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Remarks Prepared for Day of General Discussion: General Comment on the Right to Sexual and Reproductive Health

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Introduction

I am deeply honored to have this opportunity to share some thoughts with the Committee, which I should note draw heavily upon the submission of the Center for Economic and Social Rights, which I chair. [i] I want to begin by applauding the leadership of the Committee in choosing to issue a General Comment regarding sexual and reproductive health (SRH). Despite the many statements and rich jurisprudence regarding SRH rights, the topic continues to be subject to both tremendous neglect and political manipulation at both national and international levels. Therefore, in my view it is important that a robust understanding of SRH rights be firmly anchored in an authoritative interpretation of the binding legal commitments that States parties to the Covenant undertake.

I want to stress, however, that for this General Comment to add value it is imperative that the Committee consolidate and forcefully reaffirm the broad array of standards that have already been established with respect to SRH rights obligations, and to fill gaps where they exist. I will briefly make five points.

I. The Definition of Sexual and Reproductive Health is well-established

Sexual and reproductive health were defined through two foundational international consensus documents, the 1994 International Conference on Population and

Development Programme of Action (Cairo) and the 1995 Fourth World Conference on Women Platform for Action (Beijing).[ii] Sexual rights have subsequently been elaborated further but according to these documents, reproductive health includes sexual health, "the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted disease;" it address the reproductive processes, functions and system at all stages of life, in the context of "complete physical, mental and social well-being."[iii] SRH is predicated on the ability of men and women to have a "responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[iv] SRH also requires "equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the integrity of the person, [and] mutual respect, consent, and shared responsibility for sexual behavior and its consequences;" it also requires that women "have control over and decide freely and responsibly on matters related to their sexuality, including SRH, free of coercion, discrimination and violence.[v]"

These definitions signal that SRH is not merely a matter of "natural" biological causes or behavioral factors. On the contrary, patterns of SRH are the products of social relations and social choices-- of laws, policies, programs, institutional arrangements and practices that on the one hand promote not only formal but also substantive equality, as set out in General Comment 20, as well as a wide array of rights—or, alternatively, do not.

II. The General Comment must reaffirm that the Right to SRH is integral to and indivisible from other human rights

This Day of General Discussion relates to a "right to SRH." As the Commission on Human Rights affirmed in 2003: "Sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." [vi] It therefore makes sense for this General Comment to be grounded in the analytical framework of and to follow the structure of General Comment 14 on the right to the highest attainable standard of health.

However, both conceptually and normatively it is critical to underscore that the right to SRH has important relations with other rights in the Covenant, as well as with civil and political rights. The consensus documents emerging from Cairo and Beijing explicitly recognized reproductive and sexual health as a fundamental aspect of many human rights that are well enshrined in international law, including the rights to bodily integrity and security of person, to non-discrimination and equality between women and men, and to an array of economic and social rights. As a background document prepared for the General Comment notes, this understanding has been reflected in the work of all the UN treaty bodies that have addressed SRH from different perspectives. Therefore, it is critical that this General Comment stress the indivisibility and interrelation of the right to SRH with other human rights, both civil and political, and economic, social and cultural.[vii]

III. The General Comment provides an opportunity to clarify the nature of governmental and international obligations.

As with previous General Comments, the Committee can provide invaluable guidance to states by clarifying the nature of obligations to respect, protect and fulfill the right to SRH. The General Comment can add particular value by shedding light on the scope and content of the obligation to fulfill, as it is the most poorly understood obligation and, as such, one of the most neglected in the framing and implementation of policies related to SRH. In particular, the Committee should elucidate states' legal obligations related to the progressive realization of SRH according to maximum available resources.[viii]

In addressing the resource dimensions of the obligation to fulfill, the General Comment should also examine the extra-territorial obligations of States in a position to provide international assistance and cooperation to other states with limited capacity to meet their full SRH obligations. The General Comment should also stress that the duty to respect and protect the right to SRH extends to ensuring that states' international trade, aid and investment policies do not undermine the realization of this right in other jurisdictions.

Furthermore, the evident stalling in global progress in the last decade along many of the indicators related to SRH[ix] may in some respects be attributable to deliberately retrogressive measures, such as the adoption of increasingly restrictive abortion laws which place women's lives and health at risk, or the inequitable allocation of resources, goods and services in ways that widen SRH disparities between population groups.[x]

In addition to clarifying obligations of progressive realization, the General Comment should emphasize that states have immediate obligations with respect to SRH, including eliminating discrimination. In keeping with General Comments 3 and 14, immediate obligations also require states to prioritize the universal attainment of "minimum essential levels" in relation to SRH. [xi]

Minimum levels of SRH goods and services and, in turn, specific packages of goods and services, will necessarily evolve as medical and scientific knowledge continually comes to light . However, there are elements of a minimum core that are already well-grounded in international law, which include: certain categories of services; the obligation to provide certain *free services where necessary*; SRH information; skilled SRH health professionals; essential medicines and technologies; and the adoption and implementation of a national strategy and plan of action.[xii]

IV. The General Comment should address gaps in General Comment 14, as well as in other international statements on SRH

Other speakers will no doubt speak to specific gaps, and the need to address issues relating to specific groups, but I want to mention two cross-cutting issues here.

A. Health systems

Health systems lie at the center of the right to SRH, and the right to health more broadly. [xiii] Far more than delivery apparata for goods and services, health systems are core social institutions—akin to justice systems or democratic political systems, and as such they both reflect and communicate norms and values. [xiv] Poverty and exclusion are often experienced by people in need of SRH goods, services and information--particularly women, sexual minorities, and stigmatized groups--as a lack of responsiveness, access or quality in the health system. Health systems can too frequently exacerbate inequalities, stigmatization, and marginalization, and these forms of exclusion disproportionately affect SRH. On the other hand, health systems based on rights principles can promote inclusiveness and equality, and in turn facilitate a deepening of substantive democracy.

This General Comment provides an opportunity to articulate how in relation to SRH the building blocks of health systems outlined by WHO -- leadership and governance; service delivery packages and models; financing, human resources for health; health information; and medical products, vaccines and technologies— can all be informed by human rights standards and principles.[xv]

B. Social Determinants of SRH

Social determinants of health are especially critical in the field of SRH, as reflected in the language from Cairo and Beijing. Social determinants , such as gender-based discrimination and cultural norms, should be explicitly distinguished from the "underlying determinants " mentioned in General Comment 14, which refer to safe water and adequate sanitation, adequate nutritious food and housing, healthy occupational and environmental conditions, and access to health-related education and information.[xvi]

This General Comment should underscore the importance of addressing these broader social determinants, in addition to the underlying determinants, and the obligations with respect to multiple human rights that they imply, in advancing SRH. In particular, this General Comment provides an opportunity to articulate explicitly how laws act as social determinants of SRH. For example, both the criminalization of services (including abortion) and the criminalization of activities (such as sex work and IV drug use) are determining factors in the distribution of morbidity and mortality in relation to SRH, as are laws that permit discrimination.[xvii]

V. The General Comment should emphasize accountability mechanisms, including judicial enforcement of the right to SRH

The General Comment should provide guidelines for the establishment of systematic and effective monitoring and accountability systems within states to assess the obligations to respect, protect and fulfill the right to SRH. Systems to monitor fulfillment of the right to SRH should not only assess SRH outcomes in light of these principles; they should also assess states' policy efforts, including policy commitments and resource allocation, in accordance with the criteria set out in General Comment 14 and based upon indicators that are rights-sensitive and programmatically-relevant.[xviii]
The General Comment should also highlight the need to ensure the full participation of affected communities and individuals in the design, implementation and monitoring of policies relevant to SRH.

Monitoring alone, however, is not sufficient to produce accountability. Since the Committee issued General Comment 14, it has become increasingly evident that judicial remedies have a key role to play in facilitating deliberation as well as providing restitution, rehabilitation and compensation. Judicial remedies have proven critical in at least four areas related to the right to SRH: implementation of existing laws and policies;[xix] reform of policies and budgets that fail to meet standards required by the

right to SRH; [xx] removal of legal restrictions on care; [xxi] and challenges to systemic violations of reproductive and sexual health rights in practice.[xxii]

It is critical, in keeping with the evolution in international law as well as national jurisprudence, for this General Comment to underscore the importance of establishing both accessible and effective accountability mechanisms with respect to SRH, including judicial remedies and other institutions, such as National Human Rights Institutions in keeping with the jurisprudence of the Committee.

Conclusion

In conclusion I would like to paraphrase Mary Robinson, who was in turn referring to Eleanor Roosevelt's remarks to the United Nations in 1958: some of the most important rights are the ones we are discussing today—the most intimate, from the right to be free from violence in one's home to the right to control one's own sexual and reproductive choices. Only by creating the conditions under which we can all realize our rights to SRH in the small places close to home-- places like our bedrooms, schools, workplaces, and health facilities-- will we be able to realize the full scope of rights to which all human beings are entitled.[xxiii]

Today, the Committee is in a position to demonstrate great leadership on this critical subject by issuing a robust General Comment that consolidates and builds upon the numerous standards regarding SRH that already exist.

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[i] Center for Economic and Social Rights, Preliminary Contribution to the Proposed Draft General Comment on the Right to Sexual and Reproductive Health, Day of General Discussion, 45th Session of the CESCR [hereafter CESR submission].

[ii] Programme of Action adopted by the International Conference on Population and Development (ICPD), held at Cairo from 5 to 13 September 1994 (A/CONF.171/13, chap. 1, resolution 1), para. 7.2; Platform for Action adopted by the Fourth World Conference on Women, held at Beijing from 4 to 15 September 1995 (A/CONF.177/20, chap. I, resolution 1, annex II), para. 96.

[iii] ICPD, para 7.2.

[iv] ICPD, para 7.3; WHO, "Reproductive Health," http://www.who.int/topics/reproductive_health/en/.

[v] Beijing Platform for Action, para. 96. As noted in the background paper prepared for this General Comment, there have been several efforts by intergovernmental agencies such as WHO and PAHO, to further refine the definition. ["Sexual health is the experience of the ongoing process of physical, psychological and, socio-cultural well being related to sexuality. Sexual health is evidenced in the free

and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. For Sexual Health to be attained and maintained it is necessary that the sexual rights of all people be recognized and upheld."] PAHO/WHO, with WAS, Promotion of Sexual Health: Recommendations for Action, Proceedings of a Regional Consultation (2000), p.6. See Mindy Jane Roseman, Draft document for proposed CESCR General Comment on Sexual and Reproductive Health, October 2010.

[vi] Commission on Human Rights resolution 2003/28, preamble and para. 6.

vii CESR submission.

[viii] **"**The General Comment should stress that the duty of states to progressively fulfill the right to health includes putting in place progressive fiscal policies enabling them to generate the maximum of potentially available resources and to distribute these equitably so as to reduce SRH disparities between population groups. Resources must be allocated in a transparent, non-discriminatory and participatory way, giving preference to disadvantaged groups. The lack of a clearly defined budget for sexual and reproductive health programs undermines transparency and accountability. The Committee should also stress that the states' duty to ensure maximum available resources are being devoted to fulfill SRH without discrimination applies equally in the context of decentralization and privatization of health services." CESR Submission.

[ix] UNFPA, *How Universal is Access to Reproductive Health? A Review of the Evidence* (September 2010).

[x] Report of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights (A/HRC/14/39), 16 April 2010.

[xi] As a background paper prepared for the General Comment suggests: "core obligations require that States parties must guarantee SRH goods, services and facilities at some minimum level, recognizing that the reasonableness of that determination is a function of factors such as the evidence base and appropriateness (based on public health standards), adequacy (in terms of availability, accessibility, acceptability and quality) of coverage of population—including those persons and communities requiring special protection, across a range of enumerated SRH topics), and the use of maximum available resources," as well as the degree of participation, transparency and accountability of the process establishing the minimum level. Mindy Jane Roseman, Draft document for proposed CESCR General Comment on Sexual and Reproductive Health, October 2010.

[xii] For example, among other things, the Committee should make clear that States parties have a core obligation to ensure that SRH facilities, goods and services provide comprehensive family planning, STI prevention and treatment; obstetric, ante-natal and post-natal, and new born care, information and services; universal access to prevention and treatment, including prevention of maternal to child transmission of HIV. See e.g., Mindy Jane Roseman, Draft document for proposed CESCR General Comment on Sexual and Reproductive Health, October 2010.

[xiii] Paul Hunt and Gunilla Backman, "Health systems and the right to the highest attainable standard of health," *Health and Human Rights* 10 (2008); Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/7/11), 31 January 2008.

[xiv] Lynn P. Freedman, 'Achieving the MDGs: Health Systems as Core Social Institutions', *Development*, V*.* 48, pp. 19-24 (2005).

[xv] WHO, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes – WHO's Framework for Action* (Geneva: WHO, 2007).

[xvi] Ibid., para. 45.

[xvii] Report of the Special Rapporteur on the right to health to the General Assembly (A/65/255), 6 August 2010.

[xviii] In so doing, the Committee should draw on the work being done within the UN system and by non-governmental human rights and public health advocates to further develop analytical frameworks, indicators and benchmarks on sexual and reproductive health in order to assess progressive realization and other dimensions of state party obligations. UN Economic and Social Council, Report of the High Commissioner for Human Rights on the Implementation of Economic, Social and Cultural Rights (E/2009/90), 8 June 2009.

[xix] It is unfortunately all too common for legislation and policies relating to reproductive and sexual health, including laws legalizing abortion under certain circumstances, not to be implemented through the necessary regulations and protocols. In the case of *Paulina Ramirez v. Mexico*, the Center for Reproductive Rights together with the Reproductive Choice Information Group (GIRE, for its Spanish acronym) brought a petition to the IACHR in 2002 involving the failure of the government to enact adequate regulations relating to the access to abortion in rape cases, which was provided for under law. The case was settled with the Mexican government through an amicable resolution procedure, whereby the government agreed not only to compensate the named petitioner but also to issue a decree regulating guidelines for access to abortion for rape victims. Moreover, the process of litigation and the surrounding mobilization on the issue played an important role in changing the public debate around abortion in Mexico and leading to the eventual liberalization of the abortion law in Mexico City. Alicia Ely Yamin, Toward Transformative Accountability: A Proposal for Rights-based Approaches to Fulfilling Maternal Health Obligations, *Sur: An International Journal*. 2010; 7 (12): 95-122.

[xx] Remedies can achieve reforms of policies and programs that do not adequately protect the right to sexual and reproductive health as in a March 2010 decision by the Delhi High Court that called for eliminating onerous burdens of proving indigence to access reproductive health services, ensuring the portability of benefit schemes across states and guaranteeing cash assistance to women in need. India, Delhi High Court, *Laxmi Mandal v Deen Dayal Haringer Hospital & Ors Writ Petition* (2010) 8853/2008.

[xxi] Remedies must be available to challenge legal barriers to care that are discriminatory or directly violate rights to sexual and reproductive health, such as abortion-related restrictions. Constitutional Court of Colombia, *Sentencia C-355/06,* MP: Jaime Araújo Rentería y Clara Inés Vargas Hernández.

[xxii] For example, legal recourse proved a pivotal part of a larger strategy of accountability in Peru when between 1996 and 1998 an estimated 260,000 overwhelmingly indigenous women were sterilized without fully informed consent and under conditions where their rights to health and lives were at risk. A coalition of Peruvian NGOs litigated the emblematic case of Maria Mamérita Mestanza Chávez,[xxii] in which a woman was involuntarily sterilized and later died as a result of the operation as emblematic of a pattern of violations of fundamental rights and discrimination against indigenous women in Peruvian society. After the case was dismissed in the Peruvian legal system, these NGOs successfully brought a petition to the IACHR. Yamin, Toward Transformative Accountability, supra note xix.

Similarly, in 2007 the Center for Reproductive Rights brought a petition to the Committee on the Elimination of Discrimination against Women (CEDAW) against Brazil in relation to an emblematic case of systematic *de facto* discrimination against Afro-descendants in maternal health care in that country.

In the first maternal mortality case to be brought before CEDAW, the Center, together with Brazilian partner Advocaci, asked for the government not only to compensate the petitioner's surviving family, but also to prioritize the reduction of maternal mortality in practice, including by training providers, establishing and enforcing protocols, and improving care in vulnerable communities. Yamin, Toward Transformative Accountability, supra note xix.

[xxiii] Mary Robinson, Foreword, Wendy Chavkin and Ellen Chesler, *Where Human Rights Begin: Health, Sexuality and Women in the New Millennium* (Piscataway: Rutgers University Press, 2006), p. ix-xi