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SUBSTANTIVE ISSUES ARISING IN THE IMPLEMENTATION OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

Day of General Discussion on article 3 of the Covenant: equal right of men and women to the enjoyment of economic, social and cultural rights set forth in the ICESCR

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EQUAL ENJOYMENT OF THE RIGHT TO HEALTH

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* The views expressed in the present document are those of the author and do not necessarily reflect those of the United Nations.

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A General Comment on Article 3 of the ICESCR should include statements concerning:

Equality and non-discrimination in the context of the right to health:

1. In the Committee's General Comment 14 on the Right to Health[1] it defined the right to equality and non-discrimination in health as proscribing all discrimination in access to health care, as well as the underlying determinants of health, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.[2]

2. The Committee has interpreted the right to health to be an inclusive right which includes timely and appropriate health care as well as a right to the underlying determinants of health which include the interrelated elements of: **availability, accessibility, acceptability** and **quality** of health care.[3] The General Comment on equality should reaffirm States parties' obligations with respect to ensuring women's right to equality in each of these components of the right to health.

3. Equality in **availability** requires that goods, services and information that are needed by women, especially reproductive health services, be equally available in sufficient quantity as those required by men.[4] States parties must not impose barriers on availability of goods, services and information that women need in order to enjoy their right to health, such as safe abortion services, family planning services and information, etc.

4. Equality in **accessibility** requires that access to health facilities, goods and services be available to all in law and in fact, particularly to vulnerable or marginalized sections of the population. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.[5] These barriers include: lack of availability, legal restrictions, excessive regulation, third-party consent requirements, cost, lack of adequate insurance coverage and violence or coercion in the health-care context.

5. Equality in **acceptability** requires that health-care providers, facilities, goods and services be respectful and appropriately sensitive to women's health needs.

6. Equality in **quality** of health facilities, goods and services mandates that medical personnel, medications, and equipment needed to meet women's health needs be of a quality commensurate with those available to male health-care users.

States parties obligations with respect to equality and the right to health

7. The duty of States parties to ensure, on a basis of equality of men and women, access to health-care services, information and education implies an obligation to **respect, protect** and **fulfil** women's rights to health care.[6] States parties are responsible for taking measures to eliminate discrimination and other factors, which impede women's equal enjoyment of the right to the highest attainable standard of health.

8. The obligation to **respect** women's right to equality in the exercise of their right to health obligates States parties to refrain from discriminating against women in the field of health. States parties must prohibit discrimination on the ground of sex and put an end to discriminatory actions in the field of health. For example, States parties should not criminalize medical procedures needed only by women nor should they punish women who undergo those procedures.[7]

9. The obligation to **protect** women's right to equality in the exercise of their right to health requires States parties to take action to prevent and impose sanctions for violations of rights by private persons and organizations. The right to equality before the law and freedom from discrimination requires States to act against discrimination by public as well as private actors in all fields, including health. For example in the area of violence against women, States parties should enact and enforce laws and policies to address violence against women and sexual abuse of girls and ensure the provision of appropriate health services.[8]

10. The obligation to **fulfil** women's right to equality in the exercise of their right to health requires States parties to take all positive measures including legislative, judicial, administrative, budgetary, economic, and other measures to the maximum extent of their available resources, so as to enable women to enjoy their right to health on equal footing with men. In addition, States parties must make efforts to eliminate stereotypes and customary norms that contribute to the continuation of discriminatory practices that impact women's ability to enjoy their right to health. States parties' obligation to fulfil women's right to equality in the exercise of their right to health mandates that they take positive measures to organize governmental processes and all structures through which public power is exercised to promote and protect women's health.[9]

11. **Gender perspective**: States parties should integrate a gender perspective in their health related policies, planning, programmes and research.[10] States parties should report on their understanding of how policies and measures address the health rights of women from the perspective of women's needs and interests and how they address distinctive features and factors that differ for women in comparison to men.[11]

12. **Disaggregation of data**: The disaggregation of health and socio-economic data according to sex is essential for identifying inequalities in health.[12] States parties should provide disaggregated data by sex on incidence and severity of diseases and conditions hazardous to women's health and nutrition, especially those that affect women or certain groups of women differently from men.[13]

Application of the principles of equality and non-discrimination to specific health issues affecting women and girls:

13. **Population and health policies**: In regulating population, reproductive health, and family planning, Governments must ensure that laws and policies impacting women's right to health incorporate the principles of free and informed consent and choice, non-coercion, confidentially, privacy, non-discrimination and quality of care. All health related policies should incorporate a gender dimension. Underscoring this principle, this Committee has expressed its concern over the effects of governmental polices that decrease or limit access to health-care services such as inadequate budgetary allotments on women's health.[14]

14. **Contraception and family planning**: States parties should ensure access to the full range of contraceptive methods and information. They must eliminate restrictions on contraception, including excessive regulation, third-party consent requirements, and prohibitions on the dissemination of information regarding contraceptives. In particular, States parties should remove all legal and regulatory barriers to reproductive health care for adolescents and create comprehensive, age-appropriate health programmes for them, which include information and services addressing reproductive health, STIs, gender roles, sexuality, and responsible use of contraceptives. In its concluding observations to States parties, this Committee has frequently framed lack of access to family planning services as a violation of the right to health[15] and has also made the connection between lack of access to contraceptive services and high rates of abortion.[16]

15. **Maternal mortality**: In fulfilling women's right to equality in the context of health, States parties should provide universal access to maternal health care, including prenatal and post-natal care for all women, especially adolescents, regardless of their marital status. States parties are under an affirmative obligation to ensure that policies achieve reductions in maternal mortality through increasing access to services, reducing cost, and focusing resources on rural areas and particularly vulnerable populations. This Committee has frequently expressed its concern over high rates of maternal mortality[17] and has asked States parties to take measures to address it.[18]

16. **Abortion**: States parties should enact laws that permit abortion without restriction as to reason or on broad grounds and ensure access to high-quality abortion services for all women regardless of age, income, marital status, or level of education. They should also eliminate third-party consent requirements for a woman to undergo an abortion. This Committee has recognized that the criminalization of abortion or very restrictive abortion laws have a severe impact on women's health[19] and has recommended increased family planning programmes as a way of decreasing the prevalence of abortion.[20]

17. **HIV/AIDS and other STIs**: States parties are under an obligation to fulfil women's rights to equality in the context of health by promoting medical research, health education, and information campaigns on women's increased susceptibility to HIV/AIDS and other STIs. States parties should strengthen gender-sensitive policies and programmes on HIV/AIDS and other STIs and address the factors contributing to women's increased vulnerability to HIV/AIDS such as women's subordination in economic, social, civil and political spheres. States must ensure that sexual and reproductive health programmes, including family planning facilities, diagnose and treat HIV/AIDS and other STIs and promote and supply high-quality condoms and treatment for HIV/AIDS and other STIs. States parties must meet the needs of women living with HIV/AIDS and legally prohibit all forms of discrimination against them, including discrimination in access to health care. In its concluding observations, this Committee has begun to incorporate a gender dimension into its recommendations on HIV/AIDS by recognizing that women are often the first victims of the HIV/AIDS pandemic.[21]

18. **Harmful traditional practices**: States parties should ensure that national legal instruments contain protections of the rights of women and girls specifically recognizing their right to be free from harmful traditional practices such as female circumcision/female genital mutilation (FC/FGM) that undermine their right to health. These protections could include:

constitutional provisions, criminal sanctions, and civil protections and remedies that uphold women's human rights. These measures should be accompanied by appropriate and effective outreach aimed at eliminating demand for the practice In its concluding observations to States parties, this Committee has acknowledged the health-related dangers of FC/FGM[22] as well as the discriminatory aspects of the practice.[23]

19. **Violence against women**: States parties should review and amend legislation that condones violence against women such as exclusions found in penal codes for marital rape and "honour killings" and laws that excuse defendants from rape charges if they marry their victims. States parties are under a positive obligation to take measures to protect women and girls from gender-based expressions of violence on the part of third parties. To this end, States parties should punish perpetrators and sensitize the community, including health-care providers and law enforcement officials, regarding the need to protect women and girls against all forms of sexual violence, including rape, incest and trafficking. This Committee, in its concluding observations, has made numerous recommendations to States parties on domestic violence[24] and has also condemned sexual violence against women,[25] recognizing the link between economic disempowerment of women and their vulnerability to violence.[26]

Broader principles that should apply to equality and non-discrimination in the exercise of all rights enshrined in the Covenant:

20. Customary and religious laws that conflict with guarantees of equality and non-discrimination should be denied legal force. For example, in the context of right to health, formal legal provisions should have supremacy over customary and religious laws that permit or require women and girls to undergo harmful traditional practices.

21. States are under an obligation to respect, protect and fulfil the rights of particularly vulnerable groups of women such as: rural women, poor women, women who belong to racial minorities, women refugees and displaced women, elderly women, female sex workers, and female adolescents. The Committee should recognize that women who belong to these groups might experience certain forms of discrimination differently or disproportionately.

22. The General Comment should acknowledge the indivisibility and interdependence of all rights and should emphasize that guarantees of equality and non-discrimination apply to all rights enshrined in the Covenant. This is particularly relevant with respect to the right to health. Women's ability to enjoy their right to health free from discrimination impacts their ability to exercise all other rights enshrined in the Covenant.

Notes

[1] CESCR, *General Comment 14: The right to the highest attainable standard of health*, UN ESCOR, 2000, Doc. No. E/C.12/2000/4.

[2] CESCR, *General Comment 14: The right to the highest attainable standard of health*, UN ESCOR, 2000, Doc. No. E/C.12/2000/4, para. 18.

[3] CESCR, *General Comment 14: The right to the highest attainable standard of health*, UN ESCOR, 2000, Doc. No. E/C.12/2000/4, para. 12.

[4] CESCR, *General Comment 14: The right to the highest attainable standard of health*, UN ESCOR, 2000, Doc. No. E/C.12/2000/4, para. 12 (a).

[5] CESCR, *General Comment 14: The right to the highest attainable standard of health*, UN ESCOR, 2000, Doc. No. E/C.12/2000/4, para. 21.

[6] CEDAW, *General Recommendation 24: Women and health*, UN GAOR, 1999, Doc. No. A/54/38/Rev.1, para.13.

[7] CEDAW, *General Recommendation 24: Women and health*, UN GAOR, 1999, Doc. No. A/54/38/Rev.1, para. 14.

[8] CEDAW, *General Recommendation 24: Women and health*, UN GAOR, 1999, Doc. No. A/54/38/Rev.1, para. 15 (a).

[9] CEDAW, *General Recommendation 24: Women and health*, UN GAOR, 1999, Doc. No. A/54/38/Rev.1, para. 17.

[10] CESCR, *General Comment 14: The right to the highest attainable standard of health*, UN ESCOR, 2000, Doc. No. E/C.12/2000/4, para. 20.

[11] CEDAW, *General Recommendation 24: Women and health*, UN GAOR, 1999, Doc. No. A/54/38/Rev.1, para. 12.

[12] CESCR, *General Comment 14: The right to the highest attainable standard of health*, UN ESCOR, 2000, Doc. No. E/C.12/2000/4, para. 20.

[13] CEDAW, *General Recommendation 24: Women and health*, UN GAOR, 1999, Doc. No. A/54/38/Rev.1, paras. 9,10.

[14] For example, **Armenia**, 08/12/99, E/C.12/1/Add.39, para. 14.

[15] Examples include: **Armenia**, 08/12/99, E/C.12/1/Add.39, para. 15; **Poland**, 16/06/98, E/C.12/1/Add.26, para. 12; **Saint Vincent and the Grenadines**, 02/12/97, E/C.12/1/Add.21, para. 12; **Cameroon**, 08/12/99, E/C.12/1/Add.40, para. 25; **Dominican Republic**, 12/12/97, E/C.12/1/Add.16, para. 15; **Dominican Republic**, 06/12/96, E/C.12/1/Add.6, para. 22; **Paraguay**, 28/05/96, E/C.12/1/Add.1, para. 16. The Committee has also related the lack of access to contraceptive information and services to high rates of maternal mortality. **Cameroon**, 08/12/99, E/C.12/1/Add.40, para. 25; **Paraguay**, 28/05/96, E/C.12/1/Add.1, para. 16.

[16] **Armenia**, 08/12/99, E/C.12/1/Add.39, para. 15; **Poland**, 16/06/98, E/C.12/1/Add.26, para. 12.

[17] Examples include: **Argentina**, 08/12/99, E/C.12/1/Add.38, para. 24; **Dominican** Republic, 12/12/97, E/C.12/1/Add.16, para. 15, 22; **Gambia**, 31/05/94, E/C.12/1994/9, para. 16; **Mali**, 21/12/94, E/C.12/1994/17, para. 13; **Mongolia**, 01/09/2000, E/C.12/1/Add.47, para. 15; **Morocco**, 30/05/94, E/C.12/1994/5 , para. 5; **Morocco**. 01/12/2000, E/C.12/1/Add.55, para. 29; **Paraguay**, 28/05/96, E/C.12/1/Add.1, para. 16; **Solomon Islands**, 14/05/99, E/C.12/1/Add.33, para. 22.

[18] Examples include: **Morocco**, 01/12/2000, E/C.12/1/Add.55, para. 53; **Cameroon**, 08/12/99, E/C.12/1/Add.40, para. 25; **Argentina**, 08/12/99, E/C.12/1/Add.38, para. 38.

[19] **Mauritius**, 31/05/94, E/C.12/1994/8, para. 15; **Poland**, 16/06/98, E/C.12/1/Add.26, para. 12.

[20] **Armenia**, 08/12/99, E/C.12/1/Add.39, para. 19.

[21] **Guinea**, 28/05/96, E/C.12/1/Add.5, para. 22.

[22] **Guinea**, 28/05/96, E/C.12/1/Add.5, para. 22; **Nigeria**, 13/05/98, E/C.12/Add.23, paras. 20, 39.

[23] **Nigeria**, 13/05/98, E/C.12/Add.23, para. 39.

[24] Examples include: **Argentina**, 08/12/99, E/C.12/1/Add.38, paras. 25 and 39; **Bulgaria**, 08/12/99, E/C.12/1/Add.37, para. 31; **Cameroon**, 08/12/99, E/C.12/1/Add.40, paras. 16 and 34; **Democratic Republic of the Congo**, 12/05/2000, E/C.12/1/Add.45, para. 17; **Dominican Republic**, 12/12/97, E/C.12/1/Add.16, para. 22; **Egypt**, 12/05/2000, E/C.12/1/Add.44, paras. 20 and 35; **El Salvador**, 28/05/96, E/C.12/Add.4, para. 20; **Israel**, 04/12/98, E/C.12/1/Add.27, para. 31; **Italy**, 12/05/2000, E/C.12/1/Add.43, paras. 14 and 27; **Jordan**, 01/09/2000, E/C.12/1/Add.46, paras. 16 and 31-32; **Mauritius**, E/C.12/1995/18, para. 245; **Mexico**, 08/12/99, E/C.12/1/Add.41, para. 26; **Mongolia**, 01/09/2000, E/C.12/1/Add.47, para. 12; **Nigeria**, 13/05/98, E/C.12/Add.23, para. 21; **Poland**, 16/06/98, E/C.12/1/Add.26, paras. 13 and 21; **Portugal**, 01/12/2000, E/C.12/1/Add.53, para. 12; **Sri Lanka**, 16/06/98, E/C.12/1/Add.24, para. 14; and **United Kingdom of Great Britain and Northern Ireland - Hong Kong**, 04/12/97, E/C.12/1/Add.19, para. 14.

[25] **Italy**, 12/05/2000, E/C.12/1/Add.43, para. 15; and **Nigeria**, 13/05/98, E/C.12/Add.23, para. 23.

[26] **Nigeria**, 13/05/98, E/C.12/Add.23, para. 23.
