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Chairperson: Mr. Marchán Romero

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* No summary records were issued for the 46th to 48th meetings.

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The meeting was called to order at 10.10 a.m.

Substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights

Day of general discussion on the right to sexual and reproductive health

1. **The Chairperson** said that the day's general discussion would be divided up into four panels and would provide valuable inputs for the drafting of a general comment by the Committee on Economic, Social and Cultural Rights on the right to sexual and reproductive health. That comment would serve as a tool for elucidating the obligations of States parties in protecting that right under the Covenant. There was no longer any question about the fact that economic, social and cultural rights had the same legal standing as other rights and that all the rights covered by the Covenant were therefore justiciable. Thousands of people, especially women and children, died throughout the world because of the failure to implement the right to sexual and reproductive health properly.

2. **Ms. Barahona Riera** (Rapporteur for the formulation of a general comment on the right to sexual and reproductive health) said that the promotion of and respect for the right to sexual and reproductive health were essential in order to uphold human dignity. Like other human rights, the right to sexual and reproductive health was universal, indivisible and interdependent.

3. The right to make responsible decisions, free of discrimination, coercion and violence, concerning one's sexual and reproductive life and the right of men and women to enjoy sexual health in conditions of equality, with respect for the physical integrity of all, lay at the heart of the right to sexual and reproductive health. Access to safe, efficient and affordable birth control, as well as to comprehensive sexual and reproductive health care that took into equal account the needs of men and women, was also implicit in that right. Women had the right to health care that protected them from the risk of death during pregnancy, childbirth or abortion. Freedom from the danger of sexually transmitted diseases and access to adequate sex education were equally important.

4. Referring to the Committee's general comment No. 21 (E/C.12/GC/21), she emphasized that harmful practices, including those attributed to customs and traditions, such as female genital mutilation, were barriers to the full exercise by the affected persons of the right to sexual and reproductive health. Other key factors that contributed to the realization of the right to sexual and reproductive health included access to clean running water and to satisfactory general health care, food, housing, working conditions and education.

5. **The Chairperson** announced that Ms. Melo, of the United Nations Population Fund, would serve as moderator for the first panel discussion.

Panel 1: The concept of the right to sexual and reproductive health

6. **Ms. Yamin** (Harvard University) said that the right to sexual and reproductive health was greatly neglected and subject to political manipulation at the national and international levels. The Committee's general comment should aim to consolidate existing international standards on sexual and reproductive health and fill any remaining gaps in those standards.

7. The definition of sexual and reproductive health was largely based on the Programme of Action of the International Conference on Population and Development, held in Cairo in 1994, and the Beijing Platform for Action of the Fourth World Conference on Women. The promotion of equality depended to a considerable degree on legislation, government policy and institutional arrangements and practices.

8. The general comment should reaffirm that the right to sexual and reproductive health was integral to and indivisible from other human rights and should build upon general comment No. 14 (E/C.12/2000/4). The right to sexual and reproductive health was closely tied to other rights under the Covenant, as well as to civil and political rights. The consensus documents that had emerged in Cairo and Beijing had recognized sexual and reproductive health as a fundamental aspect of many rights, including the rights to bodily integrity and security of the person, to non-discrimination and to equality between women and men.

9. The obligations of States parties to respect, protect and fulfil the right to sexual and reproductive health needed to be clarified. The general comment had to underscore the legal obligation of States parties to improve sexual and reproductive health progressively using the maximum resources available to them, along with the obligation of wealthier States parties to assist countries with limited resources to meet their obligations. The international trade, aid and investment policies of States parties should not be allowed to undermine the realization of the right to sexual and reproductive health in other countries.

10. The slower progress being made in the implementation of sexual and reproductive health rights in the past decade was, in part, attributable to the adoption of retrogressive measures, such as increasingly restrictive abortion laws, and to the inequitable distribution of resources, goods and services, which deepened disparities between different population groups.

11. States parties should be made aware of their immediate obligations with regard to sexual and reproductive health, which entailed the elimination of discrimination. Certain levels of service had to be attained with respect to sexual and reproductive health care, information and the availability of skilled health professionals and essential medicines and technology. States parties also had to adopt national strategies and action plans. Shortcomings in health systems had a disproportionate impact on sexual and reproductive health and often led to the marginalization of people, particularly women, sexual minorities and stigmatized groups. Health systems based on a human rights approach, on the other hand, could promote inclusiveness and help deepen democracy.

12. The general comment should make clear how laws played a key role in establishing the level of access to sexual and reproductive health care. The criminalization of abortion, the sex trade and intravenous drug use, for instance, exposed certain groups to a higher risk of morbidity and mortality. The need for effective and accessible accountability mechanisms, including judicial enforcement and monitoring, should also be emphasized. Judicial remedies played a fundamental role in redressing violations of sexual and reproductive health rights, challenging the systematic violation of those rights and promoting policy implementation and reform and the removal of legal restrictions on care.

13. **Ms. D'Arcangues** (World Health Organization) recalled that the Population and Development Programme of Action and the World Health Organization (WHO) Reproductive Health Strategy, adopted in 2004, emphasized that sexual and reproductive health was a human right. Sexual and reproductive ill health was closely linked to poverty, because the poor had the least access to contraception, antenatal care, skilled attendance at birth and infertility care. That need not be the case however, as the substantial reduction in maternal and infant mortality in Chile and the universal availability of contraception in Bangladesh demonstrated. In Chile, the drop in mortality rates had been accompanied by a considerable narrowing of the gap in those rates between different socio-economic groups. While poverty was a common denominator in most problems of access to health care, access to sexual and reproductive health was also influenced by marital status, age, sexual orientation, gender identity and HIV status. Adolescents, for instance, had more limited access to contraception than adults.

14. A number of areas required special attention. It was critical to ensure access to accurate, evidence-based family planning information and a full range of modern contraceptive methods and to eliminate financial and legal barriers. Comprehensive, objective age-appropriate sex education, starting in childhood and continuing through adolescence, was crucial to empowering young people to protect themselves. Access to sexual and reproductive health services for young people without requiring parental consent, in keeping with their evolving capacity and best interests and in line with principles of privacy and confidentiality, was also key.

15. Access to safe abortions, when permitted by law, was sometimes available only in a few urban centres. Since 13 per cent of maternal deaths were due to unsafe abortions, broader legal grounds for safe abortions must be introduced. Regulations were needed to ensure that, if health providers raised an objection of conscience to performing an abortion, it would not prevent women from obtaining such services.

16. Consensual sexual activity among adults must cease to be an offence. Criminalization of the transmission of HIV/AIDS was an ineffective means of preventing it and threatened women's rights. The rights of HIV-positive persons and non-heterosexuals must be protected.

17. Maternal mortality and morbidity rates were influenced by geographical coverage and service costs, the allocation of resources to basic health-care infrastructure, equipment and medicine, and the number and qualifications of health-care providers. Other health determinants included the exclusion of women and girls from participation in decision-making on questions regarding their health, as well as illiteracy and gender-based violence.

18. The available statistics were often insufficient to allow for proper programme planning. There was little information on births and deaths, the sexual behaviour of adolescents or their access to care, or unsafe abortions as a cause of maternal mortality. Nor was there sufficient information on the sexual and reproductive health status of migrants, refugees, displaced persons, persons with disabilities, persons of different sexual orientation or sex workers or on medical tourism for abortion or infertility services.

19. WHO had developed norms and standards for evidence-based health policies, programmes and services concerning family planning, safe abortion, maternal, newborn and child health, primary sexual and reproductive health care, reproductive health in refugee situations and the implementation of the WHO Reproductive Health Strategy. It had developed a human-rights tool for promoting sexual and reproductive health, and a version of that tool had been adapted to the needs of adolescents. A mechanism for determining whether national regulations on sexual and reproductive health were in line with the human rights obligations of States had also been designed, and WHO continued to provide global monitoring and advocacy for the international community.

20. **Mr. Khosla** (Amnesty International) said that the Programme of Action of the International Conference on Population and Development had identified sexual health as an element of reproductive health. A comprehensive approach to sexuality and reproductive health was needed, and Amnesty International called on the Committee to position its general comment within the overall context of sexual and reproductive rights. That approach should also be reflected in its title.

21. General comment No. 14 reflected the fact that sexual and reproductive health depended on the enjoyment of a range of interrelated human rights, including the right to food, education, non-discrimination, dignity, life and equality. The proposed general comment provided an opportunity to highlight specific rights, such as freedom of thought, conscience and religion, the right to choice in marriage and freedom from all forms of gender-based violence, and their interconnection with sexual and reproductive health.

22. The realization of the right to sexual and reproductive health required a full range of information and services. A selective interpretation of that right would simply not work. The proposed general comment would give the Committee the opportunity to affirm that there was no excuse for States to fail to take appropriate steps to provide a comprehensive range of sexual and reproductive health information and services. Selective approaches that included prevention of unwanted pregnancy but neglected the provision of safe abortion services to the full extent of the law violated human rights and had an adverse impact on women's health and decision-making power. Approaches that excluded young women and girls, unmarried persons or lesbians, gays, or bisexual or transgender people violated human rights. Amnesty International's research on national laws and policies on sexual, reproductive and maternal health showed up the need for strong guidance on non-selective approaches. Many health-care laws and policies omitted or inadequately addressed issues considered to be politically or culturally sensitive, in disregard of the resulting human rights violations.

23. Non-discrimination and equality were central to sexual and reproductive health rights. The Committee's general comment No. 14 called for a gender-based approach to health. In implementing their obligations, States must be committed to ensuring gender equality and non-discrimination on the basis of age, marital status, sexual orientation or gender identity.

24. The Committee should also focus on multiple discrimination. As noted by the Committee on the Elimination of Discrimination against Women, some women suffered from cumulative discrimination based on race, ethnicity, religion, disability, age and/or social class, which impaired their access to sexual and reproductive health care. The impact of such factors must be addressed; unfortunately, recognition of the existence of compound discrimination in State policies and practices was fairly limited.

25. The proposed general comment provided an opportunity for the Committee to expand on the guidance that it had provided in general comment No. 14 on permitted and prohibited grounds of discrimination. In particular, the Committee should reflect on the reasons given for limitations that impaired the enjoyment of human rights. That issue included sexual and reproductive health interventions undertaken without the full and informed consent of the person concerned. Special attention should be given to cases in which national legislative processes were cited in support of laws and policies that violated human rights. The Committee should reaffirm that States must not invoke any custom, tradition or religious consideration to prevent the enjoyment of the right to sexual and reproductive health.

26. The Committee should also consider instances of potential conflict between moral conceptions, on the one hand, and human rights principles and public health evidence, on the other. Sexuality education was one example cited by the former United Nations Special Rapporteur on the right to education in his recent report (A/65/162), in which he had noted that comprehensive sexual education must also be based on scientific evidence and promote the integration of individuals into a more democratic and egalitarian society.

27. States parties would benefit from input on the right to remedies and adequate reparations. The general comment could usefully explore how the right to accountability mechanisms could work in respect of sexual and reproductive health and where they needed to be altered to address specific barriers. A classic example was the denial of sexual and reproductive health rights resulting from a failure to regulate health professionals' exercise of their right to conscientious objection to provide certain kinds of care. The Committee should also consider cases in which measures to secure the full enjoyment of sexual and reproductive health care should be taken as part of reparations, such as the provision of a full range of medical and psychosocial services to rape victims. The general comment must emphasize the need for disaggregated data to inform focused interventions on behalf of

groups at risk of exclusion, stigmatization or denial of autonomous decision-making power. Women and girls must have effective means to hold their Governments to account for human rights violations. The Committee had an important role to play in helping States parties develop national monitoring and accountability mechanisms.

28. **Mr. Riedel** said that he agreed with Ms. Yamin about the need to address gaps in general comment No. 14. The Committee had considered a number of cases in recent years which showed that problems relating to sexual and reproductive health remained in nearly every country. He endorsed, in particular, her remarks on the dimension of inclusiveness and on social determinants.

29. Social policy choices were at the root of the problem, and general comment No. 14 had not addressed that point in sufficient detail. He had in mind, in particular, the obligation to fulfil, an area in which the progressive realization of rights came into play. The Committee's views on resource allocation within the context of article 2, paragraph 1, of the Covenant and general comment No. 3 should be included in the proposed general comment.

30. He asked Ms. D'Arcangues what steps WHO was taking to encourage States to apply human rights standards to advance sexual and reproductive health. She had also referred to a WHO human-rights tool for sexual and reproductive health and its adaptation for adolescents, but he had the impression that WHO expected the Committee to focus on that aspect. Was that not a question to which WHO should be devoting increased attention?

31. He welcomed Mr. Khosla's reference to issues involving remedies, reparations, accountability, conscientious objection and the provision of medical and psychosocial services for rape victims, and stressed the need for judicial remedies at national level. The proposed general comment could assist national human rights institutions in that regard.

32. **Ms. Bras Gomes** said that the point of a general comment was to provide clarity on a right or component of a right. The Committee built on information which it gathered during its dialogue with States parties. Against that background, the last thing that the Committee wanted was a selective interpretation. She sought clarification as to the exact nature of the selective interpretations that the Committee should avoid in the proposed general comment.

33. **Mr. Kedzia** asked Ms. D'Arcangues to elaborate upon her comment that the criminalization of the transmission of HIV/AIDS was an ineffective means of preventing it and threatened women's human rights. He wondered whether that implied that the transmission of HIV/AIDS should be decriminalized in cases in which the infected person had knowingly transmitted it.

34. **Ms. Barahona Riera**, noting that there were differing interpretations of the concept of the right to sexual and reproductive health, asked whether any components of the definition had been left out which ought to have been included.

35. **Ms. Mostafa Rizk** (Egypt) said that her delegation would have appreciated it if prior contributions had been solicited from States parties. When the Committee engaged in a process of drafting a general comment, interpreting the Covenant and identifying lacunae in the protection of economic, social and cultural rights, States parties needed to be more closely involved.

36. She had the impression that the discussion was moving in one direction only, namely towards abortion. There were various interpretations on that very sensitive issue, and the Committee should not seek to promote the legalization of abortion by interpreting it as part of the right to sexual and reproductive health. In her view, the right to sexual and reproductive health concerned access to health care but not necessarily the issue of abortion

as it related to maternal health. She would also appreciate clarification on the issue of the criminalization of HIV/AIDS and the question of selectivity.

37. **Mr. Nabeel** (Pakistan) stressed that the enjoyment of the right to the highest attainable standard of physical and mental health was vital to the overall well-being of the human person and thus to the enjoyment of the right to life and all other rights. However, the Covenant made no mention of a right to sexual and reproductive health or, for that matter, abortion. The Committee should not draw up a general comment on matters not agreed by the States parties. Pakistan remained committed to the Covenant and took all necessary steps to ensure its maximum implementation.

38. **Mr. Flores Bermúdez** (Honduras) said that his Government had repeatedly spoken out in international forums in favour of sexual and reproductive health within the framework of its national legislation and international obligations. His Government welcomed the dialogue on the interdependence and interrelation of human rights, but maintained its position that the topic of sexual and reproductive health was not part of the Covenant.

39. **Mr. Texier**, replying to the comment made earlier by the delegation of Egypt, urged all States parties to make their voices heard by providing written material and participating in the debate.

40. He said that he strongly disagreed with the assertion that, as the right to sexual and reproductive health did not appear in the Covenant, the Committee had no right to draft a general comment on it. States parties had given the Committee a mandate not only to consider the reports of States parties, draft conclusions and make recommendations, but also to issue general comments. The fact that a right did not appear in the Covenant did not prevent the Committee from drafting a general comment on it. To cite one example, the Committee had drawn up general comment No. 15 on the right to water; that right was nowhere to be found in the Covenant, but it clearly was part of the right to health and food.

41. He agreed with previous speakers that the issue of abortion was very sensitive. The Committee itself was very divided on the complex question of when life began, and it would be a mistake to assume that it had established a clear position. On the contrary, the purpose of the current meeting was to help clarify the views of the Committee, which would not prepare its general comment until after it had held a thorough debate. The general comment would be very cautious on difficult topics such as the beginning of life and abortion. Hence the need for States parties to make their views known in writing.

42. **Mr. Sadi** said that he likewise wished to dispel the notion that the Committee was in favour of an unrestricted right to abortion. He had been hoping that some of the speakers would refer to different ways of treating sexually transmitted diseases and AIDS, in particular. Child prostitution and child marriage, sexual abuse and sexual exploitation, and the question of prostitution needed to be given closer consideration. It would be useful to list the elements which should be included in the discussion.

43. **Ms. Miller** (Malta) said that, in her delegation's view, the issue of abortion could be considered only in the framework of the right to life. Malta reaffirmed its position that abortion was a denial of the fundamental right to life, a right which it recognized from the moment of conception. References to sexual and reproductive health services and rights must not be defined as including abortion or impose the obligation to consider abortion as a right or health service. Accordingly, the issue of abortion could not be considered within the framework of rights, but only as a matter pertaining to national legislation. She referred in that context to paragraph 8.25 of the Cairo Programme of Action, which stated that "any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process". International law

had not recognized the right to abortion, and it was inappropriate for a general comment to do so in the context of sexual and reproductive health.

44. Although Malta considered that sexual and reproductive health did not include a right to abortion, it strongly agreed that action towards the fulfilment of sexual and reproductive health rights should focus on the positive aspects of education, social welfare and health care.

45. **Mr. Parodi** (Chile) said that it was important to strengthen the implementation of all fundamental human rights. The public health system must be enhanced to improve the quality of services, accessibility and non-discrimination. However, Chile condemned abortion, which was a denial of the right to life. In no case could sexual and reproductive health entail abortions.

46. **Ms. Goy** (Luxembourg) said that the general comment would be very useful to the Human Rights Council in its consideration of the question of maternal mortality, on which it had already adopted two resolutions.

47. **Ms. Barahona Riera** welcoming the participation of States parties in the day of general discussion, said that information on the event had been disseminated in good time in order to allow all interested parties to register and take part.

48. Sexual and reproductive health was one of the principal issues dealt with by the Committee in relation to article 12 of the Covenant concerning the right to health. For more than 15 years, the Committee had been making recommendations to States parties on that topic in its concluding observations. While maternal mortality, of which abortion was undeniably one of the numerous causes, was an issue of great importance for the international community, the present discussion should focus on the right to sexual and reproductive health, which many States parties had been addressing since the 1994 International Conference on Population and Development. The Committee had already referred to sexual and reproductive health in its general comment No. 14. The present forum should not be used for position statements on one particular issue, but for debate and dialogue on all aspects of the wide-ranging and complex topic of sexual and reproductive health, which affected the lives of millions of men and women and was dealt with in different ways in the legislation and practice of different countries.

49. **Mr. Hani** (Lebanon) said that, according to the definitions agreed at the International Conference on Population and Development and the Fourth World Conference on Women, reproductive health did not necessarily encompass the right to abortion. The Committee on the Rights of the Child clearly understood the protection of life to extend to the point of conception. The rights to life and health were interdependent and should be considered in conjunction with one another. A general comment by the Committee on sexual and reproductive health would be of questionable legitimacy, as the topic was not explicitly mentioned in the Covenant. The concept should, in any event, be expanded to include issues such as the health of men and boys and the prevention of breast cancer. States should combat discrimination and inequality between the sexes and violence against women and should, by all means, prevent unwanted pregnancies.

50. **Ms. Vizcaya** (Nicaragua) underscored the importance her Government attached to sexual and reproductive health at all stages of life. Her Government's health model was viewed as a social process closely linked to human development, and it built upon values and standards of behaviour for individuals, families and communities. Sexual and reproductive health was a cross-cutting issue which should be considered from the point of view of the life cycle as well as gender and rights. Nicaragua had formulated a national strategy on sexual and reproductive health which incorporated that vision. Abortion was completely prohibited and was an offence under the Criminal Code.

51. **Ms. Lee** (International Disability Alliance), highlighting the indivisibility of rights and the framework within which reproductive health should be considered, said that the Convention on the Rights of Persons with Disabilities provided useful guidance, having been adopted in recognition of widespread discrimination and abuse against persons with disabilities in many areas, including in respect of their sexual and reproductive health. It moved away from a purely medical perspective to one that recognized persons with disabilities as subjects with their own rights. She drew attention, in particular, to article 23 of the Convention on the Rights of Persons with Disabilities, which dealt with family planning, reproductive education and related issues.

52. **Ms. Mountenay** (Endeavour Forum Inc.) drew attention to the potential negative health effects of even legal abortions, referring in particular to studies pointing to a link between induced abortion and increased risk of breast cancer. In order to reduce maternal mortality in developing countries, she said, efforts should be devoted to improving access to clean water, safe blood transfusions and obstetric care, and food.

53. **Mr. Khosla** (Amnesty International), emphasizing the complex, multifaceted nature of the issue, said that there was no "one size fits all" solution. In defining sexual and reproductive health and rights, guidance should be sought from existing frameworks. The focus of the Cairo Programme of Action on sexual and reproductive health as a complete state of physical, psychological and social well-being and the enhancement of life and personal relations encouraged a perspective that was not limited solely to reproduction. Sexual and reproductive rights were inseparable; likewise, the prevention of unwanted pregnancies could not be isolated from the provision of safe abortion services. Dialogue on such a contentious issue was vital. Amnesty International's aim was not to secure abortions on demand, but to promote the decriminalization of abortion. In cases of a threat to maternal or foetal health, rape or incest, it was particularly important that abortion services should be available without threat of prosecution. The high rate of maternal mortality from unsafe abortions must push the international community to engage in dialogue on the issue. In addition, post-abortion care should be made available even where abortion was a criminal offence.

54. **Ms. D'Arcangues** (World Health Organization) said that the human-rights tool used by WHO had been adapted to address adolescent sexual and reproductive health issues. WHO reported to the human rights treaty bodies on the sexual and reproductive health situation in different countries and was currently gathering worldwide examples of how courts had invoked rights in cases related to sexual health. It provided evidence to inform discussions at global, regional and country level.

55. Given the difficulty of attributing transmission of HIV, criminalizing it was not advisable. It tended to discourage HIV testing and exacerbated the power differential between sexual partners, to the detriment of women. WHO would shortly publish its latest estimates of global abortion rates. The more restrictive legislation on abortion was, the more likely abortion was to be unsafe and to result in death. Abortion rates were not strongly influenced by legislation, but were lower where people were able to access information, sex education and family planning services. The reduction in the global abortion rate was mainly accounted for by a decrease in safe abortions as people became better informed, while the rate of unsafe abortions had remained the same for several decades. She said that no link existed between abortion and breast cancer and welcomed Mr. Khosla's comment on the importance of post-abortion care.

56. **Ms. Yamin** (Harvard University) urged the Committee not to skirt contentious issues such as prostitution and abortion in its proposed general comment. On-demand abortion was not desirable, she said, but standards already existed within the Committee, other bodies and some domestic legislation regarding circumstances in which abortion should be legal, including incest and a threat to maternal health. Many bodies, including the

Committee, had already recognized that severe restrictions on abortion threatened women's rights to life, health and freedom from cruel and inhuman treatment. Where legal, abortion services should be accessible to all women. Emergency obstetric care was crucial not only for safe pregnancy and childbirth, but also for safe abortions. Various treaty bodies had also recognized that States should not coerce confessions to abortion from women during post-abortion care and should address discrimination and its impact on abortion practices. The Committee should take account of existing standards in preparing its general comment.

57. **The Chairperson** emphasized the open and inclusive nature of the day of general discussion. He said that States parties had been notified of the Committee's agenda in advance and participation by all States parties would have been welcomed.

58. The Committee was fully competent to draft a general comment on sexual and reproductive health, partly because it considered article 12 of the Covenant to refer to the right to enjoy the highest possible standard of physical and mental health and partly because article 12 explicitly mentioned reducing infant and child mortality. General comments were not binding agreements; rather, they were intended to assist States parties in understanding the Committee's interpretation of the normative aspects of the Covenant rights. They represented the fruit of prolonged consideration and discussion with, inter alia, States parties. He encouraged the representatives of States parties and civil society to consult the various concluding observations issued by the Committee in which it had requested States parties to explain what steps they were taking to apply article 12 of the Covenant and, in particular, to reduce the number of deaths caused by abortion. Abortion, however, was not the subject of the proposed general comment.

59. The right to sexual and reproductive health was undeniable. Through the present discussion and other means, the Committee sought to solicit the views and concerns of the international community on the issue, which would inform its deliberations on a general comment. He stressed the Committee's role as an independent, non-political body charged with ensuring full respect for the rights set out in the Covenant.

60. **Ms. Melo** (United Nations Population Fund) emphasized the complexity of the right to sexual and reproductive health, which related to fundamental issues of society. The members of the panel placed their trust in the Committee and would contribute to its work in any way possible.

61. **The Chairperson** announced that the second panel would be moderated by Ms. Jane Connors of the Office of the United Nations High Commissioner for Human Rights.

Panel 2: Normative aspects

62. **Ms. Connors** (Office of the United Nations High Commissioner for Human Rights) said that the second panel discussion would focus on States parties' obligations as they applied generally and to specific groups requiring special protection. Violations and implementation at national level would also be addressed, particularly with reference to health systems. She then introduced the members of the panel.

63. **Ms. Gruskin** (Harvard University), underlining the importance of the Committee's output, its relevance for policymakers, academics and activists, and its impact on individuals' enjoyment of their rights, said that the proposed general comment should clearly establish that Governments had an obligation to ensure the sexual and reproductive health of all, including women, men, transgender people, adolescents and all groups specifically mentioned in the Committee's general comment No. 20 as requiring protection against discrimination.

64. Rather than inventing anything new, the Committee should bring together existing ideas with regard to current legal standards and related public-health evidence. The

proposed general comment should explicitly refer to sexual and reproductive health as defined by WHO and other agencies and should build on the obligations set out in the Committee's general comments Nos. 14 and 20. Obligations relating to sexual and reproductive health should be articulated in terms of the Covenant rights; mention of a specific, new right to sexual and reproductive health should be avoided in view of the legal implications, and the title of the proposed general comment should therefore be altered accordingly.

65. The Committee should avoid the temptation to suggest a minimum package of services because of the wide-ranging nature of sexual and reproductive health issues, but should focus on the protection of existing rights as they related both to the underlying determinants of health and to the delivery of accessible, high-quality sexual and reproductive health services. A broad approach should be employed, allowing States to identify minimum packages for themselves but setting out a clear obligation to work towards progressive realization. The efforts of States to protect sexual and reproductive health rights should be understood as a continuum. Lastly, she urged the Committee not to shy away from dealing with sensitive issues such as gender-based violence, abortion and adolescent access to sexual and reproductive health services.

66. **Ms. Melo** (United Nations Population Fund) drew attention to issues relating to specific groups, such as people with disabilities, indigenous peoples and older people, that should be addressed by a general comment on sexual and reproductive health.

67. Persons with disabilities were less likely to receive information on sexual and reproductive health and to have access to relevant health services, from family planning to prenatal, birth and post-natal care. Negative attitudes on the part of health workers and others often created barriers to accessing information and services. Articles 23 and 25 of the Convention on the Rights of Persons with Disabilities recognized the sexual and reproductive health rights of persons with disabilities. The entire Convention was informed by the eight fundamental principles set out in article 3, which should be applied to all individuals with disabilities without discrimination.

68. Legal and policy reform must be undertaken in consultation with persons with disabilities and their organizations. The proposed general comment should address the need for States to adopt and implement laws, policies and programmes that complied with the Convention and protected the rights of persons with disabilities to marriage, family, parenthood and relationships on an equal basis with persons without disabilities. Particular attention should be given to ensuring de facto equality for women with disabilities through, inter alia, affirmative action, and to producing sufficient disaggregated statistics on persons with disabilities to identify multiple discrimination.

69. Indigenous peoples often lacked access to health care, not only as a result of their physical isolation, but because their concerns were not taken into consideration in national priorities and frameworks. Despite some recent advances in establishing international human rights standards and in securing increased participation of indigenous peoples in political processes, their lives, health, cultures, values and traditions were still under threat.

70. The general comment on the right to sexual and reproductive health should request States to ensure that indigenous persons enjoyed the same human rights as others. Efforts to protect the human rights of indigenous peoples must take into consideration those aspects that were unique to their identity. States parties to the Covenant must recognize that indigenous peoples' traditional knowledge was essential for the realization of their right to sexual and reproductive health. Sexual and reproductive health services, for indigenous and non-indigenous persons alike, must be accessible, of good quality and culturally acceptable. The indigenous peoples of Latin America, for example, had developed a system of beliefs and practices with regard to the human body based on living in harmony with other human

beings, nature and the spiritual world. The strength and survival of indigenous peoples was linked to their traditional health systems.

71. Turning to the situation of older persons, she noted that there was a general assumption that they were not, or should not be, sexually active, which not only contributed to stereotyping and stigmatization, but also prevented them from accessing services and information. Older persons were fully entitled to preventive and curative sexual and reproductive health information and services. Health systems should be sensitive to the needs and dignity of older persons. Evidence had shown that older persons were at higher risk of contracting HIV and other sexually transmitted infections and were less likely to have protected sex. Information campaigns and programmes should therefore also target older people.

72. **Mr. Mazin** (Pan American Health Organization) said that sexual and reproductive health could and should be a source of personal and collective well-being, satisfaction and fulfilment. The right to sexual and reproductive health must therefore be a framework for States parties' efforts to promote and implement the right to total and complete health.

73. Sexuality encompassed several dimensions which, combined with social context, underpinned the social construct of gender. Reproduction was one of the facets of human sexuality, which could be gratifying when desired and free of physical risk or harm, but could also entail considerable distress when unintended or when it involved coercion or even threats to life. It could also be linked to violations of the Covenant rights. The promotion of sexual and reproductive health should encompass the removal of hurdles to fulfilling personal relations and the prevention of negative outcomes associated with sexuality and reproduction. Health-care systems' obligations with regard to rights related to sexual and reproductive health included empowering people to informed, uncoerced decisions about their sexuality and reproduction, providing equal access to sexual and reproductive health-care services at all stages of life, encouraging public participation in health-care decision-making; improving people's sexual health status through specific interventions and helping to protect people against the financial consequences of poor sexual and reproductive health.

74. Health-care systems must also treat and support victims of any violation of human rights related to sexuality and reproduction. Clandestine services must be replaced with safe alternatives for gender enhancement procedures, the management of sexually transmitted infections and the performance of abortions. The use of misleading and pseudo-scientific information to pressure people into making potentially damaging decisions must be denounced. Reproductive health programmes should also be broadened to address concerns and problems related to sexuality. Health-care providers should be trained to deal in a sensitive and respectful manner with persons of all sexual identities and orientations. Necessary interventions and materials must be provided for the prevention, diagnosis and treatment of sexually transmitted infections, including HIV, and the right to privacy of the users of those services must be respected.

75. Involuntary sterilization and female genital mutilation should be denounced, as must treatments that might stem from bigotry and hatred, such as forced sex-change operations for homosexuals and so-called conversion therapies. Services should be available to assist couples with sexual and reproductive decision-making and to address sexual concerns, and treat dysfunctions and disorders related to sexuality. Sexual and reproductive health must be recognized as essential human rights.

76. **Ms. Hoctor** (International Commission of Jurists) said that States parties' obligation to respect the Covenant rights encompassed protection from non-consensual sexual and reproductive health-care interventions by State actors, including forced sterilization, mandatory testing for pregnancy or sexually transmitted infections, imposition of

contraception and abortion, coerced gynaecological or anal examinations, and medically unnecessary operations on intersex children.

77. Legal and regulatory frameworks must not limit access to sexual and reproductive health-care services on grounds of marital status or access to information or services on the basis of age. Laws that criminalized consensual sexual activity, such as sex outside of marriage, homosexual sex, adultery and sex between adolescents, also constituted violations of the obligation to respect. State practices and policies that censored or withheld information or that presented inaccurate or discriminatory information related to sexual and reproductive health must be done away with. Examples included sex education programmes in State schools that employed entrenched gender stereotypes, misrepresented the effectiveness of condoms, or portrayed abstinence as the only effective means of preventing sexually transmitted infections and pregnancy.

78. States' obligations to protect the Covenant rights included ensuring that a legal framework was in place to prevent conduct by private actors that undermined and interfered with sexual and reproductive health. Such conduct included sexual violence and abuse, child marriage, forced marriage, coerced virginity testing and female genital mutilation. States parties must also regulate private health-care providers, health insurance companies, educational institutions and privately run detention centres in a manner that ensured that they did not undermine human rights. Violations of the obligation to protect also encompassed any failure to prevent, investigate and ensure accountability for any conduct by third parties that impeded the enjoyment of human rights related to sexual and reproductive health.

79. With regard to the obligation to fulfil the Covenant rights, she said that violations could arise if a State party failed to establish a holistic and inclusive national health policy. Examples included the absence of any sexual health policy at all, the failure of such a policy failed to address the needs of particular groups, or the failure of a national medicines list to include the medicines and devices essential to sexual and reproductive health. Lack of access to sexual health-care services and information, including contraception, also constituted a violation. States parties should provide quality maternal health care for all women under their jurisdiction, as well as effective and timely access to safe and legal abortions. Holistic, inclusive and human-rights-based sex education must be guaranteed in school curricula and delivered in an age-appropriate manner. Comprehensive, scientifically accurate information must be provided in that context on family planning and contraception and on the prevention and treatment of sexually transmitted infections, including HIV.

80. Turning to implementation, she said that States must uphold the rights of individuals and groups to participate in decision-making, with due regard for non-discrimination and equality. It was not enough to ensure the participation of women as such; steps had to be taken to ensure the participation of women from a diverse range of groups, such as women with disabilities, young women, lesbian women, migrant women, women living with HIV/AIDS and women from different socio-economic strata. The identification of relevant sexual and reproductive health indicators was also particularly important. Monitoring and assessment should be undertaken to facilitate the identification of high-risk groups on the basis of disaggregated data. States must also ensure accountability and remedies that were meaningful for the whole of society.

81. **Mr. French** (Save the Children) said that there was a close link between the sexual and reproductive rights of mothers and the rights of the child to life and health. That link should be addressed in the general comment. In that regard, the Committee should draw up on guidelines issued by the Committee on the Rights of the Child and its general comments. Models concerning the right to health should span the entire life cycle.

82. **Ms. Chojecka** (Poland) said that under Polish law, women received special protection during pregnancy, childbirth and the postpartum period. Pregnant and postnatal women were entitled to free health care, even if they did not have health insurance. Poland had recently adopted legal standards on perinatal care and the care of newborns which upheld patients' rights. Poland spared no efforts to prevent HIV transmission and to provide health care for pregnant women and children living with HIV. The maternal death rate, which had decreased by 82 per cent over the past 20 years as a result of the Polish Government's policy on maternal and newborn health, was lower than the European Union average and than rates in countries with liberal abortion laws.

83. **Ms. Okafor** (Nigeria) said that insensitivity to freedom of conscience, traditional institutions and the sovereignty of States could threaten world peace. A number of fallacies had been put forward during the current discussion, including some of the statements made concerning the connection between maternal mortality and lack of access to abortions. In many African countries, maternal mortality was in fact connected with a lack of proper perinatal care and of skilled midwives. Another such fallacy was the claim that liberalizing laws on abortion would decrease the number of abortions. Abortion was not, and never would be, legal in Nigeria. The general comment should focus not only on rights, but also on the attendant responsibilities, and must emphasize family values. Care should be taken to ensure that due consideration was given to the rights of the child, including the unborn child, and paternal rights. Values could not be imposed on States without regard for their sovereignty and their domestic values and jurisprudence.

84. **Ms. Richler** (International Disability Alliance) drew attention to the widespread sterilization of persons with disabilities, in particular those living in institutions. Persons with disabilities who had been excluded from mainstream schooling were often deprived of sex education and of information on HIV/AIDS, and therefore could not make informed decisions. There were often myths associated with disabilities that could result in abuses. Respect for reproductive rights was particularly important in breaking the genetic chain of certain disabilities.

85. **Ms. Sood** (Youth Coalition for Sexual and Reproductive Rights and the Sexual Rights Initiative) said that adolescents and young people comprised one third of the world's population, and their interests should be specifically addressed in the general comment on the right to sexual and reproductive health. Policies and laws should be aligned with the evolving capacities of adolescents and young people. Consideration should also be given to how to tailor sexual and reproductive health services to those groups and to third-gender and intersex people, as well as sex workers.

The meeting rose at 1.20 p.m.