



A Guide in Support of National Human Rights Institutions

Country Assessments and National Inquiries on Human Rights in the Context of Sexual and Reproductive Health and Well-being



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ACRONYMS

AIDS	Acquired immune deficiency syndrome
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CERD	Committee on the Elimination of All Forms of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child CRPD Convention on the Rights of Persons with Disabilities
HIV	Human immunodeficiency virus
HRBA	Human rights-based approach
ICCPR	International Covenant on Civil and Political Rights
ICDP	International Conference on Population and Development
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
LGBTI	lesbian, gay, bisexual, transsexual and intersex people
MDGs	Millennium Development Goals MMR maternal mortality rate
NGO	Non-governmental organization
NHRI	National Human Rights Institution OHCHR Office of the High Commissioner for Human Rights
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights STIs sexually transmitted infections
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme UNFPA United Nations Population Fund
UNICEF	United Nations Children’s Fund UPR Universal Periodic Review
WHO	World Health Organization

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PREFACE

National inquiries and country assessments are practical tools that support human rights protection and monitoring. The purpose of this document is to support National Human Rights Institutions (NHRIs), including National Commissions, the office of the Ombudsperson and/or Women Commissions, to conduct systematic national inquiries on human rights issues relating to sexual and reproductive health and well-being. A conceptual and methodological framework has been developed and presented step by step as practical guidance.

A variety of state and non-state institutions, including Ministries of Health, development agencies, and international cooperation agencies, produce assessments and reports on sexual and reproductive health issues. NHRIs, however, offer a special perspective. Due to their nature as independent state bodies with a mandate for human rights protection and monitoring, NHRIs can provide a unique reading of country situations; one that puts at the centre of the analysis people as rights-holders who have entitlements and legitimate claims for a life of dignity and well-being. NHRIs also have an important role in the follow-up and review of the 2030 Agenda for Sustainable Development; providing independent qualitative and contextualised analysis and guidance on the implementation of the vast majority of targets and goals at national level, including in regards to target 5.6 on universal access to sexual and reproductive health and reproductive rights.

The right to sexual and reproductive health is a universal human right. All individuals, without distinction, are entitled to this right on an equal basis. Yet, for biological and social reasons, women and girls are uniquely affected by decisions taken concerning control of reproduction and sexuality. Adolescent girls, for example, from the moment they reach puberty, are more likely to face threats to their sexual and reproductive well-being including from sexual violence, coercion into child marriage or denial of access to the information and services that would enable them to maintain their sexual and reproductive health. Furthermore, certain population groups among them are subjected to exclusion and discrimination when it comes to their exercise of human rights in relation to their sexual and reproductive health

and well-being. NHRIs, by virtue of their monitoring and investigative work, can play a critical role in bringing these realities to the surface while exposing policy failings and the shortcomings of public and private actors in respecting rights and the effective discharge of their responsibilities.

To date, however, National Human Rights Institutions have only limited experience in conducting assessments and inquiries on human rights in the area of sexual and reproductive health and well-being. One noteworthy example, and a useful model from which to learn, is that of the Kenyan Commission on Human Rights, which undertook a specific inquiry on this theme in 2011. Building on that pioneering experience, NHRIs have made some strong commitments. NHRIs attending the Eleventh International Conference of the International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights (Amman, Jordan, November 2012) committed to “protect and promote reproductive rights without any discrimination”. They also committed to “aid the compilation of an evidence base (e.g. data, inquiries, research) concerning the exercise of reproductive rights and the right to reproductive health.”

UNFPA developed this guidance tool in support of those commitments. It is intended to help equip National Human Rights Institutions with the methodological tools needed to fulfil their human rights monitoring mandate in relation to sexual and reproductive health and to step up, on the basis of evidence and their findings, advocacy efforts to promote national processes of dialogue and policy advancement.

INTRODUCTION

Objectives of the guidance note

National Human Rights Institutions are key to the promotion and protection of human rights in their respective countries. Yet, in practice, many NHRIs have not addressed sexual and reproductive health concerns or have done so only partially. A global survey conducted jointly by UNFPA and the Danish Institute for Human Rights as well as a regional survey conducted by the Asia Pacific Forum revealed that the level of knowledge and understanding of the human rights dimension of sexual and reproductive health and well-being within NHRIs tends to be insufficient or, at best, fragmented. Often, if such rights are addressed at all, the focus is narrowed to a specific issue such as forced sterilization or sexual violence, while broader issues in the country are simply ignored. Human rights tracking systems managed by NHRIs may also lack the categories needed to enable effective monitoring of violations to human rights in the context of sexual and reproductive health and well-being. The conceptual and methodological framework provided here is designed to help address this gap in order to support the following objectives:

- Assist NHRIs to develop more comprehensive information systems on human rights in the context of sexual and reproductive health and well-being;
- Ensure a standardized approach to the assessment of human rights violations in the context of sexual and reproductive health and well-being so that there is comparability of data and information both between and within countries; and
- Provide specific methodological guidance for the conduct of country analyses and national inquiries into human rights in the context of sexual and reproductive health and well-being.

These objectives are in line with the commitment made by NHRIs at the International Conference in Amman in 2012 to *“aid the compilation of an evidence base (e.g., data, inquiries, research) concerning the exercise of reproductive rights and the right to reproductive health, including but not limited to cases of de jure and de facto discrimination in access to reproductive health care information and services, forced sterilization, forced abortion, child marriage, forced*

marriage, female genital mutilation/cutting, biased sex selection and other harmful practices” (Amman Declaration, paragraph 26).

According to the Paris Principles, the set of international standards approved by the UN General Assembly in 1993 that frame and guide the work of NHRIs, cooperation with the United Nations and its various agencies, regional institutions and with other NHRIs, is a key aspect of their work. To this end, NHRIs at the Amman conference committed to *“forge strategic partnerships with UN agencies such as UN Women, UNDP, UNICEF, UNFPA, and OHCHR to strengthen cooperation with, and the capacities of, NHRIs to more effectively promote and protect women’s and girls’ human rights”* (Amman Declaration, paragraph 11). The United Nations is committed to working within a human rights-based framework. This work entails the development of national capacities for the promotion and protection of human rights, thus making NHRIs important partners; to date, the United Nations has provided assistance to more than 60 NHRIs.

This guidance note will also assist UNFPA Country Offices to better work with NHRIs as they monitor and assess human rights in the context of sexual and reproductive health. Additionally, a more systematic engagement of NHRIs in such monitoring and assessment of rights in the context of sexual and reproductive health will help to build a much-needed information base for consideration by international human rights mechanisms and for evidence-based analysis of relevant regional and global trends.

Chapter I begins by clarifying the nature and scope of human rights in respect to sexual and reproductive health and well-being. A framework for monitoring selected violations of those rights is then presented in Chapter II, including a step by step methodology for

conducting national inquiries and country assessments as well as information on state obligations, assessing state compliance and some relevant indicators. Chapter III addresses key issues in human rights and sexual and reproductive health and well-being. Chapter IV illustrates how the steps outlined in the Guide can be

translated into practices and the value this brings to efforts to advance sexual and reproductive health and rights by providing case studies from the Philippines, Malawi, El Salvador, Azerbaijan and Guatemala.

This document's primary intent is to guide NHRIs when conducting national inquiries. A national inquiry enables an institution to review the status of human rights issues more comprehensively and, subsequently, to provide appropriate recommendations to diverse stakeholders, including about remedies to the victims. A national inquiry also serves the important function of raising public awareness of and providing information about human rights in general and specifically on the issues considered. In fact, by undertaking a national inquiry an NHRI exercises many of its powers and fulfils many of its functions. All material is designed to be used and adapted by NHRIs when implementing a range of monitoring mandates and functions, i.e. when conducting fact-finding missions; in quasi-judicial investigations, national inquiries and country assessments; for thematic studies and/or for research purposes.

BOX 1. AMMAN DECLARATION AND PROGRAMME OF ACTION

The commitment of National Human Rights Institutions to reproductive rights is expressed in the Amman Declaration and Programme of Action, approved at the Eleventh International Conference of the International Coordinating Committee (ICC) of National Institutions for the Promotion and Protection of Human Rights, which took place in Amman (Jordan) from 5 to 7 November 2012. The focus of the Conference was 'The human rights of women and girls: Promoting gender equality: The role of national human rights institutions'. Participants reaffirmed that women's and girls' rights are human rights, which are guaranteed in all human rights treaties.

The Amman Declaration and Programme of Action includes a section of commitments to women's health and reproductive rights:

- **Paragraph 25:** Protect and promote reproductive rights without any discrimination, recognizing reproductive rights include the right to the highest attainable standard of sexual and reproductive health, the right of all to decide freely and responsibly the number, spacing and timing of their children, and on matters related to their sexuality, and to have the information and means to do so free from discrimination, violence or coercion, as laid out in the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development;
- **Paragraph 26:** Encourage and aid the compilation of an evidence base (e.g. data, inquiries, research) concerning the exercise of reproductive rights and the right to sexual and reproductive health, including but not limited to cases of de jure and de facto discrimination in access to sexual and reproductive health care information and services, forced sterilization, forced abortion, child marriage, forced marriage, female genital mutilation/cutting, biased sex selection and other harmful practices;



- **Paragraph 27:** Review national laws and administrative regulations relating to reproductive rights such as those governing family, sexual and reproductive health, including laws which are discriminatory or criminalize access to sexual and reproductive health services, and propose recommendations to assist States in meeting their human rights obligations; and
- **Paragraph 28:** Promote measures to ensure access to comprehensive sexual and reproductive health information and services and to remove barriers which hinder such access, and support the establishment of accountability mechanisms for the effective application of the laws and the provision of remedies when obligations have been breached.
- Additionally, the Amman Declaration and Programme of Action contains the following broad principles and areas of work for NHRIs of relevance to reproductive rights:
- **Principle 4:** Respond to, conduct inquiries into and investigate allegations of violations of women's and girls' human rights, including...violations of reproductive rights... These investigations and reports should result in recommendations to the State to meet their obligations to ensure women's and girls' human rights, and to combat impunity;
- **Principle 9:** Monitor and encourage the implementation of ...resolutions of United Nations intergovernmental bodies, including the General Assembly, Human Rights Council, Commission on the Status of Women (CSW) and the Commission on Population and Development (CPD);
- **Principle 11:** Forge strategic partnerships with United Nations agencies such as UN Women, UNDP, UNICEF, UNFPA, and OHCHR to strengthen cooperation with, and the capacities of, NHRIs to more effectively promote and protect women's and girls' human rights; and
- **Principle 16:** Prioritize and promote the human rights of women and girls and gender equality through their engagement with all international and regional human rights mechanisms, and in their engagement with global processes such as ...the ICPD Beyond 2014 Global Review.

Towards fulfilment of this last principle, NHRIs engaged actively in the various stages of the ICPD Beyond 2014 Global Review, including through participation at the International Conference on Human Rights held in the Netherlands in July 2013. Echoing the commitments made by NHRIs at the Amman conference in 2012, the ICPD Human Rights Conference recommended the strengthening of NHRIs and ombudspersons to inquire broadly into sexual and reproductive rights issues, including by investigating individual complaints; making recommendations directly to governments on alleged human rights violations; and reviewing national laws and policies relating to sexual and reproductive rights, including those that are discriminatory or which criminalize access to sexual and reproductive health information, education and services.

The **2030 Agenda for Sustainable Development**, containing the Sustainable Development Goals (SDGs), which are the lynchpin of the global development agenda, They are designed to 'leave no one behind' and are grounded in human rights principles, such as accountability, participation and non-discrimination. They include important commitments necessary for sustainable development related to sexual and reproductive health that are also in line with States' human rights obligations. In the SDGs, States agreed to, for example to:

- Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences. (Target 5.6).
- By 2030, to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes (Target 3.7)
- **End all forms of discrimination against all women and girls everywhere (Target 5.1)**
- Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation (Target 5.2).
- Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation (Target 5.3)
- By 2030, to reduce the global maternal mortality ratio to less than 70 per 100,000 live births (Target 3.1)
- By 2030, to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases Target 3.3)
- **Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard (Target 10.3)**
- **Strengthen relevant national institutions, including through international cooperation, for building capacity at all levels, in particular in developing countries, to prevent violence and combat terrorism and crime (Target 16a)**

NHRIs can play a key role in the implementation of the SDGs, and are at the core of the Agenda's accountability framework. For example, on-going NHRI monitoring of human rights is immediately relevant for specific goals and targets, such as those above, as well as Goal 16 on peace, justice and sustainable institutions; target 4.7 on human rights education, and; targets 5.c, 10.3 and 16.b on elimination of discriminatory legislation, which would include discriminatory legislation related to SRHR.

1



CHAPTER 1

Background on the nature and scope of sexual and reproductive health and rights

A UNITED NATIONS HUMAN RIGHTS TREATIES

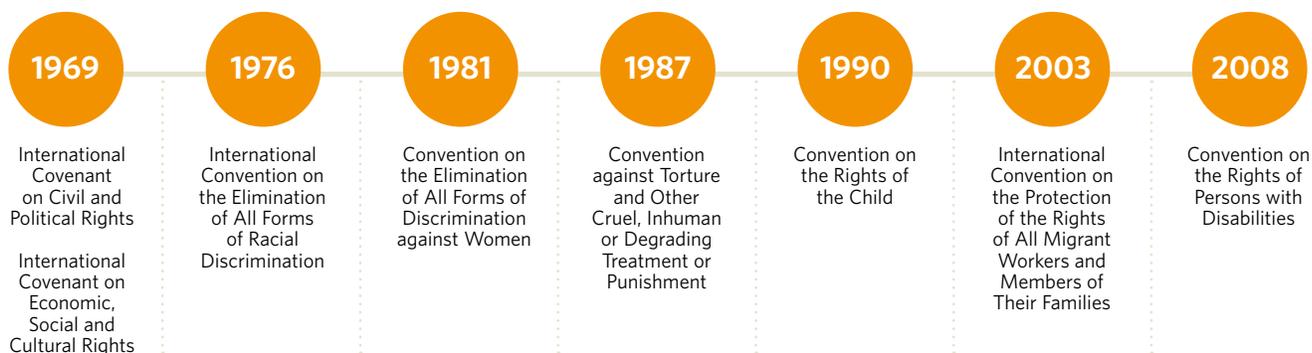
In 1994, States around the globe, under the auspices of the United Nations, gathered together in Cairo (Egypt) at the International Conference on Population and Development (ICPD). In that meeting, 179 countries agreed that population, development and human rights are inextricably linked and that empowering women and meeting people's needs for education and health, including reproductive health, are critical components of people centred development. They further recognized that reproductive rights are human rights and provided the following definition:

TIP 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 from discrimination, coercion and violence (ICPD Programme of Action, para. 7.3).

Subsequent to the ICPD, the 1995 Beijing Platform for Action² expanded these definitions by affirming, in its paragraph 96, the right to exercise control over and make decisions about one's sexuality, including sexual and reproductive health, free of coercion discrimination and violence. This has since been reiterated in a number of United Nations documents³, including through the outcomes of various monitoring and review processes of the ICPD Programme of Action and the Beijing Platform for Action.

By referring to sexual and reproductive health and reproductive rights, the ICPD Programme of Action clarifies that it is not creating new sets of rights. Rather, it encompasses both **entitlements** and **freedoms** "recognized in national laws, international human rights documents and other consensus statements" of relevance in the context of sexual and reproductive health and well-being.

Human rights standards relating to sexual and reproductive health and well-being are found in the following international human rights treaties:



Each of these major United Nations human rights treaties has a committee made up of experts mandated to monitor and provide guidance to States parties to ensure their compliance with these instruments. Amongst their several functions, treaty-monitoring bodies issue **general comments and recommendations** to clarify the content of a given right and the nature of state obligations in relation to the right, including measures that all countries should take to ensure that specific rights or issues covered by the treaty are realized. In 2016 the Committee on Economic and Social and Cultural Rights issued its General Comment No. 22, which focuses exclusively on sexual and reproductive health.

General Comment No. 22 on the Right to sexual and reproductive health; Committee on Economic, Social and Cultural rights, 7 March 2016

The General Comment cements the right to sexual and reproductive health not only as an integral part of the general right to health but fundamentally linked to the enjoyment of many other human rights, including the rights to education, work and equality, as well as the rights to life, privacy and freedom from torture, and individual autonomy. It details the obligations of States within three areas:

- An obligation to repeal, eliminate laws, policies and practices that criminalize, obstruct or undermine an individual's or a particular group's access to health facilities, services, goods and information;
- An obligation to ensure universal access to quality sexual and reproductive health care, including maternal health care, contraceptive information and services, safe abortion care; prevention, diagnosis and treatment of infertility, reproductive cancers, sexually transmitted infections and HIV/AIDS.
- An obligation to ensure all have access to comprehensive education and information that is non-discriminatory, evidence-based and takes into account the evolving capacities of children and adolescents.

The General Comment highlights how the issues are indispensable for women's right to make meaningful and autonomous decisions about their lives and health and underlines the role of gender-based stereotypes in fueling violations of their rights. It also pays special attention to other groups of individuals who may face particular challenges and multiple forms of discrimination, such as

people with disabilities, adolescents, and lesbian, gay, bisexual, transgender and intersex people.⁴

UN treaty monitoring bodies and other international and regional human rights bodies and mechanisms interpret rights under their respective treaties, how they relate to sexual and reproductive health and well-being, and how they should be applied in practice. The Human Rights Council's Universal Periodic Review (UPR) offers a novel mechanism of voluntary peer review between countries that has proven effective in reviewing human rights among Member States, and advancing universality of coverage and equal treatment. By reviewing all human rights cases, it provides a single human rights accountability mechanism, and as such, also protects reproductive rights. Two cycles of reviews between 2008-2017 highlight that one quarter of all UPR recommendations pertained to SRHR and gender equality, and almost 90% of Member States have taken action on at least half of accepted recommendations on SRHR.⁵

Table 1. provides an illustration of how existing human rights are related to the sexual and reproductive well-being and dignity of all persons.

Other civil and political rights such as the right to participate in public affairs, freedom of expression, freedom of assembly and the right to association are instrumental to the achievement of sexual and reproductive health and well-being. This is true in particular for those individuals whose sexual and reproductive health and well-being is most at risk, such as adolescent girls, stigmatized or disenfranchised women, and other individuals belonging to marginalized and excluded populations. Such rights create an enabling environment that empowers individuals and groups to claim their rights and provides specific protections allowing human rights defenders to operate in conditions of safety.

Furthermore, sexual and reproductive health and reproductive rights are essential to the realization of a wide range of other fundamental rights, such as the right to work, to education and to an adequate standard of living. These rights cannot be protected without ensuring that adults and adolescents can determine when and whether to bear children, control their bodies and sexuality, access essential sexual and reproductive health information and services, and live lives free from violence. This is only possible if women and girls have a right to access sexual and reproductive health information and services that empowers them to make informed decisions about their rights.

Table 1. Human Rights and indicative state obligations underpinning sexual and reproductive health (as set out in human rights norms and by United Nations Treaty Bodies)

<p>The Right to Life</p> <ul style="list-style-type: none"> ● Prevent maternal mortality and morbidity through safe mother-hood programmes; ● Ensure access to safe abortion services at least when the life and health of the pregnant woman is at risk and in cases of rape and severe fetal impairment. 	<p>The Right to Health</p> <ul style="list-style-type: none"> ● Ensure adolescents have access to the full range of sexual and reproductive health care services and information; ● Ensure reproductive health services are available, accessible, acceptable and of good quality (Box 2). 	<p>The Right to Education and Information</p> <ul style="list-style-type: none"> ● Ensure school curricula include comprehensive, evidence-based, and non-discriminatory sexuality education; ● Ensure accurate public education campaigns on the prevention of HIV transmission.
<p>The Right to Equality and Non-Discrimination</p> <ul style="list-style-type: none"> ● Prohibit discrimination in access to health care on grounds of sex, age, disability, race, religion, nationality, economic status, gender identity, sexual orientation, health status including HIV, etc.; ● Do not deny access to health services that only women need 	<p>The Right to Decide Number and Spacing of Children</p> <ul style="list-style-type: none"> ● Ensure the full range of modern contraceptive methods; ● Ensure women are given comprehensive and accurate; information to ensure informed consent to contraceptive methods, including sterilization. 	<p>The Right to Privacy</p> <ul style="list-style-type: none"> ● Ensure the right to bodily autonomy and decision-making around sexual and reproductive health issues; ● Guarantee confidentiality and privacy with regards to patient health care information, including prohibiting third party consent, such as spousal and parental, to sexual and reproductive healthcare services.
<p>The Right to Consent to Marriage and Equality in Marriage</p> <ul style="list-style-type: none"> ● Prohibit and punish child, early and forced marriages; ● Set the age limit for marriage at 18, equally for boys and girls. 	<p>The Right to be Free from Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment</p> <ul style="list-style-type: none"> ● Guarantee access to emergency contraception, especially in cases of rape; ● Guarantee access to termination of pregnancy when a woman's life or health is in danger, in cases of rape and fatal foetal impairment. 	<p>The Right to be Free from Practices that Harm Women and Girls</p> <ul style="list-style-type: none"> ● Prohibit and punish all forms of female genital mutilation (FGM).
<p>The Right to be Free from Sexual and Gender-Based Violence</p> <ul style="list-style-type: none"> ● Ensure gender-based violence, including domestic and intimate partner violence, is effectively prohibited and punished in law and in practice; ● Prohibit and punish all forms of rape, in peacetime and in conflict and including marital rape; ● Prohibit and punish all forms of violence perpetrated because of sexual orientation. 	<p>The Right to an Effective Remedy</p> <ul style="list-style-type: none"> ● Ensure effective mechanisms are in place for women to complain of sexual and reproductive health and reproductive rights violations; ● Ensure women who are unable to afford a lawyer access to effective counsel. 	

B APPLYING HUMAN RIGHTS STANDARDS AND PRINCIPLES IN DEVELOPMENT

The implementation of plans, policies and programmes that seek to contribute to the realization of sexual and reproductive health and rights must be grounded in human rights standards and principles.

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For ease of reference, United Nations treaty monitoring bodies have grouped the human rights standards applicable in the area of the right to sexual

and reproductive health according to four attributes, commonly known as the 'AAAQ' framework, entailing that sexual and reproductive health information, goods and services must be available, accessible, acceptable and of good quality (Box 2)⁴. These attributes provide a normative and objective set of criteria to apply human rights standards in the formulation and monitoring of policy results.

BOX 2. AVAILABLE, ACCESSIBLE, ACCEPTABLE AND OF GOOD QUALITY

States must ensure that reproductive health information, goods and services are available, accessible, acceptable and of good quality (AAAQ).

AVAILABILITY: States must ensure that there are an adequate number of functioning health care facilities, services, goods and programmes to serve the population, including essential medicines as defined by the WHO Model List of Essential Medicines, which includes a wide range of contraception methods, such as condoms and emergency contraception.

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ACCESSIBILITY: States must ensure that health facilities and services are accessible to all, without discrimination and free from barriers. This includes:

Physical accessibility: Within safe and reasonable geographical reach for all sections of the population, and adequate access to buildings for persons with disabilities.

Economic accessibility: Must be affordable for all, whether publicly or privately provided services. Payment assistance must be based on the principle of equity to ensure that impoverished families and individuals do not bear a disproportionate burden of health costs

Information accessibility: Individuals and groups must be able to seek, receive and disseminate information and ideas concerning reproductive health issues.

ACCEPTABILITY: All facilities, goods, information and services related to sexual and reproductive health must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender, age, disability, sexual diversity and life-cycle requirements.

QUALITY: Reproductive healthcare must be of good quality, meaning that it is scientifically and medically appropriate, which requires skilled (trained) medical personnel, scientifically approved and unexpired drugs and equipment.

In addition to the AAAQ framework, human rights treaties are underpinned by a core set of principles that guide all sectors⁵ of development, including sexual and reproductive health policies and interventions. These include the principles of equality and non-discrimination, participation and accountability.

1 Principles of non-discrimination and equality

Marginalized populations are often underserved. They can encounter significant barriers to realizing their sexual and reproductive health and reproductive rights, affecting their health. For example, access to sexual and reproductive health information and services may be largely unavailable for these populations or of inferior quality due to factors such as physical or geographic barriers, absent or inaccurate or incomplete or inaccessible information, and discriminatory practices.⁶ Indigenous women and those belonging to minority groups, disabled women and HIV positive women, and transgender people, for example, have been subject to coerced and forced sterilization.⁷ In some parts of the world, sex workers may be arrested for carrying a condom on the grounds that it is evidence of intent to engage in illegal sexual activity.⁸ Such practices reflect multiple forms of discrimination; violate the rights to privacy and health; and violate the right to determine the number, spacing and timing of children. Furthermore, they also violate the right to be free from inhuman and degrading treatment, and can be forms of violence against women.⁹

International human rights law requires special attention be given to populations living in situations of marginalization and disadvantage in policies, programmes, budgets, service delivery as well as through other empowering measures to promote their active participation in public affairs and development processes affecting them.¹⁰

2 Principle of participation

At all stages of decision-making, it is critical to ensure active involvement of civil society actors, individual participants and other key stakeholders in the development and monitoring of laws and policies, including budgets and use of public funds. Stakeholder voices are also important to accountability. Participation of populations most affected, and those facing significant barriers to their access to reproductive health services, ensures that their needs and priorities properly inform improvements in relevant laws and policies and in the delivery of services. International human rights law

requires States to ensure effective accountability and participation processes, including in monitoring and evaluation and the availability of effective remedies. This obliges the participation of a wide range of stakeholders in the development and implementation of laws, policies and programmes.¹¹

3 Principle of accountability

Where human rights have been violated in the context of sexual and reproductive health services, information or expression, States have an obligation to monitor and review the implementation of associated laws, programmes and policies, and to establish appropriate remedies. At the national level, this entails a number of actions:

- ensuring effective and independent national human rights institutions are in place;
- providing access to information about accountability mechanisms;
- establishing effective monitoring and review mechanisms, developing rights-based indicators, collecting disaggregated data;
- strengthening birth and death (including maternal deaths) registration systems;
- providing judicial and non-judicial remedies;
- Investigating and punishing violations as well as providing reparations;
- providing access to legal aid, and removing barriers to justice and redress systems.

These and other measures support the principle of accountability.

C DUTY OF THE STATE TO RESPECT, PROTECT AND FULFILL HUMAN RIGHTS

A State has obligations to respect, protect and fulfil human rights. These obligations include proactive measures that it must undertake, in all areas of human rights, including those human rights that interact with sexual and reproductive health and well-being.

THE OBLIGATION TO RESPECT requires States to refrain from interfering directly or indirectly with the enjoyment of human rights. For example, in regards to sexual and reproductive health, States have an obligation under international law to refrain from limiting access to contraceptives and from withholding, censoring or misrepresenting information about sexual health.

THE OBLIGATION TO PROTECT requires States to prevent third parties from interfering with the realization of these rights. In regard to sexual and reproductive health, this would include, for example, investigating and punishing practices by health care providers and others that violate human rights such as forced sterilization or forced abortion.

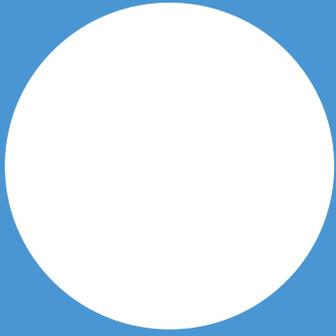
THE OBLIGATION TO FULFILL requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to enable full enjoyment of rights including those associated with sexual and reproductive health. States must, for instance, provide for sexual and reproductive health care and adopt related national health policy and/or a related national health plan, covering both the public and private sectors. The State must take active measures to deliver reproductive health services, including contraceptive services and to provide these in a manner that respects women's dignity, exercise of choice and autonomy.

Under the International Covenant on Economic, Social and Cultural Rights, States are obliged to take steps “with a view to achieving progressively the full realization of the rights recognized [in the Covenant]”, such as the right to health. This is known as the obligation of progressive realization. It acknowledges that the full realization of economic, social and cultural rights may not be feasible in a short period of time or due to budgetary constraints. However, such circumstances do not render these rights meaningless. To the contrary, States must take active measures towards achieving those rights and must not regress on measures already taken. Moreover, steps towards that goal must be deliberate, concrete and targeted as clearly as possible, using all appropriate means—including the adoption of legislative measures and the implementation of national strategies with clear objectives, benchmarks, budgetary allocations and indicators to measure progressive achievement in accordance with available resources.

Regardless of the resources available, States have certain obligations towards economic, social and cultural rights

that must be implemented immediately. The enacting of anti-discrimination provisions and the establishment of associated enforceable rights with judicial remedies within national legal systems are but two examples.

National Human Rights Institutions are increasingly examining ways to monitor the progressive realization of economic, social and cultural rights through the use of statistical indicators in order to assess legal and policy efforts as well as public budgets.¹²



CHAPTER 2

Conducting country assessments and national inquiries

Country assessments and national inquiries are part of the toolbox of initiatives NHRIs can employ in their countries to monitor human rights in the context of sexual and reproductive health and well-being. Both tools can provide baseline information and methodological frameworks for the institutions to use when putting in place more permanent mechanisms to monitor human rights for sexual and reproductive health and well-being on an ongoing basis

A DEFINITION OF TERMS

In the context of this guidance note, a **country assessment** is a systematic review of information and data compiled through various already existing sources to identify and understand the country's main human rights problems related to sexual and reproductive health and well-being and the efforts (or lack thereof) undertaken by the State as the main duty-bearer, and other non-state actors, to address these problems. A country assessment provides a firm basis on which to establish a framework for promotion and monitoring of human rights implementation. The country assessment can be used on its own to identify challenges and areas in need of improvement or be a first step in the development of a national inquiry. It explores the extent to which rights are realized and obligations are met. As such, it follows the key principles of human rights (i.e. non-discrimination and equality, participation, accountability) as outlined in the previous section.

Conducting a country assessment should not be conceived as a technocratic exercise held behind closed doors, but rather as an opportunity to build partnerships with various population groups, especially those that are more often overlooked, such as youth-led organizations, sex workers' associations, professional associations of service providers and midwives, amongst others. Their involvement in the process will not only ensure a robust country assessment that reflects the needs of persons

and groups directly affected, it will also empower them in influencing national policy dialogue, helping to build a more inclusive and democratic society.

TIP A country assessment is generally a desk review/literature review of existing data and information. ● It helps provide a baseline for understanding the issues and can help shape the focus of a national inquiry. An assessment is done before or during a national inquiry. Its findings can also be published independently of and before a national inquiry is undertaken, if desired.

A **national inquiry** is a transparent, public investigation into a systematic human rights problem in which the general public and expert stakeholders (including experts from government, academia, civil society and individuals from affected communities) are invited to participate. While NHRIs can conduct various types of inquiries to address systematic human rights violations, this document will look at a **national public inquiry**, which has the purpose of identifying the underlying and root factors of human rights violations and make recommendations for positive change. National inquiries encompass many of the functions undertaken by NHRIs and are supported by the powers given to these institutions in law.¹³

11 National inquiries involve a country assessment, or are done as a consequence of a preliminary country assessment, to gather further evidence from what was already gathered when conducting the assessment on the human rights situation in the country. In addition to the sources of information used in a country assessment, a national inquiry obtains testimony from victims, witnesses and experts, directed towards the investigation of systemic patterns of human rights violations and the identification of findings and recommendations.¹⁴

National inquiries should not replace the role of the judiciary and other law enforcement bodies.¹⁵ Their recommendations can be wide-ranging, addressing numerous relevant government offices, the parliament, civil society, academia, and even the private sector and individuals who play a significant role within the community affected.¹⁶

While a national inquiry's recommendations may include remedies for individuals, the primary purpose of an inquiry is not to resolve individual complaints, but to make concrete proposals for addressing systemic issues, including institutional gaps, policy failures and behavioural patterns. Due to its public nature, a national inquiry introduces, exposes and explains a complex situation to the affected community and to society overall, offering an analysis based in human rights law.

A public inquiry can be a powerful tool to draw attention to systemic patterns of human rights violations, which cannot be fully understood or addressed through more conventional approaches, such as investigating individual complaints or conducting ongoing human rights monitoring. Prior to the launching of a national inquiry, the NHRI has to assess the strategic opportunity of doing so. The added value for conducting a national inquiry should be clearly established from the outset.

B METHODOLOGY: FIVE STEPS FOR CONDUCTING A NATIONAL INQUIRY

This section focuses on a detailed description of the main steps entailed in the process of conducting national inquiries, which is a more complex process than that of conducting a country assessment. However, some of these steps will also be relevant for conducting country assessments.

The methodology for conducting public national inquiries should be flexible, depending on context and need. It begins with some preliminary considerations, to be resolved before commencing an inquiry, including matters such as the NHRI's mandate and budget, and involves establishing basic principles for the inquiry, such as its transparency and approach to participation. The specific scope and goals of the inquiry should be clearly defined as well as its methodology, including the balance of desk and field research, public hearings and written submissions.

Analysis and assessment of the inquiry's findings followed by the drafting of its report(s) and recommendations are important elements in the process. Development and implementation of a public communications strategy should be ongoing throughout and after the inquiry process. Finally, critically important is a follow-up advocacy strategy for adoption and implementation of the inquiry recommendations. This

may entail advocacy with individuals as well as numerous governmental and non-governmental stakeholders.

STEP 1 Address preliminary considerations and make an announcement

The NHRI, in consultation with affected communities and other relevant stakeholders, has to determine the **theme for the inquiry**. While the steps proposed below apply to any human rights issue, this guide presumes that the inquiry will focus on sexual and reproductive health and reproductive rights as the main theme.

As noted by the Office of the High Commissioner for Human Rights (OHCHR), the decision to launch a public inquiry should be founded on the following considerations:

Five Steps for Conducting a National Inquiry

STEP 1

Addressing preliminary considerations and make an announcement

- Authority
- Cost
- Participation

STEP 2

Establish an Inquiry Panel

- Multidisciplinary expertise

STEP 3

Design monitoring and analytical frameworkst

STEP 4

Gather Information

- Desk research
- Qualitative Information
- Stakeholder forums
- Field research
- Public Hearings
- Public written submissions
- Official information
- Media

STEP 5

Ensure effective reporting by the NHRI

- **AUTHORITY:** This is established by the enabling legislation of the NHRI, in which there may be an expressed or implied mandate to hold national inquiries. While this may include the authority to inquire into a single serious incident, NHRIs' mandates usually authorize examination of systemic or general human rights issues;
- **COST:** The anticipated gains must be commensurate with expected efforts and costs;
- **PARTICIPATION:** Involving a wide range of stakeholders, including affected communities and individuals is critical to the success of an inquiry.¹⁷

Certain formalities should be followed to announce publicly the launching of a national inquiry. Depending on the specificities of the NHRI, these formalities could consist of issuing a decree or a directive by the Head of the NHRI, a public announcement or any other appropriate form.

STEP 2

Establish an Inquiry Panel

A public inquiry requires the constitution of a **panel of inquiry**. The NHRI can use its own members and can also engage outside experts. In any case, the panel should include members who have an expertise in the subject matter and a clear understanding of the mandate and limitations of the NHRI. Outside experts, if engaged, should be viewed by the public and by the affected communities and individuals as being both impartial and independent.

The NHRI can also consider developing an **advisory group to the panel**. The advisory group may help

prepare the inquiry, interpret findings and evaluate effective recommendations. It may be useful to include members of affected communities who have first-hand experience in the problem being addressed by the NHRI. As noted by the OHCHR, the role of this group is limited: "It should be made clear to the advisory group, if one is established, that the panel alone is responsible for sifting and weighing the evidence [information] presented at the inquiry and preparing the final report. Ownership of the process should be with the panel and the NHRI, not the advisory group."¹⁸

Consideration should be made to ensure that the advisory group and inquiry panel have multidisciplinary expertise. The inquiry will benefit from access to advice on the various impacts that implicated laws, policies and practices have on the full range of issues under consideration, such as health, human rights, economics, service provision, budgets and even development cooperation.

STEP 3

Design monitoring and analytical frameworks

This step is also relevant for conducting country assessments.

What type of information is needed and how will it be collected? Once the information is gathered, how will it be analysed to infer and categorize the types of human rights concerns or violations that have occurred? Before undertaking the assessment and the inquiry, it is important to design frameworks with methodologies. These frameworks will help shape the scope of the

issue to be investigated, even if many of the details are unknown at the stage.¹⁹

The design process will also help in the development of clear and transparent objectives and outcomes, which are critical to the success of any inquiry. Such frameworks must not only consider the substantive issues or challenges being faced, but also the underlying structural factors leading to potential human rights violations. An assessment of the legal, policy and budgetary compliance with human rights standards is critical.

a. Developing a monitoring framework

Prior to launching a national assessment and/or national inquiry, develop a monitoring framework. This monitoring framework should include both quantitative and qualitative indicators in relation to the human rights impacting on sexual and reproductive health and well-being (see Chapter below). Having this framework developed in advance will help clarify what type of information needs to be gathered during the process and how the information will be collected, for example, through desk research, field interviews, hearings, etc, depending upon if an assessment is being conducted or a public national inquiry. Additionally, as either will likely collect a great deal of information from its research, a well-organized system of managing the information is required. The monitoring framework could be developed, for example, into a database to categorize the information gathered.

b. Developing an analytical framework

Another key step prior to conducting an assessment and/or inquiry is to develop a framework for analysis and assessment. Assessing and analysing the qualitative and quantitative information and data gathered is critical to identifying whether human rights violations have occurred, which in turn is important for recommending actions to be taken to stop violations and prevent them from occurring in the future. At a minimum, the analytical framework should be able to establish the following:

- The magnitude of the violations, and the specific groups that may have been impacted. Categorize the challenges according to the specific human rights provisions implicated;
- Who the perpetrators of these violations are or appear to be;
- Trends in terms of progressive realization of rights and non-retrogression of rights;
- Gaps in qualitative and quantitative data related to understanding the extent of the problems and violations;
- Extent to which affected groups have been able to participate in the development of laws, policies and programmes;
- Extent to which accountability mechanisms have protected the rights of aggrieved individuals and legal remedies were established;
- Responsible State entities, both local and national for development of laws, policies, programmes, practices (including data collection and legal protection) that have contributed to the violations;
- Recommendations to these State entities and to non-State actors to improve laws, policies and programmes that will stop the violations and prevent them from occurring in the future;
- Steps international bodies and donor states and agencies can take to improve the situation.

STEP 4 Gather Information

This step is also relevant for conducting country assessments.

Information should be obtained from the full range of sources, including available quantitative and qualitative data, experts, non-governmental organizations, government officials and, most importantly, communities and individuals most affected by the issue. This will be done in different ways depending if an assessment is being conducted or a public national inquiry. An inquiry panel will require a wealth of information to come to a sound conclusion. This includes an understanding of the law and its application and practices that may impact on human rights.

a. Conducting desk research/literature review

The NHRI should strive to develop a keen understanding of the issue in advance of any field research, stakeholder forums or hearings. Information obtained through desk research will prove useful to the inquiry process and will also better enable the NHRI to identify which stakeholders to interview, what questions to ask, and what aspects to focus on during public hearings and field research. It will also help the NHRI to organize public hearings and draft calls for written submissions.

Desk research will also enable the NHRI to identify research or data gaps, which can be an important component of the recommendations and can also shape the focus if a national inquiry follows.

Desk research should include all available qualitative and quantitative information and data on the subject matter. For example, Demographic Health Surveys (DHS) and the World Health Organization are useful sources (Box 3).²⁰ Other sources of information include a literature review of academic journals, and research using databases related to sexual and reproductive health issues (e.g. Pub Med at <http://www.ncbi.nlm.nih.gov/pubmed>).

Desk research also includes a thorough review of relevant laws, policies and state ratification of major United Nations human rights treaties and commitments to regional and international consensus documents, such as the ICPD Programme of Action or the Beijing Platform for Action. The national laws and policies to review will depend on the specific topic at issue. Constitutional protections and laws governing gender equality and non-

discrimination should always be included in the review. In addition, a host of laws and policies can be implicated, depending on the subject matter, including maternal health policies, public health laws, family laws, abortion laws and penal codes. The NHRI must collect as much information, documentation and knowledge as possible to ensure that the inquiry is successful.

TIP Desk research is central to conducting a national assessment and important baseline for developing the framework and topics to focus on in a public national inquiry.

b. Gathering qualitative information

Critically important to understanding the human rights situation in a country and state obligations are recommendations issued by treaty monitoring bodies (TMBs) on state compliance with a particular treaty. Called concluding observations, they can help NHRIs understand where states are meeting and failing to meet their treaty obligations on a particular issue. Information can be found in state reports and supplementary shadow reports submitted by NGOs to TMBs. Additional country-specific information can be found in the various documents prepared in the context of the Universal Periodic Review, including the state report, the compilation report of United Nations information, the stakeholders summary report, the UPR Working Group report and the UPR outcome. The country reports of United Nations Special Procedure mandate-holders can also provide valuable information and recommendations on human rights issues related to sexual and reproductive health and well-being.

United Nations agencies such as the OHCHR, UNFPA, UN Women, UNICEF and UNDP, among others, are important sources of country-specific and issue-specific information.

THE OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS provides a number of valuable online resources:

Information about human rights bodies

<http://www.ohchr.org/EN/HRBodies/Pages/HumanRightsBodies.aspx>

Information about monitoring the core international human rights treaties

<http://www.ohchr.org/EN/HRBodies/Pages/TreatyBodies.aspx>

BOX 3. KENYA NATIONAL COMMISSION ON HUMAN RIGHTS

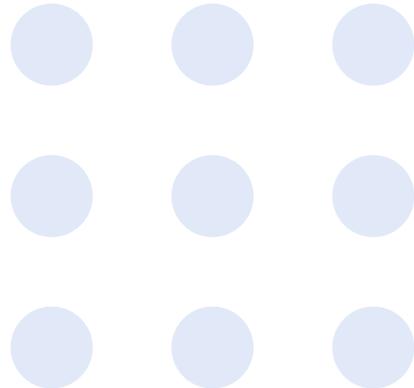
The report of the Kenya National Commission on Human Rights illustrates how reproductive rights violations they researched and documented were categorized. A clear articulation of specific human rights violations which a national inquiry process has researched and documented is critical to ensuring the realization of these rights and to ensure redress where the rights have been violated. It serves as an important awareness raising and empowerment tool so that affected communities and the public in general see how important the articulation of rights is to their lives. In addition, it supports the development of appropriate laws, policies and interventions that are reflective of international human rights obligations specific to the right at issue. Moreover, it provides a foundation to develop appropriate remedies based on the rights violated and can encourage victims of violations to seek redress in appropriate legal fora, depending on the rights at stake.

The desk research component of the Kenya National Commission on Human Rights in its public national inquiry into sexual and reproductive rights violations looked at the following topics, which derived from the main objectives of the inquiry:

- **NATIONAL AND INTERNATIONAL LEGAL AND POLICY FRAMEWORK ON SEXUAL AND REPRODUCTIVE HEALTH IN KENYA.** The inquiry reviewed international human rights treaty ratification and obligations and commitments under consensus documents such as the ICPD Programme of Action as well as relevant national laws and policies on sexual and reproductive health in the country.
- **ACCESS TO INFORMATION (AWARENESS AND EDUCATION) ON SEXUAL AND REPRODUCTIVE HEALTH IN KENYA.** An analysis of existing documentary evidence on the levels of awareness and education on sexual and reproductive health among Kenyans was undertaken with a view to establishing levels of access and exposure to information on sexual and reproductive health. Special emphasis was put on the sources, quality, quantity and accessibility of reliable information on sexual and reproductive health.

- **ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH CARE IN KENYA.** Further analysis was undertaken to establish the extent to which Kenyans are able to enjoy quality sexual and reproductive health care services. In particular, this focused on key indicators of sexual and reproductive health such as contraceptive use, maternal health, sexually transmitted infections and HIV and AIDS prevalence. The analysis also focused on the health care infrastructure development including the geographical distribution of health care facilities, supply of essential medical equipment and medicines, staffing levels and distribution of medical personnel, and financing of health care.
- **GAPS IN SEXUAL AND REPRODUCTIVE HEALTH CARE IN KENYA.** A gaps analysis was undertaken to identify factors that undermine the fullest enjoyment of sexual and reproductive health rights in Kenya.

Source: Kenya National Commission on Human Rights (April 2012), Realising Sexual and Reproductive Health Rights in Kenya: A myth or reality? A Report of the Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya.



Available at http://www.knchr.org/Portals/0/Reports/Reproductive_health_report.pdf

Access to the treaty bodies database

http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en

Recommendations issued by the United Nations Human Rights Council through its Universal Periodic Review, a mechanism used to review each of the 193

Member States of the UN on its human rights record

<http://www.ohchr.org/en/hrbodies/upr/pages/uprmain.aspx>

NON-GOVERNMENTAL ORGANIZATIONS also provide useful resources. Visit the UPR Sexual Rights Database hosted by the [Sexual Rights Initiative](#). This database allows users to access and search all the sexual rights related recommendations and references made during the Universal Periodic Review conducted by the United Nations Human Rights Council.

<http://sexualrightsinitiative.com/universal-periodic-review/data/>

Another **NGO, the CENTER FOR REPRODUCTIVE RIGHTS** has developed a series of briefing papers on the standards of United Nations treaty monitoring bodies regarding various reproductive rights issues. The series is titled *Bringing Rights to Bear*.

INTERNATIONAL HUMAN RIGHTS ORGANIZATIONS

are another source of information. Human rights fact-finding reports by national and international NGOs are important sources of qualitative information. They often include testimony by victims of abuses and present national and international law analysis on a given topic. Some international human rights organizations that produce such reports on issues related to sexual and reproductive health and reproductive rights include Amnesty International, Center for Reproductive Rights, Human Rights Watch, and the International Gay and Lesbian Association (ILGA).

c. Convening stakeholder forums

Conducting stakeholder forums can be important in gathering background information and for honing in on particular problems. Stakeholder forums should be held before undertaking desk research (assessment) conducting individual interviews, holding public hearings or receiving written submissions. Participants can be drawn from key stakeholder groups including relevant government departments and agencies, health care and other relevant institutions, and civil society organizations, including NGOs and academia. Representatives of the group(s)

most impacted must be consulted in order to ensure credibility in the process and to ensure that the research and findings are meaningful and inclusive. Moreover, given the important role that the groups most impacted can play in developing and monitoring implementation of findings and recommendations, it is critical to ensure their involvement early on and throughout the process.

The inquiry process must make a concerted effort to identify the most disadvantaged groups affected, including both grassroots organizations and national organizations that not only work with affected groups and communities, but more importantly, are led by them. While including the groups that have been most outspoken on the issue is important, just as important is identifying groups and individuals that have not had the public space to express their views and share their experiences. Many disadvantaged groups live on the margins and are not part of the most accessible civil society network, requiring the inquiry team to put considerable effort into ensuring that the representatives are credible to the groups and communities most affected.

The aim of the stakeholder forum is to review the objectives and scope of the inquiry. The stakeholder forum can also act as a broader reference group for the inquiry and establish a link between the NHRI and wider stakeholder constituencies.

TIP Stakeholder forums can lend important credibility to the inquiry process, and the NHRI would want to hold stakeholder forums prior to beginning research for an assessment or national inquiry and may consider holding numerous stakeholder forums throughout the process.

d. Conducting field research

Conducting field research is central to the public inquiry process. Field research in the form of one-on-one interviews and focus groups can corroborate information found in desk research and in stakeholder forums. This is one way to gather information directly from communities affected, especially those communities or individuals who are unable or unwilling to participate in a public hearing. It is also an opportunity for the NHRI to see first-hand the environment in which alleged violations are occurring and to ensure that the geographic scope of the inquiry is covered.

One-on-one interviews should target a range of stakeholders. In relation to an inquiry concerning sexual and reproductive health issues, stakeholders may include the government, healthcare workers and consumers of sexual and reproductive health services. Key interviewees can be selected from the following categories:

- public and private health and social services facilities and relevant departments, including hospitals, clinics and pharmacies;
- key government offices;
- academia and medical training institutions;
- civil society organizations, including relevant NGOs, community-based organizations, relief/humanitarian agencies; and
- individuals affected.

Information can be collected using structured questionnaires and checklists for each category. Effective questionnaires are based on human rights standards, state obligations and other issues identified during the desk review. Regarding individuals to interview through the one on one interviews, depending on the scope and goals of the inquiry, it is important to ensure that persons from marginalized groups and various age groups and sexes are represented and that questions are structured taking into account their various characteristics.

Focus groups discussions are useful methodologies to gather views from marginalized and hard-to- reach populations, or from particular groups that are often overlooked or have problems expressing their voice in the context of public hearings or similar participatory methodologies. Focus groups can often provide the support needed to express views on sensitive subjects.

Depending on the availability of resources and technical capacities, NHRIs can run specific or targeted surveys to collect information at service delivery points and/or to track the flow of public budgets and resources. This includes the possibility to conduct simplified versions of Poverty Expenditure Tracking Surveys (PETS) and Community Score Cards (CSC) methodologies to assess gaps in service delivery and client satisfaction. If conducting these exercises is too costly or cumbersome, the NHRI can find out if other organizations or institutions have already conducted these types of surveys in the health sector and can make the information available.

e. Holding public hearings

Public hearings are conducted in the public inquiry process. They allow victims to have an opportunity to present their views, including a statement of their experiences, including on the harm they have suffered. Further, public hearings also serve as a very important educational aspect of the inquiry process. The main purpose of a public hearing is for the NHRI to listen to experiences from individual victims, group victims and witnesses that illustrate the challenges people face in realizing their rights.

Public hearings can be run by a panel composed of NHRI members and other experts, if appropriate. If the NHRI created an inquiry panel (see Step 2), then, members of the panel can run the hearings. Public hearings led by the Kenya National Commission on Human Rights, for example, comprised three commissioners, five experts and two external consultants.

The target groups of the public hearings can include the following categories of people:

- individual members of the public;
- groups of private individuals;
- distinct minority groups or sections of the communities falling within the scope of the inquiry (i.e. LGBTI people, sex workers, women with disabilities, elderly mothers, young and adolescent mothers);
- individual professionals/experts on sexual and reproductive health issues;
- representatives of health institutions;
- government officials drawn from relevant ministries, agencies and the parliament;
- representatives of medical training institutions; and
- representatives of relevant civil society organizations.

Public hearings can be challenging due to sensitivity and stigmatization around issues of sexual and reproductive health and well-being but every effort should be made to hold public hearings because of their important education function and the redress those affected can feel once they present their experiences to the panel at the public hearing. However, some persons, especially victims, may not be comfortable appearing in a public setting. It is not always necessary for individuals to appear in person. Presentations to inquiries may be verbal or in writing.

f. Requesting public written submissions

The NHRI should consider making a public call for written submissions on the range of human rights issues related to sexual and reproductive health and well-being to be covered by the assessment and the public inquiry. Written submissions can help supplement the desk review as well as the information gathered in the field research and public hearings. Written submissions may be in the form of memoranda, research papers, videos, blogs and emails, for example. The scope of the submissions may include, among other topics:

- personal experiences with sexual and reproductive health services;
- cases of violations of rights underpinning sexual and reproductive health and well-being;
- laws, policies and human rights standards relating to sexual and reproductive health;
- adequacy of sexual and reproductive health care services in health facilities;
- social, economic and cultural factors that prevent people from accessing sexual and reproductive health care services; and
- discrimination of vulnerable groups when accessing sexual and reproductive health care.

g. Requesting official information

The NHRI may also request access to official information from relevant government entities. In many countries, the government is obliged to share public information upon request. Denial of access to information or undue delays should be noted and reported. The types of information that may be requested from government entities are the following:

- statistical information, including health, employment and professional certification data;
- internal monitoring and evaluation reports;
- reports of administrative investigations, and decisions by administrative mechanisms of protection;
- maternal death audit reports;
- financial information relating to budget expenditure for different sectors (e.g. health, education, infrastructure development) and for individual public institutions;
- Administrative protocols, circulars and instructions.

h. Involving the media

Plan media strategies and other forms of communication throughout the inquiry process, including at the start of the inquiry, during hearings and at the launch of the final report. A media campaign should be designed to achieve multiple goals including mobilization, public debate/feedback, civic education, monitoring and dissemination of Inquiry findings. A vigorous media and communication campaign, including print, TV and electronic media, has an important educational element and allows for transparency and awareness-raising concerning the work of the NHRI. A media campaign can also play an important role in reducing the stigma and controversy around sexual and reproductive health issues. The NHRI can provide support to media representatives to help them understand the issues, especially if those issues are poorly understood by the public or many myths or misconceptions exist. Media 'backgrounders' and other materials and work with journalists and communication experts can help to lay the groundwork for appropriate representation of the issues at hand and of the inquiry process. In Kenya, for example, the NHRI organized a media breakfast meeting that consolidated a working collaboration between the media and the NHRI during the inquiry period. Publicizing the inquiry will also ensure that individuals with information can share it with the NHRI.

STEP 5 Ensure effective reporting by the NHRI

The final component of the process and its main product is the compilation of the findings into a report, including recommendations for action. A report can be issued at the completion of the assessment (desk review) or can be combined with a report on the public inquiry findings. In either case, the credibility of the report is key to its influence on policy decision making and public opinion. Thoroughly review and analyse all the data, information and evidence before publication and dissemination of NHRI findings. For validation and quality control, it may be useful to include stakeholder participation prior to the publication of the report. This may include peer review and stakeholder validation workshop, for example.

Regarding recommendations, the OHCHR notes that they should be carefully crafted: "*[Without compromising the integrity of the process, the recommendations should be carefully crafted so that they are acceptable, both to the general population and to the Government, and will be implemented. They should also take into account the country's tradition, culture and fiscal realities.*"²¹

The report should include the following information:

- Background and objectives of the inquiry, including the mandate of the NHRI to undertake the inquiry and methodologies and stakeholders involved;
- Contextual explanation of the issues being covered by the inquiry, including the applicable international and regional human rights framework, national laws and policies and other states' commitments that can support the realization of human rights related to sexual and reproductive health and well-being;
- The extent of access to sexual and reproductive health services or other issues being addressed by the inquiry. This part of the report analyses qualitative and quantitative information gathered throughout the inquiry process. It can be divided by issue and/or vulnerable groups affected;
- Identification of major barriers, in law and in practice, faced by affected populations and individuals that hinder realization of the rights at issue. Particular attention may be paid to particularly disadvantaged groups, such as adolescents, indigenous peoples, persons with disabilities and people of diverse sexual orientation and gender identity;
- Nature, form and consequences of such barriers;
- Human rights implicated and their categorization;
- Review of the financing of human rights issues related to sexual and reproductive health and well-being;
- Recommendations to various stakeholders, including governmental and non-governmental bodies.

C DESIGN AND IMPLEMENT ADVOCACY STRATEGIES

Monitoring and follow up on recommendations are key to a successful Assessment and Inquiry. Effective monitoring of the implementation of recommendations is necessary in order to develop and refine advocacy strategies to follow up on the recommendations. Monitoring and advocacy are critical aspects of the inquiry process and lend credibility to the resources spent on developing the inquiry. Understanding the mandate of the NHRI is an important aspect of follow up. For example, most NHRI have a clear mandate to transmit recommendations, based on their findings, to the relevant government department or agency and allow explicitly or implicitly for the NHRI's active participation in implementation processes, such as in development of laws or budgets through testimony at parliamentary hearings, etc. Some NHRIs even have the authority to seek redress before the courts or specialized tribunals following an inquiry. Follow-up has been strongly recommended by the OHCHR:²²

- TIP** Regardless of its specific powers to follow up, an NHRI should make every effort to ensure that the results of its inquiries are made public and disseminated as widely as possible. It should carefully monitor the measures taken with respect to its recommendations and report publicly on the action by government agencies or the legislature in response to its recommendations, perhaps through its annual report. The NHRI should develop effective advocacy strategies to ensure that the recommendations are being implemented. After an appropriate interval, an institution may even schedule public follow-up meetings to ask officials directly what action they have taken.

As part of this process, the NHRI should play a continuing role in monitoring and reporting publicly on implementation of the inquiry's recommendations. Monitoring should aim to ensure that the recommendations in the report are being implemented. The advocacy strategy resulting from monitoring should not only be looking towards maintaining pressure through national level advocacy but also through use of international mechanisms, such as state reporting processes at UN treaty monitoring bodies and through the UN Human Rights Council's Universal Periodic Review (UPR). The advocacy strategy should also include building and maintaining commitment and cooperation among relevant academic and non-governmental institutions and organizations towards placing sustained pressure on the Government and others to whom recommendations are directed. The NHRI should prepare and release an annual report on implementation.²³

1. Advocating with the government and parliament

The NHRI should be the main advocate for the report's recommendations. It should take them to senior leaders of the government and opposition parties and to government officials. It should be active in persuading parliamentary committees and individual parliamentarians as well as relevant ministries, including finance, to address the inquiry's recommendations. It can encourage the government and others to whom the recommendations are directed to respond publicly to the recommendations to indicate which ones it will implement and when.

The NHRI should ensure that the report is on the political agenda and that its recommendations are given serious consideration. It can do this in numerous ways, including

by encouraging a parliamentary debate on the report or examination of the report by a relevant parliamentary committee, including holding parliamentary hearings with relevant stakeholders.

It can also arrange for questions to be asked in parliament about the government's response to the report. It can provide briefings to parliamentarians and parliamentary staff. As part of this process, the NHRI should be monitoring when relevant legislative, policy and budgetary considerations are for discussion in the government and parliament and identify opportunities where the inquiry's recommendations can be realized.

2. Engaging the community in advocacy

The success of the inquiry depends on a broad-based coalition advocating for changes to improve human rights. Community pressure by NGOs, grassroots organizations, faith-based organizations and academic institutions will sustain the effort needed to ensure that recommendations are implemented. The national inquiry process itself will identify these allies and, through the report and inquiry process, provide a strong opportunity to support their advocacy.

The NHRI should encourage these allies, especially the organizations that represent those most affected by the violations investigated, to collaborate on a joint advocacy strategy in support of the inquiry's recommendations. Thus, presenting the inquiry's findings and recommendations in community forums, such as annual meetings, conferences, workshops, and online discussions is a continuing task and an opportunity to explicitly engage groups in developing relevant advocacy strategies for monitoring and implementation.

3. Reporting on implementation domestically and internationally

The NHRI has a continuing role in monitoring and reporting publicly on implementation of the inquiry's recommendations. The NHRI should make it known publicly that it will be monitoring implementation and reporting on it nationally and internationally after the first year and subsequently. It should also make public that it will be cooperating and collaborating with civil society and key government stakeholders in the process of monitoring and reporting. Thus, the government knows of the NHRI's commitment to promoting public

accountability for the implementation of the inquiry's recommendations. There are a number of ways that an NHRI can monitor and report:

a. Request periodic statements of progress from the government and parliament in implementation;

b. Make assessments and public comments on progress or lack of progress. Prepare a follow-up report on an annual basis, at least for the first few years after the inquiry. This is a good means of monitoring implementation. These reports can serve as a kind of report card on the response to the report by the government and others to whom recommendations were made;

c. Identify and engage with international and regional forums to promote the key findings of the NHRI's inquiry, using the main and subsequent reports for evidence-based advocacy to raise the issues globally and also place pressure on the government to address them. For example, among the many avenues where international advocacy can be conducted are the post-2015 development agenda process, UN Commission on the Status of Women and UN Commission on Population and Development, which meet every year.²⁴

d. Use the findings of national inquiries and country assessments to provide input to the Universal Periodic Review (stakeholders report). Every four and a half years each country is subject to the review of its overall human rights record by the UN Human Rights Council. All UN Member States, regardless of their treaty ratification, are subject to review and to recommendations issued by other Member States on what measures should be taken to improve the human rights situation in their own country. As part of the review process, stakeholders, including NHRIs, can submit short reports to the UN Human Rights Council on a specific area of human rights that the Council should be encouraged to review. This process provides an opportunity for NHRIs and other stakeholders to have the Council take a close look at the state of human rights related to sexual and reproductive health and well-being in any given country. It is also an opportunity for Member States to provide specific recommendations on how to advance the promotion and protection of these human rights. When the Council adopts recommendations, NHRIs can also play an

important role in monitoring and reporting on their state implementation.

e. Provide reports to UN treaty monitoring bodies.

Each country reports every four to five years to the relevant treaty monitoring body on its compliance with treaty obligations once it has ratified that treaty. As part of the review process, a treaty monitoring body considers supplementary information provided to it by various national and international governmental and non-governmental bodies. National Human Rights Institutions can play a critical role by informing treaty bodies on the status of state compliance to the relevant international human rights treaty, including compliance with norms related to sexual and reproductive health and well-being. Upon review of the state report and all supplemental reports, as well as oral considerations, the treaty body issues concluding observations which recognize a) whether the state is in compliance with treaty obligations as well as b) where it falls short of compliance and issues specific recommendations on measures to take to comply with its treaty obligations. In this respect, NHRIs should identify when their country is up for review by a relevant treaty body and then advocate in numerous ways. For example, submit the NHRI inquiry report to the relevant body, explaining in a cover letter how the findings in the report are relevant to the compliance of their State with the international human rights standards. Submit information on any steps the state has or has not taken to implement the recommendations. Explicitly ask the human rights body to issue recommendations that call for the implementation of the inquiry's recommendations generally and also more specific issues identified in the report and relevant to the human rights under review. During state reporting processes, UN treaty bodies provide opportunities for short oral interventions by civil society and other stakeholders working on issues in any given country under review. If resources allow, the NHRI can also participate in this oral intervention.

f. Provide inputs to Special Procedures, particularly Special Rapporteurs who are working on a thematic

mandate related to sexual and reproductive health and well-being (e.g. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Special Rapporteur on Violence against Women). Special Rapporteurs have numerous mandates, two of which are to conduct country-specific visits in relation to their thematic and geographic mandate and issue

reports highlighting areas of concern, and issue recommendations for that country.

Special Rapporteurs also issue reports on specific thematic sub-areas that fall under their thematic mandate and are problems across many countries and regions of the world; they may provide recommendations to states on how to implement their obligations in that specific sub-area. For example, the UN Special Rapporteur on the right to the highest attainable standard of health has issued a report on the negative health and human rights impact of the criminalization of certain conduct, such as same sex conduct and abortion, and issued recommendations to states for their decriminalization. NHRIs can submit information to the relevant Special Rapporteur that will inform the scope and/or content of the report, including

the recommendations. If the Special Rapporteur is making a country visit, the NHRI should arrange to have a meeting with the Special Rapporteur and to recommend other stakeholders, including non-governmental stakeholders, with whom the rapporteur should meet. For both country and thematic reports, NHRIs can play an important role in monitoring and ensuring the implementation of recommendations.

Monitoring and Evaluation Framework

A clear framework, agreed among the key stakeholders is essential in order to carry out monitoring and evaluation systematically. Each of the 5 steps in this Guide can serve as an outline for a framework for monitoring and evaluation. Regular monitoring includes an assessment on how the implementation of activities—programmatically and financially—is progressing compared to what was planned, and on how progress is made towards the intended workplan targets. Monitoring observations must inform and influence decision making, i.e., if revisions need to be introduced to the design of the workplan or the overall programme design.

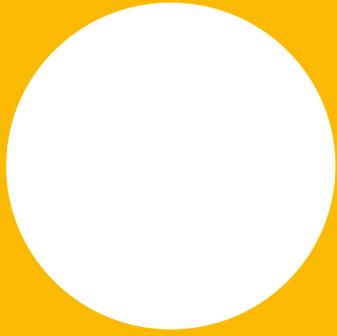
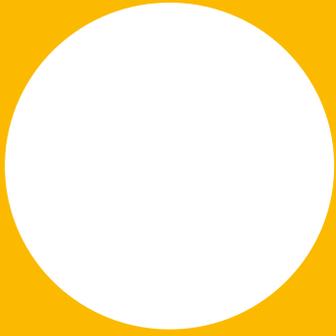
Monitoring activities might include a meeting or discussion between relevant personnel and partners. The purpose of such discussion is:

- To get an accurate assessment of activity implementation and how this relates to what was agreed upon in the workplan. This includes the periodic assessment of programmatic progress “on the ground”, as well as of the actual financial spending compared to what was initially budgeted in the workplan;
- To assess the progress towards targets specified in the workplan;

- To identify and resolve potential implementation shortfalls and obstacles, and to agree on remedial actions, if any;
- To adapt to changes in the external environment, if any.

The monitoring and evaluation framework should clarify the following for each of the 5 steps in the Guide:

- What is to be monitored and evaluated;
- The activities needed to monitor and evaluate;
- Who is responsible for monitoring and evaluation activities;
- When monitoring and evaluation activities are planned (timing);
- How monitoring and evaluation are carried out (methods);
- What resources are required and where they are committed.



CHAPTER 3

Assessing a human rights problem and corresponding state obligations

This section provides a methodological framework to assess and monitor the implementation of human rights in the context of sexual and reproductive health and well-being.²⁵ Both a country assessment and a national inquiry provide a firm basis as a framework to promote and monitor implementation of human rights in the context of sexual and reproductive health and well-being. The country assessment can be used on its own to identify challenges and areas in need of improvement or as a step in the development of a national inquiry.

A ASSESSING A COUNTRY SITUATION IN FOUR SIMPLE STEPS

A country assessment begins with:



The four simple steps proposed below will be useful in conducting a human-rights based assessment of the country situation concerning sexual and reproductive health and well-being.

STEP 1 Identify and define a key human rights problem and who is most affected.

Here it is important to identify all rights holders who are being affected, including persons belonging to the most marginalized populations. Identify the level of discrimination and inequality they experience. Ensure participation of persons belonging to those populations in identifying and defining the problem (see above sections on non-discrimination and equality, and participation).

WHAT IS THE PROBLEM? The first step in assessing human rights related to sexual and reproductive health and well-being is identifying the main problems people face. A problem can be defined as a gap between a human right in principle (what the situation should be) and the level of enjoyment of that human right in practice (what the situation is). The rights guaranteed by core UN international human rights treaties and other instruments provide a set of minimum standards against which to assess the situation in practice. Country assessments should look at whether these standards are met or not; what is the impact and the level of severity of the problem; and who are the most affected individuals and groups.

Human rights standards encompass a number of attributes that help to determine qualitative and quantitative indicators. Such indicators can be useful markers of health status, service provision, or resource allocation, and can play an important role in monitoring progress towards the realization of human rights. Indicators can also help hold States accountable for their obligations, for instance by exposing persistent problems or areas requiring greater attention. However, there is a lack of reliable and appropriately disaggregated data collected for health system indicators and other issues, which often means that indicators do not present a complete picture of the realization of human rights in the context of sexual and reproductive health and well-being (see Chapter 3 B.).²⁷

The lack of available data is not a barrier to conducting a country assessment. In fact, the assessment can help identify and recommend where data should be collected. States have an obligation under human rights law to collect disaggregated data.

Indicators are often articulated by treaty monitoring bodies as a necessary means by which States can assess their level of compliance with human rights.

They can be found in the concluding observations to individual States, in general recommendations and comments on thematic issues and in decisions of individual cases. They can also be found in recommendations under the UPR process. Additionally, the Office of the High Commissioner for Human Rights has developed indicators based on human rights obligations.²⁸

Valuable information can also be found in the country-specific concluding observations and recommendations from international and regional human rights mechanisms. They can help to identify the problems a country faces and recommended actions for addressing these problems. A good way to start a country assessment is to compile the international human rights observations and recommendations the country has received in recent years.

The following questions can help to gather information to identify the problem:

- Has the State ratified relevant international human rights treaties? If not, what are the reasons? Has the State entered any reservations to the treaties it has ratified? If so, what are they?
- Does the State regularly submit reports to UN treaty monitoring bodies? Do the reports include how the State is complying with and where it is falling short in its human rights obligations related to sexual and reproductive health and well-being?
- What have international human rights treaty bodies and UPR mechanism recommended to the country in their concluding observations in relation to sexual and reproductive health well-being? What measures has the government taken to implement these recommendations?
- Has any international human rights court, tribunal or treaty monitoring body issued decisions or communications based on complaints by individuals and/or groups in regard to human rights issues related to sexual and reproductive health and well-being?
- Has the country received human rights recommendations in relation to sexual and reproductive health and well-being as a result of the United Nations Human Rights Council Universal Periodic Review process?

- Has any report provided by a Special Rapporteur raised human rights issues in relation to sexual and reproductive health and well-being in your country?
- To what extent has the State gathered data on relevant issues being considered (box 5)?

STEP 2 Identify causes of the problem

This analysis helps to understand the underlying and root causes of the problem. These root causes may be related to policy and budgetary failures, specific barriers preventing access to acceptable and quality sexual and

reproductive health services (Box 2), or to entrenched social norms and cultural patterns. Whether the problem under analysis is maternal mortality, denial of sexual and reproductive health services, or teenage pregnancy, a causal analysis reveals a complex web of unfulfilled rights and multiple human rights deprivations underpinning the problem. For example, teenage pregnancy can be the result of the denial of the right to education, sexual violence, gender discrimination and harmful traditional practices such as child marriage. Long-term solutions to a problem and its causes requires a concerted multi-sectorial response, including improvements not only in the health sector.

BOX 4. STATES HAVE AN OBLIGATION TO GATHER DATA

The gathering of quantitative data is a challenge for most countries around the globe. However, in order to develop effective strategies for the realization of human rights and to monitor the implementation of state obligations under international human rights law, it is necessary that States collect data on a wide variety of issues broken down by different grounds, including age, gender, geographic location, disability, ethnicity and other characteristics.²⁹ In fact, the right to health includes the requirement to collect “appropriately disaggregated data” with the disaggregation of health data essential for identifying and remedying inequalities in health.³⁰ The World Health Organization has emphasized that a well-functioning health system “ensures the production, analysis, dissemination and use of reliable and timely information on health determinants ... and health status.” Data collection is also essential to promoting transparency and ensuring accountability, and is an important feature of human rights and includes the monitoring of conduct, performance and outcomes.³¹

Governments should not use the lack of official figures as a shield when confronted with claims that they are failing to address barriers to access.

There are numerous sources of useful data that should be explored. Demographic Health Surveys (DHS) are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in

the areas of population, health and nutrition. They can prove useful when researching maternal and reproductive health issues and violations. For example, DHS surveys provide data on unmet need for contraception and contraceptive use. They also provide data on prevalence of domestic violence. (Note that while some countries update their data regularly, some data may be 10 years old or older.)

For information on DHS, see

<http://www.measuredhs.com/What-We-Do/Survey-Types/DHS.cfm>

The World Health Organization also provides useful data broken down by country and region on numerous sexual and reproductive health issues, including on safe abortion:

Unsafe Abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf

List of Essential Medicines

<http://www.who.int/medicines/publications/essentialmedicines/en/index.html>

Reproductive Health Indicators: Guidelines for their generation, interpretation and analysis for global monitoring. http://whqlibdoc.who.int/publications/2006/924156315X_eng.pdf

a. What are the causes of the problem and why are certain population groups more severely affected?

Below are factors to consider when assessing the actual extent of the problem being investigated. Under each factor, an example is given to illustrate how to assess the problem. The examples focus on addressing the high level of maternal mortality.

EXAMPLE: In a given country facing a high maternal mortality problem, the sexual and reproductive health of all women, irrespective of age, race, location and marital status, may be affected by legislation and regulations preventing access to contraception and safe abortion services. This leads to high rates of unintended pregnancies. In countries with restrictive abortion legislation this could lead to unsafe abortions resulting in maternal deaths.

b. Identify the most severely affected rights-holders

and assess if they have specific needs that are not being met that are different from the needs overall, and assess why their needs are not being met. Vulnerable and marginalized populations are often underserved and encounter significant barriers to accessing sexual and reproductive health care and in exercising their human rights. Adolescents, ethnic and racial minorities, indigenous peoples, persons with disabilities, persons living with HIV, sex workers, persons living in rural areas and people of diverse sexual orientation and gender identity, including transgender people, are among some of the most marginalized. Human rights require particular attention to persons belonging to marginalized groups.

EXAMPLE: A given country can be affected overall by a high level of maternal mortality and morbidity but data disaggregation shows that maternal mortality is up to three times higher in some rural areas and among certain population groups such as indigenous women and girls. Specific barriers faced by these groups may be access to health services that respect privacy and confidentiality, lengthy distances to health clinics or lack of information in a language understandable or accessible to the patient.

c. Assess the specific legal, policy and practice barriers

which prevent individuals belonging to such groups from having their needs met and their rights realized. For example, do the laws adequately protect against non-discrimination in access to health care? Does the criminalization of certain conduct, such as sex work, inhibit access to needed health care by sex workers? Do attitudes by health workers against people

of diverse sexual orientation and gender identity or persons living with HIV result in denial of human rights?

EXAMPLE: Indigenous or migrant pregnant women may face discriminatory attitudes by health care providers, due to inability to speak the language or cultural practices that differ from their own, which inhibit them from using these services or which result in substandard care.

d. Are reproductive health information, goods and services, available, accessible, acceptable and of good quality (see Box 2 above)?

EXAMPLE: Hospitals and clinics in rural communities are often understaffed and inadequately resourced as opposed to ones in urban areas. Thus, access to the full range of modern contraceptive information and services may be limited, resulting in higher rates of unwanted pregnancy, abortion and maternal mortality in rural areas.

e. What are the unfulfilled underlying/social determinants

of the right to sexual and reproductive health? The fulfilment of sexual and reproductive health is also dependent on broad, underlying social and economic factors, some of which are also human rights. These include, but are not limited to, the right to water and sanitation, the right to education, the right to food, the right to information, and freedom from violence. An assessment identifies these economic and social factors and unfulfilled rights that impact reproductive health and rights. The assessment should establish whether the government, as the main duty bearer, is taking action for addressing these issues.

EXAMPLE: In rural areas, indigenous women have a lower level of educational attainment, there is no access to sexuality education, girls are more vulnerable to child marriage, and chronic malnutrition is more prevalent. These factors negatively impact the sexual and reproductive health of indigenous girls and women.

f. What are the root causes of the problem? Many human rights and development problems are the result of entrenched patterns of disempowerment, discriminatory social norms and behaviours, and a lack of political will. Gender discrimination is one of the key root causes for failure to fulfil numerous human rights, including those related to sexual and reproductive health and well-being. Do laws and policies set standards for

gender equality? For example, have measures been taken to eliminate child marriage, such as setting the age limit for marriage 18, equally for boys and girls? Are health programmes providing services that only women need, such as gynaecological or maternal health services, adequately resourced?

EXAMPLE: In addition to gender discrimination, women and girls from minority communities or those who live in rural areas are affected by intersecting forms of discrimination due to their location, ethnic status and age.

g. Is participation of affected individuals and communities, as well as civil society, supported in the drafting of laws and policies and the planning and design of programmes? Is participation supported in the monitoring and evaluation of policies and budgets? Are there special measures to promote the participation of marginalized groups and communities especially concerned with gender/sexual and reproductive health issues and rights?

EXAMPLE: Are adolescents involved in the design of educational programmes, both in and out of schools, which seek to prevent adolescent pregnancy?

h. Is there an enabling legal and policy environment protecting the right to information, including laws on access to public information?

EXAMPLE: Are civil society organizations able to access information on budgetary considerations on sexual and reproductive health issues from the parliament and relevant ministries, such as the Ministries of Health and Education?

i. Has the State established effective, accessible and independent mechanisms that ensure accountability for human rights violations related to sexual and reproductive health and well-being and that guarantee effective remedies? To what extent do these mechanisms respond in practice to specific obstacles women and girls face in exercising the human rights related to their sexual and reproductive health and well-being?

EXAMPLE: When a health care provider or institution denies a woman a lawful abortion, is there a mechanism in place where she could appeal this decision in a timely manner so that she could have effective access to lawful

termination of pregnancy, considering gestational time limits for abortion in that country?

STEP 3

Identify the duty-bearers and their human rights obligations and responsibilities.

Duty-bearers under international human rights law are primarily state actors and institutions at various levels of government. They are obliged to take deliberate actions in order to address the problem, its causes and the unfulfilled rights of all people, including the most deprived rights-holders. These actions would include legal, administrative, social and financial measures (see above sections on the obligations to respect, protect and fulfil human rights and on progressive realization). It is useful to keep in mind that there are other non-state duty-bearers with responsibilities in relation to the rights and needs of rights-holders. Such actors may include pharmaceutical companies, traditional leaders and religious actors, for example. Identifying the level of power they exercise in relation to rights-holders and state duty-bearers can help to identify comprehensive solutions to the problem being reviewed.³²

WHO MUST TAKE ACTION ABOUT THE PROBLEM AND WHAT ARE THEIR SPECIFIC HUMAN RIGHTS OBLIGATIONS AND RESPONSIBILITIES?

As noted above, sexual and reproductive health and well-being is grounded in a range of fundamental human rights guarantees, protected in national constitutions and in international and regional human rights treaties. There is recognition in international law of state obligations to ensure conditions that will enable persons to exercise their reproductive choices, protect their bodily autonomy and enjoy a safe, responsible and satisfying sexual life that is free of discrimination, coercion and violence. In order to assess state compliance with its human rights obligations the following two questions need to be asked.

a. Who are the duty-bearers with responsibility to take action on the problems and the series of factors identified in the previous steps?

b. What are the duty-bearer's obligations, particularly but not exclusively, the State, to address these concerns?

EXAMPLE: In the maternal health example, addressing maternal mortality and in particular the higher incidence of maternal mortality in rural and indigenous communities will require the engagement of a diverse group of duty bearers beyond the health sector, including the Ministry of Education, parliamentarians, law enforcement officials and traditional leaders.

A broad range of human rights obligations are encountered when addressing sexual and reproductive health and well-being, including access to information and services, access to safe abortion services in certain circumstances, maternal health care, HIV/AIDS prevention and treatment, comprehensive sexuality education, violence against women and concerns specific to marginalized and disadvantaged groups.

STEP 4 **Assess the level of compliance with human rights obligations**

Once duty-bearers and their corresponding obligations have been identified, the natural next step is to assess the degree to which the government, as the main duty-bearer, is complying with its human rights obligations. To that end, this guide provides a set of qualitative and quantitative indicators in seven areas, presented in the following section. These key issues and corresponding state obligations are as relevant for national inquiries as they are for country assessments.

B HUMAN RIGHTS OBLIGATIONS IN THE CONTEXT OF SEXUAL AND REPRODUCTIVE HEALTH AND WELL-BEING AND KEY PARAMETERS FOR ASSESSING STATE COMPLIANCE

This section adds specific guidance related to the methodological framework proposed for conducting country assessments and national inquiries, in particular to assess the level of state compliance with human rights obligations.

This section presents state obligations in relation to the following key issues:

- access to contraceptive information and services;
- access to safe abortion services and post-abortion care;
- maternal health care;
- prevention and treatment of HIV/AIDS;
- comprehensive sexuality education;
- violence against women and girls; and
- autonomous decision making and bodily integrity concerning select marginalized and disadvantaged groups.

For each of these seven issues, this guide provides a succinct explanation of corresponding state obligations, as established in international human rights norms and standards. Moreover, for each thematic issue, this guide provides a set of parameters (questions) to assess compliance with state obligations and illustrative indicators. These parameters and indicators do not purport to be an exhaustive list. Depending on

the country's context, the proposed parameters and indicators could benefit from adaptation and additional ones could be considered.

It is important to clarify that a country assessment or a national inquiry should not be limited to just one thematic issue, as all these issues are often inter-related and interdependent. For example, in order to lower maternal mortality and morbidity, access to modern methods of contraception and information is essential. This will help prevent unintended pregnancies and abortions. Similarly, access to comprehensive sexuality education will reduce unintended pregnancies and the risk of contracting HIV and other sexually transmitted infections.

Furthermore, in assessing or inquiring on a particular sexual and reproductive health problem, other human rights issues could be relevant in addition to the seven themes provided in this section. The causal analysis proposed in step 2 of the methodology for country assessments is a useful tool for identifying other underlying human rights issues at stake. Continuing

with the previous example, maternal mortality can be aggravated due to chronic malnutrition or lack of access to clean water and sanitation. Therefore, NHRIs may consider adding these or other inter-related issues to their assessment plans by identifying corresponding sets of parameters and indicators, as done for each of the seven themes presented below.

In addition, other sexual and reproductive health issues not covered below, may also want to be reviewed, such as breast and reproductive cancers.

1. ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES

Under the ICPD and international human rights laws, States have committed and have an obligation to ensure access to unbiased, comprehensive and evidence-based information and services for sexual and reproductive health, including family planning and contraception.

Integral to reproductive health is the obligation of **ensuring access to contraceptive information and services**. Access to family planning and contraceptive information and services enables individuals and couples to determine the number and spacing of their children, contributing to the achievement of the highest attainable standard of health and increasing their autonomy and their well-being and that of their families.³³ Such information and services are directly concerned with sexual relationships, and not just for those planning families, but for all, including adolescents. They have great potential for promoting sexual health, for ensuring a responsible, satisfying and safe sex life, and improving communication between partners and healthier sexual decision-making.³⁴ Contraceptive information and services are also critical to preventing pregnancies resulting from sexual violence, and in preventing HIV transmission and sexually transmitted infections. This includes information on the full range of contraceptive choices available, and their side effects as well success rates. Such information is necessary to inform the decision making of rights holders.

The ICPD Programme of Action, the WHO Global Reproductive Health Strategy, and the SDGs recognize the wide range of health and social benefits that a rights-based approach to the provision of family planning services can bring to individuals, families and society.

Yet despite these benefits, an estimated 214 million women in developing countries still have an unmet need for modern

contraception.³⁵ They either do not use any methods at all or rely on ineffective traditional methods, such as periodic abstinence or withdrawal. Ensuring contraceptive information and services are available, accessible, acceptable and of good quality, including that they are linked to the full range of reproductive health services, is not only sound policy from a public health perspective but it is also a human rights obligation: States are required to take affirmative measures to ensure the realization of rights and to remove any barriers jeopardizing them.³⁶

Rights implicated include the right to decide the number, spacing and timing of children; the rights to health and to life; the right to non-discrimination; and the right to private life.

a. State obligations

State obligations regarding access to reproductive health information and services include the following:

- Ensure that family planning services are fully integrated and readily available and accessible in clinics and reproductive health and other health services, allowing choice from the full range of quality modern contraceptive methods;
- Provide accurate and comprehensive sexual and reproductive health information, particularly on family planning and modern contraception;
- Provision of contraceptive services, including but not limited to sterilization, must be based on full and informed consent;
- Eliminate all coercive contraceptive practices, including the provision of financial and other incentives and consent based on misinformation;
- Prohibit and punish all forms of coercive and forced contraceptive practices, including but not limited to sterilization;
- Make available and accessible contraceptive commodities listed in national formularies that should be based on the WHO's Model List of Essential Medicines that guides procurement and supply of medicine;
- Set up programmes that address financial barriers, such as insurance coverage and other budgetary and economic measures to make contraceptive products and services affordable, especially for people with lower incomes and those living in poverty and extreme poverty;

- Ensure the high quality of contraceptive commodities and services, within easy access to and choice from a range of contraceptive methods, and evidencebased information on effectiveness and safety, and respecting client’s desires, life cycle, circumstances and health provided by technically competent health workers (including community lay health workers) in a manner that respects privacy and confidentiality, and ensures informed decision-making and consent;
- Provide young people both in and out of schools with comprehensive sexuality education and information on contraceptive choices that is objective and scientifically accurate; gender sensitive; free from stigma, prejudice and discrimination; and adapted to their level of maturity;
- Abolish laws and practices that require spousal or parental authorization access contraceptive services as they are discriminatory and contrary to the right to health and the right to privacy. States, instead, should apply the principle of ‘evolving capacities’ which relates to the adolescent’s acquisition of sufficient maturity and understanding to make informed decisions on matters of importance, without the authorization of their parents or guardians, to sexual and reproductive health services, including family planning;
- Ensure that emergency contraceptives are available to all women, especially women and girls who have been raped;
- Regulate the practice of conscientious objections by health providers, so that patient’s health and rights to receive family planning services and commodities are not in jeopardy;
- Provide special attention to the contraceptive choices and needs of women and adolescents, as well as those of marginalized and disadvantaged populations, such as racial and ethnic minorities, indigenous peoples, migrants, refugees and internally displaced persons, persons with physical or mental disabilities, and sex workers—particularly women belonging to these groups;
- Ensure that civil society and other stakeholders play a central role in the development of laws, policies and programmes on family planning and that those remedies are available when violations occur.

a. Assessing state compliance

Developing effective laws and policies, including budgets

- To what extent has the State gathered data on a range of contraceptive issues and on a range of vulnerable groups?
- To what extent has the State developed and implemented a national strategy or plan that includes measures to ensure access to contraceptive information and service?
- Are emergency contraception and modern contraception on the country’s essential medicines list making them accessible and affordable for all? What types of modern contraception (emergency contraception, male/female condoms, the pill, injectable, IUD) are on the essential medicines list?
- To what extent has the State allocated adequate budgetary, human and administrative resources to the implementation of such strategies or plans?
- Are there adequate funds available for implementing plans to provide access to contraceptive information and services?

Removing barriers and ensuring access

- What measures has the State taken to ensure that a full range of contraceptive methods, including emergency contraception, are available, accessible, acceptable and of good quality, both in law and in practice?
- What measures has the State taken to ensure that contraceptives are accessible to all women in various geographical locations?
- What measures has the State taken to make scientifically accurate information on a full range of contraceptive methods available, accessible, acceptable and of good quality (e.g. through comprehensive sexuality education or public education campaigns)?
- What steps has the State taken to eliminate third-party authorization (e.g. parental, spousal, guardian) for contraceptive methods?
- What steps has the State taken to eliminate other conditions on access to contraceptives, such as requiring a minimum number of children and/or

reaching a certain age before allowing a woman to undergo surgical sterilization or restricting access to contraceptives on the basis of age or marital status?

- What steps has the State taken to ensure the affordability of contraceptives, for instance by ensuring that a full range of contraceptive services are covered by public health insurance or available at no or low cost in public health facilities?
- What measures has the State taken to ensure that contraceptive services and commodities are delivered by healthcare workers in accordance with quality of care standards, including respect for the right to privacy, free and informed consent, and freedom of choice from a full range of contraceptive methods?
- What specific measures has the State taken to prevent or eliminate policies and practices resulting in involuntary family planning and contraception, including sterilization?
- To what extent does the State ensure that access to contraceptive information and services is not impeded by the exercise of conscientious objection by a health care provider or pharmacist?
- Have the structures, processes, training and needed resources been made available to translate laws and policies into practice?

Remedies

- What types of administrative or judicial safeguards has the State enacted in instances where a woman is impermissibly denied access to a particular contraceptive method or where she is coerced or forced into using contraceptives?
- What steps has the State taken to ensure that such administrative or judicial safeguards are accessible and timely?

Participation

- What type of mechanisms and procedures are in place to ensure the participation of affected populations in the formulation, implementation and monitoring of family planning strategies and programmes?
- What measures have been put in place to ensure the active and meaningful participation of groups in a

particular situation of marginalization and exclusion, including but not limited to adolescents?

SOME RELEVANT INDICATORS ON ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES

- Time frame and coverage of national policy on sexual and reproductive health;
- Contraceptive prevalence rate: Increase in proportion of women of reproductive age using, or whose partner is using contraceptives. Disaggregated by age, marital status³⁷, geographic location (urban, rural, suburban), and income and race/minority status. Contraceptive prevalence rates should be broken down by modern methods versus traditional methods. Modern methods include sterilization, pill, injectable, intra-uterine device (IUD), male condom, vaginal barrier methods, and implants as well as other modern methods. Traditional methods include rhythm, withdrawal and periodic abstinence;
- Unmet need for modern contraceptive methods.³⁸ Disaggregated by age, marital status, geographic location (urban, rural, suburban), and income and race/minority status;
- Number of family planning centres, including those serving the particular needs of youth, and their geographic distribution;
- Availability of the full range of contraceptive supplies;
- Adolescent birth rate;
- Adolescent abortion rate.

Related Sustainable Development Goal target:

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

Related Sustainable Development Goal indicator: 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods

SGD Indicator 5.6.1 on the proportion of women aged 15-49 years who make their own informed decisions

regarding sexual relations, contraceptive use and reproductive health care

SDG Indicator 5.6.2 on the number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education.

2. ACCESS TO SAFE ABORTION WHERE LEGAL AND POST-ABORTION CARE

Legal, regulatory and practice barriers, both in countries with more restrictive abortion regimes and those with more liberal ones, can effectively deny women access to safe abortion services. Restrictive abortion laws, criminal laws that punish women or providers for helping women undergo abortion, mandatory waiting periods and biased counseling requirements, refusals to perform legal abortions based on conscience and absence of public funding are but a few barriers women face across the globe.³⁹ World Health Organization estimates confirm that the legal status of abortion does not reduce the number of induced abortions, as women will seek abortions regardless of its legal status and lawful availability. While abortion is a safe procedure when performed by skilled health care providers in sanitary conditions, clandestine and illegal abortions, which are prevalent in countries with restrictive regulations, are generally unsafe and lead to high rates of complications.⁴⁰

In addition, timely access to post-abortion care is important to help minimize the effects of unsafe induced abortion.⁴¹

Globally, unsafe abortion results in death for approximately 47,000 women annually and disabilities for an additional 5 million women.⁴² This accounts for roughly 13 per cent of maternal mortalities globally, making unsafe abortion the third-largest cause of maternal death.⁴³ In some countries the percentage of maternal deaths resulting from unsafe abortion is much higher.⁴⁴ Also, young women are disproportionately impacted: over 60 per cent of all maternal deaths in Africa are women under the age of 25.⁴⁵

Additionally, in some countries women face barriers in accessing post-abortion care when complications arise, especially where abortion is criminalized.

Laws may require health care providers to report to law enforcement women who have undergone illegal

abortions or condition post-abortion care on confessions. Such laws and practices hinder women seeking post-abortion care, putting their lives and health at risk.⁴⁶

In 1994, governments at the ICPD agreed that where legal, abortion should be safe and accessible and post-abortion care should always be available. Since then international and regional human rights bodies and courts, have strengthened and broadened this consensus. Below are state obligations under international human rights law.

a. State obligations

Human rights bodies have articulated post-abortion and abortion-related violations as a violation of the right to life of pregnant women; the right to health; the right to non-discrimination; the right to be free from cruel, inhuman and degrading treatment; and the right to private life. States have an obligation to take measures to prevent unsafe abortions and to provide post-abortion care and, to ensure access to safe abortion where legal, and at minimum states must provide abortion 'where the pregnancy endangers the life or health of a pregnant woman, in cases of rape or incest in cases of fetal impairment'. State obligations include the following:

- Gather data on the range of abortion related issues, including abortion related mortality and morbidity and reasons;
- Ensure access to unbiased, comprehensive and evidence-based information on sexual and reproductive health, including information necessary to prevent unwanted pregnancy and reduce unsafe abortion and accurate information regarding availability and safety of abortion;⁴⁷
- Where abortion is legal, ensure access to safe abortion both in law and in practice. At a minimum ensure access to abortion where pregnancy poses a risk to the life or health of a pregnant women, in cases of severe foetal abnormality, and in cases of rape or incest.
- Eliminate punitive measures (decriminalize) for women and girls seeking abortion, and health care providers performing abortion services where consent is fully given;
- Ensure availability, accessibility (including affordability), acceptability and quality of safe abortion services, where legal. Interpret existing

health indications broadly, so as, for example, to include mental health, as per WHO's definition of health;⁴⁸

- Where abortion is legal, remove legal, regulatory and practice barriers which hinder access to safe abortion services, these include:
 - mandatory counseling and waiting periods;⁴⁹
 - unregulated practice of conscientious objection;⁵⁰
 - restrictions on essential medicines and services that make legal abortion services safer and easier to access, especially in rural settings⁵¹; and
 - judicial authorization.
 - third party authorization, including spousal authorization.⁵²

Regardless of legal status of abortion, the State must ensure access to confidential, post-abortion care, free from discrimination, coercion or violence. State obligations include the following:⁵³

- Ensure adequate training, support and supplies to ensure that abortion-related complications can be treated;
- Guarantee patient confidentiality for women and girls accessing post-abortion care, ensure that procedures are in place to investigate and sanction those who violate women's confidentiality;
- Ensure that post-abortion care is not conditioned upon admissions by women and girls seeking post-abortion care, and that these statements will not be used to prosecute them for undergoing the illegal procedure;
- Eliminate any requirements for health care providers to report patients to law enforcement who have undergone or suspected of having undergone an illegal abortion.

b. Assessing state compliance

- To what extent has the State developed and implemented measures to reduce the risk of unsafe or clandestine abortions, including developing abortion protocols? Do they reflect WHO guidelines on safe abortion?⁵⁴

- To what extent does the State collect data on abortion, including unsafe abortion, and estimates of illegal abortion? To what extent do data collection systems, protocols and data banks respect the confidentiality of individuals having undergone an abortion?
- What is the legal status of abortion? Does it reflect international human rights norms?
- Has the State repealed laws, policies or regulations that criminalize abortion? What efforts are being undertaken to do this?
- Has the State removed punitive measures against women and others who help women to undergo illegal abortions?
- Is the legal or regulatory framework clear, so as to ensure effective access to safe abortion, where legal? What efforts are being undertaken to ensure clarity?

Removing barriers and ensuring access

- What efforts has the State taken to ensure that the health grounds for abortion are read in conformity with WHO's definition of health encompassing both physical and mental health?
- To what extent has the State allocated adequate budgetary, human and administrative resources to the implementation of such strategies or plans, including ensuring that, where legal, safe abortion is accessible and affordable for all women?
- Are there policies or practices conditioning access to post-abortion care on confessing to having undergone an illegal abortion or denouncing the abortion provider? To what extent has the state refrained from imposing or eliminated such policies or practices? Has the state condemned and punished such practices?
- Is there abusive treatment of women and girls seeking abortion services where legal, or post-abortion care? What steps has the state taken to eliminate and punish such treatment?
- What efforts has the State taken to ensure effective access to quality, respectful, post-abortion care, irrespective of the legal status of abortion?
- What measures has the state taken to regulate the practice of conscientious objection so that it does not

hinder women's or girls' access to lawful services? For example, are emergency care and the provision of information on one's health status or health status of their pregnancy exempt from the practice of conscientious objection? Is there an oversight mechanism to ensure the legal regulation governing conscientious objection is adequately implemented?

- To what extent has the State eliminated or refrained from imposing other restrictions on access to safe abortion services, where legal, or post-abortion care such as laws requiring third party-authorization, or mandatory and/or biased counseling requirements?
- Does the State guarantee the confidentiality of women and girls seeking abortions where legal, or post abortion care, for instance by eliminating health care provider reporting requirements to law enforcement on women who have had abortions or are treated for post-abortion care?
- What efforts is the State taking to ensure that the law governing abortion is made available and accessible to women and girls, to health care providers and to the general public? Is there guidance provided to health care providers?
- Have the structures, processes, training and needed resources been made available to translate laws and policies into practice?

Remedies

- What types of administrative or judicial safeguards has the State enacted to provide remedy and redress where a woman or girl has been impermissibly denied access to an abortion, where legal, or post-abortion care, or when her confidentiality has been breached?
- Is such redress accessible and time sensitive?

Participation

- What type of mechanisms and procedures are in place to ensure the participation of women and girls in the formulation, implementation and monitoring of health strategies and programmes on the prevention of unsafe abortion, access to safe abortion, where legal, and post-abortion care?
- What measures have been put in place to ensure the active and meaningful participation of groups in a particular situation of marginalization and exclusion?

SOME RELEVANT INDICATORS ON ACCESS TO SAFE ABORTION AND POST-ABORTION SERVICES

- Number of unsafe abortions per 1,000 women of reproductive age;
- Number of legal abortions performed;
- Number of illegal abortions performed;
- Percentage of obstetric and gynaecological admissions owing to abortion-related complications and number of these due to illegal abortions;
- Number of health care providers, including mid-level providers, trained on providing abortion-related services (disaggregated by geographic location);
- Percentage of maternal deaths due to unsafe abortion (disaggregated by age, economic quintiles, location and race/ethnicity);
- Percentage of maternal morbidity due to unsafe abortion (disaggregated by age, economic quintiles, location and race/ethnicity).

Related Sustainable Development Goal target: 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births; 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

Related Sustainable Development Goal indicator: 3.1.1 Maternal mortality ratio; 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods

SDG Indicator 5.6.2 on the number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education.

3. MATERNAL HEALTH CARE TO ENSURE SAFE PREGNANCY AND CHILDBIRTH

It was estimated that in 2015, roughly 303,000 women died during and following pregnancy and childbirth. About 830 women die from pregnancy- or childbirth-related complications around the world every day. In sub-Saharan Africa, a number of countries halved their levels

of maternal mortality since 1990.⁵⁵ Despite progress, this figure still remains unacceptably high.

Many women face significant obstacles, including delays in seeking care, reaching healthcare facilities and receiving quality treatment by skilled professionals, resulting in high numbers of maternal mortality and morbidity.⁵⁶ Eighty per cent of maternal deaths worldwide result from severe bleeding, infections, high blood pressure during pregnancy and unsafe abortion—causes that are generally preventable if identified and properly managed in a timely manner. Women living in developing countries are burdened the most, with 99 per cent of maternal deaths worldwide.⁵⁷ Moreover, 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.⁵⁸

In addition, for every woman that dies of pregnancy and childbirth complications, at least 20 more women suffer long-term illness related to unintended pregnancy or recent childbirth.⁵⁹ Obstetric fistula is a debilitating disease whose immediate cause is very long or obstructed labour which results in the constant leaking of urine, faeces and blood, and which has significant physical and societal consequences.

Obstetric fistula is primarily preventable, through delaying the age of first pregnancy, the cessation of harmful traditional practices and timely access to obstetric care. Yet approximately two million women are living with fistula world-wide and up to 100,000 new cases occur each year.⁶⁰

Lack of access to quality maternal health care is now recognized as human rights issues involving the right to be free from discrimination and other human rights deprivations and the need for enhanced government accountability. 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.⁶¹

The ICPD Programme of Action 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.⁶² The ICPD Programme of Action's targets for the reduction of maternal mortality⁶³ were integrated into the SDGs, which call to reduce the global maternal mortality rate to less than 70 per 100,000 live births.⁶⁴

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, health, and equality and non-discrimination.

a. State obligations⁶⁵

States have an obligation to develop laws, policies, programmes and practices to ensure women's and girl's health and well-being throughout pregnancy, delivery, and the postpartum period. State obligations include the following:

- Collect, analyse and disseminate disaggregated data necessary to understand and to adequately respond to primary causes—both direct and indirect—of maternal mortality and morbidity;
- Address the underlying determinants of healthy pregnancy, including potable water, adequate nutrition, education, sanitation and transportation;
- Reduce their maternal mortality rates, by providing adequate interventions to prevent maternal mortality including by ensuring access to skilled birth assistance, prenatal care, emergency obstetric care, including effective referral systems in case of obstetric complications, safe abortion, and quality care for complications resulting from unsafe abortions;
- Remove barriers to reproductive health care such as high costs by providing free services in connection with pregnancy, childbirth and post-natal care;
- Ensure that essential medicines for pregnancy-related complications are registered and available (e.g. misoprostol to treat post-partum haemorrhage and incomplete abortion);
- Ensure the distribution of health care providers to ensure access to essential maternal health services, regardless of geographic location;
- Ensure maternal health services meet the distinct needs of women and are inclusive of marginalized sectors of society, including those with elevated rates of maternal mortality, young, poor, rural, minority and indigenous women and migrant workers;
- Regulate conscientious objection of healthcare workers so that its exercise does not prevent women

and girls from accessing information and services they need to make informed decisions regarding pregnancy and reproductive health;

- Take measures to ensure that the life and health of the pregnant woman are prioritized over protection of the foetus.

In addition, state obligations to ensure good quality maternal and reproductive health care include the following:

- Ensure that clear legal and professional regulations exist to ensure the quality of care;
- Provide high quality training of health care providers;
- Prevent and address abusive treatment of women and girls seeking reproductive health services, including maternal health care.

b. Assessing state compliance

Developing effective laws, policies and strategies

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

Ensuring access to maternal health services

- To what extent has the state increased access through primary healthcare to maternal health services including prenatal care, emergency obstetric care, post natal care, abortion and post-abortion services?
- What measures has the state taken to improve referral systems when certain maternal healthcare services such as emergency obstetric care, abortion and post-abortion services are not available at the community and primary healthcare level?
- To what extent has the state increased access to life saving commodities and essential medicines to improve maternal health?

- What policy and programming measures have been taken to address the three delays that often result in preventable maternal mortality and morbidity?

Removing barriers

- What measures has the State taken to eliminate harmful practices that can contribute to high-risk pregnancies, such as female genital mutilation or early or forced marriages?
 - What measures has the State taken to eliminate any laws, policies or practices that prioritize the foetus over life- or health-saving medical care for pregnant women and girls?
 - What steps has the State taken to ensure that women and girls are not exposed to preventable health risk by reason of pregnancy?
 - What steps has the State taken to combat early or unwanted pregnancy by ensuring access to comprehensive sexuality education and access to contraceptive information and services, including for adolescents and youth?
 - What efforts has the State taken to exercise due diligence to prevent and eliminate abusive treatment, and discriminatory attitudes, including by health providers, against women and girls seeking pregnancy-related health care, particularly women and girls from marginalized and excluded groups?
 - What efforts have been taken to ensure that maternal health care is covered by the health system or is affordable for women and girls living in poverty?
 - What efforts has the state taken to eliminate in law and in practice the need for seeking third-party (e.g. marital, parental, legal guardian) authorization in order to access maternal health care services?
- ### Remedies
- What types of administrative or judicial safeguards has the State enacted to provide remedy and redress where women's rights to access quality pregnancy-related care are violated? E.g. judicial remedies, maternal death reviews, etc.
 - What steps has the State taken to ensure that such administrative or judicial safeguards are accessible, timely, and effective?

Participation

- What type of mechanisms and procedures are in place to ensure the participation of women and girls in the formulation, implementation and monitoring of health strategies and programmes on the reduction of maternal mortality and morbidity and its underlying determinants such as harmful practices, water and sanitation, nutrition, etc.?
- What measures have been put in place to ensure the active and meaningful participation of groups of women and girls at a higher risk of maternal mortality or in a particular situation of marginalization and exclusion?

SOME RELEVANT INDICATORS ON MATERNAL HEALTH CARE⁶⁶

*Disaggregated by age, race/ethnicity, location and economic quintiles

- Time frame and coverage of national policy which focuses on or includes maternal health;
- Estimated proportions of births and deaths recorded through vital registration system;
- Maternal mortality ratio;*
- Antenatal care coverage;*
- Percentage of births attended by skilled health personnel;*
- Availability (i.e. numbers of facilities) of basic and comprehensive essential obstetric care and number of these facilities that are being used (disaggregated by geographic location);
- Proportion of women with obstetric complications using these facilities;*
- Prevalence of anaemia in women;*
- Percentage of obstetric and gynaecological admissions owing to abortion*;
- Prevalence of obstetric fistula;
- Perinatal mortality rate;*
- Lifetime risk of maternal death.*

Related Sustainable Development Goal target: 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

SDG Indicator 5.6.2 on the number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education.

Related Sustainable Development Goal indicator: 3.1.1 Maternal mortality ratio; 3.1.2: Proportion of births attended by skilled health personnel

4. PREVENTION AND TREATMENT OF HIV AND AIDS

More than 60 million people have contracted HIV and roughly 30 million people have died of AIDS since the start of the epidemic.⁶⁷ While access to anti-retroviral treatment has increased dramatically in the past decade, treatment gaps remain, including for young people and key populations (i.e. sex workers, men who have sex with men, people who use drugs and transgender people). According to UNAIDS data to date, there are 36.9 million people living with HIV. Eastern and southern Africa, is the region that is home to more than half (53%) of those living with HIV.

Women and girls continue to be disproportionately affected.

Due to social, cultural and physiological reasons, as well as the prevalence of violence against women, women account for over half of all people living with HIV. UNAIDS reports that globally, in 2017, an estimated 18.2 million women aged 15 years and older were living with HIV. This constitutes 52% of all young people and adults aged 15 years and older living with HIV.

People living with HIV have the same right to sexual and reproductive health as all other people in the community. Yet, less than half of people living with HIV are receiving treatment, and less than 50 per cent of pregnant women living with HIV in developing countries receive the most effective treatment to prevent transmission to their children. Female sex workers have a 10 times greater risk of acquiring HIV than the general population. Stigma and discrimination hinder access to HIV prevention, treatment, care and support, and result in violations of human rights. For example, people living with HIV have been targeted by coercive policies and practices such as forced sterilization, stripping them of fundamental human rights and creating mistrust in the health system, deterring them from seeking treatment. Further, the criminalization of sex worker and their clients, men who have sex with men, people who use drugs and transgender people in many countries around the world exacerbates their social exclusion and adversely affects their ability to access services. Laws criminalizing HIV transmission are ineffective at reducing transmission, as they deter individuals from undergoing HIV testing out of fear of prosecution.

UNAIDS reports that globally, two of three new HIV infections among 15-19 year olds are girls. In sub-Saharan Africa, young women are twice as likely to acquire HIV as their male counterparts. Young people are often denied access to HIV counseling and testing without parental permission. Fear and stigma compound their unwillingness to access HIV services where they do exist. The reluctance of States and religious institutions to support comprehensive sexuality education contributes to continued low rates of condom use among sexually active adolescents and young people.

a. State obligations

States must guarantee people living with HIV the equal enjoyment of their human rights by developing laws, policies and practices which ensure prevention of and treatment for HIV/AIDS. State obligations in the prevention and treatment of HIV/AIDS include the following:

- Anti-retroviral treatment should be available, affordable and accessible to all in an equitable manner and States should take measures to eradicate barriers in accessing anti-retroviral treatment, including the high cost;
- Ensure all individuals living with HIV are able to access reproductive health information, goods and services, including access to perinatal care, skilled attendance during birth, emergency obstetric care and other reproductive health medicines and technology. This includes the obligation to:
 - ensure access to non-discriminatory, non-abusive and non-stigmatizing reproductive health care for pregnant women living with HIV and for women living with HIV who wish to become pregnant; people from key populations; and sexually active adolescents and young people;
 - ensure access to anti-retroviral treatment to reduce vertical transmission; and
 - ensure that all people who need treatment receive treatment, regardless of migrant status, ethnicity, location, work, sexual orientation, age, marital status, gender identity or any other status.
- Ensure that HIV testing and treatment is voluntary, confidential and available without parental consent;

- Implement prevention strategies such as promoting condom use and access to male and female condoms ensuring access to contraceptives, and conducting evidence-based public awareness-raising campaigns;
- Ensure appropriate resources are allocated to HIV programmes, and the effectiveness of programmes should be monitored and evaluated.

Also, States should take effective measures to ensure freedom from discrimination and counter HIV-related stigma. State obligations include the following:

- Prohibit discrimination based on seropositive status;
- Ensure that people living with HIV have non-discriminatory access to reproductive health services;
- Ensure people living with HIV can make informed and voluntary decisions about reproduction and childbearing, this includes the obligation to ensure access to contraceptive information and services, safe abortion services where legal and reproductive technologies. It also requires eliminating policies or practices that promote or permit, directly or indirectly, the involuntary sterilization of people living with HIV;
- Strategies to address HIV should target key populations – sex workers, men who have sex with men, transgender people and people who use drugs – and other populations with higher vulnerability to HIV including young people, particularly adolescents, prisoners and migrants;
- States should take a gender-sensitive approach to the HIV epidemic, emphasizing the specific rights and needs of women. Eliminate the social and cultural factors that exacerbate women's and girls' increased risk of contracting HIV, including gender-based violence, gender stereotyping, lack of or inadequate sexuality education for both young women and men, and harmful practices including female genital mutilation (FGM) and child, early and forced marriage;
- Laws criminalizing consensual same-sex behaviour, sex work and HIV transmission should also be repealed by all States.

b. Assessing state compliance

Laws, policies, strategies and budgets

- To what extent has the State developed and implemented a national strategy or plan aimed at ensuring HIV prevention, treatment and care of key populations at higher risk of HIV such as women and girls, sex workers, men who have sex with men, transgender people, people who use drugs, adolescents, young people, migrants and prisoners?
- To what extent does the above plan include programmes to reduce parent-to-child transmission?
- To what extent has the State enacted legislative or regulatory protections to ensure the rights of individuals living with HIV to give informed and voluntary consent to health goods and services, including HIV testing, and to ensure confidentiality in testing and treatment?
- To what extent has the State allocated adequate budgetary, human, and administrative resources to the implementation of such strategies or plans?
- To what extent has the State enacted and enforced legislation which prohibits discrimination in access to goods and services and also in the private sector, such as employment based on HIV status? Does the law prohibit discrimination based on HIV status?
- To what extent has the state developed and implemented effective public information campaigns that inform how to protect oneself from HIV but that also counter the stigma and discrimination of persons living with HIV?
- Is the transmission of HIV criminalized? Same sex conduct? Sex work? Drug use? To what extent is it criminalized?
- What measures has the State taken to eliminate involuntary or punitive measures in HIV testing, prevention or treatment programmes, such as the mandatory HIV testing of pregnant women or girls, sex workers, people who use drugs and young people?
- What steps has the State taken to respect the rights of individuals living with HIV to make voluntary decisions around childbearing, for instance by eliminating policies or programmes that promote or condone involuntary sterilization or forced abortion for women living with HIV?
- Have the structures, processes, training and needed resources been made available to translate laws and policies into practice?
- What efforts have been taken to reduce stigma from health care providers, law enforcement and the judiciary towards key populations including sex workers, men who have sex with men, transgender people and people who use drugs?
- What monitoring efforts has the State put in place to ensure access, acceptability and quality of services for adolescents and other young people, key populations and populations at higher vulnerability to HIV?

Remedies

Ensuring access and removing barriers

- What measures has the State taken to eliminate discrimination in law and in practice against individuals with HIV, including by repealing discriminatory laws and by prohibiting discrimination on grounds of HIV status?
- What measures has the State taken to repeal laws that criminalize consensual same sex sexual relations, sex work and HIV transmission?
- What types of administrative or judicial safeguards has the State enacted to provide remedy and redress where an individual living with HIV has been denied essential health care on the basis of his or her HIV status, or received abusive, stigmatizing or discriminatory treatment in health care settings or in any other settings (e.g. workplace or participation in social and community life)?
- What steps has the State taken to ensure that such administrative or judicial safeguards are known, accessible and timely?
- What types of administrative or judicial safeguards has the State enacted to provide remedy and redress where sex workers, men who have sex with men, transgender people, people who use drugs, undocumented migrants, indigenous people and other people with higher vulnerability to HIV (and including those living with HIV) have received stigmatizing or discriminatory treatment in health care settings or in any other settings (e.g. police, judiciary, social services, workplace or participation in social and community life)?

- To what extent have complaint and redress mechanisms been used, and how accessible are they in practice for key populations, indigenous people and ethnic minorities, undocumented migrants and other people at heightened vulnerability to HIV?

Participation

- What type of mechanisms and procedures are in place to ensure the participation of key populations, indigenous people, adolescents and young people, and people living with HIV, in the formulation, implementation and monitoring of HIV strategies and programmes?
- What measures have been put in place to ensure the active and meaningful participation of key populations, indigenous people, adolescents and young people, people living with HIV, and other populations with higher vulnerability to HIV, who are marginalized, stigmatized and face social and economic exclusion?

SOME RELEVANT INDICATORS ON THE PREVENTION AND TREATMENT OF HIV/AIDS

*Disaggregated by sex, gender, age, economic quintiles, location and race/ethnicity

- Proportion of population covered under awareness-raising programmes on transmission of HIV;
- Knowledge of HIV-related preventive practices;*
- Proportion of population applying effective preventive measures against diseases such as HIV and malaria;*
- Number of programmes to prevent vertical transmission of HIV;
- HIV prevalence;*
- Prevalence of HIV infection in pregnant women (disaggregated by age, economic quintiles, location and race/ ethnicity);Prevalence of HIV infection in sex workers, men who have sex with men, transgender people, people who use drugs, adolescents and other young people (disaggregated by age, economic quintiles, location and race/ethnicity).

Related Sustainable Development Goal target: 3.3
By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat

hepatitis, water-borne diseases and other communicable diseases Related Sustainable Development Goal indicator: 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations

SDG Indicator 5.6.2 on the number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education.

5. COMPREHENSIVE SEXUALITY EDUCATION

In order to make informed decisions about sexuality and reproduction, individuals need accessible, quality, comprehensive information on effective contraceptive methods.⁶⁸ However, inadequate counseling tools and services, limited or the absence of sexuality education in and out of schools, and no or wrong information about the safety and effectiveness of contraceptives and other issues concerning reproduction and sexuality⁶⁹ hinder people's ability to make informed decisions and to enjoy a satisfying and safe sex life free from discrimination, coercion and violence as recognized in the ICPD.

According to UNESCO, comprehensive sexuality education programmes include information on the following: growth and development; sexual anatomy and physiology; reproduction, contraception, pregnancy and childbirth; HIV and AIDS; sexually transmitted infections; family life and interpersonal relationships; culture and sexuality; human rights empowerment; non-discrimination, equality and gender roles; sexual behaviour; sexual diversity; sexual abuse; gender-based violence; and harmful practices.⁷⁰

As part of state obligations under the right to the highest attainable standard of health as well as the right to education, they have an obligation to ensure that all individuals have access to comprehensive sexuality education, both within and outside the formal educational system.⁷¹ This includes the following obligations:

a. State obligations

- Make comprehensive sexuality education programmes part of the standard school curriculum, provided throughout schooling in an age-appropriate manner and without parental consent;⁷²

- Make sexuality education programmes also available outside of formal school setting, such as through community-based organizations, so as to reach individuals excluded from the educational system, including child brides and street children;
- Develop public education campaigns to raise awareness about sexual and reproductive health issues, such as risks of early pregnancy and prevention of STIs;⁷³
- Include instruction on comprehensive sexuality education programmes in teacher training programmes, to ensure that instructors are trained to provide comprehensive and accurate information in a safe learning environment.⁷⁴

Content of comprehensive sexuality education programmes

- Develop educational materials that reflect good quality, scientifically accurate, and accessible comprehensive sexuality education programmes;⁷⁵
- Note that effective programmes are ones that provide scientifically accurate information and should be taught over a period of years, according to UNESCO guidelines on sexuality education designed to help States develop comprehensive sexuality education programmes.⁷⁶
- Health-related information should be physically accessible, understandable and appropriate to children's age and educational level;⁷⁷
- States have obligations to ensure that all sexuality education programmes, both in and out of school, do not censor or withhold information or disseminate biased or factually incorrect information, such as inaccurate information on contraceptives.⁷⁸ They should be non-discriminatory both in content and in teaching methodologies.⁷⁹ This includes obligations to develop curriculum materials that do not perpetuate harmful or discriminatory stereotypes, and which pay special attention to diversity and gender issues, including gender role stereotyping.⁸⁰

b. Assessing state compliance

- Has the State developed and fully implemented a national strategy or plan to ensure access to

comprehensive and accurate sexuality education both in and out of schools?

- To what extent has the State developed curricula and teacher-training material?
- To what extent does the content of existing programmes follow international human rights norms and guidelines developed by UNESCO?
 - Is the information factually correct on sexuality or sexual and reproductive health? If not, has the state taken steps to eliminate this information?
- Are existing teachers and students of pedagogy taught about teaching sexuality education? Are they sensitized to the various needs of students and on the importance of scientific accuracy free from myths and stereotypes?
- To what extent does the State ensure access to sexuality education programmes?
 - Are the school-based curricula mandatory and provided throughout schooling in an age-appropriate manner?
 - What steps has the State taken to repeal policies, laws and regulations restricting access to sexuality education and information on sexual and reproductive health?
 - Are there limitations or restrictions, such as parental or guardian authorization for participation in such programmes? If so, to what extent has the State taken steps to eliminate such limitations?
 - Are programmes available to disabled children in a manner that is accessible to them?
 - What measures has the State taken to ensure that religious, social or other beliefs, practices and institutions do not impede individuals' access to comprehensive sexuality education?
- Have the structures, processes, training and needed resources been made available to translate laws and policies into practice?

Participation

- What type of mechanisms and procedures are in place to ensure the participation of children, parents

and educators in the design, implementation and monitoring of sexuality education programmes both in and out of schools?

- What measures have been put in place to ensure the active and meaningful participation of children belonging to marginalized groups, including but not limited to those not attending school, and those who are married?

SOME RELEVANT INDICATORS ON COMPREHENSIVE SEXUALITY EDUCATION

- Percentage of students who have received comprehensive sexuality education in schools (disaggregated by age, geographic location);
- Percentage of adolescents who understand how to prevent unwanted pregnancy and STIs (disaggregated by ethnicity/race, disability and economic quintile);
- Percentage of teachers trained in sexuality education (disaggregated by geographic location);
- Percentage of health providers trained in sexual and reproductive health counseling (disaggregated by geographic location);
- Ratio of teachers imparting sexuality education per total number of enrolled students (disaggregated by geographic location);
- Percentage of sexually active adolescents who used contraception at first or last sex (disaggregated by age).

Sustainable Development Goal target: 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes Numerous Sustainable Development Goal indicators related to HIV, modern contraception and maternal health, including: 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group

SDG Indicator 5.6.2 on the number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education.

6. VIOLENCE AGAINST WOMEN AND GIRLS

Violence against women is gender-based violence directed towards women or girls that result in or is likely to result in physical, sexual, psychological or economic harm or suffering.⁸¹ Violence against women – particularly intimate partner violence and sexual violence – is a major public health problem and a violation of women's human rights. Global estimates published by WHO indicate that about 1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.⁸²

A few examples of violence against women and girls include sexual violence and rape, domestic violence, and harmful practices such as female genital mutilation.⁸³ Numerous health-related consequences arise from such violations, including unintended pregnancies, STIs and pregnancy-related complications. Because violence against women reinforces and perpetuates gender inequities, women's ability to control their fertility is impaired. They are unable to negotiate contraceptive use or access contraceptives, making them more vulnerable to HIV and other STIs. Particularly vulnerable are girls and women in conflict and other humanitarian settings as well as adolescents. Harmful practices such as female genital mutilation or child, early and forced marriage are particularly harmful to girls, both physically and mentally. Addressing violence against women and girls requires more than criminal laws prohibiting violence; the underlying and root causes of gender-based violence must be addressed in order to eradicate the practice.

a. State obligations

Human rights bodies recognize that violence against women and girls constitutes a form of discrimination.⁸⁴ State obligations include the following:

- Take measures to modify social and cultural patterns with a view to eliminating prejudices and practices that are based on the inferiority or superiority of either of the sexes or stereotyped roles of men and women;
- Prevent and eliminate violence against women and girls in both the public and private spheres;
- Adopt adequate, comprehensive legislation and other measures, including sanctions where appropriate, to prevent and punish all forms of violence against women and girls;

- Investigate, prosecute and punish instances of gender-based violence;
 - Implement programmes to train police, prosecutors and the judiciary about gender-based violence;
 - Ensure that programmes addressing gender-based violence take into account underserved and vulnerable groups such as persons with disabilities to ensure they, as well as all women, have access to essential services and redress;
 - Implement policies that protect victims from further harm such as social, psychological and health services for victims;
 - Decriminalize abortion in instances of rape;
 - Provide survivors of sexual violence with timely access to emergency contraception;
 - Incorporate efforts to combat gender-based stereotypes and other underlying causes of gender-based violence in programmes aimed at addressing gender-based violence;
 - Initiate public education campaigns, including in schools, to raise awareness about gender-based violence and to combat root causes, including harmful gender stereotypes;
 - Ensure comprehensive training for relevant professionals, including teachers and healthcare workers;
 - Ensure effective access to justice for survivors of violence against women, legal aid and remedies, including compensation and rehabilitation.
- To what extent has the State developed and implemented plans of action/executive policy on violence against women and girls with a strong evidence base and political will for its implementation, demonstrated by budgetary allocation, timelines and clear paths of responsibility?
 - To what extent has the State prohibited or criminalized all forms of violence against women and girls and treated as serious offences, including:
 - sexual harassment and stalking;
 - domestic and intimate partner violence;
 - harmful practices, such FGM and child, early and forced marriages;
 - rape, including marital rape.
 - To what extent does the law recognize that rape is a crime against the person rather than against morals, which cannot be erased through marriage?
 - To what extent does the law protect survivors of violence, including through protective orders and through safe shelters for women and their children?
 - To what extent has the State prohibited child marriage?

Awareness-raising and training

- To what extent has the State allocated adequate resources to ensure provision of support and advocacy services by NGOs, including shelters, helplines, advocacy, counseling and other services? Are they adequately distributed across geographic locations?
- To what extent has the State collected, collated and published disaggregated data on all forms of violence against women?
- What measures has the State taken to increase awareness and sensitivity of professionals and officials who come in contact with survivors of violence, including, all law enforcement professionals, health care professionals, social workers, etc.?
- To what extent are there countrywide awareness-raising campaigns on violence against women and girls, including on debunking harmful gender stereotypes of women?

b. Assessing state compliance⁸⁵

Laws, policies and budgets

- Has the State ratified and implemented the Convention on the Elimination of Discrimination against Women, the Convention on the Rights of the Child and other relevant international and regional human rights instruments?
- To what extent has the State implemented the constitutional guarantees of equality and non-discrimination and repealed discriminatory laws?

- To what extent is violence prevention integrated into school curriculum?
- To what extent has the State developed health guidelines on managing the medical consequences of violence against women?
- To what extent is access to emergency contraception, prophylaxis for HIV and other sexually transmitted infections and, if wanted, safe abortion part of the standard of care for survivors of violence?

Remedies

- To what extent is there an effective legal framework, statute and procedural law that provides access to justice (including free legal aid), redress, protection and compensation for survivors of violence? Are they responsive to the specific obstacles women and girls face when seeking justice?
- To what extent does the State investigate promptly, impartially and seriously all allegations of violence against women and girls and bring offenders to justice?
- Do marginalized and isolated groups of women and girls have equal access to support and justice?

Participation

- What type of mechanisms and procedures are in place to ensure the participation of women survivors of violence in the formulation, implementation and monitoring of strategies and programmes on violence against women?
- What measures have been put in place to ensure the active and meaningful participation of groups in a particular situation of marginalization and exclusion, including, but not limited to women with disabilities?

SOME RELEVANT INDICATORS ON VIOLENCE AGAINST WOMEN⁸⁶

- Legally stipulated minimum age for marriage;
- Proportion of women who have experienced physical, sexual and psychological violence during the last year, by severity of violence, relationship to the perpetrator and frequency (disaggregated by age, disability, geographic location, economic quintile, race/ethnicity);

- Number of instances of violence against women reported to law enforcement and percentage of investigations of those reports (disaggregated by age, geographic location, economic quintile, disability, race/ethnicity);
- Proportion of received complaints on all forms of violence against women investigated and adjudicated by the national human rights institution(s) or other human rights mechanisms of protection and the proportion of those responded effectively by the government (disaggregated by age, geographic location, economic quintile, race/ethnicity);
- Number of prosecutions and convictions for violence against women and girls (disaggregated by age, geographic location, economic quintile, race/ethnicity);
- Percentage of health providers trained to detect signs of sexual abuse or violence (disaggregated by geographic location);
- Prevalence of female genital mutilation/cutting (disaggregated by age, geographic location, race/ethnicity).

Sustainable Development Goal target: 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

Sustainable Development Goal indicators: 5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age 5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence

Sustainable Development Goal target: 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

Sustainable Development Goal indicator: 5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18

7. AUTONOMOUS DECISION MAKING AND BODILY INTEGRITY, INCLUDING ILLUSTRATIVE EXAMPLES OF MARGINALIZED AND EXCLUDED GROUPS

Autonomy is a central component of the rights to life, privacy and liberty, among others, and includes individuals' rights to make informed decisions about their bodies, including concerning their gender identity and to determine the number and spacing of their children and to be free from coercion, discrimination and violence.⁸⁷ For example, a key component of the ICPD Programme of Action was the recognition that compelling individuals to carry out States' coercive population-based laws, policies or practices constitutes a human rights violation and should be abolished. States also agreed to take measures to ensure that third parties do not interfere with the right to autonomy; they agreed to abolish laws, policies and practices that interfere with individuals' rights to autonomous decision-making. In order to fulfil this principle, States further agreed to provide individuals with access to information and services that enable them to exercise their autonomy.

Some population groups often experience poorer sexual and reproductive health outcomes, including adolescent girls, indigenous peoples, migrants, sex workers, persons with disabilities and people of diverse sexual orientation and gender identity. Recognizing this, international commitments and human rights law require special attention be given to marginalized and disadvantaged populations. For example, with the adoption of the 2030 Agenda, UN Member States pledged to ensure that "no one will be left behind" and to "endeavor to reach the furthest behind first". Thus, all of the SDGs, including those related to sexual and reproductive health and well-being are aimed at reaching marginalized population.

Interferences with the exercise of sexual and reproductive autonomy may reflect multiple forms of discrimination prevalent in all areas of life, including in health care, education and employment, and may violate numerous human rights, such as the right to be free from inhumane and degrading treatment, and may constitute forms of violence.⁸⁸

The elimination of discriminatory laws, policies and programs are a bedrock of human rights obligations and are commitments made by states, including in adopting the SDGs.

ADOLESCENTS

Adolescents face numerous barriers in exercising their sexual and reproductive autonomy. In the area of marriage and access to sexual and reproductive health services, for example, adolescents face numerous obstacles, including stigmatization of adolescent sexuality, and laws and policies that discriminate on the basis of age or mandate parental/guardian consent or authorization for reproductive health services, and their overall low social status. According to the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), all adolescents should have the same right to access health care without third party authorization, whether that is a spouse or a parent, and whether the adolescent is married or unmarried.⁸⁹ The resulting lack of autonomy hinders access to confidential health care and comprehensive sexuality education, encountering barriers to contraceptive access. It also subjects them to harmful practices, such as early and forced marriage or female genital mutilation. Pregnancy-related deaths are the leading cause of death for adolescent girls in developing countries.⁹⁰

a. State obligations

- The Convention on the Rights of the Child requires States to apply the principle of 'evolving capacities' which relates to the adolescent's acquisition of sufficient maturity and understanding to make informed decisions on matters of importance, without the authorization of their parents or guardians, to sexual and reproductive health services. Thus, States must systematically consider the adolescent's evolving capacities, and should ensure that appropriate services are made available to them independent of parental or guardian authorization, when this is in the best interest of the child. The UN Special Rapporteur on Health has recommended states to introduce legal presumption of competence that an adolescent seeking preventive or time-sensitive sexual and reproductive health good and services, has the requisite capacity to access such goods and services without parental/guardian consent or authorization.⁹¹
- Adolescents need to be recognized by their family environment and by law as active rights-holders that have the capacity to progressively become full and responsible citizens when given proper guidance and direction.⁹²

- Even where parental authorization is not required, stigma around adolescent sexuality and prohibitive costs may be deterring adolescents to seek services. Human rights bodies have called on States to respect strictly adolescents' right to privacy and confidentiality, including with respect to advice and counseling on health matters.⁹³ In addition, health-care providers should be trained to provide information and services to adolescents according to these principles,⁹⁴ and ensure youth-friendly, confidential reproductive health including family planning services for adolescents from different socio-economic backgrounds.⁹⁵
- Adolescents have the right to information on the dangers of early marriage and early pregnancy, evidence-based sexuality education and on ways to protect themselves from unwanted sex and/ or unintended pregnancy and sexually transmitted infections.⁹⁶
- States should ensure that adolescents are not deprived of any sexual and reproductive health information or services due to providers' conscientious objections.⁹⁷
- International human rights bodies have called on States to eliminate child marriages and to stipulate that the legal minimum age for marriage should be 18 for both men and women.⁹⁸

b. Assessing state compliance

- What measures has the State taken to ensure that the legal age of child marriage is 18, for both boys and girls?
- What measures has the State taken to eliminate child marriage in practice?
- What measures has the State taken to ensure that laws and practices which require parental consent or authorization without assessing the individual needs of the adolescent first, are rescinded?
- Are youth-friendly services available throughout the country?
- Is the right to privacy and confidentiality protected by law?

- To what extent have health care providers and peer educators been training to provide youth-sensitive services and counseling?
- To what extent has the State engaged in public education campaigns on the harms of early marriage and early pregnancy, and on preventing STIs, including HIV among youth?

Participation

- What type of mechanisms and procedures are in place to ensure the participation of adolescents in the formulation, implementation and monitoring of relevant sexual and reproductive health strategies and programmes?
- What measures have been put in place to ensure the active and meaningful participation of adolescent groups in a particular situation of marginalization and exclusion?

SOME RELEVANT INDICATORS ON ADOLESCENTS

***Disaggregated by age, sex, gender, geographic location, economic quintile, race/ethnicity**

- Average age of sexual initiation;*
- Percentage of adolescents seeking counseling services;*
- Percentage of adolescents obtaining counseling services;*
- Number of youth friendly counseling and health centres and their distribution across the country (disaggregated by geographic location);*
- Number of health care providers and peer educators trained to provide services to youth and distribution across the country (disaggregated by geographic location)
- Rate of STIs among adolescents;*
- Number of child marriages.

SEX WORKERS⁹⁹

Many countries in the world criminalize sex work, including both buyer and seller or just the buyer. Other countries do not directly criminalize the exchange of sex for remuneration, but rather criminalize all surrounding activities, including soliciting or “brothel-keeping”. All such laws marginalize sex worker populations, hindering their access to health services, fuelling stigma and discrimination and making them more vulnerable to HIV and other sexually transmitted infections. Because sex workers are often outside the protection of the law, they are particularly vulnerable, increasing their risk of experiencing coercion and violence. In Asia alone, there are estimated to be 75 million male clients of sex workers paying for services each year from an estimated 10 million sex workers. The male clients of sex workers are considered to be at the epicentre of the HIV epidemic in that region.¹⁰⁰ A study shows that female sex workers are 13.5 times more likely to acquire HIV than all other women aged 15–49 years, including in high HIV-prevalence countries. Research has confirmed that of all potential interventions identified, “[d]ecriminalization of sex work would have the greatest effect on the course of HIV epidemics across all settings, averting 33–46% of HIV infections in the next decade¹⁰¹

Police abuses of sex workers, including harassment, extortion, unauthorised detention and assaults are reported across the globe.¹⁰² Sex workers are often targeted for harassment and violence because they are considered immoral and deserving of punishment. Criminalization legitimizes violence and discrimination against sex workers, particularly from law enforcement

authorities and health care providers. Criminalization makes sex workers reluctant to report abuses and makes authorities reluctant to offer protection or support to sex workers.¹⁰³ Additionally, laws that conflate human trafficking and sex work as ‘sexual exploitation’ contribute to vulnerability, generate stigma and create barriers to HIV and other health service delivery.¹⁰⁴

Mandatory, compulsory or coerced HIV or STI testing of sex workers is a widespread problem. Laws in several countries require regular testing of sex workers as a condition of on-going employment.¹⁰⁵

Such practices expose sex workers to risk of discrimination and violence, compound stigma and divert resources from effective HIV prevention and care interventions. In addition, in many places, sex workers lack the labour rights afforded to other workers, including

the legal right to a safe and healthy workplace and to reasonable terms and conditions of employment. Such practices violate numerous human rights to autonomy and privacy, liberty and security of person, and non-discrimination.

a. State obligations

- All sex workers have a human right to dignity, to liberty and security of person, and agency over their own bodies;
- All sex workers should have the same rights to safe working environments as all other workers;
- Sex workers are at increased risk of violence and need equal protection of laws against rape and other forms of violence;¹⁰⁶
- Protect sex workers’ right to health, including access to reproductive health services;¹⁰⁷
- Ensure access to sexual health information, education and services for all women, including health services for sex workers so as to curb the rise in HIV and AIDS.¹⁰⁸

b. Assessing state compliance

- To what extent has sex work been decriminalized?
- To what extent has the application of non-criminal laws and regulations against sex workers been eliminated?
- What measures has the State taken to ensure that sex workers have access to health care services that are confidential and respect their dignity and autonomy?
- To what extent has the State taken steps to stop harassment, victimization and incarceration of sex workers by law enforcement?
- What measures has the State taken to prohibit, and punish discrimination against sex workers, including in health care settings?¹⁰⁹
- What steps has State taken to ensure that sex work is an integral part of national responses to HIV?

- To what extent is access to HIV and STI testing voluntary and confidential for all, including sex workers?
- What measure has the state taken to train and sensitize law enforcement, judiciary, and health care workers about the rights of sex workers?
- What measures have been taken to ensure that sex workers enjoy labour rights like all other workers?
- To what extent are effective remedies available for sex workers whose rights have been violated?

Participation

- What type of mechanisms and procedures are in place to ensure the participation of sex workers population in the formulation, implementation and monitoring of laws, strategies and programmes affecting them, including sexual and reproductive health strategies and programmes?

SOME RELEVANT INDICATORS ON SEX WORKERS¹¹⁰

*Disaggregated by age, sex, gender, race/ethnicity, geographic location

- Number of sex workers;*
- Percentage of sex workers contacted through health outreach programmes;*
- Number of health care facilities that offer on site or referrals to care, support and treatment (disaggregated by geographic location)
- Percentage of sex workers subject to violence;*
- Percentage of violence against sex workers being effectively investigated and prosecuted;*
- Number of condoms distributed to sex workers;*
- Percentage of sex workers who come for STI screening past six months;*
- Percentage of sex workers who received HIV testing past 12 months;*
- Percentage of sex workers reporting use of condoms;*

- Percentage of sex workers who feel able to refuse a client if a condom is not used;*
- Number of STI cases among sex workers;*
- HIV prevalence among sex workers.*

SEXUAL ORIENTATION AND GENDER IDENTITY

All people, regardless of their sexual orientation or gender identity, should be able to enjoy the full range of human rights.¹¹¹ This includes lesbian, gay, bisexual, transsexual and intersex people. However, every day, across the globe, actual or perceived sexual orientation or gender identity leads to abuse in the form of discrimination, violence, imprisonment, torture and even execution. For example, Same-sex sexual practices are criminalized in 73 countries and territories. Thirteen states and jurisdictions provide for the death penalty for consensual same-sex practices. In some countries, criminal laws or civil laws restrict some forms of gender expression, such as restrictions on dressing, or public information on gender nonconformity.¹¹² The criminalization of people based on their sexual orientation contravenes international and regional human rights treaties, and hinders people from accessing sexual and reproductive health care out of fear that they may reveal potentially criminal conduct; it also encourages medical professionals to deny services, all resulting in poor health outcomes.¹¹³

Even in countries that do not criminalize same sex activity, LGBTI persons, actual or perceived, are often subject to various forms of physical and mental violence, including bullying, and are discriminated against in access to sexual and reproductive health care services.¹¹⁴ For example, in many countries transgender and often intersex people are required to undergo unwanted sterilization surgeries as a prerequisite to receiving gender affirmative treatment and gender marker changes.¹¹⁵ Additionally, the UN High Commissioner for Human Rights has recently raised concern regarding children who are intersex being subjected to discrimination in health care settings and operations to make sex traits gender congruous without consent.¹¹⁶

Such conduct violates numerous human rights, including the rights to life and health, the right to privacy and to be free from inhuman and degrading treatment, as well as the right to non-discrimination.

a. State obligations

Under international human rights law, state obligations include the following:

- Prohibit sexual orientation and gender identity as a ground of discrimination;¹¹⁷
- Enact legislation to prohibit discrimination by private parties, including through hate crime laws that address homophobic and transphobic violence;¹¹⁸
- Address violence based on sexual orientation or gender identity, including providing effective protection from violence and investigating all reports of violence;¹¹⁹
- Ensure that LGBTI persons have access to justice, and that all allegations of attacks and threats against individuals targeted because of their sexual orientation or gender identity are thoroughly investigated;¹²⁰
- Decriminalize same sex behaviour;¹²¹
- Ensure equal access to benefits, including access to health care, on the same basis as others free of coercion, discrimination and violence, including for transgender and intersex people;¹²²
- Ensure non-discrimination in realization of the right to health of adolescents, including on the basis of gender identity, sexual orientation and health status, including HIV status;¹²³
- Revise laws to remove any compulsory sterilization requirements for persons undergoing gender reassignment surgery or requesting gender marker changes;¹²⁴
- Ensure informed consent of the individual in medical and surgical intervention of intersex conditions;
- Investigate instances of such treatment without consent of the individual and provide redress to victims;
- Train medical and psychological professionals on a range of sexual and related biological and physical diversity and effectively inform patients and their parents, of consequences of unnecessary interventions for intersex people.¹²⁵

b. Assessing state compliance¹²⁶

- To what extent has the State repealed laws that criminalize individuals for engaging in consensual same-sex sexual conduct? And has it abolished the death penalty for offences involving consensual sexual relations?
- To what extent has the State ensured that other criminal laws are not used to harass or detain people based on their sexuality or gender identity and expression?
- To what extent has the State harmonized the age of consent for heterosexual and homosexual conduct?
- To what extent has the State enacted comprehensive anti-discrimination legislation that includes discrimination on grounds of sexual orientation and gender identity among prohibited grounds?
- To what extent does the anti-discrimination framework include prohibiting discrimination in access to health care?
- To what extent has the State ensured that combating discrimination on grounds of sexual orientation and gender identity is included in the mandates of national human rights institutions?
- To what extent has the State implemented appropriate sensitization and training programmes for police, prison officers, border guards, immigration officers and other law enforcement personnel?
- To what extent has the State developed public information campaigns to counter homophobia and transphobia among the general public and targeted anti-homophobia campaigns in schools?
- To what extent has the State facilitated legal recognition of the preferred gender of transgender people and established arrangements to permit relevant identity documents to be reissued reflecting preferred gender and name, without infringements of other human rights?
- To what extent has the State prohibited coercive sterilization and/or hormonal treatment against transgender and intersex people as a prerequisite to receiving gender affirmative treatment and gender marker changes on identity documents?

- To what extent has the State gathered disaggregated data on sexual orientation and gender identity?
- To what extent has the State ensured effective remedies are in place to provide redress for victims of violations based on sexual orientation and gender identity?

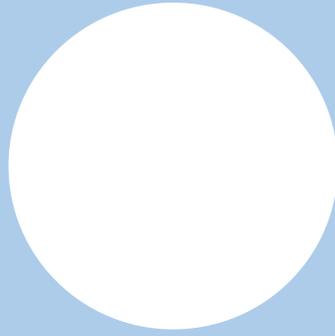
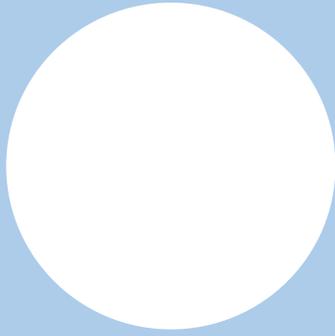
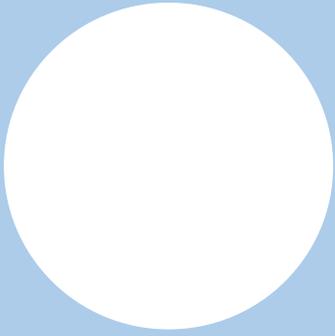
Participation

- What type of mechanisms and procedures are in place to ensure the participation of LGBTI persons in the formulation, implementation and monitoring of programmes and strategies affecting them, including sexual and reproductive health strategies and programmes?

SOME RELEVANT INDICATORS ON SEXUAL ORIENTATION AND GENDER IDENTITY¹¹⁰

***Disaggregated by age, sex, gender, race/ethnicity, geographic location**

- Proportion of LGBTI persons who have experienced physical, sexual and psychological violence during the last year, by severity of violence, relationship to the perpetrator and frequency;*
- Number of instances of violence on grounds of actual or perceived sexual orientation and gender identity reported to law enforcement;*
- Proportion of received complaints on all forms violence against LGBTI persons investigated and adjudicated by the national human rights institution(s) or other human rights mechanisms of protection and the proportion of those responded effectively by the government*
- Number of prosecutions and convictions for violence on grounds of actual or perceived sexual orientation or gender identity;*
- Number of counseling and health centres that ensure acceptable and quality care for LGBTI persons and their distribution across the country (disaggregated by geographic location);
- Number of health care providers trained to address specific needs of LGBTI persons and distribution across the country (disaggregated by geographic location).



CHAPTER 4

Five examples of NHRIs that have carried out country assessments and/or national inquiries on SRHR

In this chapter, we highlight the results and lessons learned from the work of five NHRIs that have carried out country assessments and national inquiries on SRHR using the UNFPA methodology outlined in this Guide: the Philippines, Malawi, El Salvador, Azerbaijan and Guatemala.

In the **Philippines**, a 2016 national inquiry on reproductive health rights brought to light the determining factors behind SRHR violations in the country—particularly in the case of marginalized women and girls—and identified the steps required for positive change.

In **Malawi**, a national inquiry into SRHR provided the space for women and girls to speak up and disclose mistreatment, discrimination and violence they had experienced when seeking sexual and reproductive health services.

In **El Salvador**, a 2016 country assessment on SRHR shifted the way that teenage pregnancy and gender-based

violence were viewed—from a public health challenge to a violation of the human rights of women and girls.

In **Azerbaijan**, an NHRI country assessment unveiled gaps between laws and practice, and underscored the human rights dimensions of these issues. In doing so, it placed SRHR issues squarely on the national agenda.

Finally, in **Guatemala**, a 2016 country assessment bridged a major gap in data and knowledge about SRHR issues in the country. By developing a standardized framework for investigating SRHR violations, a robust national accountability framework is now in place for monitoring State progress on meeting its obligations for SRHR.



Case study PHILIPPINES

“Let our voices be heard” the National Inquiry on Reproductive Health Rights in the Philippines

Background

In 2012, the Philippines enacted a ground-breaking law that recognized women’s sexual and reproductive rights: the Responsible Parenthood and Reproductive Health (RPRH) Act. The law guarantees universal, free access to contraception, expanded reproductive health education and recognizes a woman’s right to post-abortion care.

Various conservative Catholic groups immediately challenged the law in court, but the Supreme Court upheld it in April 2014. However, the Supreme Court struck down a few of the provisions of the law, effectively:

- allowing reproductive health service providers to deny services to patients based on their personal or religious beliefs
- requiring parental consent for adolescents seeking reproductive health care.

Even with these amendments, the law provided a huge opportunity to advance the SRHR of women in the Philippines. The Philippines has one of the highest number of women dying each year from pregnancy and childbirth in the Asia-Pacific region, with a maternal mortality ratio of 114 deaths per 100,000 live births in 2016.¹²⁸ The unmet need for family planning also increased from 15.7 per cent in 2006 to 19.3 per cent in 2011.¹²⁹

After the law was passed in 2014, its implementation faced serious challenges. Women’s organizations and reproductive health advocates denounced the challenges faced in its implementation and called on the Commission on Human Rights (CHR) to act. Responding to this call, the CHR decided to undertake a National Inquiry on Reproductive Health and Rights. The CHR approached the UNFPA for support in carrying out the inquiry.

Strategy

The inquiry was carried out from March to May 2016 and comprised three parts. The first was the launch of the National Inquiry in March 2015, and the official call for submissions from individuals and organizations detailing barriers faced in accessing reproductive health services. The second part was made up of regional consultations conducted in 15 out of the 17 regions in the country. The consultations focused on:

- access to justice, particularly in the sphere of violence against women
- access to services for marginalized women, including rural women, indigenous women, Moro (Muslim) women, women with disabilities, and lesbian, bisexual, transgender and intersex (LBTI) women
- women's SRHR issues in the context of displacement
- an overall assessment of the implementation of the RPRH Law.

The third part consisted of fact-finding missions and public hearings in five areas of the country. The aim of the missions and hearings was to document individual or systematic practices and policies that resulted in the denial of reproductive health services. The five areas were selected due to the challenging contexts they presented for accessing reproductive health services:

- Manila City, due to high density of informal settlers and slum dwellers
- Sorsogon City, where the mayor had issued a "pro-life" resolution in 2015, resulting in contraceptives being removed from health centres
- Zamboanga City, which experienced an armed conflict in 2013
- Eastern Samar, where many people were displaced after Typhoon Haiyan in 2013
- the Bukidnon region, where many indigenous people live.

Through the regional consultations and the public hearings, 1,263 individuals were consulted as part of the inquiry. To ensure that marginalized groups participated in the consultations, the inquiry took the following steps:

- The public hearings were organized in safe, private spaces so that women and girls were able to share experiences confidentially.
- To ensure accessibility for people with disabilities, the venues were all made accessible with ramps, elevators and restrooms, and sign language interpreters.
- The CHR investigators interviewed sex workers one on one, so that the women and girls felt more comfortable in telling their stories.

Findings from the National Inquiry

The inquiry findings highlighted the very uneven delivery of reproductive health services across regions and social strata, primarily due to decentralization and the autonomy of local governments units, which has fragmented the delivery of health services. Also, most women were not aware of their rights and entitlements under the RPRH Law.

Specific findings of the inquiry were:

- Local government units supported the RPRH Law inconsistently. Manila City had prohibited public funding from going to contraceptives, and Sorsogon City had refused to implement the law. As a result, all artificial contraceptives in city and community health facilities were withdrawn. Moreover, the Sorsogon City mayor sponsored a radio show that spread misinformation on contraceptives, claiming that they were cancerous.
- The absolute ban on abortion had led to a high number of unsafe abortions. When women tried to access post-abortion care, they often experienced stigma by health-care providers. For example, women explained that some doctors forced them to confide if their abortion had been spontaneous or induced before they were given proper medical care. In one case, a woman was given post-abortion care, but was arrested and sent to jail after the treatment.
- Poor women shared how they were often treated with disrespect at the health centres due to their social situation, with richer women given priority. As a result, poor women often avoided seeking health services.
- Indigenous women were not able to give birth in health centres using their traditional birthing

methods. At the same time, in some regions, indigenous women who gave birth outside birthing facilities because they preferred to follow their own birthing traditions were forced to pay fines. Although these policies were adopted to encourage facility-based delivery, it resulted in penalizing and criminalizing indigenous women and women who lived far away from health centres.

- Health-care providers often discriminated against LGBTI women and women living with HIV. Health-care providers resist providing these women with counselling and services. Also, sex workers rarely report cases of rape due to the stigma they faced.
- Young people, because they need parental consent to access sexual and reproductive health services, are not accessing modern methods of family planning or being tested for HIV. They also have little information on how to prevent pregnancies. As a result, teenage pregnancies are increasing.
- People with disabilities have limited access to health care, due to physical barriers in accessing health centres and a lack of training on behalf of health providers on how to support people with disabilities.
- Gender-based violence against people with disabilities and the lack of remedies and justice for victims was a major problem. The hearings discussed violence against people with both mental and physical disabilities, and the violence they faced from family members, neighbours and community members. Women who are deaf were unable to access justice and treatment because police and health centres did not have interpreters.
- In poor areas, such as the slum areas in Manila, expectant mothers had to line up for 3–4 hours for prenatal checkups. Also, although some health centres offer free sonograms, most women chose to go to private clinics if they could, because of the long waiting times at the public clinics.
- In regions where women had been displaced because of armed conflict or natural disasters, humanitarian responses had not focused on SRHR. The evacuation centres were not equipped to look after pregnant and lactating women, or to address the increased risk of violence against women.

The National Inquiry also brought to light some good practices that could be scaled up and replicated. For example:

- the creation of halfway houses for indigenous mothers and their husbands to enable them to wait for the delivery near the health facilities
- the inclusion of traditional birth attendants in the health centres to enable indigenous women to give birth their traditional way
- the deployment of strong and active national and regional RPRH Act implementation teams in some regions, to address complaints about the availability and accessibility of reproductive health services
- the deployment of nurses, midwives and doctors to geographically isolated and disadvantaged areas.

Results

The National Inquiry on SRHR led to the CHR identifying the underlying factors that contribute to systemic patterns of SRHR violations. It could also propose actions for different levels of government.

As a result of the National Inquiry, the Department of Health (DOH) has been reviewing how the RPRH law is being implemented in the different regions. It has also been reviewing the changing policies and practices that had inadvertently harmed women's access to reproductive services. For instance, the practice of fining women when giving birth outside of health centres has stopped. The DOH has also been training health service providers to provide effective adolescent sexual and reproductive health services and education.

Civil society and the United Nations have drawn on the inquiry's findings to engage with international human rights mechanisms, including in shadow reports to the Committee on the Elimination of Discrimination Against Women (CEDAW) and in the Philippines Universal Periodic Review (UPR) Report Consideration in 2017. As a result, CEDAW and the UPR have made several direct recommendations to the Filipino Government, including to:

- effectively implement the RPRH Act
- institutionalize justice for women with all forms of disabilities
- guarantee women's access to effective methods of family planning
- legalize abortion under certain circumstances.

THE COMMISSION ON HUMAN RIGHTS' NATIONAL INQUIRY ON
Reproductive Health Rights
 MARCH - MAY 2013

THE COMMISSION LAUNCHES THE NATIONAL INQUIRY ON REPRODUCTIVE HEALTH. THE INQUIRY COVERS:

- REGIONAL CONSULTATIONS
- FACT-FINDING & PUBLIC HEARINGS
- COLLECTION OF SUBMISSIONS / ARCHIVES OF DISCOMFORT / DOME OF THE OBJECTS OF INFORMATION

COMMISSIONER KAREN CORLES-DOMPIT

WE WILL EXAMINE THE EFFECTIVENESS & IMPLEMENTATION OF MAGNA CARTA OF WOMEN AND RESPONSIBLE PARENTHOOD & REPRODUCTIVE HEALTH LAW.

WE WILL DOCUMENT INDIVIDUAL AND SYSTEMIC DENIAL / OBLIVION / BARRETS TO R.H. SERVICES AND INFORMATION.

WE WILL ANALYZE. WE WILL RECOMMEND.

COMMISSIONER GEMMOLYN PARENTIL-GARA

LET OUR VOICES BE HEARD, AND LET OUR STORIES COUNT TOGETHER. WE CALL AND WE CLAIM REPRODUCTIVE JUSTICE!

WHY RHR?

R.H. LAW CONSTITUTIONAL
 - SUPREME COURT, 2014
BUT: 8 KEY PROVISIONS VOIDED

MAGNA CARTA GUARANTEES RH RIGHTS

S.C. ISSUES T.R.O. AGAINST IMPLANTON

R.H. LAW UNCONSTITUTIONAL!
 - CHECK GROUP, 2012

E.O. 003 "PRO-LIFE" MANILA

E.O. 003 BORDON CITY, "PRO-LIFE" CITY

E.O. 000 NO FUNDS FOR ARTIFICIAL BIRTH CONTROL

BARANGAY HEALTH CENTER

ON CENTER SUBJECT: AN OBSTETRIC CLINIC AND AN AMBULANCE WITH 100,000 & E.O. 000

WE AT 100 DEATHS PER 100,000 LIVE BIRTHS

I HAD AN ABORTION BUT I'M AFRAID TO GET POST-ABORTION CARE. I MIGHT BE IMPRISONED.

I'M PREGNANT AND DEAF. I CAN'T UNDERSTAND WHAT HAPPENED DURING MY PRE-NATAL CHECK-UP.

I'VE SAID ENOUGH! I WANTED A TUBAL LIGATION, BUT MY HUSBAND REFUSED TO GIVE HIS CONSENT.

I TROUBLED THE FAR, ONLY TO BE DENIED R.H. SERVICES!

I DON'T HAVE ACCESS TO PILL ANYMORE. OUR MAYOR DECLARED BORDON A "PRO-CITY" CITY.

I HAVE R.H. NEEDS TOO!

I CAN'T GIVE BIRTH IN THE LYING-IN. I LIVE 3 MOUNTAINS AWAY.

Vikslae

To address the National Inquiry's findings related to women with disabilities, the CHR—with the technical and financial support of UNFPA—is conducting human rights education at the community level, focusing on women and girls with disabilities. The Participatory Action Group, an intervention that informs women and girls with disabilities about SRHR, has been a key component of this education.

In January 2017, the CHR conducted an informal reflection, which “revealed gaps in knowledge and skills among CHR investigators on gender issues, and in particular in protecting and promoting reproductive rights”. In response, CHR staff underwent customized online and face-to-face workshops on gender and women’s and girls’ SRHR in collaboration with UNFPA and the Asia Pacific Forum of NHRIs.

Examples of the Philippines progress in SRHR are:

- President Rodrigo Duterte’s executive order ensuring zero unmet need for family planning in the country
- the lifting of the temporary restraining order
- the filing of the Teenage Pregnancy Prevention Act (Senate Bill 1482).

To follow to on the National Inquiry, the CHR has stated that, in 2018, it will go back to the areas where the SRHR- related ordinances were found to be punitive. This is to assess the progress made in complying with the inquiry’s recommendations.





Case study MALAWI

A public inquiry on the status of sexual and reproductive health and rights: providing a platform for the voices of women and girls to be heard in Malawi

Background

The Government of Malawi has taken several steps to strengthen access to SRHR in the country through enacting legal, policy and programme measures. Despite these efforts, the reality on the ground shows that the full enjoyment of SRHR remains a distant reality for many. Challenges in the country include:

- the high rates of HIV among women
- rampant gender-based violence
- high prevalence of harmful practices, including child marriage
- limited access to information and services on SRHR.

In 2012, the country assessed maternal and child health, with the technical support of the UNFPA and the Office of the High Commissioner for Human Rights. This

assessment raised major issues in SRHR, particularly the issue of informed consent and choice in family planning. The NHRI had also been receiving numerous SRHR-related complaints across different regions of Malawi. Hence, when UNFPA approached the NHRI to offer technical support for SRHR issues, the NHRI decided to launch a public inquiry (PI) on SRHR in Malawi. The PI used the UNFPA method as a guide. This was the first time that the NHRI carried out a PI on an issue that involved economic, social and cultural rights in Malawi.

Public inquiry

The overall objective of the PI was to establish the extent and nature of violations of SRHR—specifically, the availability, accessibility, acceptability and quality of SRHR and information—and to recommend appropriate steps for redress when these rights are violated.

Specifically, the PI aimed to:

- examine the adequacy, and need for reform, of laws, policies and practices
- assess the effectiveness of existing programmes on sexual and reproductive health (SRH) service delivery
- evaluate the availability, acceptability and accessibility of SRH services to the general population, but specifically to vulnerable groups, including women, the rural poor, people with disabilities, people living with HIV and AIDS, and adolescent girls
- examine the quality of SRH services
- assess the acts or practices that constitute systemic or individual violations of sexual and reproductive rights.

To prepare for the PI, the NHRI carried out a comprehensive desk-based analysis on the situation of SRHR in the country. Based on this analysis, it was decided to carry out the PI in the three districts where the highest number of SRHR complaints had been recorded: Rumphi, Kasungu and Mangochi.

Next, the NHRI took a number of steps to ensure the active participation of the communities from those regions, in particular women and girls, in the PI. The NHRI also aimed to reduce the social stigma associated with talking about SRHR issues—a subject often considered taboo in Malawi. The NHRI held meetings with Government district officials, law enforcement officials, village chiefs, non-governmental organizations and communities to sensitize them on what a PI entails, and what SRHR means in terms of rights and freedoms.

In December of 2014, each of the three districts held a public hearing. A female judge of the High Court of Malawi presided over each hearing. The community members were encouraged to come forward and tell their testimonies, or those they had witnessed.

The public inquiry on the status of sexual and reproductive health and rights gave a platform to the most marginalized groups, such as women with disabilities and adolescent girls, to speak out and air their views and experiences. Responses to their stories were provided immediately by members of government institutions present. (NHRI)

The judge opened the meeting explaining to the community the importance of people being free and open

to share complaints and experiences. She underlined that no one should threaten them and explained that the purpose of collecting the testimonies was to develop a plan to improve human rights. Encouraged, people—in particular women and girls—came forward and shared their stories.

Some of the most serious issues raised were:

- The low level of knowledge among many young girls on family planning methods, combined with myths and misconceptions about these methods. This resulted in low uptake of contraceptives. In addition, when women and girls sought family planning services, they were not given a choice of methods because health workers did not provide information on all available methods to enable the client to make an informed choice.

It was really impressive how rights holders came forward, opened up and talked about SRHR issues. They talked particularly on informed choice, and unequal access to information and services. (Dorothy)

- The stigma faced by women regarding HIV. When a man goes to be tested, he receives treatment without being questioned. But if a woman goes to be tested, she is harassed and ostracized. In some cases, husbands divorced their wives if she tested positive for HIV.
- When going to the hospital to deliver their babies, the midwife often did not attend pregnant women, or treated them disrespectfully. Women did not know where to go to report cases of mistreatment or malpractice during childbirth.
- Gender-based violence; sexual violence and rape often go unreported.

The testimonies brought up the social stigma and traditions that underlie many of these challenges. For instance, it is a tradition that women need the permission of their uncle before going to a hospital to deliver a baby. If they are not able to do so, they deliver the baby at home. Moreover, societal tradition condones early marriage and, until 2016, the age of marriage was 15 years with parental consent. Young couples are also expected to have children early and in quick succession. Men are mocked for not being “man enough” if they do not have children early and many of them.

Results

The PI report presents a comprehensive overview of the key gaps and challenges for SRHR, and explains the underlying factors behind them. It also makes recommendations for how the Government should address them, articulating the role of each Ministry and other duty bearers.

Duty bearers have become more aware of their responsibilities and the rights holders have also been empowered by gaining knowledge on the importance of complaining, whom to complain to and what remedies are available. (Beatrice)

The report was publicized across the country through radio and television. It was also disseminated at the district level, including in the three places where the PI took place. This strategy ensured that the dissemination of the report spanned each of the three regions of Malawi. The report is available as a public document.

To support follow-up, the NHRI established a national task force—comprising civil society organizations and State institutions such as the Malawi Law Society and the Reproductive Health Unit—to follow up on the implementation of the recommendations and hold the State accountable.

Some initial concrete results are evident since the release of the report. The age of marriage has been raised from 15 years (with parental consent) to 18. The national SRH policy was revised to include an increase in the Government's contraceptive budget and strategies to increase youth and community-based SRH initiatives. A growing number of women who were mistreated or received poor quality of care in childbirth facilities have reported cases as a result of an increased awareness of quality health care as a right and of channels for lodging complaints. Also, to address the cultural and traditional beliefs and stigma that underlie many of the reported SRHR violations, the NHRI was among the stakeholders who developed a framework to guide traditional leaders when formulating their community bylaws on gender, SRH, HIV and harmful practices. This ensures that such bylaws comply with human rights standards.

Lessons learned

The PI provided a unique opportunity to hear the views of people at the grass-roots level on issues that mattered to them. It offered a mechanism to better understand the underlying social norms and cultural beliefs behind the

high numbers of SRHR violations. And it enabled the NHRI to submit evidence-based information about SRHR from a human rights-based perspective to the Government.

Working with the NHRI to address these issues proved strategic. The NHRI has a unique ability to convene a wide range of stakeholders to discuss human rights issues. It is also in regular dialogue with national bodies, including the Parliamentary Committee. It is thus able to inform the law review and policymaking process.

The NHRI's authority and credibility has ensured that the PI national report on SRHR is used as a powerful advocacy and data tool for making policy and programming changes.

This is information that we are going to use in the country for a long time. When the report is seen as to come from a NHRI, it is found to be credible and is greatly respected. (UNFPA Assistant Representative)



Case study EL SALVADOR

El Salvador: placing teenage pregnancy on the national agenda as a human rights issue

Background

El Salvador has one of the highest rates of adolescent pregnancy in Latin America.¹³⁰ In 2015, a third of all pregnancies in El Salvador were teenage pregnancies.¹³¹ Although the Government has put in place policies and programmes to address the issue, the teen pregnancy rate remained stagnant between 2005 and 2015. Among girls aged 10–14 years, it increased.¹³² One third of adolescents who gave birth in 2012 were pregnant or new mothers two years later according to a study published in El Salvador in 2016.

These high rates of adolescent and child pregnancy are tied to such underlying causes as:

- sexual violence
- patriarchal culture promoting early union and child marriage
- social barriers, such as societal stigma around premarital intercourse
- structural barriers, such as limiting adolescents' access to reproductive health services including the use of modern contraceptives and access to comprehensive sexuality education.

There is also an absolute ban and criminalization of abortion. With a high rate of sexual assault among adolescents in the country-, a recent study found that 70 per cent of victims of sexual assault in the country were under the age of 20, and that 61 per cent of girls between the ages of 10 and 12 showed signs of sexual violence¹³⁴ adolescents have no option but to go through with unwanted pregnancies and accept the health risks it represents.¹³⁵

Recognizing the grave situation that El Salvadorian women and girls were facing in exercising their SRHR, the Ombudsperson of El Salvador carried out a national assessment on SRHR in 2016. This culminated in the Special Report on the Status of Sexual and Reproductive Health and Rights with an Emphasis on Girls, Adolescents and Women in El Salvador. The Ombudsperson's Office

used the UNFPA Methodology on Country Assessments and National Inquiries on SRHR.

Special report

The national assessment of SRHR focused on girls and adolescents, and aimed to identify the causes and consequences of adolescent pregnancy, using a human rights framework.

The assessment aimed to:

- identify the causes and consequences of early pregnancies among adolescents and girls living in vulnerable situations
- identify the State's responses and challenges in protecting girls from gender-based violence and providing adequate family planning services
- analyse the intersectional causes and effects of adolescent and child pregnancy and make recommendations for specific government institutions to act on.

Results

Using a human rights-based approach to analyse adolescent pregnancy broadened the understanding of these issues and connected them to a wide range of rights. It also brought to attention the stigma and discrimination faced by specific groups—such as people living with HIV/AIDS and members of the lesbian, gay, bisexual, transgender and intersex community—in accessing SRH services.

Key findings from the assessment were the:

- significant barriers that women who have experienced gender-based violence faced in accessing justice
- prevailing cultural and social norms regarding women and girls' societal roles
- limited access to comprehensive sexuality education and reproductive health services, including family planning, particularly for adolescents.

The report became a key reference document on gender-based violence for policymakers and other audiences, who use the report findings to advocate for, and inform,

national policies. Namely, the National Strategy for the Prevention of Pregnancy in Girls and Adolescents (2017) and the National System of Care for Women Survivors of Violence (2016).

Although the assessment's results were not surprising, by using a human rights framework, the report shifted the perception of these issues from a health and women's issue to a violation of human rights. In doing so, it underlined the State's obligation to address these violations.

The report contributed to positioning teenage pregnancy on the national agenda and shifting how the issue is perceived from a public health to a human rights issue. (Ondina, UNFPA, El Salvador).

The report also included a monitoring framework and follow-up actions directed at specific governmental institutions. This framework took the form of a series of recommendations for different national actors, including ministries, the justice system and parliament. Before the PI report had been published, these institutions had discussed and agreed to these recommendations. The report has not only reframed sexual and reproductive health issues as human rights issues, but has also reinforced the accountability framework for SRHR issues in the country.



Case study AZERBAIJAN

Strengthening accountability for sexual and reproductive health and rights by working with the national human rights institute in Azerbaijan

Background

Azerbaijan has made notable progress in SRHR. The rate of maternal mortality has fallen significantly over the past 20 years, and the Government has adopted a wide range of laws and policies to address violence against women, child marriage and other areas of reproductive health and rights.

Despite these advances, significant challenges remain. Women, particularly from rural and remote areas, refugees, internally displaced people and people with disabilities have limited access to SRHR. There is a significant gap between the existence of national laws on reproductive health and their implementation. Recommendations from international human rights mechanisms—including the UPR and the CEDAW—on SRHR issues have not been prioritized for follow-up. There is also limited access to justice and accountability for violations of sexual and reproductive rights.

Social reluctance to discuss SRHR issues and a lack of relevant data on SRHR in the country have been major

factors contributing to politicians not prioritizing these issues in developing national policies.

Strategy

In 2015, UNFPA Azerbaijan partnered with the National Ombudsperson's Office, its NHRI, to assess the country's progress in implementing treaty body¹³⁶ recommendations on SRHR. By actively and openly engaging with national authorities about SRHR, the Ombudsman helped them feel more comfortable with discussing SRHR issues. The UNFPA methodology for country assessments and national inquiries provided the Ombudsman with a framework for assessing the country's progress.

While the Ombudsman's Office had actively advocated for the recognition of the normative basis of reproductive health and rights, these efforts had been impeded due to lack of information and methodologies for assessing this area. The introduction of the UNFPA Guide for NHRIs on sexual and reproductive health and rights provided

the Ombudsman with the methodological guidance it needed to be able to take on a much more proactive role in support of these issues. (Ombudsman's Office)

Focusing on women and girls' SRHR, the country assessment analysed available data in six key areas:

- reproductive health information and services
- abortion
- maternal health
- violence against women
- comprehensive sexuality education
- HIV and AIDS.

For each area, the NHRI compiled the latest CEDAW and UPR recommendations, identified State actions and analysed discrepancies. The NHRI also developed indicators for each of the key areas to track the Government's progress in meeting these international human rights obligations. The findings from this assessment were presented in a report to Government counterparts and to civil society organizations.

Some of the key findings of the report included:

- Government spending on health care, including sexual and reproductive health care, is low. The Government only spends 1.5 per cent of the country's gross domestic product on health (the European average is 7.5 per cent).
- There are no accountability mechanisms for monitoring progress on SRHR and redressing violations.
- Public health insurance does not cover the cost of contraceptives and not all of them are free of charge.¹³⁷ Moreover, there is limited access to counselling and information on family planning. This directly contributes to Azerbaijan having one of the highest abortion rates in Central Asia, with 31 abortions per 1,000 women in 2012.
- Gender stereotypes and patriarchal attitudes that value boys more than girls have resulted in widespread sex-selective abortions since the early 1990s. The lack of systematic efforts towards societal transformation to address these stereotypes have limited the progress on SRHR.
- There is a high prevalence of violence against women, which is underpinned by patriarchal social norms, deeply rooted gender stereotypes and harmful

customary practices such as child marriage. This is compounded by low implementation of the 2010 law to prevent domestic violence, the lack of State budget allocated for combating violence, and the lack of gender sensitivity in law enforcement and judicial authorities' treatment of cases of violence.

- Data are limited about SRHR, particularly for marginalized groups, such as people with disabilities, sex workers, and lesbian, gay, bisexual and transgender people.

The study findings and the accompanying tracking framework provide a systematic way of monitoring State progress in advancing SRHR in the country. After sharing the findings and tracking framework for SRHR with relevant government stakeholders—including the Ministries of Health, Education and Labour—the Ombudsman reached an agreement with these government representatives that the indicator matrix would be updated biannually. This will be an opportunity to track progress over time, and to identify remaining discrepancies, new opportunities and bottlenecks.

Results

The assessment provided the first comprehensive evidence-based overview of the state of SRHR in Azerbaijan. It also structured SRHR within the human rights framework. By emphasizing the human rights dimensions of the issues and outlining the Government's international obligations in these areas, the Government has taken the issues more seriously.

When it comes to these taboo issues, it really helps when you start talking about government obligations. (UNFPA Azerbaijan)

Evidence and recommendations from this assessment have proven to be valuable advocacy tools for efforts to strengthen the recognition of SRHR in government policies and programmes. Drawing on the assessment's findings, the NHRI was able to ensure that SRHR issues such as human trafficking and domestic violence were included in the 2016 UPR midterm report. The assessment's findings and recommendations were also used to lobby the Parliament to incorporate SRHR issues in the State Program on Demography and Population Development and to develop the National Action Plan on Gender-Based Violence to ensure the effective implementation of the 2010 law on domestic violence prevention.



The collaboration between the NHRI and UNFPA to update indicators biannually, tracking the Government's progress on its international obligations on SRHR, will help ensure that SRHR issues remain on the national agenda.





Case study GUATEMALA

Guatemala: engaging with the national Ombudsman's Office to strengthen data and accountability for sexual and reproductive health and rights

Background

In Guatemala, patriarchal attitudes, religious norms, discrimination, poverty and geographic barriers all negatively affect women's and girls' access to quality SRHR. Sexual and reproductive services include family planning, comprehensive sexuality education, and medical care during pregnancy and labour.¹³⁸ Women and youth, and indigenous and lesbian, gay, bisexual, transgender and intersex (LGBTI) people are particularly marginalized. Although the Guatemalan Government had made headway in reducing the maternal mortality rate by 57 per cent since 1990, the country still faces one of the highest maternal mortality rates in Latin America.¹³⁹

The Ombudsman's Office of Guatemala has the role of monitoring the Government's compliance with international human rights obligations. However, the Ombudsman's Office struggled to take forward the SRHR part of its mandate. The country's information on SRHR was not up to date and, in general, the Guatemalan

Government viewed these issues as a public health concern rather than as human rights issues.

Drawing on the opportunity to pilot the UNFPA methodology for NHRIs to assess SRHR,¹⁴⁰ the UNFPA Country Office partnered with the Ombudsman's Office to strengthen their capacity to monitor SRHR.

After discussions between the two entities, the Ombudsman's Office agreed to take this national assessment process forward three phases:

- capacity-building
- establish a monitoring and evaluation system for SRHR
- a national assessment of SRHR in Guatemala.

Capacity-building

Beginning in 2015, UNFPA Guatemala began a year-long training programme with the Ombudsperson's Office. The training aimed to:

- standardize knowledge on SRHR and how SRHR are directly linked to realizing other rights
- strengthen the understanding of the 59 indicators that fall under 7 themes that UNFPA recommends for monitoring and evaluating SRHR
- strengthen the management of the Ombudsperson's Office so that staff could better carry out their functions at headquarters and in the regions in addressing SRHR.

During 2015, the Ombudsperson Office and UNFPA Guatemala led four capacity-building workshops dedicated to standardizing staff knowledge of SRHR issues. The 160 participating staff members included educators, lawyers and psychologists from the Human Rights Ombudsperson headquarters and regional offices.

Through case studies and open dialogue, the training put an emphasis on how SRHR related to various human rights, such as the right to education, the right to work and the right to life, in real-world scenarios. Participants came to understand how framing SRHR within the broader base of human rights is valuable for analysing, investigating and addressing complaints.

This preliminary phase was crucial to the development of the monitoring and evaluation system and the thematic report because it gave us an understanding of the role of the Ombudsman Office and the indicators we were going to use. (Yolanda, Programme Officer, UNFPA Guatemala).

Framework for monitoring and evaluating SRHR systematically

In 2016, with its capacity on SRHR strengthened, the Ombudsperson Office developed a standardized system for monitoring and evaluating the status of SRHR in the country using the UNFPA methodology.¹⁴¹ The framework is to be used each year to monitor and evaluate progress.

The standardized framework for SRHR is a method of qualitative investigation that allows the building of new knowledge on SRHR based on critical reflections from

the lived experiences of women and girls. (Report on the Systematization of the Process of Transferring and Producing Knowledge on Capacity-Building for the National Human Rights Institution in Guatemala¹⁴²)

In standardizing NHRI knowledge of SRHR as human rights, as well as standardizing a method of monitoring and evaluating that emphasized the role of qualitative and quantitative indicators, the NHRI was better able to ensure quality thematic reports on SRHR in the future.

Thematic report

The Ombudsperson Office developed their first report on SRHR in late 2016 using their newly developed monitoring and evaluation framework. The report is organized under the same themes that the guidelines from UNFPA use:

- Access to information and reproductive health services
- Attention to maternal health
- Prevention and treatment of HIV/AIDS
- Integral sex education
- Violence against women
- Capacity and autonomy of adolescents to make decisions
- Autonomous capacity of female sex workers to make decisions
- Autonomous capacity of LGBTI populations to make decisions.

The Ombudsperson Office's report relied on sources, such as national reports, international investigations into data from Guatemala and past Ombudsperson reports, to gather information. The report showed the clear link between the protection of human rights and the exercise of SRHR. For example, the report presents the high rates of maternal mortality in Guatemala as a violation of the right to life and of the right to the highest attainable standard of health.

This is the first time that we have supported issues related to maternity—maternal mortality, access to contraceptives, family planning—from a human rights perspective. (NHRI)

Some of the main findings of the report included:

- Although Guatemala has ratified international human rights treaties, it has not put in place adequate policies, programmes and budgets to implement the human rights obligations they have signed on to.

- The data registers about SRHR are limited and out of date, making it difficult to develop, and advocate for the implementation of, informed policy proposals.
- Both the Guatemalan population and the civil service lack knowledge about SRHR—a major hindrance to denouncing and remedying violations of SRHR. For example, the report found that the absence of comprehensive sexuality education, combined with a patriarchal culture, allowed for teenage pregnancy to be viewed as “the norm” rather than as the result of inaction by the State.
- Although Guatemalan law states that getting a girl pregnant under the age of 14 is a crime of sexual assault, it is difficult for girls to come forward with official complaints because of pressure from families to remain silent. In many cases, the assailants are family members or acquaintances of the family.

Looking ahead

We see that the report is a useful advocacy tool for organizations because they are able to use it as an impartial and authoritative reference for where we are as a country with SRHR. (Yoli)

The NHRI has shared the report with key Governmental ministries and non-governmental organizations, and it was released to the public at the end of 2017. The thematic report and the corresponding monitoring and evaluation framework are important steps in the struggle to fill in gaps in accountability, data and knowledge on SRHR issues. In early 2018, the NHRI intends to begin using the SRHR indicators that it developed as part of its overall human rights monitoring and evaluation framework.



ANNEX 1

Selected sources of information

COUNTRY-SPECIFIC SOURCES OF INFORMATION

Demographic and Health Surveys

Demographic and Health Surveys (DHS) are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition. They can be researched by topic and country. <http://www.measuredhs.com/What-We-Do/Survey-Types/DHS.cfm>

DevInfo

DevInfo is a database system for monitoring human development endorsed by the United Nations Development Group (UNDG) that enables browsing, uploading, visualizing and sharing socio-economic data. <http://www.devinform.org/libraries/asp/home.aspx>

Multiple Indicator Cluster Surveys (MICS)

UNICEF assists countries in collecting and analysing data in order to fill data gaps for monitoring the situation of children and women through this international household survey initiative. http://www.unicef.org/statistics/index_24302.html

Sustainable Development Goals

Regional and country progress reports, including Sustainable Goals Development Report 2018. <https://unstats.un.org/sdgs/>

ICPD beyond 2014

The United Nations Population Fund, UNFPA, has issued the report Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development (referred to as the ICPD beyond 2014 Global Report) <http://www.unfpa.org/public/home/sitemap/ICPDReport>

Human Development Reports

The Human Development Report (HDR) published by the Human Development Report Office of the United Nations Development Programme (UNDP), is an annual report which measures of human development across the globe. <http://hdr.undp.org/en>

International human development indicators

The HDR Office releases five indexes each year, with country profiles. <http://hdr.undp.org/en/countries>

Human Rights Bodies

Government reports to UN treaty monitoring bodies and UN treaty body recommendations to countries (called concluding comments or observations) can be searched by country. <http://www.ohchr.org/EN/HRBodies/Pages/HumanRightsBodies.aspx>

Special Procedures of the Human Rights Council

Independent human rights experts with mandates to report and advise on human rights from a thematic or country-specific perspective. See the list of Special Rapporteurs, reports and forthcoming country visits.

Additional sources of country-specific information include the following:

- population-based surveys;
 - reproductive health surveys;
 - vital registration;
 - maternal death audits;
 - health facility-based data;
 - civil registration systems and censuses;
 - routine reporting and national immunization days reporting.
- <http://www.ohchr.org/en/HRBodies/SP/Pages/Welcomepage.aspx>

WORLD HEALTH ORGANIZATION RESOURCES ON SEXUAL AND REPRODUCTIVE HEALTH

Factsheet on Violence Against Women <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>

Factsheet on Maternal Mortality <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>

Global Health Expenditure Database <http://apps.who.int/nha/database>

Commission on Information and Accountability for Women's and Children's Health (reports)
http://www.who.int/woman_child_accountability/about/coia/en/index5.html

A Policy Guide for Implementing Essential Interventions for Reproductive, Maternal, Newborn and Child Health (RMNCH)—A Multisectoral Policy Compendium for RMNCH (2014)
http://www.who.int/pmnch/knowledge/publications/policy_compendium.pdf

Making Health Services Adolescent Friendly: Developing national quality standards for adolescent-friendly health services (2012) <https://apps.who.int/iris/bitstream/handle/10665/255415/9789241512343-eng.pdf;jsessionid=D48EA226BBB7869278535B7494CD0896?sequence=1>

Safe abortion: technical and policy guidance for health systems (2012)
http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

Sexual and reproductive health: core competencies in primary care (2011)
http://www.who.int/reproductivehealth/publications/health_systems/9789241501002/en/

Unsafe abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008 (2011) http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241501118/en/

WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries (2011) http://whqlibdoc.who.int/publications/2011/9789241502214_eng.pdf

Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health (2010)
http://whqlibdoc.who.int/hq/2010/who_fch_10.06_eng.pdf

Everybody's Business: Strengthening Health Systems to Improve Health Outcomes—WHO's Framework for Action (2007)

Country Accountability Framework: A tool for assessing and planning implementation of the country accountability

framework for health with a focus on women's and children's health (IHP+ and the World Health Organization, 2012)
http://www.who.int/woman_child_accountability/about/caf_tool_uptd.pdf
<http://www.who.int/healthsystems/strategy/en/>

Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets (2004) http://whqlibdoc.who.int/hq/2004/WHO_RHR_04.8.pdf

WHO recommendations on Maternal Health (2017)
https://www.who.int/maternal_child_adolescent/documents/maternal-health-recommendations/en/

WHO recommendations on Adolescent Health (2017)
https://www.who.int/maternal_child_adolescent/documents/maternal-health-recommendations/en/

Report of the High-level Working Group on the Health and Human Rights of Women, Children and Adolescents. (2017)
<https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/ReportHLWG-humanrights-health.pdf>

UNITED NATIONS RESOURCES ON SEXUAL AND REPRODUCTIVE HEALTH

World Development Indicators

The primary World Bank collection of development indicators, compiled from officially-recognized international sources. It presents the most current and accurate global development data available, and includes national, regional and global estimates. <http://data.worldbank.org/data-catalog/world-development-indicators>

Worldwide Governance Indicators (WGI)

A project of the World Bank, Natural Resource Governance Institute and Brookings Institution.
<http://info.worldbank.org/governance/wgi/index.aspx#home>

Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health (The Partnership for Maternal, Newborn and Child Health, 2011)
http://www.who.int/pmnch/knowledge/publications/201112_essential_interventions/en/

International Technical Guidance on Sexuality Education (UNESCO, 2018) <http://www.unesco.org/new/en/hiv-and-aids/our-priorities-in-hiv/sexuality-education/international-technical-guidance-on-sexuality-education/>

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- 99 Sex workers include female, male and transgender adults who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not self-identify as sex workers. There are many reasons why people sell sex. Many sex workers choose freely to sell sex. Others enter into sex work as a result of conditions, which while deplorable, do not involve direct coercion and/or deceit by another. Examples include poverty, gender inequality, harmful cultural practices such as early child marriage, low levels of education, humanitarian emergencies and post-conflict situations. Sex workers are generally perceived as defying acceptable social norms and roles for women and men. Women who ask for compensation for sex break traditional norms expected of women in many societies, and those who engage in transactional sex are still labeled as prostitutes. Expressions of female sexuality are expected to be restricted to marriage or legal unions and to observe traditional notions of femininity, such as passivity, virginity and sexual innocence, which are dissonant in sex work. Men who have sex with men do not exemplify masculinity and face high levels of stigma and vulnerability especially where homosexuality is illegal. Deeply entrenched social standards marginalize sex workers and seriously limit their access to quality health services, particularly STI management, an essential component in HIV prevention.
- 100 WHO, UNFPA, UNAIDS. Prevention and Treatment of HIV and other Sexually Transmitted Infections for Sex Workers in Low- and Middle-Income Countries.
- 101 Ibid: K. Shannon, et al., 'Global epidemiology of HIV among female sex workers: Influence of structural determinants', *The Lancet*, 2014, p. 10, [dx.doi.org/10.1016/S0140-6736\(14\)60931-4](https://doi.org/10.1016/S0140-6736(14)60931-4)
- 102 Godwin, John. UNAIDS, UNFPA and UNDP. *Sex Work and the Law in Asia and the Pacific*. UNDP: Bangkok, 2012. Available from <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/sex-work-and-the-law-in-asia-and-the-pacific/>; Open Society Foundations, *Ten Reasons to Decriminalize Sex Work*, July 2012, <http://www.opensocietyfoundations.org/publications/ten-reasons-decriminalize-sex-work>;
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- 106 CEDAW Committee. General Recommendation No. 19, Article 116, para. 15.
- 107 CEDAW Committee, General Recommendation No. 24, para. 6.
- 108 CEDAW Committee, General Recommendation No. 24, para. 18.
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