ICPD AND HUMAN RIGHTS:

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

CENTER FOR REPRODUCTIVE RIGHTS

International Conference on Population and Development Fact Sheets

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

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

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

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

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

*** This document was drafted by the Center for Reproductive Rights, with financial support and technical input from UNFPA. The human rights issues described in this publication are built on legal and policy developments in the jurisprudence of different UN treaty monitoring bodies, in national legislation and in other sources. The views of the author do not necessarily reflect the views of UNFPA.**

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

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

Treaty Monitoring Bodies

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

International Human Rights Principles

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

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

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

Autonomy

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

Non-discrimination and Equality

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

Accountability

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

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

Participation and Empowerment

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

International Cooperation

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

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

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

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

---

1 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 7.2, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].
2 *Id.*
3 *See Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development*, U.N. GAOR, 21st Special Sess., June 30-July 3, 1999, U.N. Doc. A/S-21/5/Add.1 (1999).
4 Other important advancements in regards to sexual and reproductive rights include the Amman Declaration and Programme of Action, the United Nations Declaration on the Rights of Indigenous Peoples, the 2012 Commission on Population and Development resolution on adolescents and youth, and the 2012 Commission on the Status of Women resolution on maternal health of rural women. *See Amman Declaration and Programme of Action,* Amman, Jordan, Nov. 5-7, 2012; United Nations Declaration on the Rights of Indigenous Peoples, U.N. Doc. A/61/L.67 (Sept. 12, 2007); Commission on Population and Development Res. 2012/1 Adolescents and youth, Rep. of the Commission on Population and Development, 45th Sess., Apr. 15 & Apr. 23-27, 2012, U.N. Doc. E/2012/25, E/CN.9/2012/8 (2012); Commission on the Status of Women, Agreed conclusions on access and participation of women and girls in education, training and science and technology, including for the promotion of women's equal access to full employment and decent work, Rep. of the Commission on the Status of Women, 55th Sess., Mar. 12., Feb. 22-Mar. 4 & Mar. 14, 2011, U.N. Doc. E/2011/27, E/CN.6/2011/12 (2011).
5 *See* GA Res. 65/234, U.N. Doc. A/RES/65/234 (Apr. 5, 2011).
6 *See, e.g.*, Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 3, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW] ("States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men."); International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 2(1), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR] ("Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."); International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, art. 2(2), G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR] ("Where not already provided for by existing legislative or other measures, each State Party to the present Covenant undertakes to take the necessary steps, in accordance with its constitutional processes and with the provisions of the present Covenant, to adopt such legislative or other measures as may be necessary to give effect to the rights recognized in the present Covenant.").
7 *See* Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Costa Rica,* para. 64(b), U.N. Doc. CRC/C/CRI/CO/4 (2011) (urging the state to "Design and implement an intersectoral public policy for health, sexual and reproductive rights aimed at adolescents within and outside the educational system and

taking into account sexual and reproductive rights, healthy sexuality, prevention of unplanned pregnancies, sexually transmitted diseases, HIV/AIDS, and the accessibility and use of condoms and other contraceptives."). Examples of legislation that explicitly incorporates sexual and reproductive rights include Bolivia's 2009 Constitution and Albania's 2002 Law on Reproductive Health. *See* Nueva Constitución Política del Estado [Constitution] Oct. 2008, arts. 14-15, 45, 48 & 66 (Bolivia) [hereinafter Bolivian Constitution]; Law No. 8876, Law on Reproductive Health (Apr. 4, 2002) (Albania).
8 Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 29, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].
9 Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at para. 33, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*]; CEDAW Committee, *Gen. Recommendation No. 24, supra* note 8, para. 14.
10 ESCR Committee, *Gen. Comment No. 14, supra* note 9, para. 34.
11 *See id.* para. 33; CEDAW Committee, *Gen. Recommendation No. 24, supra* note 8, para. 15.
12 ESCR Committee, *Gen. Comment No. 14, supra* note 9, para. 35.
13 *Id.* para. 33; *see also* CEDAW Committee, *Gen. Recommendation No. 24, supra* note 8, para. 17 ("The duty to fulfill rights places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care.").
14 *See, e.g., ICPD Programme of Action, supra* note 1, para. 4.1; Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, arts. 3 & 25, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611 (*entered into force* May 3, 2008); CEDAW Committee, *Gen. Recommendation No. 24, supra* note 8, para. 31(e).
15 ESCR Committee, *General Comment No. 20: Non-discrimination in economic, social and cultural rights,* para. 29, U.N. Doc. E/C.12/GC/20 (2009) [hereinafter ESCR Committee, *Gen. Comment No. 20*].
16 *Id.* para. 32.
17 *Id.* para. 31.
18 *Id.* para. 33.
19 *See, e.g.,* C158 Termination of Employment Convention, 1982 (No. 158), *adopted* Jun. 22, 1982, art. 5, Geneva, 68th ILC Sess. (*entered into force Nov. 23, 1985*); C183 Maternity Protection Convention, 2000 (No. 183), *adopted* Jun. 15, 2000, Geneva, 88th ILC Sess. (*entered into force Feb. 7, 2002*); R191 Maternity Protection Recommendation, 2000 (No. 191), *adopted* Jun. 15, 2000, Geneva, 88th ILC Sess.
20 CEDAW, *supra* note 6, art. 3.
21 CEDAW Committee, *General Recommendation No. 28: Core Obligations of States parties under article 2 of the Convention on the Elimination of Discrimination against Women*, (47th Sess., 2010), para. 31, U.N. Doc. CEDAW/C/GC/28 (2010) [hereinafter CEDAW Committee, *Gen. Recommendation No. 28*].
22 *See generally* ESCR Committee, *General Comment No. 20, supra* note 15.
23 *Id.* para. 8(b).
24 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 8, para. 14.
25 CEDAW, *supra* note 6, arts. 2(f) ("States Parties...undertake...[t]o take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women") & 5 ("States Parties shall take all appropriate measures: (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;"); Convention on the Rights of the Child, *adopted* Nov. 20, 1989, art. 24(3), G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter CRC] ("States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."); *See* CRC Committee, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, (33rd Sess., 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter Committee on the Rights of the Child, *Gen. Comment No. 4*] (incorporating sexual and reproductive health into the right to health).
26 *ICPD Programme of Action, supra* note 1, para. 13.8(a) & (c).
27 *See id.* Preamble, Principle 10 and para. 3.18.
28 *Id.* para. 14.10.
29 Office of the United Nations High Commissioner for Human Rights, *Technical guidance on the application of human rights-based approach to implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, para. 85, U.N. Doc. A/HRC/21/22 (July 2, 2012).
30 *ICPD Programme of Action, supra* note 1, para. 14.3.
31 *See* ESCR Committee, *Gen. Comment No. 14, supra* note 9, para. 12.
32 *Id.* para. 12(a).
33 *Id.*
34 *Id.* para. 12(b)(i).
35 *Id.* para. 12(b)(ii) and (iii).
36 *Id.* para. 12(b)(iii).
37 *Id.* para. 12(b)(iv).
38 *Id.* para. 12(c).
39 *Id.* para. 12(d).

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

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

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

Maternal Mortality and Morbidity in the ICPD Programme of Action

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

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

Human Rights Standards

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

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

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

Country Examples:

Armenia

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

India

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

Nepal

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

---

1. *See* UN Department of Public Information, We Can End Poverty 2015 Millennium Development Goals: Goal 5: Improve Maternal Health (2010); Office of the United Nations High Commissioner for Human Rights, *Technical guidance on the application of human rights-based approach to implementation of policies and programmes to reduce preventable maternal morbidity and mortality,* U.N. Doc. A/HRC/21/22 (July 2, 2012).
2. World Health Organization (WHO), UNICEF, United Nations Population Fund (UNFPA) & The World Bank, Trends In Maternal Mortality: 1990 TO 2010, 1 (2012) [hereinafter Trends In Maternal Mortality]; *See also* Rafael Lozano et al., *Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis, 378 The Lancet 1139 (2011) [hereinafter Progress towards Millennium Development Goals 4 and 5].*
3. *Rep. of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights,* para. 6, U.N. Doc. A/HRC/14/39 (Apr. 16, 2010); WHO, Maternal Mortality: Fact Sheet No. 348 (2012).
4. WHO, Maternal Mortality: Fact Sheet No. 348 (2012).
5. WHO & UNFPA, Pregnant Adolescents: Delivering on Global Promises of Hope 4 (2006).
6. *Id.* at 8.
7. U.N. Secretary-General, *We the Children: End-decade review of the follow-up to the World Summit for Children,* para. 181, U.N. Doc. A/S-27/3 (May 4, 2001).
8. Paul Hunt & Judith Bueno de Mesquita, Human Rights Centre, University of Essex, Reducing Maternal Mortality: The Contribution of the right to the highest attainable standard of health (2010).
9. *Programme of Action of the International Conference on Population and Developmen*t, Cairo, Egypt, Sept. 5-13, 1994, para. 7.2, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Actio*n].
10. *Id*. para. 8.19.
11. *Id.* ("At the global level, it has been estimated that about half a million women die each year of pregnancy-related causes, 99 per cent of them in developing countries.").
12. *Id.* para. 8.22.
13. *Id.* para. 8.21.
14. *See Progress towards Millennium Development Goals 4 and 5*, *supra* note 2, at 1163.
15. *ICPD Programme of Action, supra* note 9, para. 8.21 ("Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed.").
16. *Id*. paras. 7.6, 7.24 & 8.19 ("Greater attention to the reproductive health needs of female adolescents and young women could prevent the major share of maternal morbidity and mortality through prevention of unwanted pregnancies and any subsequent poorly managed abortion.").
17. *Id.* para. 8.25 ("All Governments [should]… reduce the recourse to abortion through expanded and improved family-planning services.") & 8.26 ("Programmes to reduce maternal morbidity and mortality should include information and reproductive health services, including family-planning services. In order to reduce high-risk pregnancies, maternal health and safe motherhood programmes should include counselling and family-planning information.").
18. *Id*. para. 8.25.
19. Key Actions for Further Implementation of the Program of Action of the International Conference on Population and Development, U.N. GAOR, 21st Special Sess., June 30-July 3, 1999, para. 63, U.N. Doc. A/S-21/5/Add.1 (1999); *ICPD Programme of Action*, *supra* note 9, paras. 7.24 & 8.25.
20. *ICPD Programme of Actio*n, *supra* note 9, para. 8.23.
21. *Id*. para. 8.19.
22. *Id*. para. 8.24.
23. *See, e.g.,* Human Rights Committee (HRC), *Concluding Observations: Mali,* para. 14, U.N. Doc. CCPR/CO/77/MLI (2003).
24. Alyne da Silva Pimentel Teixeira v. Brazil, Committee on the Elimination of Discrimination against Women (CEDAW Committee), Commc'n No. 17/2008, paras. 7.5-7.6, U.N. Doc. CEDAW/C/49/D/17/2008 (2011) [hereinafter Alyne v. Brazil].
25. *See, e.g.,* HRC, *Concluding Observations: Mongolia,* para. 8(b), U.N. Doc. CCPR/C/79/Add.120 (2000); *Peru*, para. 20, U.N. Doc. CCPR/CO/70/PER (2000); *Trinidad and Tobago*, para. 18, U.N. Doc.CCPR/CO/70/TTO (2000).
26. Alyne v. Brazil, *supra* note 24, paras. 7.5-7.6.
27. *See* Human Rights Council Res. 11/8 Preventable maternal mortality and morbidity and human rights, Rep. of the Human Rights Council, 11th Sess., June 2-19, 2009, U.N. Doc. A/HRC/11/37, at 44 (Oct. 16, 2009).
28. CEDAW Committee, *Concluding Observations: Malawi,* para. 31, U.N. Doc. CEDAW/C/MWI/CO (2006); *Mexico*, para. 32, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); *Morocco, p*ara. 30, U.N. Doc. CEDAW/C/MAR/CO/4 (2008).
29. *See, e.g.,* HRC, *Concluding Observations: Chile*, para. 8, U.N. Doc. CCPR/C/CHL/CO/5 (2007); *Madagascar,* para. 14, U.N. Doc. CCPR/C/MDG/CO/3 (2007); *Panama*, para. 9, U.N. Doc. CCPR/C/PAN/CO/3 (2008).
30. *See, e.g.,* Committee in the Rights of the Child (CRC Committee), *Concluding Observations: Democratic People's Republic of Korea*, para. 50, U.N. Doc. CRC/C/15/Add.239 (2004); *Guatemala*, para. 40, U.N. Doc. CRC/C/15/Add.154 (2001); *Haiti*, para. 46, U.N. Doc. CRC/C/15/Add.202 (2003).
31. *See, e.g.,* CEDAW Committee, *Concluding Observations: Eritrea*, para. 22, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); *Mozambique*, para. 36, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007).
32. *See, e.g.,* CRC Committee, *Concluding Observations: Sudan,* para. 10, U.N. Doc. CRC/C/15/Add.10 (1993).

33. *See, e.g.,* CRC Committee, *Concluding Observations: Chile,* para. 41, U.N. Doc. CRC/S/15/Add.173 (2002).
34. Alyne v. Brazil, *supra* note 24, para.7.6.
35. *Id.* para. 7.7.
36. Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health* (Art. 12), (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at para. 44(a), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*] (noting that the provision of maternal health care arises to the level comparable to that of "core obligations" under human rights treaties).
37. *See, e.g.,* CRC Committee, *Concluding Observations: Côte d'Ivoire*, para. 39, U.N. Doc. CRC/C/15/Add.155 (2001); *Dominican Republic*, paras. 37–38, U.N. Doc. CRC/C/15/Add.150 (2001); *Lesotho*, para. 44, U.N. Doc.CRC/C/15/Add.147 (2001).
38. *See, e.g.,* ESCR Committee, *Concluding Observations: Korea*, para. 44, U.N. Doc. E/C.12/1/Add.95 (2003); *Nepal*, para. 46, U.N. Doc. E/C.12/NPL/CO/2 (2008).
39. CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 31(c), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); ESCR Committee, *Gen. Comment No. 14*, *supra* note 36, para. 14.
40. *See, e.g.,* CEDAW Committee, *Concluding Observations: Burundi*, para. 36, U.N. Doc. CEDAW/C/BDI/CO/4 (2008); *Malawi*, para. 32, U.N. Doc. CEDAW/C/MWICO (2006).
41. *See, e.g.,* CEDAW Committee, *Concluding Observations: Bolivia*, para. 43, U.N.Doc. CEDAW/C/BOL/CO/4 (2008); *Honduras*, para. 25, U.N. Doc. CEDAW/C/HON/CO/6 (2008); *Pakistan*, para. 41, U.N. Doc. CEDAW/C/PAK/CO/3 (2007).
42. *See, e.g.,* HRC, *Concluding Observations: Poland*, para. 11, U.N. Doc. CCPR/C/79/Add.110 (1999).
43. *See, e.g.,* ESCR Committee, *Gen. Comment No. 14*, *supra* note 36, para. 43(d); The WHO Model List of Essential Medicines includes misoprostol for obstetric purposes. WHO, WHO Model List of Essential Medicines 29 (17th List 2011).
44. *See, e.g.,* ESCR Committee, *Gen. Comment No. 14*, *supra* note 36, para. 12(a).
45. L.C. v. *Peru*, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).
46. *See, e.g.,* HRC, *Concluding Observations: Ecuador*, para. 11, U.N. Doc. CCPR/C/79/Add.92 (1998).
47. *See, e.g.,* HRC, *Concluding Observations: Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000).
48. *Id.*
49. *See, e.g.,* HRC, *Concluding Observations: Ireland*, paras. 448-449, U.N. Doc. A/55/40 (2000).
50. CRC Committee, *Concluding Observations: Nicaragua,* para. 20(e), U.N. Doc. CRC/C/NIC/CO/4 (2010).
51. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, *adopted* Dec. 18, 1990, G.A. Res. 45/158, U.N. Doc. A/RES/45/158 (1990); CRC Committee, *Concluding Observations: Mexico,* para. 72, U.N. Doc. CRC/C/MEX/CO/3 (2006).
52. WHO, *Maternal and newborn health: Facts and figures,* World Health Organization: Regional Office for Europe, http://www.euro.who.int/en/what-we-do/health-topics/Life-stages/maternal-and-newborn-health/facts-and-figures (last visited May 8, 2013); *Safe Motherhood,* UNFPA: Armenia, http://unfpa.am/en/safe-motherhood (last visited May 8, 2013). Armenia has a maternal mortality rate of 28.5, while the European average is 16.
53. UNFPA, UNFPA submission to the Office of the High Commissioner for Human Rights on the topic of Preventable Maternal Morbidity and Mortality and Human Rights for inclusion into the thematic study on the subject requested by the Human Rights Council Resolution A/HRC/15/17, 8 [hereinafter UNFPA, Submission to OHCHR on Preventable Maternal Morbidity and Mortality] (on file at the Center for Reproductive Rights).
54. *Id.* at 8.
55. *Id.* at 8-9.
56. Consolidated Decision, *Laxmi Mandal v. Deen Dayal Harinagar Hospital &Others,* W.P. (C) No. 8853/2008 & *Jaitun v. Maternal Home MCD, Jangpura & Others,* W.P. (C) Nos. 8853 of 2008 & 10700 of 2009 (Delhi High Court, 2010), paras. 28-29 [hereinafter Consolidated Decision, *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Jaitun v. Maternal Home MCD*].
57. *Id.* para. 62(i)-(iii).
58. *Id.* para. 62(v).
59. *Id.* para. 62(viii).
60. *Id.* para. 62(vii).
61. *Id.* para. 51-61.
62. Trends in Maternal Mortality, *supra* note 2, at 25.
63. Government of Nepal, United Nations Country Team of *Nepal*, *Nepal* Millennium Development Goals: Progress Report 2010, 48 (2010); Population Division, Ministry of Health and Population, Government of Nepal et al., Nepal Demographic and Health Survey 2011, 128 (2012).
64. Government of Nepal, National Policy on Skilled Birth Attendants: Supplement to Safe Motherhood Policy 1998 (2006).
65. Guttmacher Institute, Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies 27, 30 (2012).

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

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

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

Contraceptive Information and Services in the ICPD Programme of Action

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

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

Human Rights Standards

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

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

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

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

Country Examples:

Guatemala

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

Namibia

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

Philippines

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

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

United States

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

---

1 United Nations, The Millennium Development Goals Report 2012, 35 (2012) (These percentages reflect the increase from 1990-2010.).
2 Susheela Singh & Jacqueline E. Darroch, Guttmacher Institute, Adding It Up: Costs and Benefits of Contraceptive Services – Estimates for 2012, 1 (2012).
3 Human Rights Committee (HRC), *Concluding Observations: Hungary*, para. 11, U.N. Doc. CCPR/CO/74/HUN (2002) ("The State party should take steps to protect women's life and health, through more effective family planning and contraception (art. 6)."); Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Chile*, para. 28, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012) (expressing concern about pregnant adolescents being expelled from school); Dianne Hubbard, *Realising the right to education for all: School policy on learner pregnancy in Namibia, in* Children's Rights in Namibia, 223 (Oliver C Ruppel ed., 2009).
4 Center for Reproductive Rights, The Right to Contraceptive Information and Services for Women and Adolescents 10-11 (2010). *See* Individuals Belonging to Marginalized and Underserved Populations Fact Sheet for more information on the barriers faced by marginalized and underserved populations.
5 *See* Mayo Clinic Staff, *Family Planning: Get the facts about pregnancy spacing*, Mayo Clinic (May 27, 2011), http://www.mayoclinic.com/health/family-planning/MY01691.
6 *HIV/AIDS: Condoms for HIV prevention*, World Health Organization, http://www.who.int/hiv/topics/condoms/en/index.html (last visited May 8, 2013).
7 Coercive population policies and practices include measures that deprive women of their right to determine the number and spacing of their children in a voluntary and informed manner. This may include laws restricting the number of children a woman may have, sterilization campaigns targeting particular groups of women, and mandating or incentivizing reproductive health service providers to fulfill quotas for sterilizations, amongst others. *See, e.g.*, María Chávez v. *Peru*, Case 12.191, Inter-Am. Comm'n H.R., Report No. 71/03, OEA/Ser.L/V/II.118, doc. 70 rev. 2 (2003) [hereinafter María Chávez v. *Peru*]; Open Society Foundations, Against Her Will: Forced and Coerced Sterilization of Women Worldwide (2011) [hereinafter Against Her Will]; V.C. v. *Slovakia*, No. 18968/07 Eur. Ct. H.R. (2011) [hereinafter V.C. v. *Slovakia*].
8 *See* Against Her Will, *supra* note 7; María Chávez v. Peru, *supra* note 7; V.C. v. *Slovakia*, No. 18968/07 Eur. Ct. H.R. (2011); F.S. v. *Chile*, Inter-Am. C.H.R., pending admissibility (petition filed Feb. 3, 2009).
9 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 7.3 & Principle 8, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].
10 *Id.* paras. 7.2, 7.5(a), 7.12 & 7.14(c).
11 *Id.* para. 7.13.
12 *Id.* para. 7.16.
13 *Official list of MDG indicators*, Millennium Development Goals Indicators: The official United Nations site for the MDG Indicators (Jan. 15, 2008), http://mdgs.un.org/unsd/mdg/host.aspx?Content=indicators/officiallist.htm.
14 *ICPD Programme of Action*, *supra* note 9, para. 7.17.
15 *Id.* para. 7.3 & Principle 8.
16 *Id.* para. 7.12.
17 *Id.* para. 7.23(c).
18 *Id.* para. 7.14(c).
19 *Id.* para. 7.14(a).
20 *Id.* para. 7.15.
21 *Id.* para. 7.12.
22 *Id.*
23 *Id.* para. 7.19.
24 *Id.* para. 7.20.

预览已结束，完整报告链接和二维码如下：
https://www.yunbaogao.cn/report/index/report?reportId=5_20333

II. CONTRACEPTIVE INFORMATION AND SERVICES (continued)

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