BRIEFING PAPER

THE RIGHT TO CONTRACEPTIVE INFORMATION AND SERVICES FOR WOMEN AND ADOLESCENTS

CENTER FOR REPRODUCTIVE RIGHTS

UNFPA

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Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
United States
Tel +1 917 637 3600
Fax +1 917 637 3666

publications@reprorights.org
www.reproductiverights.org

United Nations Population Fund
605 Third Avenue
New York, NY 10158 USA
Tel +1 (212) 297-5000
Fax +1 (212) 370-0201

publications@unfpa.org
www.unfpa.org

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MISSION AND VISION

The Center's Mission and Vision

The Center for Reproductive Rights uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill.

Reproductive freedom lies at the heart of the promise of human dignity, self-determination, and equality embodied in both the U.S. Constitution and the Universal Declaration of Human Rights. The Center works toward the time when that promise is enshrined in law in the United States and throughout the world. We envision a world where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive healthcare available; where every woman can exercise her choices without coercion or discrimination. More simply put, we envision a world where every woman participates with full dignity as an equal member of society.

UNFPA's Mission

UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV, and every girl and woman is treated with dignity and respect.

UNFPA - because everyone counts

INTRODUCTION

Women's and adolescents' right to contraceptive information and services is grounded in internationally recognized human rights, including the right to life, the right to the highest attainable standard of health, the right to decide the number and spacing of one's children, the right to privacy, the right to information, and the right to equality and non-discrimination.* Guaranteeing access to available, acceptable, and good quality contraceptive information and services free from coercion, discrimination, and violence is critical for achieving gender equality and ensuring that women can participate as full members of society.

The Programme of Action from the International Conference on Population and Development, which marked a paradigmatic shift with respect to the recognition of reproductive rights as fundamental human rights,[1] recognized contraceptive information and services as essential to ensuring reproductive health and rights. It reaffirmed that "the aim of family-planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods."[2] Additionally, the Committee on the Rights of the Child has indicated that "States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs)."[3]

Governments are obligated to take affirmative steps to ensure women's and adolescents' access, in both law and practice, to the full range of contraceptive methods by removing legal, financial, informational, and other barriers. Similarly, governments should refrain from restricting women's ability to make free and informed choices, for example by strictly regulating or prohibiting a particular contraceptive method. They should also ensure the elimination of all coercive practices relating to contraceptive information and services.

Applying a human rights-based approach to the provision of contraceptive information and services can facilitate state fulfillment of these obligations and promote the full realization of women's and adolescents' fundamental rights.

This briefing paper examines the right to access contraceptive information and services for women and adolescents. In doing so, it assesses the benefits of contraceptive access, lays out the human rights framework underpinning this right, identifies the normative elements of this right, and provides an overview of how to apply a human rights-based approach to the provision of contraceptive information and services. This tool provides practical guidance for activists, scholars, UN Agencies, non-governmental organizations, governments and other actors working in the area of sexual and reproductive health to integrate human rights into programs and policies on contraceptive information and services.

* While the right to contraceptive information and services is also critical for men, this briefing paper focuses on the specific needs of women and adolescents.

AN OVERVIEW OF CONTRACEPTIVE ACCESS

The unmet need for safe and effective contraceptive services throughout the world is staggering. Despite their desire to avoid or delay pregnancy, roughly 215 million women in developing countries rely on traditional methods only, which have a high failure rate, or do not use any contraceptive method at all.[4] According to a recent survey of 65 countries, the unsatisfied demand for contraceptives exceeds actual use in at least 30 countries.[5]

This demand for modern contraception will continue to rise during the next decade because of the anticipated increase in the number of women of reproductive age and the number of women who wish to have smaller families.[6] At the same time, however, due in large part to the global financial crisis, funding for family planning programs has drastically diminished—from 55% of total assistance for population programs in 1995 to only 4% in 2009 [7]—and job losses and reduced wages translate to greater financial barriers for women and adolescents.

Ensuring access to contraceptive information and services has countless socioeconomic benefits and is central to achieving gender equality. It can empower women and couples to determine whether and when to have children; enable women to complete their education;[8] increase women's autonomy within their households;[9] and boost their earning power, thereby improving the economic security and well-being of women and their families.[10] It is also critical for protecting adolescents' health and human rights. In contrast, contraceptive inaccessibility carries devastating social, economic, and public health consequences.

Lack of access to modern contraceptive information and services means that women and adolescents are often unable to protect themselves from HIV and other sexually transmitted infections (STIs) or to control their fertility and reproduction. Both of these situations carry negative consequences for women's and adolescents' health and lives.[11] Worldwide, approximately 33 million people are living with HIV,[12] and 340 million new cases of curable STIs (such as syphilis, gonorrhea, chlamydia, and trichomoniasis) in adults aged 15–49 years occur annually.[13] Of the approximately 80 million women who annually experience unintended pregnancies, 45 million have abortions.[14] In countries where abortion is highly restricted or inaccessible, women often resort to clandestine abortions, which are frequently unsafe and pose a serious risk to their health and lives.[15] Complications from unsafe abortions are a leading cause of maternal morbidity,[16] and approximately 68,000 women die from unsafe abortions each year.[17] Satisfying the current unmet need for contraceptives could prevent roughly 150,000 maternal deaths and 25 million induced abortions worldwide annually.[18]

CONTRACEPTIVE ACCESS AT A GLANCE[1]

- At least one in four women seeking to avoid pregnancy is not using an effective contraceptive method.[2]
- Women with unmet need for modern contraceptives account for 82 per cent of unintended pregnancies.[3]
- Addressing the unmet need for contraceptive information and services would result in roughly 22 million fewer unplanned births,[4] 25 million fewer induced abortions,[5] and 150,000 fewer maternal deaths each year.[6]

Vulnerable and Marginalized Populations Encounter Significant Barriers to Contraceptive Access

ADOLESCENTS

The Committee on the Rights of the Child and the Committee on the Elimination of Discrimination against Women (CEDAW Committee) have recognized adolescents' right to contraceptive information and services.[1] However, adolescents frequently encounter significant barriers to accessing contraceptive information and services, leading to high rates of unintended pregnancy and increased risk of contracting HIV and STIs.[2] Lack of evidence-based sexuality education and information hampers adolescents' ability to make informed decisions around contraceptive use, which in turn leads to high rates of teenage pregnancy[3] and high abortion rates among adolescents and young women.[4] Despite the Convention on the Rights of the Child's recognition of the "evolving capacities" of adolescents to make decisions in matters affecting their lives,[5] many states require parental consent in order for adolescents to access contraceptive information and services, which can deter adolescents from seeking necessary reproductive health services.[6] Stigma around adolescent sexuality may similarly deter adolescents from seeking such services or may result in denials of reproductive health services, even where parental consent is not required.[7] Cost can also be a significant obstacle for adolescents, as they frequently lack their own source of income or control over their finances to be able to afford contraceptives.[8]

MINORITY AND INDIGENOUS COMMUNITIES

Minority and indigenous communities[9] may encounter significant barriers to accessing healthcare services, which often translates into a lower health status than that of the overall population.[10] As a result of persistent discrimination and marginalization, these communities often have limited access to reproductive health services, including contraceptive information and services.[11] Discrimination in healthcare settings may take different forms, including outright refusal of care or, more subtly, the provision of inferior care—both of which perpetuate mistrust and fear of the health establishment among women from indigenous and minority communities.[12] Language and cultural differences—and in remote areas, geography—can present additional barriers to accessing healthcare services.[13] Language barriers, for example, may prevent members of minority or indigenous communities from accessing contraceptive information and services in a language and form that they understand. Discrimination in the healthcare setting has also led to the implementation of coercive family planning practices, such as forced sterilization,[14] that violate fundamental human rights and fuel mistrust of public health institutions, particularly contraceptive services.

PERSONS WITH DISABILITIES

The Convention on the Rights of Persons with Disabilities explicitly recognizes that individuals with disabilities have the right 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."[15] However, women with disabilities are often subject to double discrimination based on their disabilities and their gender.[16] Reproductive health services, particularly contraceptive information and services, are largely unavailable to individuals with disabilities due to barriers to physical access, lack of disability-related technical and human support, stigma, and discrimination.[17] Despite the fact that individuals with disabilities are equally as likely to be sexually active as persons without disabilities, misconceptions that they are asexual are widespread.[18] 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 coercive or forced contraceptive policies, such as sterilization.[19]

WOMEN IN VIOLENT RELATIONSHIPS

Domestic violence can pose a significant barrier to accessing contraceptive information and services, and unintended pregnancies and STIs are among the numerous health-related consequences of sexual violence in both domestic and conflict settings (discussed below).[20] When women are subjected to sexual or domestic violence, their ability to control their fertility is impaired. In particular, violence often diminishes women's ability to negotiate contraceptive use,[21] and economic dependence may make women unable to access household resources to buy contraceptives without their partner's knowledge.[22]

WOMEN AND ADOLESCENTS IN CONFLICT AND POST-CONFLICT ZONES

Women and children account for more than 75% of the refugees and persons displaced by war, famine, and natural disasters.[23] Displaced women and adolescents often have limited access to reproductive healthcare, including contraceptive information and services,[24] and are also particularly vulnerable to sexual coercion and gender-based violence.[25] These factors contribute to high rates of unintended pregnancies, which in turn can lead to high rates of maternal mortality and unsafe abortion.[26] Indeed, up to half of all maternal deaths in refugee settings may be attributable to unsafe abortion.[27] Accordingly, access to comprehensive contraceptive information and services, including emergency contraception (EC), is particularly important in the context of internal displacement or refugee settings, both to fulfill the demand for continued contraceptive use and to address new interest in contraception given recent or ongoing precarious living conditions.[28] Lack of access to EC for rape survivors in particular can expose women in conflict and post-conflict settings to unwanted pregnancies and the attendant risk of unsafe abortions.[29]

CONTRACEPTIVE INFORMATION AND SERVICES ARE A HUMAN RIGHT

Women's and adolescents' right to contraceptive information and services is grounded in basic human rights protections. The Programme of Action from the International Conference on Population and Development recognized "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."[19]

States parties to international and regional human rights treaties have committed to promoting and protecting the basic rights that underlie the right to contraceptive information and services, including the right to equality and non-discrimination; the right to privacy; the right to determine the number, spacing, and timing of one's children; the right to life; the right to health; the right to information; the right to enjoy the benefits of scientific progress; and the right to be free from torture or cruel, inhuman, or degrading treatment (see Appendix for relevant treaty provisions).

THE RIGHTS TO EQUALITY AND NON-DISCRIMINATION

Women's and adolescents' rights to equality and non-discrimination—rights that are protected in essentially every major international and regional human rights treaty—underpin the right to access contraceptive information and services. The rights to non-discrimination and equality not only prohibit discriminatory laws and policies, but also require affirmative measures to combat socially and culturally ingrained discrimination in order to achieve substantive equality.[20] Laws and policies that deny women and adolescents access to contraceptive goods and services—for instance, by prohibiting certain contraceptive methods, such as EC, or by requiring spousal or parental authorization— constitute discrimination.[21] Additionally, practical barriers to accessing contraceptive information and services often stem from socially or culturally ingrained discrimination, and states must take steps to eliminate these barriers to ensure women's and adolescents' access to contraception. Such access is central to achieving women's and adolescents' participation as full and equal members of society.

THE RIGHTS TO PRIVACY AND TO DETERMINE THE NUMBER AND SPACING OF CHILDREN

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), along with other international and regional human rights treaties, explicitly recognizes a woman's rights to determine the number, spacing, and timing of her

children and to have access to the contraceptive information and services necessary to exercise that right.[22] The right to privacy, protected by other key international and regional treaties, protects the right of individuals and couples to make fundamental decisions about their private lives without government interference,[23] and decisions about whether and when to found a family falls within the protected zone of privacy.[24] Women's enjoyment of these rights is incumbent on access to contraceptive information and services without undue interference in their ability to select a contraceptive method that works for them. Restrictions on access to certain contraceptive methods and coercive family planning policies impair the ability of women to make informed, autonomous decisions about their personal lives and health and violate the rights to privacy and to determine the number, spacing, and timing of their children.

THE RIGHTS TO LIFE AND HEALTH (INCLUDING SEXUAL AND REPRODUCTIVE HEALTH)

The rights to life and health are central to the enjoyment of all other human rights, and access to contraceptive information and services bears directly on the enjoyment of these rights. The Human Rights Committee has indicated that the right to life should not be narrowly interpreted[25] and that the fulfillment of this right requires governments to take steps to reduce maternal mortality and increase life expectancy.[26] Both the Committee on Economic, Social and Cultural Rights (ESCR Committee) and the CEDAW Committee explicitly recognize that the right to health includes sexual and reproductive health[27] and that contraceptive information and services are necessary to fulfill this right.[28] Legal and practical barriers to contraceptive information and methods lead to higher rates of unwanted pregnancies—with the attendant risks of unsafe abortion or maternal mortality and morbidity—violating women's and adolescents' rights to life and health.

THE RIGHTS TO INFORMATION AND EDUCATION (INCLUDING SEXUAL AND REPRODUCTIVE HEALTH INFORMATION AND EDUCATION)

The rights to information and education include seeking, receiving, and imparting information and education on sexual and reproductive health, including contraceptive information.[29] A comprehensive understanding of safe and effective contraceptive methods is essential for women and adolescents to protect their health and make informed decisions about sexuality and reproduction.[30] As the CEDAW Committee has explained, "women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services" to be able to make informed decisions regarding the contraceptive method that is appropriate for them.[31] Comprehensive sexuality education, which includes information about contraceptive methods, can delay the onset of sexual activity, increase the use of contraception, and lead to fewer sexual partners, with significant benefits for the overall well-being of women and adolescents.[32] Various treaty monitoring bodies have recognized the importance of accurate and objective sexuality education as a means to reduce maternal mortality, abortion rates, adolescent pregnancies, and HIV/AIDS prevalence.[33] Inadequate

counseling on contraceptive methods or a failure to implement comprehensive, evidence-based sexuality education programs in schools can violate the rights to information and education, with negative consequences for women's and adolescents' other fundamental rights.

THE RIGHT TO ENJOY THE BENEFITS OF SCIENTIFIC PROGRESS

Women and adolescents have the right to enjoy the benefits of scientific progress, particularly when such advances may be integral to the fulfillment of other rights, such as the right to health. Technological innovations open the door for safer, more effective contraceptive methods; yet a variety of factors can inhibit women's and adolescents' ability to benefit from these advances, limiting their ability to access contraceptive methods that may be safer or more suitable for their needs. Prohibitively high costs of newer contraceptive methods, for example, may result in low-income, adolescent, or other marginalized groups of women being compelled to choose among outdated or unsuitable contraceptive methods—or being denied contraception entirely—and may reinforce social and economic inequalities.[34] As the medical and scientific communities make advances in contraceptive technologies, states must seek to facilitate women's and adolescents' enjoyment of those advances.[35]

THE RIGHT TO BE FREE FROM TORTURE OR CRUEL, INHUMAN, OR DEGRADING TREATMENT

The right to be free from torture or cruel, inhuman, or degrading treatment prohibits actions that cause physical or mental suffering or lasting physical or psychological effects, and extends to actions within medical institutions.[36] Policies and practices that infringe on women's and adolescents' right to make voluntary and informed decisions regarding their sexuality and reproduction may violate these prohibitions. Coercive sterilization, for instance, causes lasting physical and psychological effects, permanently robbing women of their reproductive capabilities and inflicting mental distress on them. States must ensure that women and adolescents receive contraceptive information and services in a manner that facilitates autonomous decision making about whether and when to use contraceptive methods, as well as the choice of method.

NORMATIVE CONTENT OF THE RIGHT TO CONTRACEPTIVE INFORMATION AND SERVICES

The right to contraceptive information and services carries with it freedoms and entitlements for women and adolescents, as well as certain state obligations.

FREEDOMS AND ENTITLEMENTS

Contraceptive Goods and Services

The right to contraceptive information and services entitles women and adolescents to contraceptive goods and services that are available, accessible, acceptable, and of good quality.[37] Not every contraceptive method will be right for every person; women and adolescents can realize this right only if they have access to a full range of contraceptive methods in a setting that allows them to make an informed choice as to the appropriate method for them. A full range of methods includes male and female condoms, vaginal barrier methods, oral contraceptives, implants, injectables, intrauterine devices, male and female voluntary sterilization, and EC.[38]

Access to Contraceptive Goods and Services Includes Emergency Contraception

EC is a safe and effective means of preventing unintended pregnancies.[1] It is intended as a back-up contraceptive method in the event of unprotected intercourse or contraceptive failure.[2] As such, EC fills a unique role in the range of modern contraceptive methods and is particularly valuable for victims of sexual violence, adolescents, and other marginalized groups who may have greater difficulty accessing other contraceptive methods.[3] At the same time, however, EC is one of the most heavily restricted forms of modern contraceptives, due in part to misinformation about its safety and misconceptions that it acts as an abortifacient.[4] Barriers to accessing EC include legislative or policy restrictions or the absence of a clear government policy on the provision of EC;[5] requirements for a doctor's prescription;[6] parental consent and minimum age requirements;[7] pharmacists' unwillingness to provide women and adolescents with EC;[8] and lack of awareness of EC.[9] Because EC is most effective when taken within 72 hours of unprotected intercourse,[10] such barriers can effectively deny women's access to the drug.[11] The right to contraceptive information and services obligates states to remove such barriers and ensure access to EC.

Contraceptive Information and Sexuality Education

The right to contraceptive information and services entitles women and adolescents to sexual and reproductive health-related information, including comprehensive information about the contraceptive methods available and suitable to them.[39] States should develop counseling services and training programs on reproductive health to provide information about contraceptives in healthcare facilities[40] and should guarantee comprehensive, evidence-based sexuality education programs in schools and community organizations [41] to ensure that contraceptive information is accessible to a wide audience. Such information should be scientifically accurate, objective, and free of prejudice and discrimination.[42] Awareness-raising campaigns can be another effective tool in providing women and adolescents with necessary information about contraception.[43]

Mainstreaming Emergency Contraception in Kenya through Public Awareness

In late 2006, the Kenyan Ministry of Public Health and Sanitation collaborated with two nongovernmental organizations (NGOs), the Population Council and Population Services International, to launch an initiative to mainstream EC in Kenya. The initiative included a core set of activities aimed at improving overall awareness of EC across the country and strengthening the quality of EC services in both the public and private sectors. Outcomes of the initiative included dramatic increases in public awareness, increased utilization of EC, and inclusion of EC in the National Family Planning Guidelines and the Nursing Council's curriculum and procedure manual for nurses.[1]

Informed Consent and Freedom from Discrimination, Coercion, or Violence

The right to contraceptive information and services requires that women and adolescents be able to make an informed choice, free from discrimination, coercion, or violence. Informed consent is a process of communication between a healthcare provider and patient that requires the patient's consent to be given freely and voluntarily, without threats or inducements, after the patient has been counseled on available contraceptive methods and the benefits, risks, and potential side effects of different methods, in a manner that is understandable to the patient.[44] Such a process is central to ensuring a woman's right to be involved in medical decision making.[45] While the process of obtaining a patient's informed consent may be difficult and time consuming, such difficulties do not absolve healthcare providers from meeting these requirements.[46] Failure to secure full and informed consent for permanent contraceptive methods, as in the case of coercive or forced sterilization, violates the right to access contraceptive information and services free from discrimi-

nation, coercion, or violence.[47] Other forms of abusive or humiliating treatment on the part of healthcare providers similarly violate women's and adolescents' right to access such services free from discrimination, coercion, or violence.[48]

STATE OBLIGATIONS

Respect, Protect, and Fulfill

States have specific duties to respect, protect, and fulfill the right to contraceptive information and services. These obligations include both limitations on the actions that the state may take and proactive measures that the state must take (positive obligations).

Respect. The duty to respect requires states to refrain from interfering directly or indirectly in the enjoyment of the right to contraceptive information and services.[49] For example, states should not restrict access to contraceptive methods through spousal or parental consent laws or prohibit a particular method.

Protect. The duty to protect requires states to prevent third parties from infringing on a woman's right to contraceptive information and services, and to take steps to investigate and punish such violations when they occur.[50] For example, states must ensure that a pharmacist's refusal to disburse legally available contraceptive methods (such as EC) does not deny women access to the full range of contraceptive methods.

Fulfill. The duty to fulfill requires that states adopt whatever measures necessary—legislative, budgetary, judicial, and/or administrative—to achieve the full realization of women's right to contraceptive information and services.[51] For example, states may need to subsidize contraceptive goods and services where prohibitively high costs otherwise prevent women and adolescents from realizing this right.

Availability, Accessibility, Acceptability, and Quality

Contraceptive information and services must be available, accessible, acceptable, and of good quality in order for states to meet their obligations to respect, protect, and fulfill this right.

Availability. States must ensure the availability of the full range of contraceptive methods. Because not every contraceptive method will be acceptable or effective for every woman or adolescent, guaranteeing the availability of the full range of contraceptive methods increases the likelihood that they will be able to successfully plan whether and when to have children and to protect themselves from STIs and HIV.[52] In addition to ensuring that facilities are stocked with the full range of contraceptive methods, the state must ensure that an adequate number of facilities providing comprehensive contraceptive information and services are available throughout the country.[53]

Chile Guarantees the Right to Contraceptive Information and Services

In January 2010, Chile enacted the Law on Information, Orientation and Provision of Methods to Regulate Fertility. The law guarantees every person's right to decide freely and responsibly on the contraceptive method of his or her choice and to receive comprehensive and unbiased information, education, and orientation on available contraceptive methods. The law also guarantees each individual's right to privacy and confidentiality regarding his or her method of choice. To give effect to these rights, the government must ensure access to all modern contraceptives, including hormonal and non-hormonal contraception and EC. Additionally, all accredited secondary schools must provide sexuality education programs that include information on approved and available contraceptive methods.[1]

Accessibility. States have a responsibility to ensure women's and adolescents' access, in both law and practice, to contraceptive information and services. Access requires that services be non-discriminatory, affordable, and physically accessible, and includes access to necessary contraceptive information.[54] Legal barriers (such as spousal or parental consent requirements, restrictions on particular contraceptive methods, restrictions based on marital status, or requirements that women have a minimum number of children before being able to access permanent contraceptive methods)[55] and practical barriers (such as prohibitively high costs,[56] geographic inaccessibility, or lack of sexuality education and information) impede women's and adolescent's access to contraceptive information and services.

Contraceptive Affordability

When high costs prevent women and adolescents from realizing their right to contraceptive information and services, states must take steps to eliminate financial barriers—for example, through contraceptive subsidies.

The ESCR Committee has indicated that provision of the drugs included in the World Health Organization (WHO) Model List of Essential Medicines[1]—a list that includes a range of contraceptive methods—is a core minimum obligation of states in realizing the right to health.[2] Additionally, treaty monitoring bodies and European institutions have identified cost as a considerable obstacle to realizing the right to contraceptive information and services and have urged states to ensure that contraceptive goods and services are available at an affordable price, particularly for low-income women and other marginalized populations.[3]

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Romania Ensures Access to Contraceptives through Subsidies

Romania has made great strides in improving contraceptive access through subsidization. Following a comprehensive assessment on contraception in Romania undertaken in 2001, the WHO recommended that the government offer free or subsidized contraceptives, along with reliable information on the benefits of modern contraception.[4] As a result, Romania's Ministry of Health and Family earmarked considerable funds to provide free contraceptives to eligible women.[5] The Ministry continues to provide free contraceptives to eligible groups.[6]

Also in 2001, the Romanian Ministry of Health and Family, the United States Agency for International Development (USAID), and the John Snow Research and Training Institute launched the Romanian Family Health Initiative, a six-year partnership with the goal of expanding and improving equitable access to family planning and other reproductive health services, particularly in rural areas. One of the program's central pillars was to provide free contraceptives to low-income communities. The provision of free contraceptives contributed to a significant increase in contraceptive prevalence, which rose from 29.5% in 1999 to 38.2% in 2004; a decrease in the rate of abortion (the average number of abortions a woman has in her lifetime) from 2.2 in 1999 to 0.84 in 2004; and a 36.8% decline in abortion-related maternal mortality during this period.[7]

Acceptability. States must ensure that contraceptive policies and programs are culturally sensitive and take into account the varying needs of women at different life stages.[57] States must identify barriers that marginalized populations—such as adolescents, minorities and indigenous peoples, women living with HIV, and women with disabilities—face in accessing contraceptive information and services, and take steps to ensure that the needs of vulnerable populations are addressed on a non-discriminatory basis.[58]

Home Delivery of Contraceptives in Pakistan Promotes Access

Community-based distribution of contraceptives can promote access among populations in which geographical distances or stigma around contraceptive use might otherwise prevent women from accessing these goods and services. In 1993, Pakistan initiated a program to increase access to basic health services, including contraceptive information and services, in rural areas. "Lady Health Workers," as they are called, visit women in their homes and provide contraceptive information and supplies, such as condoms and oral contraceptives, as well as referrals for long-acting or permanent contraceptive methods. A national program evaluation in 2001 found that 20% of women in rural areas serviced by the Lady Health Workers were using modern contraceptives, whereas only 14% of women in other rural areas relied on modern contraceptive methods.[1]

Quality. States have an obligation to ensure that healthcare facilities provide contraceptive information and services that are scientifically accurate, medically appropriate, and provided in a way that respects human rights.[59] Additionally, as the medical and scientific communities make advances in contraceptive technologies, governments must enable women and adolescents to benefit from such advances, providing women with a full range of modern contraception and appropriate and reliable information about available contraceptive methods.[60] Women and adolescents should be able to choose the contraceptive method that is appropriate for them given their life cycle, circumstances, and health, among other considerations. As such, healthcare providers must receive training in all available modern contraceptive methods and be able to provide quality healthcare, counseling, and information.[61]

Conscientious Objection and the Right to Contraceptive Information and Services

States must guarantee that the practice of conscientious objection on the part of healthcare providers does not infringe on women's and adolescents' right to contraceptive information and services.[1] Because a conflict of conscience can be experienced only by an individual, conscientious objection cannot be exercised on behalf of an institution.[2] The International Federation of Gynecology and Obstetrics acknowledges that while providers may practice conscientious objection, they must provide patients with accurate information on reproductive health services and avoid "mischaracteriz[ing] them on the basis of personal beliefs."[3]

States have an obligation to regulate conscientious objection to ensure that a woman's access to contraceptive services is not compromised. In particular, governments should require that conscientious objectors inform patients about all available contraceptive methods and refer patients to non-objecting healthcare providers; make clear that the use of conscientious objection is limited to individuals and does not extend to institutions; require health facilities to have non-objectors available to provide medical services and goods; require objectors to submit their objections in writing and for review; and prohibit individuals not engaged directly in the the provision of the service (including administrative staff) from exercising conscientious objection.[4]

In the case of *Pichon and Sajous v. France*, for example, the European Court of Human Rights held that pharmacists cannot invoke personal religious beliefs as a justification for refusing to sell legal contraceptives.[5] In Belgium, the Code of Physicians' Ethics states that physicians play a fundamental role in providing complete, objective, and accurate information related to sexuality and contraception; the law requires that doctors, when unable to provide certain information due to personal objections, give their patients the opportunity to seek such information from another physician.[6]

Pogressive Realization, Maximum Available Resources, and Core Obligations

As explained above, governments are obligated to ensure that contraceptive information and services are available, accessible, acceptable, and of good quality. Human rights law recognizes that resource constraints may prevent governments from immediately fulfilling certain economic, social, and cultural rights underpinning women's right to contraceptive information and services.[62] Nonetheless, states must demonstrate that they are taking steps "with a view to achieving progressively the full realization"[63] of these rights, to the maximum extent of their available resources.[64]

The obligation to use maximum available resources requires taking appropriate steps toward realizing the right to contraceptive information and services, including the allocation of sufficient economic resources.[65] Although evaluating a state's compliance with this duty may be difficult, comparing the country's relevant health indicators, such as unmet need for contraception, with those of countries with similar resources provides a useful benchmark for evaluating a state's progress toward its obligations.[66] Governments must also guarantee that access to contraceptive information and services is incorporated into national public health strategies, which should include benchmarks for measuring progressive realization of the right to contraceptive information and services, with a particular emphasis on access for vulnerable or marginalized populations.[67] States must also avoid retrogressive measures that erode the realization of the right to contraceptive information and services;[68] for example, introducing fees for contraception in a situation in which contraception was previously subsidized could constitute a retrogressive measure.[69]

Additionally, states have immediate obligations—often called "minimum core obligations"[70]—that are not dependent on the socioeconomic context and thus are not subject to progressive realization. These minimum core obligations include the duty to ensure access to contraceptive information and services "on a non-discriminatory basis, especially for vulnerable or marginalized groups" and "[t]o provide essential drugs, as . . . defined under the WHO Action Programme on Essential Drugs,"[71] which includes the full range of contraceptive methods.[72]

A HUMAN RIGHTS-BASED APPROACH TO CONTRACEPTIVE INFORMATION AND SERVICES

Applying a human rights-based approach to the delivery of contraceptive information and services helps facilitate the development of effective, evidence-based policies.

Drawing on human rights principles of universality, participation, accountability, equality and non-discrimination, and rule of law, a human rights-based approach can empower local communities to claim their right to contraceptive information and services. Additionally, a human rights-based approach can help clarify governments' obligations under human rights law and ensure support to states to comply with their international legal commitments.

PARTICIPATION

A human rights-based approach to the provision of contraceptive information and services requires that the voices of key stakeholders contribute to all stages of decision making, from development and implementation of policies and programs to monitoring and accountability.[73] Participation of key stakeholders—particularly marginalized populations who face significant barriers to accessing contraceptive information and services—ensures that the needs and priorities of those who are most affected by family planning policies inform the delivery of such services.[74] Ensuring active participation in all stages may require either building or reinforcing individuals' capacity to claim their rights and duty-bearers' capacity to meet their obligations to respect, protect, and fulfill these rights.[75] Engaged and informed participation of stakeholders can foster a sense of ownership over the process. In addition, it can lead to successful outcomes by ensuring that services are delivered in a culturally appropriate manner that women and adolescents are more likely to access.[76]

Putting It into Practice: Participation

- Convene a national conference, bringing together diverse stakeholders—including NGOs, service providers, and government officials—to develop a national plan on the provision of contraceptive information and services and to select benchmarks and indicators for evaluating progress in implementing the plan.
- Conduct a public education campaign on the right to contraceptive information and services to raise awareness and empower community members to claim this right.
- Establish local health committees to facilitate ongoing communication between local communities and decision makers regarding contraceptive access and to track implementation of contraceptive policies and programs.

EQUALITY AND NON-DISCRIMINATION

Equality and non-discrimination is the cornerstone of all human rights. Individuals should enjoy all of their human rights irrespective of sex, race, ethnicity, age, income, health, or other status. A human rights-based approach to contraceptive information and services requires states to ensure that individuals are not discriminated against when accessing contraceptive information and services. Similarly, policies and programs should guarantee access to contraceptive information and services for the most marginalized groups, including adolescents, women with disabilities, and minority or indigenous women. Accordingly, contraceptive programs and policies must ensure the participation of marginalized groups in all stages of the policy-making process to reduce exclusion and identify the needs and priorities of these groups. This approach helps ensure that quality contraceptive information and services are available, accessible, and acceptable to marginalized groups[77] and facilitates the development of effective and sustainable programs.[78]

Putting It into Practice: Equality and Non-Discrimination

- Organize focus groups and interviews with vulnerable or marginalized populations to identify their needs, priorities, and challenges in accessing contraceptive information and services.
- Develop a mobile health unit to bring safe, effective, and comprehensive contraceptive information and services to remote areas.
- Establish youth-friendly reproductive health centers to improve access to comprehensive, non-judgmental information and services.

Guatemala Integrates a Human Rights-Based Approach into Its Contraceptive Policies

In 2005, Guatemala passed legislation to ensure universal access to all contraceptive methods. Despite multiple legal challenges, the law went into effect in October 2009.[1] The Universal and Equitable Access to Family Planning Services Law establishes the goal of achieving universal access to modern contraceptives throughout the country and includes strategies for addressing various barriers to access. In addition to guaranteeing access to contraceptive methods, the law includes provisions that ensure free and informed decision making, adequate contraceptive information and counseling, provider training, and sexuality education in both primary and secondary schools. To help meet these goals, the law incorporates elements of a human rights-based approach. For example, it targets vulnerable groups, including adolescents and individuals living in rural areas, who lack access to basic health services. Additionally, the law calls for national surveys to identify the unmet need for family planning and recommends the development of tools for monitoring the provision of contraceptive services and evaluating progress in removing barriers to access.[2]

MONITORING

Ongoing monitoring and evaluation plays two important roles in ensuring that contraceptive policies and programs promote and protect women's and adolescents' human rights. First, it provides governments with the information necessary to determine which areas to focus on in order to meet their human rights obligations. For example, monitoring can help states identify the major barriers to accessing contraceptives and the populations that are most affected by these barriers, so that planning processes can take these factors into consideration and ensure the participation of the most affected groups. Second, monitoring provides rights-holders with information necessary to hold governments accountable when human rights obligations have not been fulfilled.[79] During the planning stage, stakeholders should agree on relevant benchmarks and indicators for gauging the effectiveness of contraceptive policies and programs,[80] such as disaggregated data on the unmet need for modern contraception. Ongoing monitoring of these indicators can ensure that policies and programs are being effectively implemented and can facilitate improvement or reform when policies and programs fall short.[81]

Putting It into Practice: Monitoring

- Undertake a national survey to collect data on relevant benchmarks and indicators. Indicators should include outcome indicators (such as unmet need for modern contraception) and process indicators (such as the participation of diverse stakeholders in the development and implementation of contraceptive policies and programs).
- Publish collected and disaggregated data on contraceptive information and services in a clear and accessible format.
- Support community and NGO efforts to monitor the demand for modern contraceptives, as well as the availability, accessibility, acceptability, and quality of contraceptive information and services at the community or district levels.

ACCOUNTABILITY

Accountability mechanisms, in conjunction with monitoring, are central to identifying state responsibility regarding human rights obligations and ensuring that governments are fulfilling these responsibilities.[82] When a state is not meeting its obligations to guarantee the right to contraceptive information and services, accountability mechanisms provide an opportunity to expose the primary barriers to contraceptive access and to offer appropriate redress.[83] Moreover, such mechanisms help states identify the gaps and failures in existing policies and programs and give them an opportunity to improve them.

Accountability mechanisms can include a variety of processes and institutions, including judicial mechanisms; quasi-judicial mechanisms, such as national human rights institutions and regional and international human rights bodies; administrative mechanisms, such as human rights impact assessments; political mechanisms,

such as parliamentary reviews of budgetary allocations and the use of public funds; and social mechanisms, such as public hearings, social audits, and civil society involvement in monitoring the provision of contraceptive information and services.[84] Incorporating accountability processes into the development and implementation of contraceptive policies and programs enhances the transparency of policy development, promotes compliance with the right to contraceptive information and services, and ensures effective remedies for violations of this right.[85]

Putting It into Practice: Accountability

- Designate a health ombudsperson or a health commissioner within a national human rights institution who can receive complaints from individuals or organizations and who can oversee implementation of national health plans and policies, including on contraceptive access and information.
- Use confidential questionnaires to assess the quality of contraceptive information and services offered by healthcare institutions.
- Initiate a public awareness campaign on patients' right to quality sexual and reproductive health services, including contraceptive information and services. Publish posters and signs outlining patients' rights that can be placed inside hospitals and clinics.

Using National Human Rights Institutions to Promote Accountability

National human rights institutions—ombudspersons or human rights commissions—can play a significant role in holding governments accountable for failing to meet their obligations to guarantee the right to contraceptive information and services. Both Peru and Uganda have designated units within their national human rights institutions to investigate and respond to complaints on violations of reproductive rights.

The Peruvian Ombudsman (Defensoría del Pueblo) has a dedicated Women's Rights Unit. Among the functions of the unit is to "[i]nvestigate and document complaints against … health care centers and hospitals for irregularities in the application of the Reproductive Health and Family Planning Program," [1] and the Ombudsman's office has investigated violations of the right to access contraceptive services free from coercion.[2]

In 2007, the Uganda Human Rights Commission (UHRC) established a Right to Health Unit, in response to recommendations by the UN Special Rapporteur on the right to the highest attainable standard of physical and mental health. The Right to Health Unit relies on the ESCR Committee's broad conception of the right to health, and recognizes that it encompasses sexual and reproductive freedoms and includes a right to sexual and reproductive information and education.[3] The UHRC also included access to family planning services in its most recent annual report.[4]

INTERNATIONAL ASSISTANCE AND COOPERATION

Donor states, in addition to their obligations to guarantee the right to contraceptive information and services at home, have an added responsibility to improve sexual and reproductive health, including access to contraceptive information and services, through international assistance and cooperation.[86] International assistance and cooperation includes both financial assistance and technical cooperation, and it compels donor states to participate in activities that promote the right to contraceptive information and services and to refrain from activities that could jeopardize this right.[87]

Putting It into Practice: International Assistance and Cooperation

- Ensure that the policies and programs on sexual and reproductive health supported by donor countries and multilateral institutions prioritize access to the full range of contraceptive information and services.
- Establish global partnerships to coordinate government, NGO, and private-sector efforts to advance contraceptive information and services in developing countries.
- Support the UN Agencies' technical cooperation programs in the area of sexual and reproductive health, including contraceptive information and services.

United States Promotes Evidence-Based, Participatory Approach to Family Planning

The United States has recently made significant strides in promoting an evidence-based and participatory approach to family planning, including contraceptive information and services, through United States Agency for International Development (USAID) programs. In September 2009, USAID's Health Policy Initiative brought together 26 family planning providers, researchers, and government officials for a capacity-building workshop aimed at developing participants' leadership skills, technical expertise, policy analysis skills, and advocacy skills in order to promote evidence-based family planning and reproductive health policies, programs, and funding. Participants represented countries in which shortages in contraceptive supplies, legal and practical barriers to contraceptive services, and weak government commitments to sexual and reproductive health presented serious obstacles to the realization of women's right to contraceptive information and services.

The workshop empowered key stakeholders to ensure that contraceptive policies are accountable to the needs of their communities and to promote the realization of women's and adolescents' right to contraceptive information and services. Participants have already reported successes. As

of February 2010, 74% of participants indicated that they had participated in advocacy events or policy dialogues. For example, a participant from Uganda engaged with district-level community development officers to advocate for reductions in the price of contraceptives, and a Nigerian participant's efforts successfully prompted the launch of the Usmanu Danfodiyo University Teaching Hospital's revolving fund and oversight committee to ensure access to contraceptives for women within the hospital.[1]

APPENDIX: REGIONAL AND INTERNATIONAL TREATY PROVISIONS RELATED TO CONTRACEPTIVE ACCESS

RIGHT TO EQUALITY AND NON-DISCRIMINATION

International Covenant on Civil and Political Rights

Article 2(1)

Each State Party to the present Covenant undertakes to respect and to ensure to all individuals . . . the rights recognized in the present Covenant, without discrimination of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

International Covenant on Economic, Social and Cultural Rights

Article 2(2)

The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Convention on the Elimination of All Forms of Discrimination against Women

Article 1

[T]he term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Article 3

States Parties shall take in all 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.

Convention on the Rights of the Child

Article 5

States Parties shall respect the responsibilities, rights and duties of parents, or where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Convention on the Rights of Persons with Disabilities

Article 6(1)

States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.

African Charter on Human and Peoples' Rights

Article 2

Every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, color, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or any status.

Article 18(3)

The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of women and the child as stipulated in international declarations and conventions.

American Convention on Human Rights

Article 1(1)

The States Parties to this Convention undertake to respect the rights and freedoms recognized herein and to ensure to all persons subject to their jurisdiction the free and full exercise of those rights and freedoms, without any discrimination for reasons of race, color, sex, language, religion, political or other opinion, national or social origin, economic status, birth, or any other social condition.

European Convention on Human Rights

Article 14

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

Article 2(1)

States Parties shall combat all forms of discrimination against women through appropriate legislative, institutional and other measures. . .

RIGHTS TO PRIVACY AND TO DETERMINE THE NUMBER AND SPACING OF CHILDREN

International Covenant on Civil and Political Rights

Article 17(1)

No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home. . . .

Convention on the Elimination of All Forms of Discrimination against Women

Article 16(1)

States Parties shall . . . ensure, on a basis of equality of men and women . . .
(e) [t]he same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights. . . .

Convention on the Rights of the Child

Article 16(1)

No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home. . . .

Convention on the Rights of Persons with Disabilities

Article 22(1)

No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home. . . .

Article 23(1)

States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure . . . [t]he rights of persons 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 are recognized, and the means necessary to enable them to exercise these rights are provided. . . .

American Convention on Human Rights

Article 11(2)

No one may be the object of arbitrary or abusive interference with his private life, his family, his home. . . .

European Convention on Human Rights

Article 8(1)

Everyone has the right to respect for his private and family life, his home and his correspondence.

Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine

Article 10(1)

Everyone has the right to respect for private life in relation to information about his or her health.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

Article 14

States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes: a) the right to control their fertility; b) the right to decide whether to have children, the number of children and the spacing of children; c) the right to choose any method of contraception; d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS; . . . f) the right to have family planning education.

RIGHTS TO LIFE AND HEALTH

International Covenant on Civil and Political Rights

Article 6(1)

Every human being has the inherent right to life. This right shall be protected by law.

International Covenant on Economic, Social and Cultural Rights

Article 12(1)

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Convention on the Elimination of All Forms of Discrimination against Women

Article 12(1)

States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Convention on the Rights of the Child

Article 6(1)

States Parties recognize that every child has the inherent right to life.

Article 24(1)

States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health. . .

Convention on the Rights of Persons with Disabilities

Article 10

States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.

Article 25

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. . . .

African Charter on Human and Peoples' Rights

Article 4

Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.

Article 16

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2. State Parties . . . shall take the necessary measures to protect the health of their people. . . .

American Convention on Human Rights

Article 4(1)

Every person has the right to have his life respected.

European Convention on Human Rights

Article 2(1)

Everyone's right to life shall be protected by law.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

Article 4(1)

Every woman shall be entitled to respect for her life and the integrity and security of her person. . . .

Article 14

1) States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. . . . 2) States Parties shall take all appropriate measures to: a) provide adequate, affordable and accessible health services, including information, education and communication programs to women especially those in rural areas. . .

Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women

Article 4(1)

Every woman has . . . a) The right to have her life respected. . . .

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights

Article 4(1)

Every woman shall be entitled to respect for her life. . . .

Article 10(1)

Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.

European Social Charter

Article 11

[T]he Parties undertake . . . to take appropriate measures designed [to ensure the right to protection of health]: 1) to remove as far as possible the causes of ill-health; 2) to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health. . . .

Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine

Article 3

Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to healthcare of appropriate quality.

RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH INFORMATION AND EDUCATION

Convention on the Elimination of All Forms of Discrimination against Women

Article 10(h)

States Parties shall . . . ensure . . . [a]ccess to specific educational information to help ensure the health and well-being of families, including information and advice on family planning.

Convention on the Rights of Persons with Disabilities

Article 23(1)

States Parties shall . . . ensure . . . [t]he rights of persons with disabilities . . . to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided. . . .

African Charter on Human and Peoples' Rights

Article 9(1)

Every individual shall have the right to receive information.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

Article 14(1)

States Parties shall ensure . . . (f) the right to have family planning education.

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights

Article 10(2)

In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right: . . . [e]ducation of the population on the prevention and treatment of health problems. . . .

Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine

Article 5

An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks. The person concerned may freely withdraw consent at any time.

RIGHT TO ENJOY THE BENEFITS OF SCIENTIFIC PROGRESS

International Covenant on Economic, Social and Cultural Rights

Article 15(1)

The States Parties to the present Covenant recognize the right of everyone: . . .
(b) To enjoy the benefits of scientific progress and its applications. . . .

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights

Article 14(1)

The States Parties to this Protocol recognize the right of everyone: . . . b. [t]o enjoy the benefits of scientific and technological progress. . . .

RIGHT TO BE FREE FROM TORTURE OR CRUEL, INHUMAN, OR DEGRADING TREATMENT

International Covenant on Civil and Political Rights

Article 7

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Article 2(1)

Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.

Article 16(1)

Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture. . . .

Convention on the Rights of the Child

Article 37(a)

[States Parties shall ensure that n]o child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.

Convention on the Rights of Persons with Disabilities

Article 15(1)

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

African Charter on Human and Peoples' Rights

Article 5

Every individual shall have the right to the respect of the dignity inherent in a human being. . . . All forms of exploitation and degradation particularly . . . torture, cruel, inhuman or degrading punishment or treatment shall be prohibited.

American Convention on Human Rights

Article 5

1) Every person has the right to have his physical, mental, and moral integrity respected. 2) No one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment. All persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person.

European Convention on Human Rights

Article 3

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

Article 4(1)

. . . All forms of exploitation, cruel, inhuman or degrading punishment and treatment shall be prohibited.

Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women

Article 4(1)

Every woman has . . . d) [t]he right not to be subjected to torture. . . .

ENDNOTES

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women), (68th Sess., 2000), *in* Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 228, para. 20, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter HRC, *General Comment 28*]; Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, (34th Sess.), para. 29, U.N. Doc. E/C.12/2005/4 (2005); CEDAW Committee, *Concluding Observations: Chile*, paras. 228-29, U.N. Doc. A/54/38/Rev.1 (1999); *Indonesia*, para. 284(c), U.N. Doc. A/53/38/Rev.1 (1998); *Saint Vincent and the Grenadines*, para. 140, U.N. Doc. A/52/38/Rev.1 (1997).

[22] CEDAW, *supra* note 20, art. 16(1)(e); *see also* Convention on the Rights of Persons with Disabilities, *adopted* Jan. 24, 2007, art. 23(1)(b), G.A. Res. 61/106, UN GAOR, 61st Sess., U.N. Doc. A/RES/61/106, Annex I (*entered into force* May 3, 2008); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, art. 14, para. 1.

[23] *See, e.g.,* International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, art. 17, paras. 1–2, 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); *see also* Convention on the Rights of the Child, *adopted* Nov. 20, 1989, arts. 16(1–2), 22(1), 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]; American Convention on Human Rights, *adopted* Nov. 22, 1969, art. 11, para. 2, O.A.S.T.S. No. 36, O.A.S. Off. Rec. OEA/Ser.L/V/II.23, doc. 21, rev. 6 (*entered into force* July 18, 1978), *available at* http://www.cidh.oas.org/Basicos/English/Basic3.American%20Convention.htm.

[24] *See, e.g.*, CEDAW Committee, *General Recommendation 21: Equality in marriage and family relations*, (13th Sess., 1994), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies (Vol. II), at 337, para. 22, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (1994) [hereinafter CEDAW Committee, *General Recommendation 21*]; *see also* K.L. v. Peru, Human Rights Committee, Communication No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); Tysiąc v. Poland, App. No. 5410/03, Eur. Ct. H.R., para. 107 (2007); HRC, *General Comment 28*, *supra* note 21, para. 20; *Beijing Declaration and the Platform for Action, Fourth World Conference on Women,* Beijing, China, Sept. 4–15 1995, para. 96, U.N. Doc. A/CONF.177/20 (1996).

[25] Human Rights Committee, *General Comment 6 (Article 6, Right to Life)*, (16th Sess., 1982), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies (Vol. I), at 176, para. 1, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).

[26] *Id.* para. 5.

[27] CEDAW Committee, *General Recommendation 24, supra* note 21, para. 1; ESCR Committee, *General Comment No. 14 (Art. 12, Right to the highest attainable standard of health)*, para. 8, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter ESCR Committee, *General Comment 14*].

[28] ESCR Committee, *General Comment 14*, *supra* note 27, para. 34; CEDAW Committee, *General Recommendation 24*, *supra* note 21, para. 17; CEDAW Committee, *General Recommendation 21*, *supra* note 24, para. 22.

[29] *See* Center for Reproductive Rights, *Bringing Rights to Bear: The Human Right to Information on Sexual and Reproductive Health: Government Duties to Ensure Comprehensive Sexuality Education* (2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/BRB_SexEd.pdf; *see also,* e.g., CRC, *General Comment 4*, *supra* note 3, para. 28; Vernor Muñoz, *Report of the United Nations Special Rapporteur on the right to education*, paras. 19, 24–37, U.N. Doc. A/65/162 (2010); CEDAW Committee, *Concluding Observations: Antigua and Barbuda*, para. 267, U.N. Doc. A/52/38/Rev.1, Part II (1997); *Belize*, paras. 56–57, U.N. Doc. A/54/38 (1999); *Bosnia and Herzegovina*, para. 36, U.N. Doc. CEDAW/C/BIH/CO/3 (2006); *Chile*, para. 227, U.N. Doc. A/54/38 (1999); *Dominican Republic*, para. 349, U.N. Doc. A/53/38 (1998); *Greece*, para. 208, U.N. Doc. A/55/38 (1999); *Peru*, para. 342, U.N. Doc. A/53/38 (1998); *Slovakia*, para. 92, U.N. Doc. A/53/38/Rev.1 (1998); *Slovenia*, para. 119, U.N. Doc. A/52/38/Rev.1 (1997); *Zimbabwe*, para. 161, U.N. Doc. A/53/38 (1998); ESCR Committee, *General Comment 14*, *supra* note 27.

[30] *See* Center for Reproductive Rights, *An International Human Right: Sexuality Education for Adolescents in Schools,* 1 (Sept. 2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_fs_sex-ed_2008_0.pdf [hereinafter *Sexuality Education for Adolescents in Schools*].

[31] CEDAW Committee, *General Recommendation 21*, *supra* note 24, para. 22.

[32] *See* International Planned Parenthood Federation, From Evidence to Action: Advocating for comprehensive sexuality education 8–9 (2009), *available at* http://www.gfmer.ch/SRH-Course-2010/adolescent-sexual-reproductive-health/pdf/IPPF-SexEdAdvocacy-2009.pdf.

[33] *See, e.g.,* CEDAW Committee, *Concluding Observations: Belize*, paras. 56-57, U.N. Doc. A/54/38 (1999); *Burundi*, para. 62, U.N. Doc. A/56/38 (2001); *Chile*, paras. 226–27, U.N. Doc. A/54/38 (1999); *Dominican Republic*, para. 349, U.N. Doc. A/53/38 (1998); *Lithuania*, para. 25, U.N. Doc. CEDAW/C/LTU/CO/4 (2008); *Nigeria*, para. 33, U.N. Doc. CEDAW/C/NGA/CO/6 (2008); Committee on the Rights of the Child, *Concluding Observations: Cambodia*, para. 52, U.N. Doc. CRC/C/15/Add.128 (2000); *Colombia*, para. 48, U.N. Doc. CRC/C/15/Add.137 (2000); *Dominican Republic*, para. 37, U.N. Doc. CRC/C/15/Add.150 (2001); *Ethiopia*, para. 61, U.N. Doc. CRC/C/15/Add.144 (2001); ESCR Committee, *Concluding Observations: Bolivia*, para. 43, U.N. Doc. E/C.12/1/Add.60 (2001); *Honduras*, para. 27, U.N. Doc. E/C.12/1/Add.57 (2001); *Libyan Arab Jamahiriya*, para. 36, U.N. Doc. E/C.12/LYB/CO/2 (2006); *Senegal*, para. 47, U.N. Doc. E/C.12/1/Add.62 (2001); *Ukraine*, para. 31, U.N. Doc. E/C.12/1/Add.65 (2001).

[34] *See, e.g.*, Center for Reproductive Rights, Calculated Injustice: The Slovak Republic's Failure to Ensure Access to Contraceptives (forthcoming 2011).

[35] *See* Center for Reproductive Rights, Gaining Ground: A Tool for Advancing Reproductive Rights Law Reform 35 (2006), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_GG_contraception.pdf [hereinafter Gaining Ground].

[36] Human Rights Committee, *General Comment 20 (Article 7, prohibition of torture, or other cruel, inhuman or degreading treatment or punishment)*, (44th Sess., 1992), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 200, para. 5, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).

[37] ESCR Committee, *General Comment 14*, *supra* note 27, para. 12.

[38] Gaining Ground, *supra* note 35, at 34.

[39] ESCR Committee, *General Comment 14*, *supra* note 27, para. 11; *see also* CEDAW Committee, *General Comment 21*, *supra* note 24, para. 22.

[40] *See* ESCR Committee, *Concluding Observations: Cameroon*, para. 45, U.N. Doc. E/C.12/1/Add.40 (1999); *Honduras*, para. 48, U.N. Doc. E/C.12/1/Add.57 (2001); *see also* CEDAW Committee, *General Recommendation 24*, *supra* note 21, para. 23.

[41] *See Sexuality Education for Adolescents in Schools*, *supra* note 30, at 1; *see also* CEDAW Committee, *General Recommendation 24*, *supra* note 21, para. 23.

[42] *See Sexuality Education for Adolescents in Schools*, *supra* note 30.

[43] *See, e.g.*, ESCR Committee, *Concluding Observations: Mexico*, paras. 25, 44, U.N. Doc. E/C.12/MEX/CO/4 (2006); *Republic of Moldova*, para. 49, U.N. Doc. E/C.12/1/Add.91 (2003); *Russian Federation*, paras. 35, 63, U.N. Doc. E/C.12/1/Add.94 (2003); *see also* Committee on the Rights of the Child, *Concluding Observations: Honduras*, para. 63(e), U.N. Doc. CRC/C/HND/CO/3 (2007).

[44] International Federation of Gynecology and Obstetrics, Ethical Issues in Obstetrics and Gynecology 13-14 (Oct. 2009), *available at* http://www.figo.org/files/figo-corp/Ethical%20Issues%20-%20English.pdf.

[45] *See* Anand Grover, *Report of the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health*, paras. 30–31, U.N. Doc. A/64/272 (2009) [hereinafter *Annual Report of the Special Rapporteur, 2009*].

[46] *Id.* at 10.

[47] *See* A.S. v. Hungary, CEDAW Committee, Communication No. 4/2004, paras. 11.2-11.4, U.N. Doc. CEDAW/C/36/D/4/2004 (2006); *see also Annual Report of the Special Rapporteur, 2009*, *supra* note 45; Center for Reproductive Rights, Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities 28 (2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/chilereport_FINAL_singlepages.pdf.

[48] *See, e.g.*, Center for Reproductive Rights, *The Reproductive Rights of Adolescents: A Tool for Health and Empowerment*, 8 (Sept. 2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/adolescents%20bp_FINAL.pdf; *see also* Center for Reproductive Rights & Federation of Women Lawyers-Kenya (FIDA-Kenya), Failure to Deliver 21 (2007), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf ("'They made you feel like using ['artificial contraception'] was a sin.'").

[49] Paul Hunt & Judith Bueno de Mesquita, University of Essex Human Rights Centre, The Rights to Sexual and Reproductive Health 10 (2007), *available at* http://www.essex.ac.uk/human_rights_centre/research/rth/docs/TheRightsToSexualHealth.pdf [hereinafter Sexual and Reproductive Health].

[50] *Id.*

[51] *Id.*

[52] *Id.* at 9. Mexico offers a positive example of meeting the availability requirement. In July 2005, Mexico incorporated EC into its list of required medicines, requiring that all public health facilities stock the drug. *Vigésima Segunda Actualización del Cuadro Básico y Catálogo de Medicamentos*, [22nd Update of the Basic Scheme and List of Medicines], Diario Oficial de la Federación [D.O.], July 11, 2005 (Mex.).

[53] Sexual and Reproductive Health, *supra* note 49, at 9.

[54] *Id.*

[55] *See, e.g.*, CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, para. 228, U.N. Doc. A/55/38 (2000); *see also* Gaining Ground, *supra* note 35, at 37; Center for Reproductive Rights, *Governments Worldwide Put Emergency Contraception into Women's Hands: A Global Review of Laws and Policies*, 5, 11 (2004) *available at* http://reproductiverights.org/sites/default/files/documents/pub_bp_govtswwec.pdf.

[56] Center for Reproductive Rights, *Slovakia: International Standards on Subsidizing Contraceptives* (2009), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_fac_slovak1_international%20standards_9%2008_WEB.pdf.

[57] Office of the United Nations High Commissioner for Human Rights (OHCHR) & WHO, *Fact Sheet No. 31: The Right to Health,* 4 (2008), *available at* http://www.ohchr.org/Documents/Publications/Factsheet31.pdf [hereinafter OHCHR & WHO, *Fact Sheet No. 31*] (discussion of the obligations to respect, protect, and fulfill in the context of the right to health); *see also* CEDAW Committee, *Concluding Observations: India*, para. 41, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

[58] Sexual and Reproductive Health, *supra* note 49, at 8.

[59] OHCHR & WHO, *Fact Sheet No. 31*, *supra* note 57, at 4.

[60] Gaining Ground, *supra* note 35, at 35.

[61] OHCHR & WHO, *Fact Sheet No. 31*, *supra* note 57, at 4.

[62] ESCR Committee, *General Comment 3 (Art. 3, the nature of States parties' obligations)*, (5th Sess., 1990), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 7, para. 9, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *General Comment 3*].

[63] International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 2, para. 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].

64 *Id.*

65 CEDAW Committee, *General Recommendation 24*, *supra* note 21, para. 17.

66 Center for Economic and Social Rights, Country Fact Sheets, http://www.cesr.org/article.php?list=type&type=38 (last visited Nov. 24, 2010).

67 OHCHR & WHO, *Fact Sheet No. 31*, *supra* note 57, at 24.

68 ESCR Committee, *General Comment 3*, *supra* note 62, para. 9.

69 OHCHR, Fact Sheet No. 33: Frequently Asked Questions on Economic, Social and Cultural Rights 16 (2008), *available at* http://www.ohchr.org/Documents/Publications/FactSheet33en.pdf.

70 ESCR Committee, *General Comment 14*, *supra* note 27, para. 43.

71 *Id.* paras. 43(a), 43(d).

72 WHO, WHO Model List of Essential Medicines (Mar. 2010), *available at* http://www.who.int/medicines/publications/essentialmedicines/Updated_sixteenth_adult_list_en.pdf.

73 UNFPA, Rights into Action: UNFPA implements Human Rights-Based Approach 6 (2005), *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2005/rights_action.pdf.

74 UNFPA & Harvard School of Public Health, *Module 2: A Human-Rights Based Approach*, *in* UNFPA & Harvard School of Public Health, A Human Rights-Based Approach to Programming 71 (2010), *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/hrba/hrba_manual_in%20full.pdf [hereinafter UNFPA *Module 2*].

75 *Id.* at 78.

76 *Id.* at 82; *see also* Sexual and Reproductive Health, *supra* note 49, at 10.

77 Paul Hunt & Judith Bueno de Mesquita, University of Essex Human Rights Centre, Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health 11 (2007), *available at* http://unfpa.dexero.com/webdav/site/global/shared/documents/publications/reducing_mm.pdf.

78 *Id.* at 11.

79 Helen Potts, University of Essex Human Rights Centre, Accountability and the Right to the Highest Attainable Standard of Health 13 (2008), *available at* http://www.essex.ac.uk/human_rights_centre/research/rth/docs/HRC_Accountability_Mar08.pdf [hereinafter Accountability].

80 Helen Potts, University of Essex Human Rights Centre, Participation and the Right to the Highest Attainable Standard of Health 17 (2005), *available at* http://www.essex.ac.uk/human_rights_centre/research/rth/docs/Participation.pdf.

81 UNFPA *Module 2*, *supra* note 74, at 110.

82 Accountability, *supra* note 79, at 13.

83 *Id.* at 7.

84 *Id.* at 17.

85 OHCHR, Frequently Asked Questions on the Human-Rights Based Approach to Development Cooperation 17 (2006) *available at* http://www.ohchr.org/Documents/Publications/FAQen.pdf.

86 Judith Bueno de Mesquita & Paul Hunt, University of Essex Human Rights Centre, International Assistance and Cooperation in Sexual and Reproductive Health: A Human Rights Responsibility for Donors 2 (2008), *available at* http://www.essex.ac.uk/human_rights_centre/research/rth/docs/Final_PDF_for_website.pdf [hereinafter International Cooperation]; *see also* ICESCR, *supra* note 63, art. 2.1; CRC, *supra* note 23, art. 24(4).

87 International Cooperation, *supra* note 86, at 10.

ENDNOTES FOR BOXES

CONTRACEPTIVE ACCESS AT A GLANCE

1 Statistics are drawn from data on developing countries, which are defined by UNFPA as including all countries except Australia, Canada, Japan, New Zealand, the United States, and all European countries.

2 Susheela Singh et al., Guttmacher Institute & United Nations Population Fund (UNFPA), Adding it Up: The Benefits of Investing in Sexual and Reproductive Healthcare 17 (2009), *available at* http://www.guttmacher.org/pubs/AddingItUp2009.pdf.

3 *Id.*

4 *Id.* at 19.

5 *Id.*

6 *Id.* at 20.

VULNERABLE AND MARGINALIZED POPULATIONS ENCOUNTER SIGNIFICANT BARRIERS TO CONTRACEPTIVE ACCESS

1 Both the CEDAW Committee and the Committee on the Rights of the Child have urged states parties to increase the availability of sexuality education and contraceptive services to adolescents. *See, e.g.*, CEDAW Committee, *Concluding Observations: Antigua and Barbuda*, paras. 248, 267, U.N. Doc. A/52/38/Rev.1, Part II (1997); *Chile*, para. 227, U.N. Doc. A/54/38 (1999); *Ghana*, para. 32, U.N. Doc. CEDAW/C/GHA/CO/5 (2006); *Mexico*, para. 33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); *Ireland*, para. 186, U.N. Doc. A/54/38 (1999); *Kazakhstan*, para. 106, U.N. Doc. A/56/38 (2001); *Mauritius*, para. 31, U.N. Doc. CEDAW/C/MAR/CO/5 (2006); *Mongolia*, para. 274, U.N. Doc. A/56/38 (2001); *Nicaragua*, para. 303, U.N. Doc. A/56/38 (2001); *Nigeria*, para. 171, U.N. Doc. A/53/38/Rev.1 (1998); *Philippines*, para. 28, U.N. Doc. CEDAW/C/PHI/CO/6 (2006); *Saint Vincent and the Grenadines*, para. 147, U.N. Doc. A/52/38/Rev.1 (1997); *United Kingdom of Great Britain and Northern Ireland*, para. 310, U.N. Doc. A/54/38 (1999); *Uruguay*, para. 203, U.N. Doc. A/57/38, Part I (2002); *Venezuela*, para. 243, A/52/38/Rev.1 (1997); *Viet Nam*, para. 267, U.N. Doc. A/56/38 (2001); *Zimbabwe*, paras. 148, 161, U.N. Doc. A/53/38 (1998); *see also* Committee on the Rights of the Child, *Concluding Observations: Argentina*, para. 19, U.N. Doc. CRC/C/15/Add.35 (1995); *Armenia*, para. 39,

U.N. Doc. CRC/C/15/Add.119 (2000); *Belarus*, para. 14, U.N. Doc. CRC/C/15/Add.17 (1994); *Bhutan*, para. 45, U.N. Doc. CRC/C/15/Add.157 (2001); *Bolivia*, para. 50, U.N. Doc. CRC/C/15/Add.256 (2005); *Brunei Darussalam*, para. 46, U.N. Doc. CRC/C/15/Add.219 (2003); *Bulgaria*, para. 29, U.N. Doc. CRC/C/15/Add.66 (1997); *Burkina Faso*, para. 14, U.N. Doc. CRC/C/15/Add.19 (1994); *Burundi*, para. 59, U.N. Doc. CRC/C/15/Add.133 (2000); *Cambodia*, para. 53, U.N. Doc. CRC/C/15/Add.128 (2000); *Central African Republic*, para. 61, U.N. Doc. CRC/C/15/Add.138 (2000); *Comoros*, para. 36, U.N. Doc. CRC/C/15/Add.141 (2000); *Cuba*, para. 37, U.N. Doc. CRC/C/15/Add.72 (1997); *Djibouti*, para. 46, U.N. Doc. CRC/C/15/Add.131 (2000); *Dominican Republic*, para. 38, U.N. Doc. CRC/C/15/Add.150 (2001); *Egypt*, para. 44, U.N. Doc. CRC/C/15/Add.145 (2001); *Ethiopia*, para. 61, U.N. Doc. CRC/C/15/Add.144 (2001); *Georgia*, para. 51, U.N. Doc. CRC/C/15/Add.222 (2003); *Guatemala*, para. 45, U.N. Doc. CRC/C/15/Add.154 (2001); *Hungary*, para. 36, U.N. Doc. CRC/C/15/Add.87 (1998); *Iran (Islamic Republic of)*, para. 44, U.N. Doc. CRC/C/15/Add.123 (2000); *Jamaica*, para. 43, U.N. Doc. CRC/C/15/Add.210 (2003); *Japan*, para. 42, U.N. Doc. CRC/C/15/Add.90 (1998); *Kiribati*, para. 49, U.N. Doc. CRC/C/KIR/CO/1 (2006); *Kyrgyzstan*, para. 44, U.N. Doc. CRC/C/15/Add.127 (2000); *Lao People's Democratic Republic*, para. 47, U.N. Doc. CRC/C/15/Add.78 (1997); *Latvia*, para. 40, U.N. Doc. CRC/C/15/Add.142 (2001); *Lesotho*, para. 46, U.N. Doc. CRC/C/15/Add.147 (2001); *Lithuania*, para. 40, U.N. Doc. CRC/C/15/Add.146 (2001); *Mali*, para. 27, U.N. Doc. CRC/C/15/Add.113 (1999); *Malta*, para. 40, U.N. Doc. CRC/C/15/Add.129 (2000); *Marshall Islands*, para. 51, U.N. Doc. CRC/C/15/Add.139 (2000); *Palau*, para. 49, U.N. Doc. CRC/C/15/Add.149 (2001); *Paraguay*, para. 45, U.N. Doc. CRC/C/15/Add.27 (1997); *Poland*, para. 43, U.N. Doc. CRC/C/15/Add.194 (2002); *Romania*, para. 15, U.N. Doc. CRC/C/15/Add.16 (1994); *Russian Federation*, para. 56, U.N. Doc. CRC/C/RUS/CO/3 (2005); *Saint Kitts and Nevis*, para. 26, U.N. Doc. CRC/C/15/Add.104 (1999); *Saint Vincent and the Grenadines*, para. 41, U.N. Doc. CRC/C/15/Add.184 (2002); *Slovakia*, para. 38, U.N. Doc. CRC/C/15/Add.140 (2000); *Suriname*, para. 46, U.N. Doc. CRC/C/15/Add.130 (2000); *Tajikistan*, para. 41, U.N. Doc. CRC/C/15/Add.136 (2000); *Thailand*, para. 25, U.N. Doc. CRC/C/15/Add.97 (1998); *The Former Yugoslav Republic of Macedonia*, para. 40, U.N. Doc. CRC/C/15/Add.118 (2000); *Trinidad and Tobago*, para. 35, U.N. Doc. CRC/C/15/Add.82 (1997); *Turkey*, para. 54, U.N. Doc. CRC/C/15/Add.152 (2001); *Uganda*, para. 32, U.N. Doc. CRC/C/15/Add.80 (1997); *United Kingdom of Great Britain and Northern Ireland*, para. 30, U.N. Doc. CRC/C/15/Add.63 (1996); *United Kingdom of Great Britain and Northern Ireland—Overseas Territories*, para. 38, U.N. Doc. CRC/C/15/Add.135 (2000); *United Republic of Tanzania*, para. 49, U.N. Doc. CRC/C/15/Add.156 (2001); *Uruguay*, para. 22, U.N. Doc. CRC/C/15/Add.62 (1996); *Vanuatu*, para. 20, U.N. Doc. CRC/C/15/Add.111 (1999); *Venezuela*, para. 27, U.N. Doc. CRC/C/15/Add.109 (1999); *Yemen*, para. 25, U.N. Doc. CRC/C/15/Add.102 (1999).

[2] *See* Center for Reproductive Rights, *The Reproductive Rights of Adolescents: A Tool for Health and Empowerment* (Sept. 2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/adolescents%20bp_FINAL.pdf [hereinafter *Reproductive Rights of Adolescents*].

[3] *See* CEDAW Committee, *Concluding Observations: Bosnia and Herzegovina*, para. 35, U.N. Doc. CEDAW/C/BIH/CO/3 (2006).

[4] *See* CEDAW Committee, *Concluding Observations: Greece*, para. 207, U.N. Doc. A/54/38 (1999).

[5] Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, arts. 5, 12(1), U.N. Doc. A/44/49 (1989), *reprinted in* 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990).

[6] *See* Center for Reproductive Law and Policy (now Center for Reproductive Rights) & Child and Law Foundation (Zimbabwe), State of Denial: Adolescent Reproductive Rights in Zimbabwe 51 (2002), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/zimbabwe_report.pdf; *see also Reproductive Rights of Adolescents*, *supra* note 2, at 8.

[7] *See Reproductive Rights of Adolescents*, *supra* note 2, at 8.

[8] *See* Susheela Singh et al., Guttmacher Institute & United Nations Population Fund (UNFPA), Adding it Up: The Benefits of Investing in Sexual and Reproductive Healthcare 12 (2009), *available at* http://www.guttmacher.org/pubs/AddingItUp2009.pdf.

[9] Minority communities include individuals of shared race, color, descent, or national or ethnic origins.

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Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005

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