ICPD Beyond 2014 Notes on key issues

Introduction

The notes on the topics listed as follows contain definitions, evidence as well as highlights of progress States have made through their laws and policies to implement the ICPD Programme of Action and describe national and international human rights developments on a number of select issues related to sexual and reproductive health and rights:

Maternal Mortality and Morbidity

Comprehensive Sexuality Education for Young People

Reproductive rights and reproductive health

Contraceptive Information and Services

Abortion

Sexual and Reproductive Health Education and Information

Adolescents and Youth

Individuals Belonging to Marginalized and Underserved Populations

HIV/AIDS

Violence against Women

Harmful Traditional Practices: Female Genital Mutilation and Child Marriage

Rational for 15-24 year age group for youth cohort

Maternal Mortality and Morbidity

Since Cairo a fundamental shift has occurred in the international community's approach to maternal mortality and morbidity. Whereas maternal mortality and morbidity were previously thought to be solely within the realm of healthcare, they are now recognized as human rights issues involving the right to nondiscrimination and other human rights deprivations and the need for enhanced government accountability. It is widely accepted that maternal mortality is generally preventable and that States have an affirmative obligation to prevent it.[1] Alongside these changes, the annual number of maternal deaths has decreased by 47 percent worldwide between 1990 and 2010.[2] Eighty percent of maternal deaths worldwide result from severe bleeding, infections, high blood pressure during pregnancy and unsafe abortion - these causes are generally preventable if they are identified and properly managed in a timely manner.[3]

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

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

Maternal Mortality and Morbidity in the ICPD Programme of Action

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

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

Human Rights Standards

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

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

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

Country Examples:

Armenia

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

India

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

Nepal

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

The Need for Comprehensive Sexuality Education for Young People

Young people around the world have many specific concerns and needs related to sexuality. Yet, few receive adequate preparation for their sexual lives and often face barriers that prevent them from accessing accurate information about sexuality and sexual and reproductive health. This means young people often lack information, are exposed to misinformation, including through either glamorized or misogynistic media images, and have many questions without knowing where they can find reliable answers. The capacity of parents to respond to these questions varies but evidence shows that young people are influenced to a considerable extent by their peers. Studies also show wide variations in the effectiveness of social institutions, including

schools that contribute to reinforcing the values of individuals and communities, with their effectiveness dependent on their understanding of the needs and interests of young people.

The consequences are numerous: young people may lack self-confidence and are unable to make informed decisions about their sexuality. This leaves them potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexually transmitted infections (STIs), including HIV. UNAIDS data in 2010 shows that 42% of all new HIV infections occur among young people. Young women undergo two thirds of the unsafe abortions worldwide1,2 the majority of these abortions are unsafe. Ten per cent of births worldwide are to adolescent mothers, who experience much higher rates of maternal mortality than older women.3 In many cases adolescent pregnancy is responsible for school dropouts. Not only do these young girls have their first sexual experience and first child early, they are more likely to be poor and to be forced into early marriage, or to have been coerced into sex. Pregnancy is a leading cause of death for young women aged 15 to 19 worldwide, with complications of childbirth and unsafe abortion being the major factors.

Comprehensive sexuality education (CSE) is an important strategy that can help overcome these challenges. Solid scientific evidence demonstrates that CSE empowers young people to make responsible and autonomous decisions about their sexuality and sexual and reproductive health.4 Evidence also suggests that rights-based and gender-sensitive CSE programmes can lead to greater gender equality. By placing gender and rights at the center, CSE is an essential component of women's empowerment, which in turn has major benefits for national development.

International consensus, among professional and policy makers, has been growing around two key areas: (1) Recognition of young people's human rights relating to sexual and reproductive health, specifically the right to information and comprehensive education on sexuality; and (2) The importance of promoting gender focused and rights based comprehensive sexuality education in order to better reach desired health outcomes. For example, the international community has recognized the right for young people to access "comprehensive education on human sexuality, on sexual and reproductive health, on gender equality and on how to deal positively and responsibly with their sexuality" (CPD 2009, E/CN.9/2009/10E/2009/25). The right to sexuality and HIV education is grounded in fundamental human rights, namely the right to education and to health that are established in numerous international agreements. The 1994 International Conference on Population and Development Programme of Action (ICPD PoA) explicitly calls on governments to provide sexuality education to promote the wellbeing of adolescents and specifies key features of such education.5

[1] WHO, 2004. Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000.
[2] World Health Organization. 2007. Unsafe abortion: Global and regional estimates of incidence of unsafe abortion and associated mortality in 2003. Geneva, World Health Organization. Available online at http://www.who.int/reproductive-health/publications/unsafeabortion_2003/ua_estimates03.pdf
[3] WHO, 2008. Adolescent Pregnancy, in MPS Notes. WHO: Geneva.
[4] IPPF 2009. *From evidence to action: Advocating for comprehensive sexuality education*. Available at: http://www.ippf.org/en/Resources/Guides-toolkits/From+evidence+to+action+advocating+for+comprehensive+sexuality+education.htm
[5] ICPD POA, paragraphs 4.29, 7.37, 7.41, and 7.47.

As young people's sexual and reproductive rights have become increasingly recognized, international guidelines and standards for sexuality education have progressively become more aligned with a human rights based approach and incorporate a stronger focus on human rights in sexuality education content. Thus, we are now seeing a trend towards a more holistic approach to sexuality education that seeks to support and empower young people to handle sexuality in responsible, safe and satisfactory ways, instead of focusing primarily on individual issues or threats. By emphasizing rights and gender issues, comprehensive sexuality programs can aim to influence a wider range of outcomes, such as reducing gender-based violence and bullying, promoting safe schools, empowering young people to advocate for their own rights and avoid harmful choices, and advancing gender equality more broadly.

There are several misperceptions about sexuality education. Some believe that it encourages behaviours considered immoral or unsafe, such as earlier sexual debut, sex before marriage or having multiple partners. In practice, the implementation by Governments of CSE is based on an understanding of the respective different cultural contexts and the interface with sexual health and reproductive rights as well as on evidence-based international technical guidance adapted to local realities (this includes local decisions on what is age appropriate).

Within that context, CSE programmes in all regions of the world today, have the following objectives:

- Provide accurate information about human sexuality, including growth and development, sexual anatomy and physiology; reproduction, contraception; pregnancy and childbirth, HIV and AIDS, STIs; family life and inter-personal relationships; culture and sexuality, human rights empowerment; non-discrimination, equality and gender roles, sexual behavior, sexual abuse, gender-based violence, and harmful practices.

- Provide opportunities to explore values, attitudes and norms concerning sexual and social relationships

- Promote the acquisition of skills

- Encourage young people to assume responsibility for their own behavior and to respect the rights of others

Through comprehensive sexuality education programmes, young people learn about their bodies, feelings, sexuality, reproduction, marriage, and relationships. In the context of human capital development, young people are able to stay in school, get livelihoods skills, contribute to their societies if they are able keep a good sexual and reproductive health status, prevent sexually transmitted diseases including HIV, and prevent early unintended pregnancies, gain knowledge and learn about values, attitudes and norms including peaceful conflict resolution, and respect for gender equality.

(2) Existing agreed language on comprehensive sexuality education

CPD 2009 OP9: "… And education on counseling, as appropriate, on human sexuality, reproductive health and responsible parenthood…"

CPD 2009 OP16: "Calls upon governments, with the full involvement of young people and with the support of the international community, to give full attention to meeting the reproductive health-care service, information and education needs of adolescents to enable them to deal in a positive and responsible way with their sexuality".

ICPD +5 para 73(c) Develop at national and other levels, as appropriate, action plans for adolescents and youth, based on gender equity and equality, that cover education, professional and vocational training and income-generating opportunities. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family planning practices, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention (Programme of Action, para. 7.47). Adolescents and youth themselves should be fully involved in the design and implementation of such information and services, with proper regard for parental guidance and responsibilities. Special attention should be devoted to vulnerable and disadvantaged youth.

ICPD+5 para 35 (b) Include at all levels, as appropriate, of formal and non-formal schooling, education about population and health issues, including sexual and reproductive health issues, in order to further implement the Programme of Action in terms of promoting the well-being of adolescents, enhancing gender equality and equity as well as responsible sexual behaviour, protecting them from early and unwanted pregnancy, sexually transmitted diseases including HIV/AIDS, and sexual abuse, incest and violence. Ensure the active involvement and participation of parents, youth, community leaders and organizations for the sustainability, increased coverage and effectiveness of such programmes;

ICPD para 4.29 National and community leaders should promote the full involvement of men in family life and the full integration of women in community life. Parents and schools should ensure that attitudes that are respectful of women and girls as equals are instilled in boys from the earliest possible age, along with an understanding of their shared responsibilities in all aspects of a safe, secure and harmonious family life. Relevant programs to reach boys before they become sexually active are urgently needed.

Regional Perspective (6th APPC)

A Joint United Nations Programme on HIV/AIDS (UNAIDS) 2011 Global HIV/AIDS Response Epidemic update and health sector progress towards universal access progress report provides evidence that well-planned and executed sexuality education programmes implemented in schools and communities resulted in increased knowledge of human sexuality, can help delay onset of sexual activity among adolescents and young people, reduce the frequency of unprotected sex and the number of sexual partners, and increase condom use and contraceptive use. According to a 2012 review of sexuality education policies in 20 countries in the Asia-Pacific Region, with the exception of Pakistan, all the other countries had sexuality education as part of the national secondary school curriculum. No information was available on Kiribati.

There was limited information on the coverage of sexuality education for out-of-school populations. However, both coverage and content varied widely across countries, and across levels of education. In some instances, selected areas of knowledge were covered through extra-curricular or non-compulsory, and overall, the emphasis was on knowledge and less on imparting life skills.

Reproductive rights and reproductive health

(As defined in the ICPD Programme of Action)

7.2. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

7.3. Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in

most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

7.4. The implementation of the present Programme of Action is to be guided by the above comprehensive definition of reproductive health, which includes sexual health.

The definition contained in the ICPD Programme of Action explains that sexual health is included in the definition of reproductive health. The terms reproductive health and sexual and reproductive health are therefore interchangeable. The definition also uses the expression "services", which is found in other parts of the Programme of Action, when addressing sexual and reproductive health, including family planning.

Contraceptive Information and Services

Over the past two decades, the percentage of women in developing regions ages 15-49 using contraceptives increased from 52 percent to 62 percent, while in developed regions, the percentage increased from 68 percent to 72 percent.[66] Despite these advancements, in developing countries across the globe, 222 million women who desire to avoid pregnancy are either not using any method of contraception or are utilizing a traditional method of contraception, which have high failure rates.[67] This unmet need for modern methods of contraception prevents women from exercising their reproductive rights, including their rights to health and education.[68] Furthermore, barriers to accessing contraceptives disproportionately impact vulnerable and marginalized populations, such as adolescents, minorities and indigenous communities, and persons with disabilities, as services are not designed to ensure accessibility for persons belonging to these groups.[69] In many countries, restrictive abortion laws mean that an unwanted pregnancy inevitably results in carrying the pregnancy to term or the woman risking her health and life to seek out an unsafe, clandestine abortion. Furthermore, when women have access to contraception, they can space their pregnancies and childbirths, which studies demonstrate lead to healthier pregnancies.[70] Lack of access to condoms also leaves women unable to protect themselves against sexually transmitted infections, including HIV.[71]

Certain groups, such as unmarried women and adolescents, may face particular obstacles in accessing contraceptive information and services, based on the notion that they should not be sexually active. Furthermore, coercive policies and practices such as forced sterilization, which were prominent in the past and continue to be practiced today,[72] violate numerous human rights and disproportionately affect members of vulnerable groups such as the poor, disabled, ethnic and racial minorities, and women living with HIV.[73]

Global estimates by Guttmacher show that 52 million never-married women, mostly adolescents and young women aged 15-24 in the developing world, are sexually active and in need of contraceptives in 2012. A recent Guttmacher report notes that there is a steady long-term trend towards increased levels of sexual activity among this group, due to reasons such as the declining age of menarche, the rising age at marriage and hanging societal values.[74]

This trend emphasizes the growing need to ensure all adolescents and young women have access to sexual and reproductive health services, including contraception suitable to their needs, as envisaged in the ICPD PoA.[75]In Latin America and the Caribbean, young women age 15-24 have the highest rates of dissatisfaction with contraceptive methods compared to all regions in the world. Contraception discourses and services in the South Asia sub-region lie mostly within the context of marriage.

Among the countries reviewed in the ICPD+20 global south monitoring report for the Asia Pacific region, Cambodia and the Philippines have the lowest CPR rates among those age 15-19 in the region, followed by Nepal and Pakistan. For young women aged 20-24, Pakistan, Cambodia, and the Philippines remain among the countries with the lowest CPR rates in the region. The highest CPR rates are recorded in Bangladesh and Indonesia. It is difficult for adolescents in the MENA region to obtain contraceptives regardless of whether or not they are married due to various social and cultural reasons.

Despite information and the existence of sex education in primary and secondary schools, CPR rates in Eastern Europe are relatively low. Withdrawal and abortion are the primary means of family planning and contraceptive use in some of the countries in the region. In the region, the condom is the most popular method of contraception and this raises questions on the availability of a range of contraceptive methods to adolescents and young people. Service providers can also create barriers in accessing contraceptive methods, contributing significantly to the problem.

In the Sub-Saharan Africa region only 21% of married adolescents are using a modern contraceptive method, and this is more pronounced.[76] In this region the overall levels of unmet need is higher for all women, and this more pronounced among adolescents at 68%.[77] Across the global south regions, the pattern of contraceptive use poses challenges for both married and unmarried young women to Young married women who might be under pressure to conceive right after marriage due to socio-cultural motives which put emphasis on fertility.

Never-married women, including adolescents and young women, have a great disadvantage in obtaining contraceptives largely due to stigma attached to being sexually active before marriage. Among women in need of contraceptives, use of modern methods is 31 percentage points lower among never married women than among married women in Asia; this difference is 10 percentage points in Latin America and the Caribbean. However, the situation is reversed in Sub-Saharan Africa, where the proportion of never-married, mostly adolescents and young women in need using modern contraceptives is 19 percentage points higher than among their married counterparts.[78]

Contraceptive Information and Services in the ICPD Programme of Action

The ICPD Programme of Action recognizes that "reproductive rights… rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so."[79] To realize this, States agreed that individuals must have access to a variety of safe, quality, effective, affordable, convenient and acceptable methods of family planning.[80] The ICPD Programme of

Action recognizes the unmet need for contraceptives worldwide[81] and States committed to providing universal access to a full a range of contraceptives by 2015.[82] Millennium Development Goal 5B aims to achieve universal access to reproductive health; contraceptive prevalence is one of the indicators for determining the attainment of this goal.[83]

States committed to ensuring that family planning programs abide by human rights norms and ethical and professional standards.[84] To this end, contraceptive services must be free from coercion and discrimination,[85] ensure informed decision-making,[86] respect privacy[87] and confidentiality,[88] and respect the dignity of all persons.[89] States should use all available means to ensure that voluntariness is at the foundation of all family planning programs.[90] The ICPD Programme of Action recognizes that government schemes designed as either incentives or disincentives to individuals and families about whether to have children have been ineffective and counterproductive[91] and that demographic goals, such as targets or quotas, should not be imposed on family planning providers.[92] Furthermore, States agreed to "identify and remove all the major remaining barriers to the utilization of family-planning services"[93] including "unnecessary legal, medical, clinical and regulatory barriers."[94]

Human Rights Standards

Treaty monitoring bodies have repeatedly recognized the correlation between unmet need for contraceptives and elevated rates of teenage pregnancy,[95] abortion,[96] and maternal mortality.[97] In accordance with human rights principles, women's right to decide on the number and spacing of their children incorporates the right to have the information and resources to do so,[98] including access to sexuality education and family planning services.[99] States must ensure access to medications on the WHO Essential Medicines List, including hormonal contraception and emergency contraception.[100] States should implement programs to guarantee access to a full range of high-quality family planning services and contraceptives,[101] and long-term forms of contraception, such as sterilization.[102] Building upon ICPD's recognition of the need to eliminate all obstacles to accessing contraception,[103] treaty monitoring bodies have determined that such obstacles include high costs,[104] marital status requirements,[105] third-party authorization,[106] and parental consent.[107] Treaty monitoring bodies have framed such obstacles as potentially violating the rights to nondiscrimination[108] and health.[109]

To comply with their human rights obligations, States should take measures to ensure vulnerable groups, such as adolescents and women and girls in rural and impoverished areas, can access contraception.[110] Confidential and child-sensitive counseling services should also be provided[111] and adolescents should have access to information and medical services without parental consent, in accordance with their maturity.[112]

Treaty monitoring bodies have made clear that States must take measures to ensure that the use of contraceptives is voluntary and fully informed.[113] Forced and coerced sterilization of women violates the right to nondiscrimination, to health, to determine the number and spacing of one's children and to be free from cruel, inhuman and degrading treatment.[114] Instances of involuntary sterilization should be investigated and prosecuted,[115] and redressed, including compensation, for people who are forcibly sterilized.[116] States should provide training on patients' rights in order to prevent involuntary sterilizations.[117] Preventative measures should be implemented in order to

prevent involuntary sterilization of groups that have been targeted by involuntary sterilization, including women with disabilities, indigenous women, and ethnic minorities.[118] Treaty monitoring bodies have recognized that women in these groups may face multiple forms of discrimination and have advised States to adopt comprehensive strategies to address this.[119]

Country Examples:

Guatemala

In April 2006, Guatemala adopted the Law on Universal and Equitable Access to Family Planning Services,[120] which guarantees universal access to family planning services, including contraception, information, counseling, and sexual and reproductive health education.[121] The law establishes measures for service provision of contraception in both public and private health facilities, particularly aiming to ensure contraceptive access to adolescents, geographically isolated populations, underserved populations and rural communities.[122] The law also requires voluntary, informed consent for contraception, requiring that its use should never be induced or coerced.[123] The legislation requires that national surveys be utilized in order to identify unmet need for family planning and to inform how the need will be met.[124] The law also establishes a strategy designed to expand services to adolescents and mandates sexuality and reproductive health education in both primary and secondary schools.[125]

Namibia

In 2012, the Namibian High Court decided the case of *L.M. and Others v. the Government of the Republic of Namibia*, wherein it ruled that medical practitioners in State-run hospitals involuntarily sterilized three women living with HIV.[126] While all three women in this case signed consent forms for sterilization, the court determined that they did so without the necessary information to make an informed decision, as they did not receive adequate counseling and one was told that medical treatment would be withheld if she did not sign the consent form.[127]

Philippines

In 2012, the Philippines passed the Reproductive Health Law, which guarantees the country's poorest women universal and free access to modern contraceptives at government health centers.[128] The law prohibits and includes sanctions for providers who knowingly withhold or restrict dissemination of information on reproductive services and programs, as well as for those who intentionally disseminate incorrect information.[129] Furthermore, the law prohibits and sanctions providers who refuse to provide reproductive healthcare based on lack of spousal consent.[130]

United States

In 2010, the United States passed the Patient Protection and Affordable Care Act, which greatly expanded women's access to preventive health care, including contraceptives, without cost-sharing requirements such as co-payments or deductibles.[131] In accordance with the law, most employers are required to include contraception for their employees under their insurance schemes.[132] This provision ensures that women who are insured are able to afford contraceptives and therefore are better equipped to plan the number and spacing of their children.

Abortion

Since the adoption of the ICPD Programme of Action, over 30 countries worldwide have liberalized their abortion laws – broadening the grounds under which women can access legal abortion and abolishing laws criminalizing women for having abortions.[133] Importantly, a number of these liberalizations have been in Latin America and Africa, two regions where highly restrictive abortion laws are pervasive.[134] Only 6 countries- Chile, Dominican Republic, Malta, Nicaragua, El Salvador and Holy See- do not allow abortion under any circumstances. As the World Health Organization (WHO) has recognized, restrictive abortion laws do not reduce the number of abortions – instead, they force women to seek out clandestine and unsafe abortions, which jeopardize their lives and their health.[135] Today, unsafe abortion still accounts for roughly 13% of maternal mortalities,[136] resulting in approximately 47,000 maternal deaths from unsafe abortion annually worldwide.[137] In some countries, the percentage of maternal deaths resulting from unsafe abortion is much higher, accounting for upwards of 30 percent.[138]

Globally, 60 percent of women live in countries where abortion is permitted without restriction as to reason or on broad socioeconomic grounds. The remaining 40 percent of the global population lives in countries with restrictive abortion laws that either do not permit abortion at all or only permit abortion under certain circumstances, such as when the pregnancy poses a risk to the woman's life or health, or in instances of rape, incest or fetal impairment. Notably, only a few countries have restricted their abortion laws to eliminate all exceptions to abortion, making abortion illegal even when the pregnancy poses a risk to the woman's life.

Adolescent girls age 10-19 account for at least 2.2-4 million unsafe abortions in developing countries. [139]Young women under the age of 25 account for almost half of all abortion deaths[140] and this group is seriously affected by the consequences of unsafe abortion. Adolescent girls and young women living in developing countries account for a significant proportion of unsafe abortions. These countries have abortion permitted on restrictive grounds, and where abortion is permitted, access to safe abortion services especially for adolescents and young girls remains a challenge.

In Sub-Saharan Africa, adolescent girls account for a quarter of all unsafe abortion and almost 60% of unsafe abortions are among young women aged less than 25 years.[141] About 10,000 adolescent girls in Nigeria die due to unsafe abortions each year. The latest estimates from WHO indicate that there are more than 3 million unsafe abortions performed in 2008 in the MENA region, accounting for 14% of maternal mortality.[142] Abortion is permitted on at least one ground in Egypt and Yemen and it is permitted on all grounds in Turkey and Tunisia.

Legal restrictions on abortion lead women to seek it unsafely and the latest estimates from the WHO indicate that more than 3 million unsafe abortions were performed in 2008 in the MENA region, accounting for 14% of maternal mortality.[143] Data on induced and unsafe abortion are severely lacking. As a result, the issue of unsafe abortion is a silent agony in the MENA region and, as it is illegal in many cases, it is severely underreported and poses great health risks on women. Young women are exceptionally vulnerable for unsafe abortions since they lack access to information, social support and financial resources. Because most young unmarried women deny involvement in premarital sexual activities due to cultural norms, their knowledge of

contraception is limited and their access to it is even more limited. Eighty percent of young women in the MENA region live in countries with restrictive laws on abortion.

Abortion policies in countries in the ICPD+20 global south monitoring report for Latin America and the Caribbean are heavily influenced by religious and cultural norms. In Mexico, abortion is legal on all grounds only in the Federal District. Other states in Mexico either have restrictions or totally ban abortion. Abortion is restricted on all grounds in Nicaragua and Dominican Republic.[144] In Asia, 30% of unsafe abortions are among women under 25 years of age.[145]Vietnam, Nepal, Cambodia and China have abortion permitted on all grounds. Abortion is permitted at least on one ground in the ICPD+20 global south monitoring report Asia-Pacific region countries. Eastern Europe region has higher abortion rates in comparison to all of the Europe.

The countries under review in the region have abortion permitted on all grounds, with the exception of Poland. Poland has one of the most restrictive abortion regulations in Europe. Moreover, in 2012, the initiatives to restrict access to abortion appeared in Azerbaijan, Bulgaria, Hungary, Poland, Russian Federation and Ukraine.[146] Adolescents face more barriers accessing abortion and among these laws are clauses that require young girls to obtain parental consent for the procedure prior to performing it.

Gestational limits, parental and spousal consent, mandatory waiting periods and counseling, and lack of information on the legality of abortion among adolescents and young people and service providers, stigma and religious influence impede abortion access for adolescents and young women. As a result this group is more like to suffer from abortion-related complications, including immediate and long-term disability and death.[147]

Even when abortion is legal, there remain barriers to women's access to safe abortion services. WHO recognizes, laws and policies that require women to obtain parental or spousal consent, undergo mandatory delays and mandatory ultrasounds, or listen to biased counseling prior to undergoing an abortion are medically unnecessary and hinder women's access to safe abortion services.[148] WHO strongly advocates for women to be provided with complete, accurate and understandable information about their pregnancies and safe abortion services, including prenatal diagnostic testing, to enable them to make informed, autonomous decisions about pregnancy.[149] Furthermore, WHO also recognizes that lack of clarity of laws that only permit abortion under certain circumstances and lack of implementation of abortion protocols further prevent women from accessing safe abortion services.[150] Finally, the WHO also notes that stigma surrounding abortion prevents women from accessing information about legal abortion and can deter women from seeking safe abortion services or post-abortion care when they face complications arising from unsafe abortions.[151] All of these barriers inhibit women from exercising their right to reproductive autonomy and contribute to elevated levels of maternal mortality and morbidity.

Abortion in the ICPD Programme of Action

The ICPD Plan of Action calls upon governments and all stakeholders to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. The POA calls for women's access to

quality services for the management of complications arising from abortion. Post abortion counseling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions.

In the ICPD Programme of Action, States agreed that where abortion is legal, it should be safe and accessible through the primary healthcare system.[152] The ICPD Programme of Action recognizes that unsafe abortion is a leading cause of maternal mortality and morbidity, with harmful effects on women and their families.[153] States committed "to reduce greatly the number of deaths and morbidity from unsafe abortion,"[154] and to take measures to prevent unsafe abortion, such as by expanding and improving family planning services.[155] Particular attention should be paid to adolescents and young women in the provision of programs to prevent unwanted pregnancies and treat unsafe abortions.[156] Finally, under the ICPD Programme of Action States agreed that "[i]n all cases, women should have access to quality services for the management of complications arising from abortion" and "[p]ost-abortion counselling, education and family-planning services should be offered promptly.".[157]

Human Rights Standards

Since ICPD, the international human rights standards have substantially strengthened and expanded States' human rights obligations regarding abortion. Treaty monitoring bodies have clearly elucidated the connection between restrictive abortion laws and high rates of unsafe abortion and maternal mortality.[158] They have repeatedly condemned absolute bans on abortion as being incompatible with international human rights norms[159] and have urged States to eliminate punitive measures for women and girls who undergo abortions and for healthcare providers who provide abortion services.[160]

Treaty monitoring bodies have called on States to decriminalize and ensure access to abortion, at a minimum, when the pregnancy poses a risk to the woman's life or health, when the pregnancy results from rape or incest, and when there is a severe fetal abnormality.[161] Human rights bodies have clearly indicated that denying women access to abortion in such instances violates the rights to health,[162] privacy[163] and to be free from cruel, inhumane and degrading treatment.[164] The Human Rights Committee has indicated that these limited exceptions may be insufficient to guarantee women's human rights, urging a State with such exceptions to further liberalize its abortion law.[165] Treaty monitoring bodies have urged States to interpret exceptions to restrictive abortion laws broadly to incorporate suicide as a threat to a woman's life[166] and mental health conditions as a threat to their health.[167]

Human rights bodies have noted that where abortion is legal, States must ensure that it is available, accessible (including affordable), acceptable and of good quality.[168] They have also urged States to abolish barriers to accessing safe abortion services, such as third-party authorization requirements, including spousal authorization,[169] and lack of clear guidelines on the conditions under which abortion is legal.[170] Human rights standards dictate that States should ensure that women's access to and the availability of abortion is not hindered by conscientious objection[171] by monitoring its practice[172] and implementing mechanisms to ensure that women systematically receive timely, appropriate referrals to another service provider.[173] Treaty monitoring bodies have instructed States that conscientious objectors maintain the

responsibility to treat an individual whose life or health is immediately affected.[174] States should also take measures to address the sociocultural factors which lead to son preferences and sex-selective abortion.[175] Despite the legal status of abortion, human rights bodies have made clear that States must ensure women receive confidential and adequate post-abortion care.[176] Post-abortion care must not be conditioned upon admissions by women that will be used to prosecute them for undergoing the illegal procedure, as this may amount to cruel, inhuman and degrading treatment.[177]

A number of countries have shown how access to modern contraceptive commodities and information can virtually eliminate the need for abortions such as the Netherlands; or Uruguay, which until it passed its new abortion law, had managed to eliminate mortality linked to abortion through providing information and access to contraception, as well as putting the focus on safeguarding the lives and women and girls

Country Examples:

Colombia

In May 2006, the Colombian Constitutional Court issued a groundbreaking decision declaring that women have a right to terminate a pregnancy when it poses a risk to the woman's life or health; when the fetus suffers from severe impairment, causing it to be nonviable; and when the pregnancy results from rape, incest or involuntary artificial insemination.[178] Prior to this decision, Colombia's abortion law banned abortion in all circumstances without any explicit exceptions.[179] The Court stated that "a criminal law that prohibits abortion in all circumstances extinguishes the woman's fundamental rights, and thereby violates her dignity by reducing her to a mere receptacle for the fetus, without rights or interests of constitutional relevance worthy of protection."[180] To implement the Constitutional Court's decision, in December 2006, Colombia's president signed into law Decree 444 (*Decreto 444*) mandating that the public health system cover the cost of legal abortion services, prohibiting health service providers from creating barriers to women's access to abortion and only permitting individuals directly involved in the abortion procedure to invoke conscientious objection.[181]

France

In 1988, France became the first country to license the use of medical abortions,[182] wherein women are administered medications to induce abortion instead of undergoing surgery.[183] Medical abortions have a number of advantages over surgical abortions, as they are less invasive, do not require anesthesia, and may be administered at home.[184] Studies indicate that many women view medical abortion at home as more confidential, comfortable and convenient.[185] In 2001, France's Agence Nationale d'Accréditation et d'Évaluation en Santé (ANAES) issued guidelines establishing that medical abortions may be administered by women in their homes, or wherever they feel most comfortable, after receiving counseling and the medication from a physician.[186] The guidelines also recognize that when possible, women should be given the choice between medical or surgical abortion. Additionally, in 2013, the French healthcare system began covering the full cost of abortion, whereas previously only 70 to 80 percent was covered,[187] noting that it deemed this step to be critical to ensure all women access to abortion services.[188]

South Africa

In November 1996, South Africa enacted the Choice on Termination of Pregnancy Act, liberalizing its restrictive abortion law, which only permitted abortion when there was a threat to a woman's life or in cases of rape, incest, or fetal impairment, to permit abortion without restriction as to reason during the first twelve weeks of pregnancy.[189] From the 12th to 20th week, abortion is permissible if a physician certifies that the pregnancy poses a risk to the woman's physical or mental health, in cases of severe fetal impairment, if the pregnancy results from rape or incest, or if continuing the pregnancy would significantly affect the woman's economic or social circumstances.[190] After the 20th week, abortion is available if two healthcare providers determine that the pregnancy threatens the woman's life, would result in a severe malformation of the fetus or would pose a risk of injury to the fetus.[191] The law also importantly grants minors the right to abortion without parental or guardian consent,[192] and requires that counseling on abortion be non-mandatory and non-directive.[193] A study on the impact of the Choice on Termination of Pregnancy Act found that abortion-related maternal deaths decreased by 91% following the law's implementation.[194]

Uruguay

In 2012, Uruguay approved a new law permitting abortion without restriction as to reason during the first 12 weeks of gestation, and thereafter up to the fourteenth week of gestation when the pregnancy results from rape.[195] Previously, abortion was only permitted when the pregnancy posed a risk to the woman's life or health and in instances of rape. The change in Uruguay's abortion law was a significant departure from the norm in Latin America and the Caribbean, where abortion without restriction as to reason is only legal in several countries. Uruguay's new law requires a woman to explain to a gynecologist any economic, social or family hardship that she would experience if she carried her pregnancy to term and to appear before an interdisciplinary group to receive information about the law, the abortion process, risks of having an abortion and alternatives to abortion.[196] These requirements are waived if the pregnancy poses a grave risk to the woman's life or health, if it results from rape and in cases of fetal malformation.[197]

Sexual and Reproductive Health Education and Information

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

Every year, adolescents account for 16 percent of all births in Sub-Saharan Africa, 12 percent in South Central and Southeast Asia, and 18 percent in Latin America and the Caribbean.[198] Sexuality education enables adolescents and youth to prevent unwanted pregnancies,[199] thereby reducing the health risks associated to unsafe abortions and the negative impact of adolescent pregnancies in the enjoyment of other rights. For instance, in addition to the health risks

associated with adolescent pregnancy and childbirth,[200] it may also compel girls to drop out of school or result in expulsion by school authorities.[201] Studies demonstrate that sexuality education can also help adolescents to delay their sexual debut,[202] and prevent sexually transmitted infections, including HIV.[203] In accordance with U.N. Educational, Scientific and Cultural Organization's International Technical Guidance on Sexuality Education, sexuality education should incorporate human rights principles;[204] employ participatory teaching methods; provide evidence-based, scientifically accurate information; address norms about use of condoms and other types of contraception; and cover a range of topics including human sexuality, sexual and reproductive health, human rights and gender equality.[205] Sexuality education should not reinforce stereotypes or prejudice and should not include discriminatory information on sexual minorities.[206]

Misinformation on sexual and reproductive health, such as intentionally exaggerated health risks associated with contraception or abortion, also poses a significant barrier to sexual and reproductive health and may both deter and prevent individuals, including adolescents, from using reproductive health services.[207] Access to information and education on sexual and reproductive health remains hindered due to parental apprehension and resistance to sexuality education, the spread of misinformation and information that is not scientifically-based, laws inhibiting access to information, and lack of political will. [208] Furthermore, several States have enacted or attempted to enact laws specifically designed to inhibit access to information on sexual and reproductive health and rights, including laws prohibiting or criminalizing dissemination of sexual and reproductive health information;[209] in addition to preventing individuals from accessing information, such laws stigmatize and may cause a chilling effect on the exercise of sexual and reproductive health and rights.

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

The ICPD Programme of Action identifies inadequate knowledge about human sexuality and poor-quality reproductive health information as barriers to attaining a state of reproductive health.[210] All couples and individuals have the right to the information and education necessary to make informed decisions about the number and spacing of their children.[211] States agreed that everyone has the right to education, which "should be designed to strengthen respect for human rights and fundamental freedoms, including those related to population and development."[212] Comprehensive reproductive healthcare includes information, counseling and education on reproductive health and sexuality.[213] Family planning programs should provide accessible, complete and accurate information about "the widest possible range of safe and effective family-planning methods."[214] Furthermore, States committed to remove unnecessary legal, medical and regulatory barriers to information.[215]

In terms of adolescents, under the ICPD Programme of Action States agreed to protect and promote adolescents' rights to reproductive health education and information[216] and to guarantee universal access to comprehensive and factual information on reproductive health.[217] The ICPD Programme of Action recognizes the connection between early marriage, adolescent childbearing and elevated rates of adolescent maternal mortality, and highlights the critical role that education

can play in preventing these harms.[218] The provision of information should enable adolescents to make responsible decisions about their reproductive health, understand their sexuality and prevent unwanted pregnancies.[219] States agreed to implement educational strategies to ensure that adolescents have access to information about responsible sexual behavior, family planning, reproductive health and human sexuality.[220] Sexuality education should take place in a number of different settings, including within the family, community, the media, and in schools.[221]

Human Rights Standards

Since ICPD, treaty monitoring bodies have recognized that the right to health extends "to the underlying determinants of health, such as… access to health-related education and information, including on sexual and reproductive health,"[222] and protects the right to seek, receive and disseminate information on health issues.[223] States must ensure women's access to health care information on an equal basis with men.[224] The right to health requires States to remove all barriers interfering with access to health education and information,[225] including barriers to sexuality education such as parental consent requirements.[226]

Treaty monitoring bodies have recognized that sexuality education contributes to the prevention of HIV/AIDS,[227] teenage pregnancy,[228] unwanted pregnancies,[229] abortions,[230] and maternal death.[231] Treaty monitoring bodies have made clear States should ensure that all adolescents have access to information on sexual and reproductive health[232] and have reinforced ICPD's recognition that States should implement sexuality education programs in all schools[233] and in other settings to reach adolescents who are not enrolled in schools.[234] Human rights bodies have noted sexual and reproductive health information should be comprehensive, unbiased, and scientifically accurate.[235] Sexuality education programs should include information on preventing unwanted pregnancy,[236] sexual and reproductive health and rights,[237] risks of unsafe abortions,[238] the legality of abortion,[239] and preventing sexually transmitted infections, including HIV/AIDS.[240] Sexuality education should also aim to transform cultural views about adolescents' need for contraception and other taboos regarding adolescent sexuality.[241]

Country Examples:

<u>Colombia</u>

In 2011, a lawsuit was filed against a number of Colombian public officials from the *Procuraduría General de la Nación* alleging violations of women's rights to information, health and life, amongst others, following the government's distribution of official documents that contained false and misleading statements on sexual and reproductive health.[242] The public officials' statements included a number of falsehoods, such as stating that emergency contraception causes abortions; that healthcare providers and institutions are entitled to deny women access to legal reproductive health services based on religious or moral objections, and that there is no right to access safe abortion services in Colombia.[243] The Constitutional Court ruled that the officials' spreading of misinformation violated women's right to access reproductive health services by denying them necessary information. The Court noted that access to information is vital for the exercise of reproductive rights "because one of the mechanisms to perpetuate the historical discrimination suffered by women has been and continues to be,

precisely, denying and creating obstacles to access to accurate and impartial information in this field."[244] Furthermore, the Court found that these acts threatened women's rights to dignity, life and physical and mental health.[245] The Court ordered that the public officials rectify these statements by providing the public with true and accurate information on the various issues about which they had spread falsehoods.[246]

Estonia

In 1996, Estonia established a compulsory, national curriculum on Human Studies, which includes sexuality education. This educational program is provided in conjunction with Youth Counseling Centers, which provide young people with free counseling on sexual and reproductive health, including safe sex, family planning and STI prevention.[247] The national curriculum and the Youth Counseling Centers are credited with the reduction of HIV and STI rates and increased condom and contraception use among adolescents.[248] The abortion rate among 15-19 year olds decreased by 45% between 2001 and 2009, while the HIV infection rate among 15-19 year olds decreased by 96% during the same time period.[249]

Iceland

In Iceland, the Ministry of Health establishes the sexuality education framework, which serves as a regulation which schools must follow in the provision of sexuality education.[250] The framework establishes that sexuality education should cover both biological and psychosocial considerations, including contraception, sexually transmitted infections, equality, gender identity and gender roles.[251] Sexuality education is mandatory, and as such, parents may not opt-out on behalf of their children.[252] In 2011, Iceland earmarked funding specifically for the incorporation of education on sexual assault in school curricula.[253] Under this initiative, students will learn about what constitutes sexual assault, issues related to consent, and how to report sexual violence.[254]

Adolescents and Youth

In addition to inadequate access to reproductive health education and information, adolescents face a range of other unique barriers including accessing comprehensive sexual and reproductive health services. In the context of reproductive and healthcare, laws denying adolescent's decision-making capacity or requiring them to obtain parental consent results in denial of their autonomy; this lack of autonomy can prevent or deter them from receiving confidential reproductive health services which can in turn compromise their physical and mental health. Adolescents may also be deterred from accessing reproductive health services due to fear of stigma and discrimination on the basis one's marital status.[255] Adolescents also may be unable to access such services due to their lack of finances and inability to access or afford transportation.[256]

Adolescent girls are particularly vulnerable and comprise one fifth of all women of reproductive age but have been widely underserved by reproductive health services worldwide.[257] Every year, approximately 16 million adolescents between the ages of 15 and 19 give birth,[258] with potentially harmful health impacts; complications arising from pregnancy and child birth are the leading causes of death for 15 to 19-year-old girls in the developing world.[259] Adolescents

between the ages of 15 and 19 are at twice the risk of dying due to pregnancy-related complications compared to women in their twenties,[260] while girls under the age of 15 have five times the risk of pregnancy-related deaths worldwide.[261] Furthermore, adolescents who become pregnant are likely to have lower educational attainments,[262] in part due to policies in some countries permitting or mandating expulsion of pregnant students.[263]

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

Adolescents and Youth in the ICPD Programme of Action

The ICPD Programme of Action aims to "promote to the fullest extent the health, well-being and potential of all children, adolescents and youth."[264] Recognizing the special needs of adolescents and youth and the unique barriers they face in accessing quality reproductive health services, the ICPD Programme of Action aims to overcome these barriers;[265] to this end, States agreed to remove regulatory, legal and social barriers that hinder adolescents' access to reproductive health information and services.[266] Recognizing that adolescents and youth have historically been neglected from the provision of reproductive health services,[267] States agreed to actively participants in the planning, implementation and evaluation of programs affectingyouth and adolescents, particularly in the area ofreproductive and sexual health.[268]

Statesfurther agreed to employ an approach that recognizes the "evolving capacities" of adolescents;[269] such an approach appreciates that as adolescents grow, they become increasingly more responsible and autonomous, allowing them greater decision-making capacity.[270] Adolescents should also be provided with appropriate sexual and reproductive health services and counseling;[271] such services "must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs."[272]

Human Rights Standards

International human rights standards provide adolescents and youth special protection ensuring that they are able to exercise their human rights in accordance with their evolving capacities.[273] Recognizing the evolving capacities of adolescents, States should develop programs for the provision of sexual and reproductive health services for adolescents,[274] including family planning. States should also ensure adolescents access to sexuality education and information.[275] Furthermore, the Committee on the Elimination of Discrimination against Women (CEDAW) has urged States not to limit access to health facilities and information based on third-party consent requirements, such as spousal, parental or health authority consent, [276] and to eliminate laws criminalizing consensual sexual behavior between adolescents, as such laws hinder their access to sexual and reproductive health services.[277] Human rights treaty monitoring bodies have continuously urged States to ensure that individuals are not discriminated against on the basis of their marital status,[278]particularly in the provision of reproductive health services. Adolescents and youth must also have access to confidential and child-sensitive services.[279] States should put

in place measures ensuring adolescents who become pregnant are able to remain in and return to school.[280]

States must take measures to eliminate harmful traditional practices that affect the right to health,[281] including child marriage and FGM. Additionally, children and adolescents are at a heightened risk of being victimized by sexual violence in both public and private settings, such as in the home, in healthcare institutions or in educational settings.[282] States should undertake measures to prevent sexual violence, provide rehabilitation and redress to victims of sexual violence, and prosecute offenders.[283]

Country Examples:

Panama

In 2002, Panama passed a legislation guaranteeing comprehensive healthcare, education and legal protection for pregnant adolescents.[284] According to this law all pregnant adolescents have the right to be informed of available public and private healthcare centers and to receive information about their particular rights and legal protections that are established by law.[285] Under this legislation, the Ministry of Education must ensure that the proper arrangements are made to enable pregnant adolescents to remain in school, including assigning a teacher to be responsible for the adolescent's academic advancement.[286] The law forbids discrimination against students based on pregnancy and calls for the Ministry of Education to provide the proper training for teachers on adolescent pregnancy in order to eradicate stigma and discrimination.[287] The legislation also establishes sanctions for the failure to inform pregnant students of their rights and to provide them with proper educational and health services.[288]

Uganda

In 2001, Uganda created the National Youth Policy to enhance awareness about the issues youth face and to provide space for youth to participate in the formation of national policies and development[289]and seeks to ensure their meaningful participation.[290] As a priority of focus, the policy seeks to improve access to health services for youth by removing barriers to such services and ensuring that they are youth-friendly.[291]

United Kingdom

In 2004, the United Kingdom's Department of Health issued best practice guidance to advise healthcare professionals about addressing the sexual and reproductive health needs of patients under the age of sixteen,[292] such as accessing contraception. The guidance identifies lack of confidentiality as one of the most prominent deterrents for young people to access sexual and reproductive health services and emphasizes that healthcare professionals owe the duty of confidentiality to all patients, including those under the age of sixteen.[293] As such, all reproductive health services should guarantee individuals under the age of sixteen the same right to confidentiality as adults.[294] Within healthcare facilities, effective training should be provided in order to realize employers' affirmative duty to ensure that their staff members maintain patients' confidentiality, and breaches of confidentiality should result in serious disciplinary matters.[295] Health service providers' personal beliefs should not interfere with their administration of care to minors; should such beliefs prevent the provision of care, the health

professional must make alternative arrangements for another professional to fulfill the patient's needs.[296]

Individuals Belonging to Marginalized and Underserved Populations

Individuals belonging to marginalized and underserved populations commonly face discrimination, in law or in practice, in accessing or in receiving reproductive health services. Persons belonging to indigenous populations; ethnic, religious and linguistic minorities; older persons; adolescents; persons with disabilities; people living with HIV; rural women; sex workers; LGBT persons and persons with intersex conditions are particularly affected.[297] Adolescents are also a marginalized and underserved population. At the core of persons belonging to these groups' right is discrimination in access to comprehensive reproductive healthcare since reproductive health policies and programs have historically neglected the specific needs of such groups. For example, the distribution of health centers may inadequately address the needs of rural populations, or biases of health facility staff members' against members of particular groups may result in lower service quality or abusive treatment at health facilities. Cultural, geographic and language barriers may also exclude many vulnerable individuals from the provision of social services. Furthermore, women belonging to marginalized and underserved populations may also face multiple forms of discrimination based on their status as women and as part of a marginalized group. Introduction of health systems that are sensitive to the needs of indigenous peoples, ethnic, religious and linguistic minorities etc. in a number of countries has helped overcome some of these barriers.[298]

Persons belonging to these groups also require special attention for the realization of their sexual and reproductive health and rights due to discriminatory healthcare systems. For example, a number of these groups have been or continue to be singled out under coercive or eugenic-based population policies aimed at depriving them of their reproductive capacities, such as persons with mental disabilities, transgendered people and people living with HIV.[299] Furthermore, a number of States have enacted laws criminalizing particular conduct of certain marginalized groups, such as laws criminalizing same-sex behavior, HIV-transmission and undocumented immigrants. For example, 77 countries worldwide still have laws criminalizing people based on their sexual orientation or gender identity.[300] These laws also deter individuals from accessing reproductive health services and exercising their sexual and reproductive health and rights out of fear of being deemed criminals. These laws also stigmatize members of vulnerable and marginalized groups. Even when discriminatory laws or policies have ended, individuals from these groups may be deterred from utilizing government-sponsored reproductive health programs due to prevailing discriminatory attitudes.

Marginalized and Underserved Populations in the ICPD Programme of Action

The ICPD Programme of Action recognizes the vulnerability of migrants, adolescents, and persons with disabilities, indigenous people, refugees, internally displaced persons and elderly people. States agreed to emphasize and prioritize the needs of vulnerable and underserved populations in the expansion of the provision of reproductive health services, including safe motherhood, prenatal care, delivery assistance and family planning services.[301] Recognizing the discrimination faced by vulnerable groups which is at times institutionalized in laws and

policies,[302] States committed to eliminate all forms of coercion,[303] discrimination and violence.[304] They agreed that sexual and reproductive health programs and services should address specific needs of vulnerable populations'[305] and should be socially and culturally appropriate.[306] The ICPD Programme of Action recognizes the importance of including vulnerable populations in the design, implementation, and monitoring of sexual and reproductive health programs.[307]

In addition, States also agreed to "ensure the realization of the rights of all persons with disabilities, and their participation in all aspects of social, economic and cultural life,"[308] including their reproductive health needs, such as their sexual health and their needs pertaining to family planning, access to information, education and HIV/AIDS.[309] The Programme of Action recognizes that elderly people, especially impoverished elderly women, are particularly vulnerable.[310] The Programme of Action further recognizes that reproductive health includes the right of *all* people to have a satisfying and safe sex life, and the capability to reproduce.[311]

Human Rights Standards

Since ICPD much attention has been paid to the rights of underserved and vulnerable populations. International human rights standards call for, States to guarantee non-discrimination in provision of healthcare services and the underlying determinants of health; this includes eradicating discrimination on the basis of race, sex, color, religion, language, physical or mental disability, health status (including HIV/AIDS), intersex or transgender status and sexual orientation, among others.[312] In providing reproductive healthcare, human rights bodies have urged States to pay particular attention to vulnerable and marginalized groups to ensure that they are receiving adequate, appropriate, accessible, and quality care[313] that responds to their particular needs.[314] This requires to overcome barriers faced by vulnerable groups in accessing health facilities[315] including structural changes to make them accessible for people with physical disabilities and providing translation services for people who do not speak a State's dominant language. Strategies for the prevention and treatment of diseases, including HIV/AIDS, should also pay particular attention to vulnerable groups,[316] as they may face a higher risk of HIV infection and transmission due to social and economic factors such as neglect within the formal healthcare system.

To comply with their international human rights obligations, States must take all appropriate measures to eliminate discrimination both in law and in practice.[317] This obligation is non-derogable and subject to immediate application; even in circumstances where States face extreme resource constraints, low-cost, targeted programs must be adopted in order to protect vulnerable members of society.[318] Measures should be taken to eradicate stereotypes and discrimination against these groups,[319] including through awareness-raising campaigns on diversity and tolerance;[320] and instituting disciplinary, administrative and penal sanctions when violations occur.[321] Treaty monitoring bodies have also advised States to adopt comprehensive strategies to address multiple forms of discrimination against women belonging to marginalized groups.[322]

Country Examples:

<u>Bolivia</u>

In 2009, Bolivia adopted a new constitution that includes expansive protections for indigenous rights, women's rights, and sexual and reproductive rights. The constitution prohibits

discrimination based on sexual orientation, gender identity, culture, disability, and marital status, amongst others.[323] It also protects indigenous populations' rights to cultural identity, practices and customs and universal healthcare that respects their traditional and cultural practices.[324] Furthermore, the constitution explicitly "guarantees women and men the right to exercise their sexual and reproductive rights."[325]

Canada

Canada's Human Rights Act protects individuals from discrimination based on "race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital status, family status, disability and conviction for which a pardon has been granted."[326] The prohibition of discrimination based on sex includes discrimination based on pregnancy and childbirth.[327] Since the adoption of ICPD, the law was amended to protect certain indigenous groups from discrimination, such as Canada's First Nations, and to forbid discrimination on the basis sexual orientation.[328] Many members of First Nations live on reservations that are characterized as having lower levels of educational attainment, lower quality of housing, and lower incomes;[329] as a result of their inclusion in the Human Rights Act, these groups can now seek recourse for discriminatory practices.[330]

Republic of the Congo

In 2011, the Republic of the Congo became one of the few countries in Africa to inaugurate legislation specifically designed to protect the rights of indigenous populations. In addition to prohibiting discrimination against members of indigenous populations,[331] the law also enshrines State's affirmative duty to ensure meaningful participation of indigenous populations in the formulation and implementation of legislation and development programs.[332] The law also explicitly guarantees indigenous populations access to primary healthcare,[333] and protects the right to education, calling upon the State to take special measures to ensure nondiscriminatory access to education for all indigenous children.[334]

HIV/AIDS

Since the inception of HIV/AIDS epidemic, more than 60 million people have contracted HIV and roughly 30 million have died of AIDS.[335] In 2011, 34.2 million people were living with HIV, 69 percent of which are in sub-Saharan Africa.[336] Treatment of people living with HIV has transformed in the last twenty years since adoption of ICPD, although the epidemic has continued to intensify worldwide. The access to medication and treatment, where available, has changed HIV from a death sentence to a chronic, manageable disease.; Further with proper therapies, the risk of parent to child transmission of HIV can be reduced to less than 2 percent in non-breastfeeding populations.[337] Yet, the global and regional disparities means that only less than half of people living with HIV receive treatment[338] and less than fifty percent of pregnant women living with HIV in developing countries receive the most effective treatment to prevent transmission to their children.[339] It is critical that disparities in treatment for HIV/AIDS are addressed in accordance with international human rights standards and intergovernmental agreements on HIV/AIDS.[340] Additionally, people living with HIV have been target of coercive

policies and practices, such as forced sterilization and stripping them of their reproductive capacity.[341]

The criminalization of HIV transmission in over 60 countries worldwide contributes to the marginalization of people living with HIV. Laws criminalizing HIV are ineffective at reducing transmission, as they deter individuals from undergoing HIV testing out of fear of prosecution.[342] Such laws compound the barriers to accessing adequate care for HIV/AIDS faced by vulnerable or marginalized groups that have an elevated risk of HIV infection such as men who have sex with men, sex workers, transgender persons, intravenous drug users, prisoners and migrants.[343] Women also bear an elevated risk of HIV infection due to social, cultural and physiological reasons[344] including gender based violence;[345] economic dependence, which limits their ability to control with whom they have sex;[346] and harmful cultural practices.[347] Women now account for over half of all people living with HIV and the HIV prevalence rate among women aged 15 - 24 is twice that of young men in the same age range.[348]

HIV/AIDS in the ICPD Programme of Action

Under the ICPD Programme of Action, States agreed to "provide all means to reduce the spread and the rate of transmission of HIV/AIDS infection"[349] and provide treatment for HIV.[350] The Programme of Action aims to ensure people living with HIV receive adequate medical care and counseling.[351] States agreed that sexual and reproductive health programs should address HIV/AIDS[352] and integrate identification of sexually transmitted infections into reproductive health programs.[353] The ICPD Programme of Action recognizes that women are particularly susceptible to HIV due to social and economic inequalities and the greater likelihood of transmission from men to women.[354] States committed to have a multisectoral approach to address HIV/AIDS `keeping in view socioeconomic factors influencing the spread of the disease.[355] The ICPD Programme of Action recognizes the need to eliminate discrimination against people living with HIV,[356] and States agreed to develop policies and guidelines to this effect. Additionally, HIV-testing and other HIV-related programs must also ensure confidentiality.[357]

Human Rights Standards

Since ICPD, as a result of continued growth of HIV/AIDS epidemic , international human rights bodies have increasingly addressed the rights of people living with HIV, establishing that States must guarantee people living with HIV the equal enjoyment of their human rights.[358] In accordance with human rights standards, antiretroviral treatment should be available, affordable and accessible to all in an equitable manner[359] and States should take measures to eradicate barriers in accessing antiretroviral treatment,[360] including the high cost.[361] States should implement prevention strategies such as promoting condom use and access to condoms (including female condoms),[362] ensuring access to contraceptives,[363] and conducting awareness-raising campaigns.[364] Human rights bodies have made clear that appropriate resources must be allocated to HIV/AIDS programs,[365] and the effectiveness of programs should be monitored and evaluated.[366]

States should also take effective measures to counter stigma and discrimination related to HIV/AIDS.[367] Treaty monitoring bodies have urged States to prohibit discrimination based on seropositive status[368] and take steps to ensure that people living with HIV have nondiscriminatory access to reproductive health services,[369] including treatments to reduce the risk of parent-to-child HIV transmission.[370] States should ensure people living with HIV can make informed and voluntary decisions about reproduction,[371] by eliminating policies that promote or permit the involuntary sterilization of people living with HIV[372] and ensuring that HIV testing and treatment is voluntary, confidential[373] and available without parental consent.[374] Treaty monitoring bodies have advised States that strategies to address HIV/AIDS should target high-risk groups,[375] such as young women,[376] people in rural areas, and ethnic minority groups,[377] as well as older persons.[378] In accordance with human rights standards, States should take a gender-sensitive approach to the HIV epidemic,[379] emphasizing the rights and needs of women.[380] Laws criminalizing consensual same-sex behavior and HIV transmission should also be repealed.[381]

Country Examples:

Nicaragua

In 1996, Nicaragua enacted a legislation designed to have human rights based response to HIV/AIDS.[382] The law is based on the right to life and health and the principles of non-discrimination, confidentiality and autonomy.[383] The law guarantees all people living with HIV the right to receive reproductive health and family planning information, counseling and services.[384] Furthermore, it guarantees the rights to work, education and recreation for all people living with HIV.[385] It also created a National HIV/AIDS commission, comprising of representatives from a number of government ministries, including health, education, work and social security, responsible for overseeing implementation of the law.[386]

Philippines

The Philippines' AIDS Prevention and Control Act of 1998 guarantees all people living with HIV the full protection of their civil liberties and human rights,[387] including basic health and social services.[388] The law requires written, informed consent for HIV testing and forbids compulsory HIV testing;[389] to this effect, HIV testing may not be required as a precondition for employment, educational opportunities or the provision of services, including medical services.[390] Furthermore, the law forbids discrimination against people living with HIV and people perceived to or suspecting of having HIV.[391] Additionally, the State has an obligation to address issues which aggravate the spread of HIV, such as poverty, gender inequality and marginalization.[392]

Rwanda

Rwanda's 2009-2012 National Strategic Plan on HIV & AIDS[393] aims to universalize access to HIV prevention, treatment and care; reduce by one-half the incidence of HIV; significantly reduce morbidity and mortality of individuals living with HIV; and ensure equal opportunities for people living with HIV.[394] The Plan identifies women's particular vulnerability to HIV, and seeks to work in collaboration with women to diminish stereotypes that contribute to women's heightened vulnerability.[395] The National Strategic Plan seeks to ensure that women living with

HIV are empowered to make informed reproductive health decisions[396] and to reduce mother-to-child transmission of HIV.[397] The Plan identifies other vulnerable groups that are at an elevated risk of being infected with or transmitting HIV and identifies measures to reach these populations.[398]

South Africa

In 2002, the Constitutional Court of South Africa ruled that the government must remove restrictions on Nevirapine, a pharmaceutical which reduces the risk of mother-to-child transmission of HIV. Prior to this ruling, despite its affordability, Nevirapine was only being provided to women at a limited number of pilot sites, outside of which it was generally unavailable in public health facilities.[399] The Court ordered the State to take pro-active measures to permit, facilitate and expedite Nevirapine's use[400] and to ensure presence of appropriate staff at public hospitals to provide counseling on the use of Nevirapine.[401]

Violence Against Women

Approximately one out of every three women across the globe[402] will experience some form of violence causing, or likely to cause, physical, sexual, psychological or economic harm or suffering –[403]Examples of violence against women include domestic violence, rape, sexual abuse of children, and female genital mutilation. While violence against women and girls encompass a broad range of forms, these forms share a number of commonalities: they reflect the inequalities between men and women in societies, which manifest themselves through patriarchal sentiments enabling males, as the dominant sex, to physically, verbally and psychologically mistreat women.[404] In a cyclical manner, violence against women reinforces and perpetuates gender inequities, as women frequently feel unable to speak up about the violence due to social norms and/or fear of retribution.[405]The threat of gender based violence is heightened for refugees and women in conflict settings; and the harm associated with such violence may be exacerbated by lack of access to comprehensive sexual and reproductive healthcare.[406]

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

Violence against Women in the ICPD Programme of Action

In accordance with the ICPD Programme of Action, States agreed to take measures to eliminate all forms of violence against women, including enacting laws on sexual abuse and violence where they do not yet exist, strengthening existing laws and enforcing such laws.[407] States further agreed to take effective steps to address and eliminate sexual abuse of children[408] and to better provide assistance to individuals and families affected by domestic and sexual violence.[409]

Migrants and displaced persons may be particularly vulnerable to sexual violence;[410] as such, services should be designed to address their specific reproductive health needs, including those resulting from sexual violence.[411] Educational programs at the national and community level should promote open discussion about the need to protect women, youth and children from sexual abuse and violence.[412] States agreed to create conditions and implement procedures to encourage victims to report crimes,[413] and take measures to rehabilitate victims of violence.[414]

Human Rights Standards

The human rights standards on violence against women have increasingly strengthened since ICPD, and human rights bodies have also framed intimate-partner violence and violence based on sexual orientation or gender identity as having similar underlying causes and consequences as violence against women. Human rights bodies recognize that violence against women constitutes a form of discrimination,[415] and as such, States must adopt adequate, comprehensive legislation and other measures, including sanctions where appropriate, to eradicate violence against women.[416] To this end, States should investigate, prosecute and punish instances of gender-based violence,[417] and implement programs to train police, prosecutors and the judiciary about gender-based violence.[418] Treaty monitoring bodies have instructed that State programs addressing gender-based violence should take into account underserved and vulnerable groups, such as persons with disabilities, to ensure they have access to appropriate services and redressal.[419] Furthermore, States should take steps to address violence based on sexual orientation or gender identity , including providing effective protection from violence and investigating all reports of violence.[420]

Human rights bodies have urged States to implement policies that protect victims from further abuse, such as social, psychological and health services for victims.[421] Abortion should be decriminalized in instances of rape, and survivors of sexual violence should have access to emergency contraception.[422] Programs aimed at addressing gender-based violence should incorporate efforts to combat gender-based stereotypes and other underlying causes of gender-based violence.[423] Such efforts should include campaigns to raise awareness about gender-based violence;[424] comprehensive training for relevant professionals, including teachers and healthcare workers; and education in schools about gender-based violence.[425]

Country Examples:

<u>Argentina</u>

In 2009, under the Law on the Comprehensive Protection to Prevent, Punish and Eradicate Violence against Women,[426] Argentina adopted an expansive definition of violence against women to beall conduct, acts or omissions that are based on the unequal power relations between men and women and affect women's life; liberty; dignity; physical, psychological, sexual or economic integrity; or personal security.[427] The law explicitly recognizes violence against reproductive freedom, defining it as interfering with a woman's right to decide freely and responsibly on the number and spacing of her pregnancies and childbirths,[428] such as health care workers' failure to provide counseling about and access to contraception.[429] The law also recognizes obstetric violence as occurring when health care providers exert control over

women's bodies and reproductive processes, treat women inhumanely, or abuse the medical processes,[430] including inhumane or degrading treatment of patients in need of post-abortion care, irrespective of whether the abortion was legal or illegal.[431]

Kenya

In 2009, Kenya's Ministry of Health issued the National Guidelines for the Medical Management of Rape/Sexual Violence,[432] which explicitly recognizes that ICPD and the Millennium Development Goals obligate the State to take measures to address sexual violence.[433] The guidelines highlight the importance of having emergency contraception readily available at all times and free of charge when treating a victim of sexual assault, and instructs that emergency contraception is not an abortifacient and will not harm an early pregnancy.[434] Survivors of sexual assault should be offered follow-up pregnancy tests and, if pregnant, should be informed that in these circumstances abortion is legal under Kenyan law.[435] If a survivor of sexual assault decides to terminate the pregnancy, the provider should treat her with compassion and refer her to an appropriate provider.[436] The guidelines include the administration of Post-Exposure Prophylaxis (PEP) for HIV,[437] and highlight the importance of providing pre- and post-test counseling on HIV.[438] The guidelines also provide specific instructions for addressing instances of sexual violence against men.[439]

Spain

In 2004, Spain enacted the Law on Integrated Protection Measures against Gender Violence to address physical and psychological violence utilizing a holistic approach.[440] The law aims to strengthen public awareness about preventive measures; ensure victims' right to rapid, transparent and effective access to services; improve the provision of information and integrated recovery services; guarantee victims of violence economic rights, including employment; and strengthen institutional protections.[441] It also emphasizes the educational systems' duty to prevent and address gender-based violence through educational programs and services.[442] The Act also underlines the need to provide sensitization training to health professionals to be able to detect signs of gender-based violence and provide the necessary care for victims.[443] It also delineates the rights of victims of gender-based violence including the right to integrated social assistance and free legal counsel, employment rights and Social Security benefits, and institutional protection.[444]

Harmful Traditional Practices: Female Genital Mutilation and Child Marriage

Harmful traditional practices include, but are not limited to, female genital mutilation (FGM); child marriage; and other harmful practices stemming from societies' discrimination against women.[445] FGM, defined as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons,"[446] has been practiced on between 100 and 140 million women and girls,[447] and has been documented in 29 countries in Africa, Asia and the Middle East[448] and Latin America.[449] Of these 28 countries, 22 have enacted laws banning FGM,[450] demonstrating that in many places it is no longer understood as an acceptable cultural practice, but instead as a harmful violation of women and girls' rights with horrific health consequences including severe pain, hemorrhaging, sepsis and complications during childbirth.[451]

Similarly to FGM, countries have increasingly addressed child marriage, as at least 158 countries have set the minimum age for marriage without parental consent at 18 or over.[452] Nonetheless, child marriage persists, as 41 countries have rates of child marriage of 30 percent or more[453] and 52 countries allow children under the age of 15 to marry with parental consent.[454] Child marriage is most common in South Asia and West and Central Africa, where two in five girls marry before they reach 18.[455] Of the nearly 16 million girls between the ages of 15 and 19 who give birth annually in developing countries, nine out of ten are married;[456] reducing child marriage can prevent adolescent pregnancy and resulting maternal mortalities.[457] Despite critical advances in human rights standards on this issue, worldwide trends have been stagnant in the past ten years.[458] If current trends continue, 142 million girls will be married in the next decade.[459] In addition to early child-rearing and elevated maternal mortality rates, child marriage is also linked to increased risk of sexually transmitted diseases, including cervical cancer, resulting from HPV infection, and HIV, and other diseases such as malaria, due to pregnancy's ability to suppress the immune system.[460]

Harmful Traditional Practices in the ICPD Programme of Action

Under the ICPD Programme of Action, States agreed to take measures to eliminate harmful traditional practices. The ICPD Programme of Action recognizes that FGM "is a violation of [women's] basic rights and a major lifelong risk to women's health."[461] FGM should be prohibited[462] and States should urgently adopt and enforce measures to eliminate FGM.[463] In order to eliminate FGM, States should conduct community outreach with village and religious leaders,[464] provide education and counseling on the harmful impact of FGM,[465] and "vigorous[ly] support... efforts among non-governmental and community organizations and religious institutions to eliminate such practices."[466] Actively discouraging FGM should be an integral component of primary and reproductive health care programs[467] and States should provide girls who suffered FGM appropriate treatment, rehabilitation and counseling.[468]

The ICPD Programme of Action recognizes that early marriage and early motherhood "can severely curtail educational and employment opportunities and [is] likely to have a long-term, adverse impact on [young women's] and their children's quality of life."[469]As early marriage is connected to early childbearing, the ICPD Programme of Action recognizes the harmful effects of early childbearing, including increased risk of maternal mortality and morbidity and its impact as an impediment to improving women's educational, economic and social status.[470] States should strictly enforce laws designed to prevent forced marriage and should put in place educational and employment opportunities to enhance social support for such laws.[471]

Human Rights Standards

Under the international human rights framework, States have a positive obligation to protect adolescents from all harmful traditional practices, including FGM and child marriage.[472] Treaty monitoring bodies frame harmful traditional practices as violations of the right to life,[473] equality,[474] non-discrimination[475] and to be free from cruel, inhuman and degrading treatment.[476] Under the Convention on the Rights of the Child, States must "take measures to abolish traditional practices that are harmful to children's health"[477] including by enacting and enforcing specific, effective legislative measures prohibiting such practices[478] and eradicating customary laws that encourage such practices.[479] States should also take measures to address traditional and

cultural factors that contribute to such practices.[480] Such programs should involve and reach religious and community leaders,[481] support practitioners of FGM to find alternative sources of income[482] and include training for law enforcement and the judiciary.[483]

Treaty monitoring bodies have agreed that 18 is the appropriate minimum age for marriage for both men and women;[484] to this effect, States should enact legislation increasing the minimum age for marriage, with or without parental consent, to age 18.[485] Treaty monitoring bodies recognize that child, early and forced marriage pose serious threats to the right to health,[486] as there is a connection between these practices and high maternal mortality rates,[487] elevated school dropout rates,[488] and an increased risk of sexual abuse.[489]

Country Examples:

Benin

In 2003, Benin adopted legislation banning all forms of female genital mutilation.[490] The law defines FGM as "any partial or total removal of the external genitalia of females and/or any other operations on these organs."[491] Anyone who is found to participate in FGM faces six months to three years in prison.[492] Should the girl or woman die as a result of the procedure, the person may be imprisoned between five and twenty years.[493] Accomplices, including those who help during, assist in, provide means for or solicit the procedure, face the same penalties as the principal actor.[494] In instances of repeat offenders, the maximum penalty shall be imposed.[495] The law also places an affirmative obligation on individuals to report instances of FGM to the police or prosecutor; those who know of an impending FGM procedure who do not report it or take action to prevent it can be penalized by a fine of up to 100,000 francs.[496] Finally, the legislation requires that health facilities treat victims of FGM and report instances of FGM to the police or prosecutor.[497]

Ethiopia

Despite Ethiopia's legal restrictions prohibiting marriage before age 18, in Ethiopia's rural Amhara region, fifty percent of girls is married by age 15 and eighty percent of girls are married by age 18.[498] In 2004, Ethiopia began implementing a program called Berhane Hewan to protect girls at risk of child marriage and to support married adolescent girls.[499] The program seeks to reduce early marriage by addressing the economic and social factors that contribute to its occurrence through the provision of support for girls to remain in the education system and cash incentives for families to keep unmarried girls in school.[500] It also organizes information sessions, led by adult female mentors, for girls to learn about reproductive health, family planning services and livelihood skills.[501]An evaluation of the program conducted in 2006 found a substantial improvement in school attendance and literacy levels among girls, increased educational attainment, and delays in the age of marriage among young girls.[502]

Senegal

In 2008, as a participant in the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting, a non-formal education program entitled the Community Empowerment Programme (CEP) was implemented in Senegal.[503] The three-year program focuses on education and dialogue on issues such as democracy, human rights, health and education, amongst others. In learning about human rights and health, students began questioning the impact of FGM on

women, girls and the community.[504] They came to the conclusion the FGM should not be practiced and publicly declared their support for ending FGM.[505] Villages participating in this program demonstrated a marked reduction in reports of girls who were subjected to FGM – with only 30% of women reporting that at least one daughter was subjected to FGM compared to 69% of women in villages where the program was not present.[506]

Turkey

In 2001, Turkey reformed its Civil Code in order to recognize the equality of the rights of spouses in marriage. The Civil Code sets the minimum age for marriage at 18, while previously it was 17 for males and 15 for females.[507] Spouses have equal rights under the code, and are both equally entitled to rights over the family's home and property acquired during the marriage.[508] Should the woman be coerced into the marriage, she can later file for an annulment based on these grounds.[509] Prior to these reforms, the Turkish Civil Code established the supremacy of men and the subordination of women.[510] In 2001, the Constitution was also amended to state that "the family is the foundation of Turkish society and is based on equality between the spouses."[511]

Rational for 15-24 year age group for youth cohort

(As agreed in 1995 General Assembly resolution on the World Programme for Youth to the Year 2000 and beyond A/RES/50/81) "The world youth population—defined by the United Nations as the age cohort 15-24—was estimated to be 1.03 billion, or 18 per cent of the total world population. The majority of the world youth population (84 per cent in 1995) lives in developing countries. This figure is projected to increase to 89 per cent by 2025. The difficult circumstances that people experience in many developing countries are often even more difficult for young people because of limited opportunities for education and training, viable employment and health and social services, and because of a growing incidence of substance abuse and juvenile delinquency. Many developing countries are also experiencing unprecedented rates of rural-urban migration by young people.

Apart from the statistical definition of the term "youth" mentioned above, the meaning of the term "youth" varies in different societies around the world. Definitions of youth have changed continuously in response to fluctuating political, economic and sociocultural circumstances. Young people in industrialized countries comprise a relatively smaller proportion of the total population because of generally lower birth rates and longer life expectancy. They comprise a social group that faces particular problems and uncertainties regarding its future, problems that relate in part to limited opportunities for appropriate employment. Young people in all countries are both a major human resource for development and key agents for social change, economic development and technological innovation. Their imagination, ideals, considerable energies and vision are essential for the continuing development of the societies in which they live. Thus, there is special need for new impetus to be given to the design and implementation of youth policies and programmes at all levels. The ways in which the challenges and potentials of young people are addressed by policy will influence current social and economic conditions and the well-being and livelihood of future generations."

[1] See http://www.un.org/millenniumgoals/pdf/MDG_FS_5_EN_new.pdf;
http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf

[2] http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf at 1; See also http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61337-8/fulltext (The lancet, Progress Towards MDGs 4 and 5 on maternal and child mortality: an updated systematic analysis (2011))

[3] http://www.who.int/mediacentre/factsheets/fs348/en/index.html - find cite to journal article

[4] http://www.who.int/mediacentre/factsheets/fs348/en/index.html

[5] http://www.who.int/maternal_child_adolescent/documents/9241593784/en/

[6] http://whqlibdoc.who.int/publications/2006/9241593784_eng.pdf at 8.

[7] http://www.advocatesforyouth.org/component/content/article/436-adolescent-maternal-mortality-an-overlooked-crisis (citing World Health Organization, UNFPA. *Pregnant Adolescents*. Geneva: WHO, 2006 & UNFPA (2005). *State of World Population 2005: The Promise of Equality*. New York: Author)

[8] http://www.unfpa.org/webdav/site/global/shared/documents/publications/reducing_mm.pdf

[9] ICPD POA, para. 7.2.

[10] ICPD POA, para. 8.19.

[11] ICPD POA, para. 8.19 ("At the global level, it has been estimated that about half a million women die each year of pregnancy-related causes, 99 per cent of them in developing countries.").

[12] ICPD POA, para. 8.22.

[13] ICPD POA, para. 8.21

[14] See http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673611613378.pdf?id=e16241398b8eb460:-76be3076:13abbfb8f73:9b71351777331508 at 1163.

[15] ICPD POA, para. 8.21 ("Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed.")

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

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

[18] ICPD POA, para. 8.25.

[19] ICPD +5, para. 63 (http://www.unfpa.org/webdav/site/global/shared/documents/publications/1999/key_actions_en.pdf); add ICPD POA citation.

[20] POA, para. 8.23.

[21] ICPD POA, para. 8.19.

[22] ICPD POA, para. 8.24.

[23] See, e.g., **Mali**, ¶ 14, U.N. Doc. CCPR/CO/77/MLI (2003).

[24] Alyne v. Brazil (need full cite, with para. #).

[25] *See, e.g.*, **Ecuador**, ¶ 11, U.N. Doc. CCPR/C/79/Add.92 (1998); **Georgia**, ¶ 12, U.N. Doc. CCPR/C/79/Add.75 (1997); **Mongolia**, ¶ 8(b), U.N. Doc. CCPR/C/79/Add.120 (2000); **Peru**, ¶ 20, U.N. Doc. CCPR/CO/70/PER (2000); **Poland**, ¶ 11, U.N. Doc. CCPR/C/79/Add.110 (1999); **Trinidad and Tobago**, ¶ 18, U.N. Doc.CCPR/CO/70/TTO (2000).

[26] Alyne v. Brazil (add para. #)

[27] See http://ap.ohchr.org/documents/E/HRC/resolutions/A_HRC_RES_11_8.pdf;

[28] **Malawi**, ¶ 31, U.N. Doc. CEDAW/C/MWI/CO (2006); **Mali**, ¶ 33, U.N. Doc. CEDAW/C/MLI/CO/5 (2006); **Mexico**, ¶ 32, U.N. Doc. CEDAW/C/MEX/CO/6, (2006); **Mongolia**, ¶ 273, U.N. Doc. A/56/38 (2001); **Morocco**, ¶ 30, U.N. Doc. CEDAW/C/MAR/CO/4 (2008);

[29] *See, e.g.*, **Chile**, ¶ 8, U.N. Doc. **CCPR/C/CHL/CO/5 (2007); Chile,** ¶ 15, U.N. Doc. CCPR/C/79/Add.104 (1999);**;**
Costa Rica, ¶ 11, U.N. Doc. CCPR/C/79/Add.107(1999); **Guatemala**, ¶ 19, U.N. Doc. CCPR/CO/72/GTM; **Kuwait**, ¶ 16, U.N. Doc. CCPR/CO/69/KWT (2000); **Madagascar**, ¶ 14, U.N. Doc. CCPR/C/MDG/CO/3 (2007);

Panama, ¶ 9, U.N. Doc. CCPR/C/PAN/CO/3 (2008); **Paraguay**, ¶ 10, U.N. Doc. CCPR/C/PRY/CO/2 (2006); **Peru**, ¶ 20, U.N. Doc. CCPR/CO/70/PER (2000); **Trinidad and Tobago**, ¶ 18, U.N. Doc. CCPR/CO/70/TTO (2000); (noting elevated rates of maternal mortality and recommending that States amend restrictive abortion provisions).

[30]*See, e.g.*, **Chad**, ¶ 30, U.N. Doc. CRC/C/15/Add.107 (1999); **Colombia**, ¶ 48, U.N. Doc. CRC/C/15/Add.137 (2000); **Democratic People's Republic of Korea**, ¶ 50, U.N. Doc. CRC/C/15/Add.239 (2004); **Guatemala**, ¶ 40, U.N. Doc. CRC/C/15/Add.154 (2001); **Haiti, ¶ 46, U.N. Doc. CRC/C/15/Add.202 (2003);**

[31]*See, e.g.*, **Eritrea**, ¶ 22, U.N. Doc. CEDAW/C/ERI/CO/3, (2006); **Mexico**, ¶ 445, U.N. Doc. A/57/38 (2002); **Mozambique**, ¶ 36, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007); **Paraguay**, ¶ 123, U.N. Doc. A/51/38 (1996); **Peru**, ¶ 337, U.N. Doc. A/53/38/Rev.1 (1998); **Uganda**, ¶ 147, U.N. Doc. A/57/38 (2002).

[32]*See, e.g.*, **Sudan**, ¶ 10, U.N. Doc. CRC/C/15/Add.10 (1993).

[33]*See, e.g.*, **Chile**, ¶ 41, U.N. Doc. CRC/S/15/Add.173 (2002).

[34]Alyne v. Brazil, para 7.6.

[35]Alyne v. Brazil, para 7.7.

[36] Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the HighestAttainable Standard of Health (Art. 12)* ¶ 44(a), U.N. Doc. HRI/GEN/1/Rev.7 (2004) (noting that the prevention of maternal mortality arises to the level comparable to that of "core obligations" under human rights treaties).

[37]*See, e.g.*, **Côte d'Ivoire**, ¶ 39, U.N. Doc. CRC/C/15/Add.155 (2001); **Dominican Republic**, ¶¶ 37–38, U.N. Doc. CRC/C/15/Add.150 (2001); **Grenada**, ¶ 22, U.N. Doc. CRC/C/15/Add.121 (2000); **Lesotho**, ¶ 44, U.N. Doc. CRC/C/15/Add.147 (2001).

[38]*See, e.g.*, **Azerbaijan**, ¶ 56, U.N. E/C.12/1/Add.104 (2004); **Korea**, 12/12/2003, U.N. Doc. E/C.12/1/Add.95, ¶ 44; **Nepal**, ¶ 46, U.N. Doc. E/C.12/NPL/CO/2 (2008); **Russia**, ¶ 63, ,U.N. Doc. E/C.12/1/Add.94 (2003).

[39] ADD CITE

[40]*See, e.g.*, **Burundi**, ¶ 36, U.N. Doc. CEDAW/C/BDI/CO/4 (2008); **Malawi**, ¶ 32, U.N. Doc. CEDAW/C/MWI/ CO (2006); **Morocco**, ¶ 78; 0, U.N. Doc.A/52/38/Rev.1 (1997).

[41]*See, e.g.*, **Bolivia**, ¶ 43, U.N.Doc. CEDAW/C/BOL/CO/4 (2008); **Honduras**, ¶ 25, U.N. Doc. CEDAW/C/HON/CO/6 (2008); **Pakistan,** ¶ 41, U.N. Doc. CEDAW/C/PAK/CO/3 (2007); **Peru**, 08/07/98, U.N. Doc.A/53/38/Rev.1, ¶ 34.

[42]*See, e.g.*, **Poland**, ¶ 11, U.N. Doc. CCPR/C/79/Add.110 (1999).

[43]*See, e.g.*, ESCR Committee, *General Comment No. 14*, ¶ 43(d). The WHO Model List of Essential Medicines includes misoprostol for obstetric purposes. WHO, WHO MODEL LIST OF ESSENTIAL MEDICINES 29 (2011).

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

[45]L.C. v. Peru, CEDAW Committee, No. 22/2009, ¶ 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011);

[46]*See, e.g.*, **Ecuador**, ¶ 11, U.N. Doc. CCPR/C/79/Add.92 (1998).

[47]*See, e.g.*, **Argentina**, ¶ 14, U.N. Doc. CCPR/CO/70/AR G (2000).

[48]*See, e.g.*, **Argentina**, ¶ 14, U.N. Doc. CCPR/CO/70/AR G (2000).

[49]*See, e.g.*, **Ireland**, ¶¶ 27–28, U.N. Doc. A/55/40 (2000).

[50] CRC/C/NIC/CO/4, para. 20(e)

[51] Convention on migrant workers; CRC/C/MEX/CO/3, para. 72

[52] http://www.euro.who.int/en/what-we-do/health-topics/Life-stages/maternal-and-newborn-health/facts-and-figures. Armenia has a maternal mortality rate of 28.5, while the European average is 16.

[53] UNFPA submission to OHCHR on the subject of Preventable Maternal Morbidity and Mortality and Human Rights for Inclusion into the thematic study on the subject requested by the Human Rights Council Resolution A/HRC/15/17, at 8.

[54] UNFPA submission to OHCHR on the subject of Preventable Maternal Morbidity and Mortality and Human Rights for Inclusion into the thematic study on the subject requested by the Human Rights Council Resolution A/HRC/15/17, at 8.
[55] UNFPA submission to OHCHR on the subject of Preventable Maternal Morbidity and Mortality and Human Rights for Inclusion into the thematic study on the subject requested by the Human Rights Council Resolution A/HRC/15/17, at 8-9.
[56]*LaxmiMandal v. DeenDayalHarinagar Hospital &Ors*and *Jaitun v. Maternity Home MCD, Jangapura&Ors*.The facts of each case can be found in paras 28 – 29 of the Judgment.
[57]Judgment, para.62(i)-(iii).
[58]Judgment, para.62(v).
[59]Judgment, para.62(viii).
[60]Judgment, para.62(vii).
[61]Judgment, para. 51-61.
[62]
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf at 25.
[63] Nepal Millennium Development Goals Progress Report 2010 at 48.;http://www.measuredhs.com/pubs/pdf/FR257/FR257%5B13April2012%5D.pdf at 128.
[64] http://www.mohp.gov.np/english/files/news_events/6-1-Safe-Motherhood-and-SBA-Policy.pdf
[65] http://www.guttmacher.org/pubs/abortion-services-laws.pdf at 27 & 30.
[66]Millennium Development Goals Report 2012, at p. 35 *available at* http://www.undp.org/content/dam/undp/library/MDG/english/The_MDG_Report_2012.pdf (These percentages reflect the increase from 1990-2010.)
[67] http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf at 1.
[68]Concluding Observations of the Human Rights Committee, Hungary, U.N. Doc. CCPR/CO/74/HUN, para. 11 ("The State party should take steps to protect women's life and health, through more effective family planning and contraception (art. 6)."); Add cite for right to education.
[69] See http://www.unfpa.org/webdav/site/global/shared/documents/publications/2011/Contraception.pdf at 10-11. For more information on the barriers faced by marginalized and underserved populations, see fact sheet on marginalized and underserved populations [need to make sure this accurately cross-references that fact sheet!].
[70] See http://www.mayoclinic.com/health/family-planning/MY01691
[71]http://www.who.int/hiv/topics/condoms/en/index.html
[72] Coercive population policies and practices include measures that deprive women of their right to determine the number and spacing of their children in a voluntary and informed manner. This may include laws restricting the number of children a woman may have, sterilization campaigns targeting particular groups of women, and mandating or incentivizing reproductive health service providers to fulfill quotas for sterilizations, amongst others. See, e.g., MM v. Peru; OSF, Against Her Will; VC v. Slovakia.
[73]*See* OSF, Against my Will; ; MM v. Peru; VC v. Slovakia, F.S. v. Chile
[74] Singh, S. and Darroch, JE. (2012). Adding It Up: Costs and Benefits of Contraceptive Services— Estimates for 2012, New York, NY: Guttmacher Institute and United Nations Population Fund (UNFPA) Retrieved from < http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf>.

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[78] Singh, S. and Darroch, JE. (2012). Adding It Up:Costs and Benefits of Contraceptive Services— Estimates for 2012, New York, NY: Guttmacher Institute and United Nations Population and (UNFPA) Retrieved from < http://www. guttmacher.org/pubs/AIU-2012-estimates.pdf>.

[79] ICPD POA, par. 7.3. See also ICPD, Principle 8.
[80]ICPD, para.7.2, 7.5(a), 7.12, 7.14(c).
[81]ICPD, para. 7.13.
[82]ICPD, para. 7.16.
[83]http://whqlibdoc.who.int/hq/2011/WHO_RHR_HRP_11.02_eng.pdf at 4 (would prefer a UN MDG cite of this fact if possible).
[84]ICPD, para. 7.17.
[85]ICPD, Principle 8; ICPF POA. Para. 7.3.
[86]ICPD, para. 7.12.
[87]ICPD, para.7.23(c).
[88]ICPD, para.7.14(c).
[89]ICPD, para.7.14(a).
[90]ICPD, para. 7.15.
[91]ICPD, para. 7.12.
[92]ICPD, para. 7.12.
[93] ICPD POA, para. 7.19.
[94] ICPD POA, para. 7.20.
[95]CEDAW/C/IDN/CO/5,para. 37 ("The Committee also recommends that measures be taken to guarantee effective access of women and girls to information and services regarding sexual and reproductive health and contraception in order to reduce the rate of unsafe abortions and teenage pregnancy. ")
[96]Albania, 02/12/2004, U.N. Doc. CCPR/CO/82/ALB, ¶ 14; Ecuador, 18/08/1998, U.N. Doc. CCPR/C/79/Add.92, ¶ 11; **Equatorial Guinea**, 30/07/2004, U.N. Doc. CCPR/CO/79/GNQ, ¶ 9; **Georgia**, 01/04/1997, U.N. Doc. CCPR/C/79/Add.75, ¶ 12.
[97]**Democratic Republic of Congo**, 26/04/2006, U.N. Doc. CCPR/C/COD/CO/3, ¶ 14; **Ecuador**, 18/08/1998, U.N. Doc. CCPR/C/79/Add.92, ¶ 11; **Equatorial Guinea**, 30/07/2004, U.N. Doc. CCPR/CO/79/GNQ, ¶ 9; **Hungary**, 19/04/2002, U.N. Doc. CCPR/CO/74/HUN, ¶ 11;
[98] CEDAW, Article 16.
[99]Committee on the Elimination of Discrimination against Women, General Recommendation 21: Equality in Marriage and Family Relations, ¶ 22, U.N. Doc. A/49/38 (1994).
[100] CESCR, General Comment No. 14, para 12(a); Add cite to WHO list of medicines (w/page # for contraceptives and EC)
[101]Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12) (22nd Sess., 2000), in Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 90, ¶ 14, U.N. Doc. HRI/GEN/1/Rev.5 (2001).
[102]*See* CRC/C/CRI/CO/4, para. 64(e) (Recommending the State "Ensure that girls and adolescents have free and timely access to emergency contraception and raise awareness among women and girls about their right to

emergency contraception, particularly in cases of rape."). *See also* A/HRC/14/20/Add.3, para. 85(h)(urging the State to allocate **sufficient public health funds for sterilization procedures and other modern methods of contraception.)**

[103]CESCR, Gen. Comment No. 14, para. 21.

[104] *See, e.g.*, CEDAW Committee, *Concluding Observations: Hungary*, para. 254, U.N. Doc. A/51/38 (1996); *Kazakhstan*, para. 106, U.N. Doc. A/56/38 (2001); *Slovakia*, paras. 42-43, U.N. Doc. CEDAW/C/SVK/CO/4 (2008); *see also* Human Rights Committee, *Concluding Observations: Poland*, para. 9, U.N. Doc. CCPR/CO/82/POL (2004);

[105]See, **Mauritius**, ¶ 211, U.N. Doc. A/50/38 (1995).

[106]CEDAW, Gen. Rec. No. 24, para. 14.

[107]CEDAW, General Recommendation No. 24, para. 14.

[108]See, e.g., **Argentina**, 03/11/2000, U.N. Doc. CCPR/CO/70/ARG, ¶ 14; **Georgia**, 01/04/1997, U.N. Doc. CCPR/C/79/Add.75, ¶ 12; **Poland**, 29/07/1999, U.N. Doc. CCPR/C/79/Add.110, ¶ 11.

[109]**Armenia**, 08/12/1999, U.N. Doc. E/C.12/1/Add.39, ¶ 15; **Poland**, 19/12/2002, U.N. Doc. E/C.12/1/Add.82, ¶ 28; **Poland**, 16/06/1998, U.N. Doc. E/C.12/1/Add.26, ¶ 12.

[110]**Burkina Faso**, ¶ 274, U.N. Doc. A/55/38 (2000); **Cape Verde**, ¶ 30, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); **Colombia**, ¶ 396, U.N. Doc. A/54/38 (1999); **Eritrea**, ¶ 23, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); CEDAW/C/PAN/CO/7 ,para. 43("The Committee urges the State party to improve access to health services for all women and in particular for the most vulnerable groups of women, such as indigenous, Afro- and Asian-descendant women."); CRC/C/15/Add.115, para. 51 ("The Committee recommends that the State party strengthen the existing National Reproductive and Child Health programme, targeting the most vulnerable groups of the population. ")

[111] See Oman 29/09/2006, U.N. Doc. CRC/C/OMN/CO/2, ¶ 50; **Paraguay**, 06/11/2001, U.N. Doc. CRC/C/15/Add.166, ¶ 42; **Russian Federation**, 30/09/2005, U.N. Doc. CRC/C/15/Add.274, ¶ 56;

[112]CEDAW, General Recommendation No. 24, para. 14; **Austria**, 07/05/1999, U.N. Doc. CRC/C/15/Add.98, ¶ 15; **Bangladesh**, 27/10/2003, U.N. Doc. CRC/C/15/Add.221, ¶ 60; **Barbados**, 24/08/1999, U.N. Doc. CRC/C/15/Add.103, ¶ 25; **Benin**, 12/08/1999, U.N. Doc. CRC/C/15/Add.106, ¶ 25;

[113]See **Slovakia**, 22/08/2003, U.N. Doc. CCPR/CO/78/SVK, ¶ 12. (Add additional cites, from various TMBs)

[114] See *A.S. v. Hungary*; Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, (68th Sess., 2000), *in* Compilation of General Comments and Recommendations Adopted by Human Rights Treaty Bodies, at 228, para. 20, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); CAT Committee, *Concluding Observations: Czech Republic*, paras. 12-13, U.N. Doc CAT/C/CZE/CO/4-5,(2012) [hereinafter CAT Committee, *Concluding Observations: Czech Republic* (2012)].

[115]**China**, ¶ 32, U.N. Doc. CEDAW/C/CHN/CO/6 (2006); **Czech Republic**, ¶ 24, U.N. Doc. CEDAW/C/CZE/CO/3 (2006).

[116]See **Czech Republic**, ¶ 23, U.N. Doc. CEDAW/C/CZE/CO/3 (2006); **Japan**, 19/11/1998, U.N. Doc. CCPR/C/79/Add.102, ¶ 31; **Slovakia**, 22/08/2003, U.N. Doc. CCPR/CO/78/SVK, ¶ 12.

[117]CEDAW/C/CZE/CO/3, para. 24

[118]See Committee on the Rights of the Child, General Comment 9: The Rights of Children with Disabilities, ¶ 60, U.N. Doc. CRC/C/GC/9 (2007);**China (including Hong Kong and Macao)**, 13/05/2005, U.N. Doc. E/C.12/1/Add/107, Part 1: China, ¶ 36.
[119] CRC/C/15/Add.259, para. 21; CRC/C/SGP/CO/2-3, para. 30(b).
[120]*Decreto No. 87-2005, Ley de Acceso Universal y Equitativo de Servicios de Planificación Familiar y suintegración en el Programa Nacional de Salud Sexual y Reproductiva*[Law on Universal and Equal Access to Family Planning Services and its Integration into the National Program on Sexual and Reproductive Health], DIARIO DE CENTRO AMÉRICA, No. 17, April 27, 2006 (Guat.) *available at* http://www.oj.gob.gt/es/QueEsOJ/EstructuraOJ/UnidadesAdministrativas/CentroAnalisisDocumentacionJudicial/cds/CDs%20leyes/2005/pdfs/decretos/D087-2005.pdf.
[121] *Decreto No. 87-2005*, preamble and Art. 1.
[122] *Decreto No. 87-2005*, art. 2-3, 5, 6 & 9.
[123] *Decreto No. 87-2005*, art. 13.
[124] *Decreto No. 87-2005*, art. 5.
[125] *Decreto No. 87-2005*, art. 10.
[126] *L.M. and Others v. the Government of the Republic of Namibia*, Para 80.
[127] *L.M. and Others v. the Government of the Republic of Namibia*, Para 40.
[128] Act Providing for a National Policy on Responsible Parenthood and Reproductive Health, Republic Act No. 10354, Section 2 (http://www.gov.ph/2012/12/21/republic-act-no-10354/?fb_action_ids=516802451675079&fb_action_types=og.recommends&fb_source=timeline_og&action_object_map={%2251680245167507 9%22%3A504955856216477}&action_type_map={%2251680245167507 9%22%3A%22og.recommends%22}&action_ref_map).
[129] Act Providing for a National Policy on Responsible Parenthood and Reproductive Health, Republic Act No. 10354, Section 23.
[130] Act Providing for a National Policy on Responsible Parenthood and Reproductive Health, Republic Act No. 10354, Section 23.
[131] GUTTMACHER INSTITUTE, *NEW FEDERAL PROTECTIONS EXPAND COVERAGE WITHOUT COST-SHARING OF CONTRACEPTIVES AND OTHER WOMEN'S PREVENTIVE SERVICES* (2011) *available at*http://www.guttmacher.org/pubs/gpr/14/3/gpr140324.pdf
[132]GUTTMACHER INSTITUTE, *NEW FEDERAL PROTECTIONS EXPAND COVERAGE WITHOUT COST-SHARING OF CONTRACEPTIVES AND OTHER WOMEN'S PREVENTIVE SERVICES* (2011) *available at* http://www.guttmacher.org/pubs/gpr/14/3/gpr140324.pdf
[133] *See* Seventeen Years of Reform; since the publication of this document, there have been further liberalizations of a number of abortion laws, including Uruguay, Brazil, Argentina, Luxemburg, and Mauritius.
[134] See http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf at 25 (Table 1.2). See also, worlds abortion laws map.
[135] WHO Safe abortion Guidance at 23; http://www.guttmacher.org/pubs/fb_IAW.html
[136] http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf at 1.
[137] WHO Safe abortion guidance
[138] https://centre.icddrb.org/images/WHO_Analysis_of_Causes_of_Maternal_Death_-_Khan_&_co..pdf at 1066.
[139] Pan-African Conference on Celebrating Courage and Overcoming Harmful Traditional Practices in Africa. (2011). Report on the Pan-African Conference on Celebrating Courage and Overcoming Harmful Traditional Practices, 5-7 October 2011 Retrieved from (http://au.int/en/ p/sa/sites/default/files/English%20Final%20Report%20HTP%20.pdf).

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[147] Postabortion Care Consortium. (2006). Technical guidance on youth-friendly postabortion care. Watertown, MA: Pathfinder International. Retrieved from <http://www.pathfinder.org/publications-tools/Technical-Guidance-on-Youth-Friendly-Postabortion-Care. html>.

[148] See WHO Safe abortion guidance at 95-96 (noting that third party authorization requirements and mandatory waiting periods cause delays) http://www.guttmacher.org/pubs/MandatoryCounseling.pdf; See also http://www.ncbi.nlm.nih.gov/pubmed/7672103.

[149] WHO SA guidance at 36-37, 93, 97; See also RR v. Poland; SR on Torture's 2013 report on torture in healthcare settings (cite para. Referencing RR);

[150] See WHO Safe abortion Guidance, at 95; see also http://www.guttmacher.org/pubs/abortion-services-laws.pdf

[151] See WHO Safe abortion Guidance, at 23 & 95; See also http://www.guttmacher.org/pubs/IB_AWW-Latin-America.pdf.

[152] ICPD POA, para. 7.6, 8.19 ("All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include… abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion"- para. 7.6)

[153] ICPD POA, para. 8.19.

[154] ICPD POA, para. 8.20(a).

[155] ICPD POA, para. 8.52

[156] ICPD POA, para. 8.19.

[157] ICPD POA, para. 8.25.

[158] CEDAW/C/PRY/CO/6, para.31(a)

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

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

[161] SAFE ABORTION GUIDANCE at 91-93; L.C. v. Peru, CEDAW Committee, No. 22/2009, ¶ 12(b)(i), U.N. Doc. CEDAW/C/50/D/22/2009 (2011) [hereinafter L.C. v. Peru]; CEDAW Committee, *Concluding Observations:Sri Lanka*, ¶ 283, U.N. Doc. A/57/38, Part I (2002); *See, e.g.*,L.C. v. Peru, *supra* note 8, ¶¶ 9(b)(i), 9(b)(iii); CEDAW Committee, *Concluding Observations: Sri Lanka*, ¶ 283, U.N. Doc. A/57/38, Part I (2002); CRC Committee, *Concluding Observations: Chad*, ¶30, U.N. Doc. CRC/C/15/Add.107 (1999); *Chile*, ¶56, U.N. Doc. CRC/C/CHL/CO/3 (2007); *Guatemala*, ¶ 40, U.N. Doc. CRC/C/15/Add.154 (2001); Human Rights Committee, *Concluding Observations: Guatemala*, ¶ 20, U.N. Doc. CCPR/C/GTM/CO/3 (2012); *Dominican Republic*, ¶ 15, U.N. Doc. CCPR/C/DOM/CO/5 (2012); *Panama*, ¶ 9, U.N. Doc. CCPR/C/PAN/CO/3 (2008); ESCR Committee, *Concluding Observations: Chile*, ¶ 53, U.N. Doc. E/C.12/1/Add.105 (2004); *Costa Rica*, ¶¶ 25, 46, U.N. Doc. E/C/12/CRI/CO/4 (2008); *Nepal*, ¶ 55, U.N. Doc. E/C.12/1/Add.66 (2001); Committee against Torture, *Concluding Observations: Peru*, ¶ 23, U.N. Doc. CAT/C/PER/4 (2006).

[162] LC v. Peru

[163] K.L. v. Peru (add para #)

[164] K.L. V. Peru; L.M.R. v. Argentina
[165] HRC, CO: Poland, para. 8, UN Doc. CCPR/CO/82/POL (2004).
[166] WHO Safe Abortion Guidance at 92; need to add cite for suicide! (See HRC to Ecuador - Ecuador, ¶ 11, U.N. Doc. CCPR/C/79/Add.92 (1998).
[167] Concluding Observations of the Committee on the Rights of the Child: **Chad**, ¶ 30, U.N. Doc. CRC/C/15/Add.107 (1990).
[168]*See*, *e.g.*, K.L. v. Peru, Human Rights Committee, No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005) [hereinafter K.L. v. Peru]; L.M.R. v. Argentina, Human Rights Committee, No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011) [hereinafter L.M.R. v. Argentina]; L.C. v. Peru, *supra* note 8; *Rep. of the Special Rapporteur on the right to health*, *supra* note 10, ¶ 29. (ADD COs maybe?)
[169] CEDAW/C/KWT/CO/3-4, para 43(b) ("The Committee urges the State party… To abolish, as a matter of priority, the requirement of a male guardian's consent to urgent or non-urgent medical treatment of a woman"); ("The Special Rapporteur believes that ability to consent to a procedure should be determined on a case-by-case basis, taking into account the maturity of the minor in question, and her understanding of the procedure and its risks.") A/HRC/14/20/Add.3 ,para. \.
[170] CEDAW: Costa Rica ¶ 32 U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011) ("The Committee... is concerned that women do not have access to legal abortion because of the lack of clear medical guidelines outlining when and how a legal abortion can be conducted." ; CEDAW: Kuwait ¶ 42, 43 U.N. Doc. CEDAW/C/KWT/CO/3-4 (2011) ("The absence of clarity about the medical standard establishing grounds for abortion in the cases of rape and incest is yet another source of concern.")
[171]CEDAW/C/POL/CO/6, para.25; A/HRC/14/20/Add.3, para. 50.
[172]A/HRC/14/20/Add.3, para. 50
[173]E/C.12/POL/CO/5, para. 28.
[174]A/HRC/14/20/Add.3, para. 50
[175] CRC/C/15/Add.115, para. 32, 33, 49.
[176] CEDAW Committee, *General Recommendation No. 24*, *supra* note 12, ¶ 12(d) (identifying violations of medical confidentiality as a form of discrimination against on women); Convention on the Elimination of All Forms of Discrimination against Women, art. 2(b), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1981) [hereinafter CEDAW] (requiring States to "adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women.").(ADD COs maybe?)
[177] CAT/C/CR/32/5 , para. 7(m); *See also* CEDAW Committee, *Concluding Observations: Chile*, ¶ 229, U.N. Doc. A/54/38 (1999); *Rep. of the Special Rapporteur on the right to health*, *supra* note 10, ¶ 30. (Review these to alter language)
[178] Colombia Constitutional Court, C-355/2006.
[179]Colombia Penal Code, Article 122. (ADD quote of what it said).
[180]Colombia Constitutional Court, C-355/2006.(translation from WLWW doc - cite doc.)
[181]Guttmacher Institute, Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies 22(2012).
[182] http://www.prochoice.org/education/resources/med_history_overview.html
[183]http://www.mayoclinic.com/health/medical-abortion/MY00819
[184]http://www.astra.org.pl/pdf/publications/tool6.pdf
[185] http://gynuity.org/downloads/Medical_abortion_brief_2009_2.pdf at 3.
[186]http://www.ancic.asso.fr/textes/ressources/techniques_priseencharge.html; http://www.has-sante.fr/portail/upload/docs/application/pdf/2011-04/ivg_2001_-_recommandations_revues_2010_2011-04-28_15-29-11_241.pdf
[187] http://www.france24.com/en/20121001-france-cover-100-percent-abortion-costs - find better cite!
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[189]Choice on Termination of Pregnancy Act 1996, Section 1.
[190]Choice on Termination of Pregnancy Act 1996, Section 2(b).
[191]Choice on Termination of Pregnancy Act 1996, Section 3.
[192]Choice on Termination of Pregnancy Act 1996, Section 5(3).
[193]Choice on Termination of Pregnancy Act 1996, Section 4.
[194]*See*Guttmmacher Institute, Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies 11 -12(2012).

[195] Interrupcíon Voluntaria del Embarazo, Ley Nº 18.987, Publicada D.O. 30 oct/012 - Nº 28585, Articles 2 & 6(c) (available at http://www.parlamento.gub.uy/leyes/AccesoTextoLey.asp?Ley=18987&Anchor=).
[196] Interrupcíon Voluntaria del Embarazo, Ley Nº 18.987, Publicada D.O. 30 oct/012 - Nº 28585, Article 3.
[197] Interrupcíon Voluntaria del Embarazo, Ley Nº 18.987, Publicada D.O. 30 oct/012 - Nº 28585, Article 6.
[198]Guttmacher Institute and IPPF, *Facts on the Sexual and Reproductive Health Of Adolescent Women in the Developing World,* http://www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf
[199] http://www.guttmacher.org/pubs/gpr/14/3/gpr140317.html ("There is now clear evidence that sexuality education programs can help young people to delay sexual activity and improve their contraceptive use when they begin to have sex.").
[200] ADD CIte for health risks of adolescent pregnancies

[201] Michelle J. Hindin and AdesegunO. Fatusi, *Adolescent Sexual and Reproductive Health in Developing Countries: In Overview of Trends and Interventions* 58, International Perspectives on Sexual and Reproductive Health Vol. 35 No.2 (June 2009)
[202]http://www.guttmacher.org/pubs/gpr/14/3/gpr140317.html ("There is now clear evidence that sexuality education programs can help young people to delay sexual activity and improve their contraceptive use when they begin to have sex.").
[203]See http://www.who.int/school_youth_health/media/en/90.pdf
[204] UNESCO International Technical Guidance on Sexuality Education, Volume III at 17-20.
[205] See, e.g., http://unesdoc.unesco.org/images/0018/001832/183281e.pdf at 18-22; http://unesdoc.unesco.org/images/0018/001884/188495e.pdf at 20-22 & http://www.un.org/esa/population/cpd/cpd2012/Agenda%20item%208/Decisions%20and%20resolution/Resolution%202012_1_Adolescents%20and%20Youth.pdf, para. 26.
[206] See INTERIGHTS v. Croatia.
[207] See http://www.guttmacher.org/pubs/gpr/14/3/gpr140317.html. See also http://reproductiverights.org/sites/crr.civicactions.net/files/documents/WEB_pub_fac_sexed_10.10.pdf.
[208] For information on the criminalization of access to information, See, e.g., http://www.un.org/ga/search/view_doc.asp?symbol=A/66/254 (Anand grover's criminalization report UN DOC. A/66/254).
[209] See, e.g., http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=12964&LangID=E; http://www.ilga-europe.org/home/guide/country_by_country/lithuania/lithuania_and_the_law_against_propaganda_of_homosexuality_and_bisexuality/ban_on_information_about_homosexuality_reintroduced_in_lithuanian_law_president_s_draft_returned_for_consideration_once_again
[210] ICPD POA, para. 7.3.
[211] ICPD POA, Principle 8.
[212] ICPD POA, Principle 10.
[213] ICPD POA, para. 7.6.
[214] ICPD POA, para. 7.23(a) & 7.23 (b).
[215] ICPD POA, para. 7.20.
[216] ICPD POA, para. 7.46.
[217] ICPD POA, para. 7.5(a).
[218] ICPD Poa, para. 6.7(c), 7.42.

[220] ICPD POA, para. 7.41 & 7.47; ICPD POA, para.6.4; ICPD POA, para. 7.37.
[221] ICPD POA, para. 7.37.
[222]Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12), ¶ 11, U.N. Doc. E/C.12/2000/4 (2000).
[223]Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest

Attainable Standard of Health (Art. 12), ¶ 12(b), U.N. Doc. E/C.12/2000/4 (2000).
[224]CEDAW, Gen Rec. No. 24 (need para. #).
[225]Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12), ¶ 21, U.N. Doc. E/C.12/2000/4 (2000).
[226]See **Ireland**, ¶ 52, U.N. Doc. CRC/C/IRL/CO/2 (2006).
[227]See, e.g., **Dominican Republic**, ¶ 349, U.N. Doc. A/53/38 (1998); **Togo**, ¶ 29, U.N. Doc. CEDAW/C/TOG/CO/5 (2006); **Uganda**, ¶ 338, U.N. Doc.A/50/38 (1995).
[228]**Belize**, ¶¶ 56–57, U.N. Doc. A/54/38 (1999); **Chile**, ¶¶ 226–227, U.N. Doc. A/54/38 (1999); **Greece**, ¶¶ 207–208, U.N. Doc. A/55/38 (1999); **Saint Vincent and the Grenadines**, ¶ 147, U.N. Doc. A/52/38/Rev.1 (1997); **Togo**, ¶ 29, U.N. Doc. CEDAW/C/TOG/CO/5 (2006); **United Kingdom of Great Britain and Northern Ireland**, ¶¶ 309–310, U.N. Doc.A/54/38 (1999).
[229]See, e.g., **Belize**, ¶ 56, U.N. Doc. A/54/38 (1999); **Nepal**, ¶ 148, U.N. Doc.A/54/38 (1999).
[230]**Belize**, ¶¶ 56–57, U.N. Doc. A/54/38 (1999); **Burundi**, ¶ 62, U.N. Doc. A/56/38 (2001); **Cape Verde**, ¶ 29, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); **Greece**, ¶¶ 207–208, U.N. Doc. A/55/38 (1999); **Slovakia**, ¶ 92, U.N. Doc. A/53/38/Rev.1 (1998); **Slovenia**, ¶ 119, U.N. Doc. A/52/38/Rev.1 (1997); **Spain**, ¶ 266, U.N. Doc. A/54/38 (1999).
[231]See, e.g., **Cape Verde**, ¶ 29, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); **Togo**, ¶ 28, U.N. Doc. CEDAW/C/TOG/CO/5 (2006).
[232]Committee on the Rights of the Child, General Comment 4: Adolescent Health and Development in the Context of the Convention of the Rights of the Child, ¶ 26, U.N. Doc. CRC/GC/2003/4 (2003).
[233]Committee on the Elimination of Discrimination against Women, General Recommendation 24: Women and Health, ¶ 23, U.N. Doc. A/54/38/Rev.1 (1999); *See***Turkmenistan**, ¶¶ 30–31, U.N. Doc. CEDAW/C/TKM/CO/2 (2006); Add more cites!
[234]Committee on the Rights of the Child, General Comment 4: Adolescent Health and Development in the Context of the Convention of the Rights of the Child, ¶ 28, U.N. Doc. CRC/GC/2003/4 (2003).
[235] *See, e.g.*, Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*,¶ 10 (2000), U.N. Doc. HIR/GEN/1/Rev.9 (Vol. I), at 168 (2008); CEDAW Committee, *Concluding Observations: Benin*, ¶158, U.N. Doc. A/60/38 (2005); *Bosnia and Herzegovina*, ¶ 36, U.N. Doc. CEDAW/C/BIH/CO/3 (2006); *Burkina Faso*, ¶ 350, U.N. Doc. A/60/38 (2005); *Cape Verde*, ¶ 30, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); *Eritrea*, ¶ 23, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); *Lebanon*, ¶ 112, U.N. Doc. A/60/38 (2005); CRC Committee, *Concluding Observations: Antigua and Barbuda*, ¶ 54, U.N. Doc. CRC/C/15/Add.247 (2004); *Chile*, ¶ 56, U.N. Doc. CRC/C/CHI/CO/3 (2007); *Colombia*, ¶ 71, U.N. Doc. CRC/C/COL/CO/3 (2006); ESCR Committee, *Concluding Observations: Benin*, ¶ 42, U.N. Doc. E/C/12/1/Add.78 (2002); *Bolivia*, ¶ 43, U.N. Doc. E/C.12/1/Add.60 (2001); *Mexico*, ¶ 43, U.N. Doc. E/C.12/1/Add.41 (1999); Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, ¶ 65(l), U.N. Doc A/66/254 (2011). – Cites pulled from Monitoring Tool. Need to go through and determine which are appropriate; See also *Report of the Special Rapporteur on the Right to Education, UN Doc. A/65/162.*
[236]**Antigua and Barbuda**, ¶ 267, U.N. Doc.

A/52/38/Rev.1, Part II (1997); **Belize**, ¶¶ 56–57, U.N. Doc. A/54/38 (1999); **Bosnia and Herzegovina**, ¶ 36, U.N. Doc. CEDAW/C/BIH/CO/3 (2006);

[237]**Jamaica**, ¶ 224, U.N. Doc. A/56/38 (2001); **Nicaragua**, ¶ 303, U.N. Doc. A/56/38 (2001); **Saint Vincent and the Grenadines**, ¶ 147, U.N. Doc. A/52/38/Rev.1 (1997); **Zimbabwe**, ¶ 161, U.N. Doc.A/53/38 (1998).

[238]CEDAW/C/OMN/CO/1, para.41(b)

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

[240]**Cape Verde**, ¶ 30, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); **Dominican Republic**, ¶ 349, U.N. Doc. A/53/38 (1998); **Ghana**, ¶ 32, U.N. Doc. CEDAW/C/GHA/CO/5 (2006);

[241] Committee on the Rights of the Child, General Comment 4: Adolescent Health and Development in the Context of the Convention of the Rights of the Child, ¶ 30, U.N. Doc. CRC/GC/2003/4 (2003).

[242]http://www.corteconstitucional.gov.co/relatoria/2012/t-627-12.htm at 1. See also http://www.womenslinkworldwide.org/wlw/new.php?modo=detalle_proyectos&dc=67.

[243]http://www.corteconstitucional.gov.co/relatoria/2012/t-627-12.htmat ??

[244]http://www.corteconstitucional.gov.co/relatoria/2012/t-627-12.htm Para. 56, ("*porque uno de los mecanismos para perpetuar la discriminación histórica sufrida por las mujeres ha sido y continúa siendo, precisamente, negar u obstaculizar el acceso a información veraz e imparcial en este campo [de los derechos reproductivos] con el objetivo de negarles el control sobre este tipo de decisiones*")

[245]http://www.corteconstitucional.gov.co/relatoria/2012/t-627-12.htmat ??

[246]http://www.corteconstitucional.gov.co/relatoria/2012/t-627-12.htmat ??

[247] http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/ED/pdf/CostingStudy.pdf at 26-27; http://data.unaids.org/pub/Report/2008/estonia_2008_country_progress_report_en.pdf at 15.

[248] http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/ED/pdf/CostingStudy.pdf at 30.

[249] http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/ED/pdf/CostingStudy.pdf at 30.

[250]http://www.ippfen.org/NR/rdonlyres/7DDD1FA1-6BE4-415D-B3C2-87694F37CD50/0/sexed.pdf at 51.

[251]http://www.ippfen.org/NR/rdonlyres/7DDD1FA1-6BE4-415D-B3C2-87694F37CD50/0/sexed.pdf at 51.

[252]http://www.ippfen.org/NR/rdonlyres/7DDD1FA1-6BE4-415D-B3C2-87694F37CD50/0/sexed.pdf at 51.

[253] http://www.grapevine.is/News/ReadArticle/Government-Earmarks-Millions-For-Sexual-Violence-Education

[254] http://www.grapevine.is/News/ReadArticle/Government-Earmarks-Millions-For-Sexual-Violence-Education

[255] http://www.guttmacher.org/pubs/ParentalInvolvementLaws.pdf; Center for Reproductive Rights, *Parental Involvement Laws*, http://reproductiverights.org/en/project/parental-involvement-laws (Jan.1, 2009); http://www.ippf.org/resources/publications/how-can-parents-effectively-support-autonomous-decision-making-young-people at 4.; *See* Center for Reproductive Rights, *The Reproductive Rights of Adolescents: A Tool for Health and Empowerment*, at 8 (Sept. 2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/adolescents%20bp_FINAL.pdf .

[256]*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.

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

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

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

[260] United Nations Population Fund (UNFPA), State of the World Population 2004, http://www.unfpa.org/swp/2004/pdf/en_swp04.pdf

[261] http://www.unfpa.org/webdav/site/global/shared/safemotherhood/docs/maternalhealth_factsheet_en.pdf

[262] http://www.guttmacher.org/pubs/journals/2702395.html

[263] *See* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_Tanzania_Shadow_Letter_2012.pdf; CRC/C/TZA/CO/2, para. 56(c); CEDAW/C/BLZ/CO/4, para. 23-24.

[264] ICPD Poa, para. 6.7(a),

[265] ICPD Poa, para. 6.7(a), 6.15; CRC, Art.XX(Right to health).

[266] ICPD Poa, para. 7.45.

[267] ICPD Poa, para. 7.41.

[268] ICPD Poa, para. 6.15.

[269] ICPD Poa, para. 7.45.

[270] http://www.unicef-irc.org/publications/pdf/evolving-eng.pdf at ix (

[271] ICPD Poa, para. 7.44(a).

[272] ICPD Poa, para. 7.45.

[273] CRC, Gen. Comment No. 4, para. 1; See also http://www.unicef-irc.org/publications/pdf/evolving-eng.pdf- Maybe add more cites to show the general acknowledgment of this?

[274] Committee on the Rights of the Child, General Comment 4: Adolescent Health and Development in the Context of the Convention of the Rights of the Child, ¶ 31, U.N. Doc. CRC/GC/2003/4 (2003).

[275] Committee on the Elimination of Discrimination against Women, General Recommendation 24: Women and Health, ¶ 23, U.N. Doc. A/54/38/Rev.1 (1999); *See* **Turkmenistan**, ¶¶ 30–31, U.N. Doc. CEDAW/C/TKM/CO/2 (2006); Add more cites!

[276] CEDAW Committee, GR 24, para.

[277] **Austria**, 07/05/1999, U.N. Doc. CRC/C/15/Add.98, ¶ 15; **Bangladesh**, 27/10/2003, U.N. Doc. CRC/C/15/Add.221, ¶ 60; **Barbados**, 24/08/1999, U.N. Doc. CRC/C/15/Add.103, ¶ 25; **Benin**, 12/08/1999, U.N. Doc. CRC/C/15/Add.106, ¶ 25; E/C.12/PER/CO/2-4, para. 21.

[278] See CEDAW/C/SGP/CO/3, para.14.

[279] See **Oman** 29/09/2006, U.N. Doc. CRC/C/OMN/CO/2, ¶ 50; **Paraguay**, 06/11/2001, U.N. Doc. CRC/C/15/Add.166, ¶ 42; **Russian Federation**, 30/09/2005, U.N. Doc. CRC/C/15/Add.274, ¶ 56; CRC/C/TJK/CO/2, para. 54-55

[280] CRC/C/SEN/CO/2, para. 54-55; CRC/C/ARG/CO/3-4, para. 68; CEDAW/C/LCA/CO/6, para. 28

[281] CRC, Article 23(1)?? – check Article!

[282] Add cite; While rates of sexual violence are extremely difficult to gauge due to high rates of non-reporting and lack of routine statistics collection, a 2005 World Health Organization survey found that over 50 percent of women in some places were victimized by sexual violence during

their lifetimes. (see http://whqlibdoc.who.int/publications/2010/9789241564007_eng.pdf at 12-13; http://www.who.int/gender/violence/who_multicountry_study/Chapter3-Chapter4.pdf at 28 (Table 4.1 & Figure 4.1 & 4.2) and http://www.who.int/gender/violence/who_multicountry_study/Chapter5-Chapter6.pdf at 44 (Table 5.1))

[283] Add COs.
[284] Ley. No. 29, AsambleaLegislativa, QueGarantiza la salud y la Educacion de la AdoescenteEmbarazada (Jun. 13, 2002), Art. 1.
[285] Ley. No. 29, AsambleaLegislativa, QueGarantiza la salud y la Educacion de la AdoescenteEmbarazada (Jun. 13, 2002), Art. 4.
[286] Ley. No. 29, AsambleaLegislativa, QueGarantiza la salud y la Educacion de la AdoescenteEmbarazada (Jun. 13, 2002), Art. 5.
[287] Ley. No. 29, AsambleaLegislativa, QueGarantiza la salud y la Educacion de la AdoescenteEmbarazada (Jun. 13, 2002), Art. 7.
[288] Ley. No. 29, AsambleaLegislativa, QueGarantiza la salud y la Educacion de la AdoescenteEmbarazada (Jun. 13, 2002), Art. 10.
[289] http://www.youth-policy.com/Policies/Uganda%20National%20Youth%20Policy.pdf at para. 4.0.
[290] http://www.youth-policy.com/Policies/Uganda%20National%20Youth%20Policy.pdf at paras. 2.6 & 5.5.
[291] http://www.youth-policy.com/Policies/Uganda%20National%20Youth%20Policy.pdf at 8.4.
[292] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086960
[293]http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086960 at 1.
[294]http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086960 at 1.
[295]http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086960 at 2-3.
[296]http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086960 at 3-4.
[297] *See* CESCR, General Comment No. 20; CAT, General Comment No. 2; CAT/C/PRY/CO/4-6, para. 19(d).
[298] See http://www.unicef.org/cbsc/index_55850.html;
[299] Such groups include persons with disabilities, indigenous persons, ethnic minorities, transgender and intersex people and women living with HIV.
[300] http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G11/170/75/PDF/G1117075.pdf?OpenElement), para. 40.
[301] ICPD POA, para. 3.19, 7.16 & 8.8, 8.17.
[302] ICPD POA, para. 6.22.
[303] ICPD POA, para. 6.25 (referring to indigenous populations) &6.30 ("Governments should eliminate specific forms of discrimination that persons with disabilities may face with regard to reproductive rights, household and family formation")
[304] ICPD POA, para. 6.20 & 6.30.
[305] ICPD POA, para. 6.25.
[306] ICPD POA, para. 6.24(b).
[307] ICPD POA, para. 6.24(a), 6.28, 6.16
[308] ICPD POA, para. 6.29(a).
[309] ICPD POA, para. 6.30.
[310] ICPD POA, para. 6.16.
[311] ICPD POA, para. 7.2 (emphasis added).
[312] CESCR, Gen. Comment no. 14, para. 18; CESCR, Gen. Comment No. 20
[313] See CESCR, General Comment 14, para. 12 (Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds"); CEDAW/C/PAN/CO/7, para.43; CRC/C/15/Add.115, para.51; E/C.12/NDL/CO/4-5, para.27; E/C.12/MKD/CO/1, para. 46.
[314]CRC/C/15/Add.136, para. 39. ;CESCR, General Comment No. 14, para. 37.

[315] See CESCR, General Comment 14, para. 12 (Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds"); Add cites!
[316] CEDAW/C/UKR/CO/7,para.39; CRC/C/LVA/CO/2, para.27(b).
[317] CEDAW, Arts. 1 & 2 (add other hr treaties)
[318] CESCR, General Comment No. 3, para. 12; CESCR, Gen. Comment no. 14, para. 18.
[319] CEDAW/C/UKR/CO/7, para.25; CRC/C/THA/CO/3-4, para.62(b).
[320] **CRC/C/GBR/CO/4, para.25(b); CERD/C/MAR/CO/17-18, para. 20.**
[321] CRC/C/GBR/CO/4, para.25(c).
[322] CRC/C/15/Add.259, para. 21; CRC/C/SGP/CO/2-3, para. 30(b).
[323] Bolivian Constitution, Art. 14(II).
[324] Bolivian Constitution, Art. 30.
[325] Article 66 ("Se garantiza a las mujeres y a los hombres el ejercicio de sus derechos sexuales y sus derechos reproductivos.")
[326] Human Rights Act, Article 3(1)
[327] Human Rights Act, **Art. 3(2)**
[328] http://www.mcgilldaily.com/2011/09/canadian-human-rights-act-amended-to-include-aboriginal-citizens/
[329] http://www.aadnc-aandc.gc.ca/eng/1100100016600/1100100016641
[330] *See* http://www.cbc.ca/news/canada/story/2012/06/18/aboriginal-human-rights-complaints.html
[331] Act No. 5-2011 of 25 February 2011 On the Promotion and Protection of Indigenous Populations, Art. 2.
[332] Act No. 5-2011 of 25 February 2011 On the Promotion and Protection of Indigenous Populations, Art. 3.
[333] Act No. 5-2011 of 25 February 2011 On the Promotion and Protection of Indigenous Populations, Art. 17.
[334] Act No. 5-2011 of 25 February 2011 On the Promotion and Protection of Indigenous Populations, Art. 17.
[335] http://www.who.int/gho/hiv/en/index.html
[336] http://www.slideshare.net/UNAIDS/2012-unaids-epidemiology-slides, slide 4 (indicating that 23.5 out of 34.2 million people living with HIV are in sub-Saharan Africa).
[337] WHO, PMTCT Strategic Vision 2010-2015: Preventing Mother-to-Child Transmission of HIV to Reach the UNGASS and Millennium Development Goals 6 (2010) available at http://www.who.int/hiv/pub/mtct/strategic_vision.pdf; Who, Dept. of hIV/AIDS, Prevention of Mother-to-Child Transmission (PMTCT): Briefing Note 3 (oct. 1, 2007), available at http://www.who.int/hiv/pub/toolkits/PmTCT%20hIV%20Dept%20brief%20oct%2007.pdf.
[338] http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2225_UNAIDS_datatables_en.pdf at 2.
[339] http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2225_UNAIDS_datatables_en.pdf at 7.
[340] See http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G10/178/42/PDF/G1017842.pdf?OpenElement; http://www.ohchr.org/Documents/Publications/HandbookHIVNHRIs.pdf; http://www.ohchr.org/Documents/Issues/HIV/ConsolidatedGuidelinesHIV.pdf
[341] See, e.g., CRR, Dignity Denied; OSF, Against her Will.
[342] http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf at 8.
[343] See generally http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf
[344] http://www.unfpa.org/swp/2005/english/ch4/chap4_page1.htm
[345] See, e.g., See, e.g., Yakin ertürk, Report of the Special Rapporteur on Violence against Women; Amnesty International, Women, HIV/AIDS and Human rights 4–8 (2004), available at http://www.amnesty.org/en/library/asset/ACT77/084/2004/en/1358d0afd55f-11dd-bb24-1fb85fe8fa05/act770842004en.pdf
[346] Amnesty International, Women, HIV/AIDS and Human rights 9 (2004), available at http://www.amnesty.org/en/library/asset/ACT77/084/2004/en/1358d0af-d55f-11dd-bb24-1fb85fe8fa05/act770842004en.pdf
[347] UNAIDS, Factsheet, HIV/AIDS, gender and Violence against Women, available at http://www.unfpa.org/hiv/docs/factsheet_vaw.pdf; amnesty international, Women, HIV/AIDS and human rights 4–8 (2004), available at http://www.amnesty.org/en/library/asset/ACT77/084/2004/en/1358d0afd55f-11dd-bb24-1fb85fe8fa05/act770842004en.pdf

[348] http://www.amfar.org/about_hiv_and_aids/facts_and_stats/statistics__women_and_hiv_aids/
[349] ICPD POA, Para. 7.33.
[350] ICPD POA, Para. 7.29.
[351] ICPD POA, Para. 8.29(b).
[352] ICPD POA, Para. 8.29(b).
[353] ICPD POA 8.31.
[354] ICPD POA, Para. 7.28.
[355] ICPD POA, Para. 8.30.
[356] ICPD POA, Para. 8.29(b).
[357] ICPD POA, Para. 8.29(b) ("Services to detect HIV infection should be strengthened, making sure that they ensure confidentiality").
[358]See **Ethiopia**, ¶ 161, U.N. Doc. A/51/38 (1996).
[359]See CESCR, General Comment No. 14, para. 12(b); **United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories**, ¶ 40, U.N. Doc. E/C.12/1/Add.79 (2002); See **Kenya**, ¶ 15, U.N. Doc. CCPR/CO/83/KEN (2005).
[360]See, e.g., **Honduras**, ¶¶ 26, 47, U.N. Doc. E/C.12/1/Add.57 (2001); **Zambia**, ¶ 30, U.N. Doc. E/C.12/1/Add.106 (2005).
[361] See **Sudan**, ¶ 27, U.N. Doc. E/C.12/1/Add.48 (2000); See also OHCHR, International Guidelines on HIV/AIDS and Human Rights at 18, *available at* http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf
[362] **Burkina Faso**, ¶ 276, U.N. Doc. A/55/38 (2000); **Burundi**, ¶ 60, U.N. Doc. A/56/38 (2001); **Cameroon**, ¶ 60, U.N. Doc. A/55/38 (2000); (ADD CITE for female condoms); See also OHCHR, International Guidelines on HIV/AIDS and Human Rights at 26, *available at* http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf
[363] **Mali**, ¶ 57, U.N. Doc. CRC/C/MLI/CO/2 (2007).
[364] **Togo**, ¶ 47, U.N. Doc. CRC/C/15/Add.83 (1997); **Turkey**, ¶ 54, U.N. Doc. CRC/C/15/Add.152 (2001); **Viet Nam**, ¶ 46, U.N. Doc. CRC/C/15/Add.200 (2003);
[365] CRC, Gen. Com. 3, (Need para. #)
[366]CRC/C/15/Add.206, para.51(d)..
[367] CRC/C/BTN/CO/2, para 59(d); CRC/C/KAZ/CO/3, para. 54(d).
[368] CRC, Gen. Com. 3, (Need para. #);
[369] See ESCR Committee, General Comment No. 20, para. 33 .
[370] ICESCR, Art. 129c); CESCR General Comment No, 14, para. 16; See also OHCHR, International Guidelines on HIV/AIDS and Human Rights at 38, *available at* http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf
[371] CEDAW, Gen Rec. No. 24, para. 22.
[372] See CEDAW, General Rec. no. 24, para. 22.
[373]CRC/C/BEN/CO/2, para.58(f).
[374]**Latvia**, ¶ 40,U.N. Doc. CRC/C/15/Add.142 (2001); **Lesotho**, ¶ 46, U.N. Doc. CRC/C/15/Add.147 (2001); **Lithuania**, ¶ 40, U.N. Doc. CRC/C/15/Add.146 (2001);
[375]See, e.g., **Republic of Moldova**, ¶ 31, U.N. Doc. CEDAW/C/MDA/CO/3 (2006); **Myanmar**, ¶ 96, U.N. Doc. A/55/38 (2000).
[376]See **Lithuania**, ¶ 12, U.N. Doc. CCPR/CO/80/LTU (2004).
[377]See **People's Republic of China**, **Hong Kong and Macao**, ¶ 60, U.N. Doc. E/C.12/1/Add.107 (2005).
[378] CEDAW/C/ZMB/CO/5-6, para. 36(a); CEDAW/C/UGA/CO/7, para. 46
[379]See **Antigua and Barbuda**, ¶ 261, U.N. Doc. A/52/38/Rev.1, Part II (1997).
[380] CEDAW, General Rec. 15 (Need para. #)
[381]SR on the right to health. Para. 76(a) and 76(c), U.N. Doc.A/HRC/14/20 (2010).
[382] Ley No. 238, Ley de Promoción, protección y Defensa de los Derechos Humanos ante el SIDA, el 6 de diciembre de 1996, available at http://www.hsph.harvard.edu/population/aids/nicaragua.aids.96.pdf.

[383] Ley No. 238, Ley de Promoción, protección y Defensa de los Derechos Humanos ante el SIDA, el 6 de diciembre de 1996, Art. 1.
[384] Ley No. 238, Ley de Promoción, protección y Defensa de los Derechos Humanos ante el SIDA, el 6 de diciembre de 1996, Art. 26.
[385] Ley No. 238, Ley de Promoción, protección y Defensa de los Derechos Humanos ante el SIDA, el 6 de diciembre de 1996, Art. 22, 24, & 25.
[386] Ley No. 238, Ley de Promoción, protección y Defensa de los Derechos Humanos ante el SIDA, el 6 de diciembre de 1996, Art. 32-33.
[387]Republic Act 8504, The Phiippine AIDS Prevention and Control Act of 1998, Sec 2(b).
[388]Republic Act 8504, The Phiippine AIDS Prevention and Control Act of 1998, Sec 2(b).
[389] Republic Act 8504, The Phiippine AIDS Prevention and Control Act of 1998, Sec 15.
[390] Republic Act 8504, The Phiippine AIDS Prevention and Control Act of 1998, Sec 15.
[391]Republic Act 8504, The Phiippine AIDS Prevention and Control Act of 1998, Sec 2(b).
[392]Republic Act 8504, The Phiippine AIDS Prevention and Control Act of 1998, Sec 2(d).
[393] http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127584.pdf
[394]http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127584.pdf at 3.
[395] http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127584.pdf at 54.
[396] http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127584.pdf at 64.
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[398] http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127584.pdf at 55-57.
[399] Constitutional Court of South Africa, Case CCT 8/02, para. 10-11.

[400] Constitutional Court of South Africa, Case CCT 8/02, para. 135.
[401] Constitutional Court of South Africa, Case CCT 8/02, para. 135.

[404] Constitutional Court of South Africa, Case CCT 8/02, para. 135.
[405] Gender-based violence may be directed at other populations, such as transgender and gender nonconforming individuals, but we focus here on the reproductive health implications of gender-based violence directed at women and girls.
[407] ICPD POA, para. 7.39.
[408] ICPD POA, para. 6.9.
[409] ICPD POA, para. 5.10.
[410] ICPD POA, para. 7.11 & 9.19.
[411] ICPD POA, para. 7.11.
[412] ICPD POA, para. 7.39.
[413] ICPD POA, para. 7.39.
[414] ICPD POA, para. 4.9.
[415] CEDAW, General Rec. no. 19, para. 6
[416] CEDAW, Art. 2(b) (ADD other discrimination prohibitions from ICCPR, CESCR, CRC).
[417] CO: Jamaica, CCPR/C/JAM/CO/3, para. 19 (2011); CCPR/C/NOR/CO/6, para. 9;
[418]CEDAW/C/PER/CO/6, para.19; CCPR/C/NOR/CO/6, para. 9;
[419]CRPD/C/ESP/CO/1, para.22; A/HRC/17/26/Add.3, para.82(c).

[420] CCPR/C/MEX/CO/5, para. 21; CESCR, GC 20, para. 32 (recognizing gender identity as a prohibited grounds of discrimination and increased risk of human rights violations among transgender, transsexual or intersex persons); CESCR, GC 14, para. 18 (prohibiting discrimination in the provision of health care on the grounds of sexual orientation).
[421]CAT/C/SYR/CO/1, para. 27(c); CO: Jamaica, CCPR/C/JAM/CO/3, para. 19 (2011); CCPR/C/SMR/CO/2, para. 8
[422]CRC/C/CRI/CO/4 , para.64(e); E/C.12/KEN/CO/1, para. 33.
[423]CEDAW/C/PER/CO/6, para. 19.
[424]CEDAW/C/PER/CO/6, para. 19.
[425]CCPR/C/GTM/CO/3, para. 19.
[426] Ley 26.485, Ley de Proteccion Integral Para Prevenir, Sancionar y Eradicar la Violencia Contra Las Mujeres en los Ambitos en QueDesarrollensusRelacionesInterpersonales, Art. 2.
[427] Ley 26.485, Ley de Proteccion Integral Para Prevenir, Sancionar y Eradicar la Violencia Contra Las Mujeres en los Ambitos en QueDesarrollensusRelacionesInterpersonales, Art. 4.
[428] Ley 26.485, Ley de Proteccion Integral Para Prevenir, Sancionar y Eradicar la Violencia Contra Las Mujeres en los Ambitos en QueDesarrollensusRelacionesInterpersonales, Art. 6(d).
[429]Ley de Proteccion Integral a Las Mujeres, Decreto 1011/2010, Art.6(d).
[430] Ley 26.485, Ley de Proteccion Integral Para Prevenir, Sancionar y Eradicar la Violencia Contra Las Mujeres en los Ambitos en QueDesarrollensusRelacionesInterpersonales, Art. 6(e).
[431]Ley de Proteccion Integral a Las Mujeres, Decreto 1011/2010, Art. 6(de.
[432]http://www.svri.org/nationalguidelines.pdf
[433] Ministry of Health (Kenya), National Guidelines for the Medical Management of Rape/Sexual Violence xi.
[434] http://www.svri.org/nationalguidelines.pdf at 12.
[435] http://www.svri.org/nationalguidelines.pdf at 13.
[436] http://www.svri.org/nationalguidelines.pdf at 13.
[437] http://www.svri.org/nationalguidelines.pdf at 10-12.
[438] http://www.svri.org/nationalguidelines.pdf at 22.
[439] http://www.svri.org/nationalguidelines.pdf at 14-15.
[440] ORGANIC ACT 1/2004 OF 28 DECEMBER ON INTEGRATED PROTECTION MEASURES AGAINST GENDER VIOLENCE(*Available at* http://sgdatabase.unwomen.org/uploads/Spain%20-%20Organic%20Act%20on%20Integrated%20Measures%20against%20Gender-Based%20Violence%20%282004%29%20%28eng%29.pdf), Art. 1.
[441]ORGANIC ACT 1/2004 OF 28 DECEMBER ON INTEGRATED PROTECTION MEASURES AGAINST GENDER VIOLENCE, Art 2.
[442]ORGANIC ACT 1/2004 OF 28 DECEMBER ON INTEGRATED PROTECTION MEASURES AGAINST GENDER VIOLENCE, Art. 4-9.
[443]ORGANIC ACT 1/2004 OF 28 DECEMBER ON INTEGRATED PROTECTION MEASURES AGAINST GENDER VIOLENCE,Art. 15.
[444]ORGANIC ACT 1/2004 OF 28 DECEMBER ON INTEGRATED PROTECTION MEASURES AGAINST GENDER VIOLENCE, Title II.
[445]https://www.un.org/womenwatch/daw/egm/vaw_legislation_2009/Report%20EGM%20harmful%20practices.pdf at 8.
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http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf at 1.
[447]http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html
[448]http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html
[449] FGM has been documented among the Embera-Chami, an indigenous community in Colombia. See http://www.sofeminine.co.uk/key-debates/ending-female-genital-mutilation-colombia-d18489.html - could use better cite.

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[454] http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf at 12.
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[459] http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf p44. (over the next decade refers to 2011-2020).
[460] Health Consequences of Child Marriage in Africa, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3372345/.
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[462] ICPD PoA, para. 4.22.
[463] ICPD PoA, para. 5.5 & 7.40.
[464] ICPD PoA, para. 7.40.
[465] ICPD PoA, para. 7.40.
[466] ICPD PoA, para. 4.22.
[467] ICPD PoA, para. 7.6.
[468] ICPD PoA, para. 7.40.
[469] ICPD PoA, para. 7.41.
[470] ICPD PoA, para. 7.41.
[471] ICPD PoA, para. 4.21.
[472] Committee on the Rights of the Child, General Comment 4: Adolescent Health and Development in the Context of the Convention of the Rights of the Child (33rd Sess., 2003), ¶ ¶ 24, 39(g), U.N. Doc. CRC/GC/2003/4 (2003).
[473] See, e.g., **Lesotho**, ¶ 12, U.N. Doc. CCPR/C/79/Add.106 (1999); **Senegal**, ¶ 12,, U.N. Doc. CCPR/C/79/Add.82 (1997).
[474] Committee on Economic, Social and Cultural Rights, General Comment 16: The Equal Right of Men and Women to the Enjoyment of all Economic, Social and Cultural Rights (Art. 3) (34th Sess., 2005), ¶ 29, U.N. Doc. E/C.12/2005/4 (2005).
[475] See, e.g., **Central African Republic**, ¶ 11, U.N. Doc. CCPR/C/CAF/CO/2 (2006); **Nigeria**, ¶¶ 291, 296, U.N. Doc. CCPR/C/79/Add.65 A/51/40, (1996); **Senegal**, ¶ 12 , U.N. Doc. CCPR/C/79/Add.82 (1997); **Zimbabwe**, ¶ 12, U.N. Doc. CCPR/C/79/Add.89 (1998); See, e.g., **Burkina Faso**, ¶ 261, U.N. Doc. A/55/38 (2000); **Cameroon**, ¶¶ 53–54,U.N. Doc. A/55/38 (2000);, **Democratic Republic of the Congo**, ¶ 215, U.N. Doc. A/55/38 (2000); See also, CRC, Gen Comment No. 7.
[476] Human Rights Committee, General Comment 28: Equality of Rights Between Men and Women (Art. 3) (68th Sess., 2000), in Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 168, 11, U.N. Doc. HRI/GEN/1/Rev.5 (2001)..
[477] CRC, Art. 24(3).
[478] CEDAW, General Rec. 24, para. 15(d); See, e.g., **Mali**, ¶ 53, U.N. Doc. CRC/C/MLI/CO/2 (2007); **Sierra Leone**, ¶¶ 57-58, CRC/C/SLE/CO/2 (2008); see also Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health, para. 22; See, e.g., **Australia**, ¶ 33, U.N. Doc. CAT/C/AUS/CO/3 (2008); **Cameroon**, ¶¶ 7(b), 11(c), U.N. Doc. CAT/C/CR/31/6, (2004).
[479] **Nigeria**, ¶¶ 54–55, U.N. Doc. CRC/C/15/Add.257 (2005); **Sierra Leone**, ¶¶ 24–25, U.N. Doc. CRC/C/15/Add.116 (2000); **Timor Leste**, ¶¶ 62-63, U.N.

Doc. CRC/C/TLS/CO/1 (2008);
[480] See, e.g., **Ethiopia**, ¶ 252, U.N. Doc. A/59/38 (2004); **Gambia**, ¶ 196,U.N. Doc. A/60/38 (2005); **Kenya**, ¶ 214, U.N. Doc. A/58/38 (Part 1) (2003); **Nigeria**, ¶ 300, U.N. Doc. A/59/38 (2004); **Togo**, ¶ 15,,U.N. Doc. C/TGO/CO/5 (2006); **Yemen**, ¶ 399, U.N. Doc. A/57/38 (2002); *See, e.g.,* **Gambia**, ¶ 210, U.N. Doc. A/60/38 (2005); **Hungary**, ¶ 334, U.N. Doc. A/57/38 (2002); **Peru**, ¶ 489, U.N. Doc. A/57/38 (2002); **Serbia**, ¶ 36, U.N. Doc. CEDAW/C/SCG/CO/1 (2007); **Yemen**, ¶ 395, U.N. Doc. A/57/38 (2002).
[481]**Togo**, ¶ 48, U.N. Doc. CRC/C/15/Add.83 (1997); **Togo**, ¶¶ 57(b), 57(c), U.N. Doc. CRC/C/15/Add.255 (2005); **Uganda**, ¶ 56,, U.N. Doc. CRC/C/15/Add.270 (2005).
[482] CRC/C/SEN/CO/2, para. 51(b);
[483] See **Benin**, ¶ 47, U.N. Doc. E/C/12/BEN/CO/2 (2008); *See* **Nepal**, ¶ 209, U.N. Doc. A/59/38 (2004). (Find another cite!)
[484] See Committee on the Elimination of Discrimination against Women, *General Recommendation 21: Equality in Marriage and Family Relations*, ¶ 36, U.N. Doc. HRI/GEN/1/Rev.5 (2001); CRC, *General Comment 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, ¶ 20, U.N. Doc. CRC/GC/2003/4 (2003).
[485] Committee on the Rights of the Child, *General Comment 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, ¶ 20, U.N. Doc. CRC/GC/2003/4 (2003).
[486] Committee on the Elimination of Discrimination against Women, *General Recommendation 21: Equality in Marriage and Family Relations*, ¶ 36, U.N. Doc. HRI/GEN/1/Rev.5 (2001);
[487]*See* Div. of Reproductive Health, World Health Organization, *World Health Day, Safe Motherhood, 7 April 1998, Delay Childbearing, at* http://www.who.int/archives/whday/en/pages1998/whd98_04.html (last visited October 1, 2007; ADD TMB CITES!
[488]*See, e.g.*, **Colombia**, ¶ 76(f), U.N. Doc. CRC/C/COL/CO/3 (2006); **Kyrgyzstan**, ¶ 53, U.N. Doc. CRC/C/15/Add.244 (2004); **Mozambique**, ¶ 56(c), U.N. Doc. CRC/C/15/Add.172 (2002); **United Republic of Tanzania**, ¶¶ 24–25, U.N. Doc. CRC/C/TZA/CO/2 (2006).
[489]*See* **Mozambique**, ¶¶ 38–39, U.N. Doc. CRC/C/15/Add.172 (2002).
[490]http://apps.who.int/idhl-rils/idhl/rilsB%C3%A9nin07001.pdf, Law No. 2003-03, Art. 1-2.
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[492] Law No. 2003-03, Art. 4.
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