶ 30, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); *Eritrea*, ¶ 23, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); *Lebanon*, ¶ 112, U.N. Doc. A/60/38 (2005); CRC Committee, *Concluding Observations: Antigua and Barbuda*, ¶ 54, U.N. Doc. CRC/C/15/Add.247 (2004); *Chile*, ¶ 56, U.N. Doc. CRC/C/CHI/CO/3 (2007); *Colombia*, ¶ 71, U.N. Doc. CRC/C/COL/CO/3 (2006); ESCR Committee, *Concluding Observations: Benin*, ¶ 42, U.N. Doc. E/C/12/1/Add.78 (2002); *Bolivia*, ¶ 43, U.N. Doc. E/C.12/1/Add.60 (2001); *Mexico*, ¶ 43, U.N. Doc. E/C.12/1/Add.41 (1999); Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* ¶ 65(l), U.N. Doc A/66/254 (2011).

11 *See, e.g.*,L.C. v. Peru, *supra* note 8, ¶¶ 9(b)(i), 9(b)(iii); CEDAW Committee, *Concluding Observations: Sri Lanka*, ¶ 283, U.N. Doc. A/57/38, Part I (2002); CRC Committee, *Concluding Observations: Chad*, ¶30, U.N. Doc. CRC/C/15/Add.107 (1999); *Chile*, ¶56, U.N. Doc. CRC/C/CHL/CO/3 (2007); *Guatemala*, ¶ 40, U.N. Doc. CRC/C/15/Add.154 (2001); Human Rights Committee, *Concluding Observations: Guatemala*, ¶ 20, U.N. Doc. CCPR/C/GTM/CO/3 (2012); *Dominican Republic*, ¶ 15, U.N. Doc. CCPR/C/DOM/CO/5 (2012); *Panama*, ¶ 9, U.N. Doc. CCPR/C/PAN/CO/3 (2008); ESCR Committee, *Concluding Observations: Chile*, ¶ 53, U.N. Doc. E/C.12/1/Add.105 (2004); *Costa Rica*, ¶¶ 25, 46, U.N. Doc. E/C/12/CRI/CO/4 (2008); *Nepal*, ¶ 55, U.N. Doc. E/C.12/1/Add.66 (2001); Committee against Torture, *Concluding Observations: Peru*, ¶ 23, U.N. Doc. CAT/C/PER/4 (2006).

[12] *See,e.g.*, Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, ¶ 14 (1999), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 358 (2008) [hereinafter CEDAW Committee, *General Recommendation No. 24*]; *Rep. of the Special Rapporteur on the right to health*, *supra* note 10, ¶¶ 21, 65(h); Human Rights Committee, *Concluding Observations: Costa Rica*, ¶ 11, U.N. Doc. CCPR/C/79/Add.107 (1999); *Ecuador*, ¶ 11, U.N. Doc. CCPR/C/79/Add.92 (1998), *Gambia*, ¶ 17, U.N. Doc. CCPR/CO/75/GMB (2004).

[13] *See, e.g.*, *Rep. of the Special Rapporteur on the right to health*, *supra* note 10, ¶ 29.

[14] *See, e.g.*, K.L. v. Peru, Human Rights Committee, No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005) [hereinafter K.L. v. Peru]; L.M.R. v. Argentina, Human Rights Committee, No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011) [hereinafter L.M.R. v. Argentina]; L.C. v. Peru, *supra* note 8; *Rep. of the Special Rapporteur on the right to health*, *supra* note 10, ¶ 29.

[15] *See, e.g.*, Committee against Torture, *Concluding Observations: Chile*, ¶ 7(m), U.N. Doc. CAT/CR/32/5 (2004); *Rep. of the Special Rapporteur on the right to health*, *supra* note 10, ¶¶ 27, 65(k).

[16] *See*, e.g., *Rep. of the Special Rapporteur on the right to health*, *supra* note 10, ¶ 30 (noting that post-abortion care should not be "used as evidence in any proceeding" against the woman seeking the care).

[17] CEDAW Committee, *General Recommendation No. 24*, *supra* note 12, ¶ 12(d) (identifying violations of medical confidentiality as a form of discrimination against on women); Convention on the Elimination of All Forms of Discrimination against Women, art. 2(b), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1981) [hereinafter CEDAW] (requiring States to "adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women.").

[18] *See, e.g.*, Committee against Torture, *Concluding Observations: Chile*, ¶ 7(m), U.N. Doc. CAT/CR/32/5 (2004).

[19] *See, e.g.*, CEDAW Committee, *Concluding Observations: Chile*, ¶ 229, U.N. Doc. A/54/38 (1999); *Rep. of the Special Rapporteur on the right to health*, *supra* note 10, ¶ 30.

[20] The WHO has explained that national standards and guidelines can facilitate access to abortion where legal and should cover "types of abortion service, where and by whom they can be provided; essential equipment, instruments, medications, supplies and facility capabilities; referral mechanisms; respect for women's informed decision-making, autonomy, confidentiality and privacy, with attention to the special needs of adolescents; special provisions for women who have suffered rape; and conscientious objection by health-care providers." Safe Abortion Guidance, *supra* note 2, at 63.

[21] CEDAW Committee, *General Recommendation No. 24*, *supra* note 12, ¶ 11; *Rep. of the Special Rapporteur on the right to health*, *supra* note 10, ¶ 29.

V. COMPREHENSIVE SEXUALITY EDUCATION

Comprehensive sexuality education is essential for individuals to protect themselves from unwanted pregnancy and health risks such as sexually transmissible infections (STIs) and to make informed decisions around sexuality and reproduction. Comprehensive sexuality education includes "accurate information about human sexuality, including: growth and development; sexual anatomy and physiology; reproduction; contraception; pregnancy and childbirth; HIV and AIDS; STIs; family life and interpersonal relationships; culture and sexuality; human rights empowerment; non-discrimination, equality and gender roles; sexual behavior; sexual diversity; sexual abuse; gender-based violence; and harmful practices."[1] Effective comprehensive sexuality education must also include scientifically accurate information, and should be taught over a period of years to introduce age-appropriate concepts consistent with the evolving capacities of children and young people.[2]

Comprehensive sexuality education can delay the onset of sexual activity, increase the use of protection against unwanted pregnancy and STIs, and lead to fewer sexual partners, with significant benefits for individuals' overall health and well-being.[3]

Components of State Obligations

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.[4] This requires that:

- States take steps to ensure the ability of all individuals to seek, receive, and impart information on sexual and reproductive health.[5] This includes the obligation to:
    - Refrain from censoring or withholding information or disseminating biased or factually incorrect information, such as disseminating inaccurate information on contraceptives.[6]
- States take steps to ensure that all individuals have access to comprehensive sexuality education, both within and outside of the formal educational system.[7] This includes the obligation to:
    - Make comprehensive sexuality education programs part of the standard school curriculum.[8]
    - Make comprehensive sexuality education programs available in the informal sector (e.g. through community-based organizations) to reach individuals excluded from the educational system.[9]
    - Include instruction on comprehensive sexuality education in teacher training programs to ensure that instructors are adequately trained to provide comprehensive information in a safe learning environment.[10]
    - Develop materials to ensure quality, scientifically accurate, and accessible comprehensive sexuality education programs.[11]
- States take steps to ensure that comprehensive sexuality education programs are free from harmful sex- or gender-based or heteronormative stereotypes, or those based on mental or physical ability.[12] This includes the obligation to:
    - Develop curricular materials that do not perpetuate harmful and discriminatory stereotypes,[13] and which pay special attention to gender issues and diversity.[14]
    - Ensure that comprehensive sexuality education is taught in a safe learning environment, where individuals are able to participate free from discrimination, harassment, and violence.[15]
- States develop public education campaigns and programs to raise awareness about sexual and reproductive health issues, such as the risks of early pregnancy and prevention of STIs, through the media and other alternative forums.[16]

Assessing State Compliance

- To what extent has the State developed and implemented a national strategy or plan to ensure access to comprehensive sexuality education both within and outside of educational institutions?
- To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans?
- To what extent has the State developed comprehensive sexuality education curricula and teacher-training materials?
- What steps has the State taken to eliminate the dissemination of biased, discriminatory or factually incorrect information on sexuality or sexual and reproductive health?
- What efforts has the State taken to eliminate limitations or restrictions on access to comprehensive sexuality education, for instance requirements of parental authorization for participation in such programs?
- What steps has the State taken to repeal laws, policies and regulations restricting access to sexuality education and information on sexual and reproductive health[17]
- What measures has the State taken to ensure that religious, social, or other beliefs, practices and institutions do not impede individuals' access to comprehensive sexuality education?

Relevant Indicators

Relevant indicators include, but are not confined to:

- Percentage of adolescents who have received comprehensive sexuality education in schools (process indicator)
- Percentage of adolescents who understand how to prevent unwanted pregnancy and STIs (process indicator)
- Percentage of health providers trained in sexual health counseling (process indicator)
- Ratio of teachers imparting sexuality education per total number of enrolled students (process indicator)
- Percentage of sexually active adolescents who used contraception at first or last sex (process indicator)

Additional Resources from the Center for Reproductive Rights

Bringing Rights to Bear: The Human Right to Information on Sexual and Reproductive Health
The Right to Contraceptive Information and Services for Women and Adolescents
The Reproductive Rights of Adolescents: A Tool for Health and Empowerment
An International Human Right: Sexuality Education for Adolescents in Schools

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1 United Nations Educational, Scientific, and Cultural Organization (UNESCO), International Technical Guidance on Sexuality Education: An Evidence Informed Approach to Effective Sex, Relationship, and HIV/STI Education Vol. II: Topics and learning objectives 5 (2009) [hereinafter UNESCO, International Technical Guidance Vol. II].

2 *See, e.g.*, UNESCO, International Technical Guidance Vol. II, *supra* note 1, at 23.

3 *See* United Nations Educational, Scientific, and Cultural Organization (UNESCO), International Technical Guidance on Sexuality Education: An Evidence Informed Approach for Schools, Teachers, and Health Educators Vol. I 2 (2009).

4 *See, e.g.*, Special Rapporteur on the right to education, *Report of the United Nations Special Rapporteur on the right to education*, ¶ 87(c), U.N. Doc. A/65/162 (2010) [hereinafter *Rep. of the Special Rapporteur on the right to education*].

5 *See, e.g.*, Committee on the Rights of the Child, *General Comment No. 3: HIV/AIDS and the rights of the child*, ¶ 26 (2003), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 398 (2008) [hereinafter CRC, *General Comment No. 3*]; Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health*, ¶ 12(b) (2000), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I), at 78 (2008) [hereinafter ESCR Committee, *General Comment No. 14*].

[6] *See, e.g.*, CRC, *General Comment No. 3*, *supra* note 5, ¶ 16, U.N. Doc. CRC/GC/2003/3 (2003); ESCR Committee, *General Comment No. 14*, *supra* note 5, ¶ 34; INTERIGHTS v. Croatia, European Committee of Social Rights No. 45/2007, ¶ 47 (2009) [hereinafter INTERIGHTS v. Croatia]; *Rep. of the Special Rapporteur on the right to education, supra* note 4, ¶ 39.

[7] *See, e.g.*, Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, ¶¶ 26, 28, 39(b) (2003), U.N. Doc. HIR/GEN/1/Rev.9 (Vol. II), at 410 (2008) [hereinafter CRC, *General Comment No. 4*]; Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, ¶ 18 (1999), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 358 (2008) [hereinafter CEDAW Committee, *General Recommendation No. 24*]; ESCR Committee, *General Comment No. 14, supra* note 5, ¶ 11.

[8] *See, e.g.*, Human Rights Committee, *Concluding Observations: Poland*, ¶ 11, U.N. Doc. CCPR/C/79/Add.110 (1999); INTERIGHTS v. Croatia, *supra* note 6, ¶ 47; *Rep. of the Special Rapporteur on the right to education, supra* note 4, ¶87(c).

[9] *See, e.g.*, CRC, *General Comment No. 4*, *supra* note 7, ¶ 28; *Rep. of the Special Rapporteur on the right to education, supra* note 4, ¶ 87(f).

[10] *See, e.g.*, CEDAW Committee, *General Recommendation No. 24*, *supra* note 7, ¶18; INTERIGHTS v. Croatia, *supra* note 6, ¶ 47; *Rep. of the Special Rapporteur on the right to education, supra* note 4, ¶ 87(e).

[11] *See, e.g.*, INTERIGHTS v. Croatia, *supra* note 6, ¶ 47; *Rep. of the Special Rapporteur on the right to education, supra* note 4, ¶ 87(d).

[12] *See, e.g.*, *Rep. of the Special Rapporteur on the right to education, supra* note 4, ¶¶ 62-63.

[13] *See, e.g.*, INTERIGHTS v. Croatia, *supra* note 6, ¶ 48; *Rep. of the Special Rapporteur on the right to education, supra* note 4, ¶ 63.

[14] *See, e.g.*, *Rep. of the Special Rapporteur on the right to education, supra* note 4, ¶¶ 21-23, 87(d).

[15] *See, e.g.*, CRC, *General Comment 4*, *supra* note 7, ¶ 39(a).

[16] *See, e.g.*, CRC, *General Comment 4*, *supra* note 7, ¶ 28; CRC, *Concluding Observations: Honduras*, ¶ 63(e), U.N. Doc. CRC/C/HND/CO/3 (2007); *Rep. of the Special Rapporteur on the right to education, supra* note 4, ¶ 87(f).

[17] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* ¶¶ 56, 64, 65(e), U.N. Doc A/66/254 (2011) [hereinafter *Rep. of the Special Rapporteur on the right to health,* 2011].

Violence against women—that is, gender-based violence against women and girls[1] that results in, or is likely to result in, physical, sexual, psychological or economic harm or suffering, whether in public or private sphere[2]—violates women's and girls' fundamental rights and can pose a significant barrier to the enjoyment of sexual and reproductive rights. Unintended pregnancies, STIs, and pregnancy-related complications are among the numerous health-related consequences of sexual or domestic violence. When women and girls are subjected to sexual or domestic violence, their ability to control their fertility is impaired. In particular, violence may diminish the ability to negotiate contraceptive use or access contraceptives, and may limit women's and girls' reproductive autonomy and ability to access sexual and reproductive health services. Economic dependence on a batterer, for instance, may leave a woman unable to access household resources to pay for sexual and reproductive health goods or services without her partner's knowledge.

Harmful practices, such as female genital mutilation or early or forced marriage, are a form of violence against women and a violation of a number of human rights. They can severely limit the realization of sexual and reproductive rights. Female genital mutilation, for example, carries long-term physical, sexual, and psychological harms; can lead to serious pregnancy-related complications; and can increase the risk of infant and maternal mortality and contraction of STIs, including HIV. Child marriage often leads to early pregnancy, and adolescent girls are more likely to experience complications during pregnancy and childbirth.

Components of State Obligations

States have an obligation to develop laws, policies, and practices to prevent, punish, and eliminate violence against women in both the public and private spheres.[3] This requires that:

- States recognize and take steps to prevent all forms of violence against women, including physical, sexual, psychological, and economic violence, including domestic violence, sexual harassment, sexual assault, trafficking, and female genital mutilation. This includes the obligation to:
    - Take measures to modify social and cultural patterns with a view to eliminating prejudices and practices that are based on the inferiority or superiority of either of the sexes or stereotyped roles of men and women;[4]
    - Take necessary legislative measures to prevent all forms of violence against women, including female genital mutilation, marital rape, and so-called "honor" killings;[5]
    - Train judges, law enforcement officers, and health care providers to recognize and respond to different forms of violence against women in a gender-sensitive and effective manner;[6]
    - Provide shelters, sexual and reproductive healthcare (e.g., access to emergency contraception, abortion, and prophylactic antiretroviral treatment for survivors of sexual violence), counseling, orders of protection, and legal services to survivors of violence.[7]
- States exercise due diligence to investigate and punish the perpetrators of violence against women. This includes the obligation to:
    - Investigate promptly, thoroughly, impartially, and seriously all allegations of violence against women and bring the offenders to justice;[8]
    - Provide victims of violence with access to justice, including free legal aid where necessary, in order to ensure them available, effective, and sufficient remedies, including compensation and rehabilitation.[9]

- States collect, analyze, and disseminate disaggregated data on the extent, causes, and effects of violence against women, and on the effectiveness of measures to prevent and deal with violence.[10]
- States develop public education campaigns to combat the root causes of violence against women; promote the rights of women and girls who may be susceptible to gender-based violence; raise awareness of the issue; and reduce stigma and discrimination that contributes to, and is directed at, survivors of violence.[11]

Assessing State Compliance

- To what extent has the State developed and implemented national strategies and plans aimed at preventing, punishing, and eradicating all forms of violence against women, including harmful or abusive practices against adolescents[12]?
- To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans?
- To what extent does the State penalize violent crimes against women?[13] What steps has the State taken to eliminate loopholes for escaping liability, for instance by allowing a rapist to escape criminal liability by marrying his victim?
- What steps has the State taken to eliminate violence against women in institutional settings, such as violence against girls in educational institutions or involuntary sterilization in health facilities[14]?
- What steps has the State taken to prevent, address and eliminate violence against women in conflict or post-conflict settings, for instance the use of rape and other forms of sexual violence during armed conflict?
- What steps has the State taken to prevent, address and eliminate violence against women in the private and community sphere—including harmful practices, such as marital rape, "honor" killings, forced or child marriage, or sexual violence directed at sex workers?[15]
- What measures are in place for the State to exercise due diligence to investigate and punish acts of violence against women?
- What protective measures has the State put into place to prevent violence, such as creating effective protective orders or establishing shelters[16]?
- What steps has the State taken to ensure access to emergency contraception or abortion for survivors of sexual violence both in law and in practice[17]?
- What steps has the State taken to ensure that accountability mechanisms that facilitate access to justice are available to survivors of violence, and to what extent are these mechanisms responsive to the specific obstacles women and girls face when seeking justice?

Relevant Indicators

Relevant indicators include, but are not confined to:

- Legally stipulated minimum age for marriage (structure indicator)
- Proportion of received complaints on all forms of VAW investigated and adjudicated by the national human rights institution, human rights ombudsperson or other mechanism and the proportion of these responded effectively by the government (process indicator)

- Number of instances of violence against women reported (process indicator)
- Percentage of health providers trained to detect signs of sexual abuse or violence (process indicator)
- Development of guidelines on managing the medical consequences of violence against women (process indicator)
- Number of prosecutions and convictions for violence against women (process indicator)
- Proportion of women subjected to female genital mutilation (outcome indicator)
- Proportion of women who have experienced physical, sexual and psychological violence during the last year [life time], by severity of violence, relationship to the perpetrator and frequency (outcome indicator)

Additional Resources from the Center for Reproductive Rights

Bringing Rights to Bear: Freedom from Violence is a Human Right
Litigation Briefing Series: M.N.N. v. Attorney General of Kenya

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[1] Gender-based violence may be directed at other populations, such as transgender and gender nonconforming individuals, but we focus here on the reproductive health implications of gender-based violence directed at women and girls.

[2] *See, e.g.,*. Council of Europe Convention on preventing and combating violence against women and domestic violence, art. 3 (2011) [hereinafter CoE Convention on violence against women]; Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women "Convention of Belem do Para", art. 1 (1995) [hereinafter Convention Belem do Para].

[3] *See* Committee on the Elimination of Discrimination against Women, *General Recommendation No. 19: Violence against women*, (1992), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 331 (2008) [hereinafter CEDAW Committee, *General Recommendation No. 19*]; A.T. v. Hungary, CEDAW Committee No. 2/2003, U.N. Doc. CEDAW/C/32/D/2/2003 (2005) [hereinafter A.T. v. Hungary]; CoE Convention on violence against women, *supra* note 1; Convention Belem do Para, *supra* note 1; Opuz v. Turkey No. 33401/02, Eur. Ct. H.R. (2009); Maria da Penha Maia Fernandes v. Brazil, Case 12.051, Inter-Am. Comm'n H.R., Report No. 54/01, OAE/Ser./L/V/II.111, doc. 20 rev. (2000); Jessica Gonzales v. United States, Case 12.626, Inter-Am. Comm'n H.R, Report No. 52/07, OAE/Ser.L/V/II.130, doc. 22, rev. 1 (2007).

[4] Convention on the Elimination of All Forms of Discrimination against Women, art. 5(a), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1981); A.T. v. Hungary, *supra* note 3; CoE Convention on violence against women, *supra* note 1, art. 12(1).

[5] *See, e.g.*, CEDAW Committee, *General Recommendation No. 19, supra* note 3, ¶¶ 24(a), 24(b), 24(l), 24(r)(ii); A.T. v. Hungary, *supra* note 3,¶ 9.6(II)(e); Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, ¶ 11 (2000), U.N. Doc. HIR/GEN/1/Rev.9 (Vol. I), at 168 (2008) [hereinafter Human Rights Committee, *General Comment No. 28*].

[6] *See, e.g.*, CEDAW Committee, *General Recommendation No. 19, supra* note 3, ¶¶ 24(b), 24(k); A.T. v. Hungary, *supra* note 3, ¶ 9.6(II)(d).

[7] *See, e.g.*, CEDAW Committee, *General Recommendation No. 19, supra* note 3, ¶¶ 24(k), 24(t)(iii); A.T. v. Hungary, *supra* note 3, ¶ 9.6(II)(e); Human Rights Committee, *General Comment No. 28*, *supra* note 5, ¶ 11.

[8] *See, e.g.*, A.T. v. Hungary, *supra* note 3, ¶ 9.6(II)(f).

[9] *See, e.g.*, CEDAW Committee, *General Recommendation No. 19*, *supra* note 3, ¶ 24(t)(i); A.T. v. Hungary, *supra* note 3, ¶ 9.6(II)(g); Human Rights Committee, *General Comment No. 28*, *supra* note 5, ¶ 11.

[10] *See, e.g.*, CEDAW Committee, *General Recommendation No. 19*, *supra* note 3, ¶ 24(c).

[11] *See, e.g.*, CEDAW Committee, *General Recommendation No. 19*, *supra* note 3, ¶¶ 24(f), 24(t)(ii); Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, ¶ 24 (2003), U.N. Doc. HIR/GEN/1/Rev.9 (Vol. II), at 410 (2008) [hereinafter CRC, *General Comment No. 4*].

[12] *See, e.g.*, CEDAW Committee, *General Recommendation No. 19*, *supra* note 3, ¶ 24(l).

[13] *See, e.g.*, A.T. v. Hungary, *supra* note 3, ¶ 9.6(II)(b).

[14] *See, e.g.*, CEDAW Committee, *General Recommendation No. 19, supra* note 3, ¶ 24(m); A.S. v. Hungary, CEDAW Committee No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).

[15] *See, e.g.*, A.T. v. Hungary, *supra* note 3, ¶ 9.6(II)(b).

[16] *See, e.g.*, CEDAW Committee, *General Recommendation No. 19, supra* note 3, ¶ 24(t)(iii).

[17] *See, e.g.*, CEDAW Committee, *General Recommendation No. 19, supra* note 3, ¶ 24(m).

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 and the freedom to have a safe and satisfying sex life. Yet, individuals living with HIV frequently encounter discrimination in accessing sexual and reproductive health services, which can deter them from seeking necessary health care and undermine prevention and treatment programs.[1]

Lack of information about HIV prevention and methods of transmission prevent individuals from taking the necessary precautions to protect themselves from contracting HIV, and can contribute to misconceptions that fuel stigma and discrimination against individuals living with HIV.

Components of State Obligations

States have an obligation to develop laws, policies, and practices to ensure prevention of and treatment for HIV/AIDS and to ensure freedom from discrimination on grounds of HIV status. This requires that:

- States take steps to eliminate the social and cultural factors that exacerbate women and girls' heightened risk of contracting HIV, including gender-based violence, gender stereotyping, lack of or inadequate sexuality education for both young women and young men, and child marriage.[2]
- States take steps to ensure access to HIV prevention, treatment, and care for all individuals.[3] This includes the obligation to ensure information and education on HIV,[4] access to condoms (including female condoms),[5] voluntary and confidential counseling and testing for HIV,[6] nondiscriminatory health care,[7] and affordability of necessary medications for individuals living with HIV.[8]
- States take steps to ensure that all individuals living with HIV are able to make informed and voluntary decisions around childbearing.[9] This includes the obligation to ensure access to contraceptive information and services, safe abortion services, and reproductive technologies.
- States take steps to ensure that all individuals living with HIV are able to access reproductive health information, goods, and services, including access to perinatal care, skilled attendance during birth, emergency obstetric care, and medicines and technology essential to sexual and reproductive health.[10] This includes the obligation to:
    - Ensure access to nondiscriminatory, nonabusive reproductive health care for pregnant women living with HIV and for women living with HIV who wish to become pregnant;[11]
    - Ensure access to the medicines and technology necessary to reduce the risk of parent-to-child transmission of HIV.[12]
- States develop scientifically accurate public education campaigns on HIV to raise awareness of the virus, including methods of transmission and prevention, and to reduce stigma against, and promote the rights of, individuals living with HIV.[13]

Assessing State Compliance

- To what extent has the State developed and implemented a national strategy or plan aimed at ensuring prevention, treatment, and control of HIV, including by ensuring access to prevention and treatment programs (including programs to reduce parent-to-child transmission)[14] and eliminating discrimination against individuals living with HIV[15]?
- To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans?

- To what extent has the State enacted legislative or regulatory protections to ensure the rights of individuals living with HIV to give informed and voluntary consent to health goods and services, including HIV testing, and to ensure confidentiality in testing and treatment[16]?
- What measures has the State taken to eliminate involuntary or punitive measures in HIV testing, prevention, or treatment programs, such as the involuntary HIV testing of pregnant women or girls[17]?
- What measures has the State taken to repeal laws that criminalize consensual same-sex sexual relations and HIV transmission?[18]
- What steps has the State taken to respect the rights of individuals living with HIV to make voluntary decisions around childbearing, for instance by eliminating policies or programs that promote or condone involuntary sterilization or abortion for women living with HIV[19]?
- To what extent has the State enacted, implemented, or enforced laws and policies to safeguard individuals living with HIV from discrimination in the private sphere, such as termination of an employee living with HIV[20]?
- What types of administrative or judicial safeguards has the State enacted to provide remedy and redress where an individual living with HIV has been denied essential health care on the basis of his or her HIV status, or received abusive or discriminatory treatment in health care settings?
- What steps has the State taken to ensure that such administrative or judicial safeguards are accessible and timely?

Relevant Indicators

Relevant indicators include, but are not confined to:

- Proportion of population covered under awareness raising programmes on transmission of diseases (e.g. HIV/AIDS) (process indicator)
- Proportion of population applying effective preventive measures against diseases (e.g. HIV/AIDS, malaria) (process indicator)
- Number of programs to prevent parent-to-child transmission of HIV (process indicator)
- HIV prevalence (outcome indicator)

Additional Resources from the Center for Reproductive Rights

Bringing Rights to Bear: Human Rights in the Context of HIV/AIDS and Other Sexually Transmissible Infections (STIs)
Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities
At Risk: Rights Violations of HIV-Positive Women in Kenyan Health Facilities
Litigation Briefing Series: F.S. v. Chile

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[1] Office of the United Nations High Commissioner for Human Rights & UNAIDS, International Guidelines on HIV and Human Rights 2006 Consolidated Version (2006), ¶ 96.

[2] *See, e.g.*, Convention on the Elimination of All Forms of Discrimination against Women, art. 5, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1981) [hereinafter CEDAW]; Committee on the Elimination of Discrimination against Women, *General Recommendation No. 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)* (1990), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 327 (2008) [hereinafter CEDAW Committee, *General Recommendation No. 15*]; Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, ¶ 18 (1999), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 358 (2008) [hereinafter CEDAW Committee, *General Recommendation No. 24*; Committee on the Rights of the Child, *General Comment No. 3: HIV/AIDS and the rights of the child* (2003), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II), at 398 (2008) [hereinafter CRC, *General Comment No. 3*].

[3] International Covenant on Economic, Social and Cultural Rights, art. 12(c), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) [hereinafter ICESCR]; CEDAW Committee, *General Recommendation No. 24*, *supra* note 2, ¶ 18; CRC, *General Comment No. 3*, *supra* note 2; Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health*, ¶ 16 (2000), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I), at 78 (2008) [hereinafter ESCR Committee, *General Comment No. 14*].

[4] CEDAW Committee, *General Recommendation No. 24*, *supra* note 2, ¶ 18; ESCR Committee, *General Comment No. 14*, *supra* note 3, ¶ 16.

[5] Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, ¶ 30 (2003), U.N. Doc. HIR/GEN/1/Rev.9 (Vol. II), at 410 (2008) [hereinafter CRC, *General Comment No. 4*].

[6] CEDAW Committee, *General Recommendation No. 24*, *supra* note 2, ¶ 18.

[7] Committee on Economic, Social and Cultural Rights, *General Comment No. 20: Non-discrimination in economic, social and cultural rights*, ¶ 33, U.N. Doc. E/C.12/GC/20 (2009) [hereinafter ESCR Committee, *General Comment No. 20*]; ESCR Committee, *General Comment No. 14*, *supra* note 3, ¶¶ 12(b), 18; CRC, *General Comment No. 3*, *supra* note 2; CRC, *General Comment 4*, *supra* note 5, ¶ 41(b).

[8] ESCR Committee, *General Comment No. 14*, *supra* note 3, ¶ 12(b).

[9] *See, e.g.*, CEDAW Committee, *General Recommendation No. 24*, *supra* note 2, ¶ 22.

[10] *See, e.g.*, ESCR Committee, *General Comment No. 20*, *supra* note 7, ¶ 33 (proscribing differential treatment in access to healthcare for persons living with HIV).

[11] *See, e.g.*, ESCR Committee, *General Comment No. 14*, *supra* note 3, ¶ 12(b).

[12] *See, e.g.*, ICESCR, *supra* note 3, art. 12(c); ESCR Committee, *General Comment No. 14*, *supra* note 3, ¶ 16.

[13] *See, e.g.*, ESCR Committee, *General Comment No. 14*, *supra* note 3, ¶ 16.

[14] *See, e.g.*, ESCR Committee, *General Comment No. 14*, *supra* note 3, ¶ 16.

[15] *See, e.g.*, ESCR Committee, *General Comment No. 14*, *supra* note 3, ¶ 12(b); ESCR Committee, *General Comment No. 20*, *supra* note 7, ¶ 33.

[16] *See, e.g.*, CEDAW Committee, *General Recommendation No. 24*, *supra* note 2, ¶ 22; ESCR Committee, *General Comment No. 14*, *supra* note 3, ¶ 8.

[17] *See, e.g.*, ESCR Committee, *General Comment No. 14*, *supra* note 3, ¶ 8.

[18] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* ¶¶ 76(a), 76(c), U.N. Doc. A/HRC/14/20 (2010).

[19] *See, e.g.*, CEDAW Committee, *General Recommendation No. 24*, *supra* note 2, ¶ 22.

[20] *See, e.g.*, Committee on Economic, Social and Cultural Rights, *General Comment No. 18: The right to work*, ¶ 12(b)(i) (2005), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I), at 139 (2008).