Reproductive, maternal, newborn and child health and human rights:

A toolbox for examining laws, regulations and policies

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Module 1: Sexual and Reproductive Health

Module 2: Newborn and Child Health (Forthcoming)

Checklist (Forthcoming)

World Health Organization

Reproductive, maternal, newborn and child health and human rights: a toolbox for examining laws, regulations and policies

The "Continuum of Care" for reproductive, maternal, newborn and child health (RMNCH) includes integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood. Such care is provided by families and communities, through outpatient services, clinics and other health facilities.*

The Continuum of Care recognizes that safe childbirth is critical to the health of both the woman and the newborn child—and that a healthy start in life is an essential step towards a sound childhood and a productive life.

Laws, policies and regulations have a profound impact on an individual's ability to have access to the continuum of care in relation to RMNCH. Laws, policies and regulations can both facilitate or obstruct an individual's access to RMNCH programmes, services and information. In many countries, laws, regulations and policies are not always consistent with human rights standards and may represent a barrier for people achieving the highest attainable standard of health.

This WHO RMNCH Toolbox (Toolbox) enables countries to use a human rights framework to identify those barriers and make proposals to overcome or reduce them.

In addition, using the Tool will help countries to:

- recognize national human rights obligations related to RMNCH;
- review and document efforts by governments to establish legal and policy frameworks that support RMNCH;
- identify the most vulnerable groups and existing government efforts to address their needs;
- engage actors from the health sector and non-health sectors to help eliminate legal, policy and regulatory barriers to RMNCH.

The Toolbox is divided into two modules and a checklist.

Module 1: provides guidance on a comprehensive analysis of laws, policies and regulations in relation to Sexual and Reproductive Health. The module also covers specific issues related to adolescent sexual and reproductive health and maternal health.

Module 2: provides guidance on a comprehensive analysis of laws, policies and regulations in context of Newborn and Child Health.

Checklist: provides countries with an opportunity to undertake an assessment of laws, policies and regulations in relation to RMNCH, and to identify areas for further in-depth analysis through use of Modules 1 and 2.

The Toolbox is jointly developed by the Department of Reproductive Health and Research and Department of Maternal, Newborn and Child Health at the World Health Organization (WHO), Geneva, Switzerland.

* PMNCH, *Factsheet: RMNCH Continuum of Care*, 2011, Geneva.

Contents

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Module 1: Sexual and Reproductive Health

A. Users' guide

What is the Sexual and Reproductive Health and Human Rights Module?

Laws and policies play a key role in upholding human rights and promoting sexual and reproductive health. Yet, in many countries, laws, regulations and policies are not always consistent with human rights standards and may also represent a barrier for people achieving the highest attainable standard of sexual and reproductive health. This Sexual and Reproductive Health and Human Rights Module allows countries to use a human rights framework to identify those barriers and make proposals to overcome or reduce them.

In addition, using the Module will help countries to:

- recognize national human rights obligations related to sexual and reproductive health;
- review and document efforts by governments to establish legal and policy frameworks that support sexual and reproductive health;
- identify the most vulnerable groups and existing government efforts to address their needs;
- engage actors from the health sector and non-health sectors to help eliminate legal, policy and regulatory barriers to sexual and reproductive health.

The Module consists of a process that engages many stakeholders. It involves compiling health, legal and policy information from readily available sources, and analysing these data drawing on a human rights framework. On the basis of this analysis, the stakeholders generate recommendations and assign responsibilities for action. The ultimate aim is to ensure a positive, enabling environment to foster the enjoyment of rights, in support of the achievement of sexual and reproductive health.

The Module was developed by the Department of Reproductive Health and Research at the World Health Organization (WHO), Geneva, Switzerland, in collaboration with the Program on International Health and Human Rights at the School of Public Health, Harvard University, Boston, USA. It has been field-tested in different forms and in various countries including: Brazil, Indonesia, Malawi, the Republic of Moldova, Mozambique, Sri Lanka, Switzerland and Tajikistan. Results from all tests were used to improve both the process and the data compilation instrument.

Why use human rights?

Promoting and protecting human rights has been the focus of increased attention since the late 1990s and is recognized as an important way to advance all fields of development. In answer to the United Nations Secretary-General's call for integrating human rights across the entire UN system in 1997, nearly all UN agencies have developed explicit policies or strategies for applying rights-based approaches to their respective fields of intervention. The development of the Module is one of a number of initiatives being undertaken by the World Health Organization to fulfil this mandate.

Using human rights guarantees that attention is paid to three key human rights principles: non-discrimination, participation and accountability. The principle of non-discrimination holds that the human rights of all individuals must be protected and promoted, "without

distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."[1] States and others may neglect the needs and interests of certain individuals or groups of people, intentionally or not. They may have supportive laws but not apply them systematically. For instance, neglecting the needs of adolescents for information and services in sexual and reproductive health violates the right to non-discrimination on the grounds of age.[2] The principle of participation means that in order for people to determine their own development, they need to be involved in formulating the programmes and policies that affect them. The principle of accountability implies that states must do everything they can to promote and protect their populations' rights, and must put in place mechanisms of redress for those whose rights are violated.[3]
Without explicit attention to these fundamental principles, people's rights tend to be neglected or even violated, with serious consequences for human development, including health.

How do human rights apply to sexual and reproductive health?

Universal access to reproductive health is essential to achieving most of the United Nations Millennium Development Goals (MDGs), and is one of the MDG targets. It is recognized that achieving universal access will require a wide array of comprehensive actions and inputs. This includes a focus on health systems and health service delivery, and also ensuring that the legal and policy environment is conducive to the achievement of sexual and reproductive health, and does not pose any unnecessary barriers. Achieving universal access to sexual and reproductive health will also require societal changes that redress inequalities among, and between, populations and population groups – men and women, young and old, rural and urban, rich and poor, ethnic minorities and other vulnerable populations. This cannot be done without systematic attention to human rights.

Human rights have been applied to a wide range of sexual and reproductive health issues, both through the application of different international and regional treaties, as well as through national instruments such as constitutions and other laws. All governments in the world have ratified at least one human rights treaty,[4] legally binding upon them. When ratified, governments have an obligation to respect, protect and fulfil the human rights designated and described in the treaty. The rights that are related to sexual and reproductive health include (among others): the right to non-discrimination; the right to life, survival and development; the right to the highest attainable standard of health; the rights to education and to information; and the right

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1 International Covenant on Civil and Political Rights, Article 2(1).

2 Cook RJ, Dickens BM, Fathalla M. *Reproductive health and human rights: integrating medicine, ethics and law.* Oxford, Clarendon Press, 2003.

3 Mokhiber C. Toward a measure of dignity: indicators for rights-based development. *Stat J UN Eco Comm Eur* 2001; 18(2–3):155–62.

4 The international treaties are: Convention on the Elimination of All Forms of Racial Discrimination (in force 4 January 1969); the International Covenant on Civil and Political Rights (in force 23 March 1976); the International Covenant on Economic, Social and Cultural Rights (in force 23 March 1976); the Convention on the Elimination of Discrimination against Women (in force 3 September 1981); the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (in force 26 June 1987); the Convention on the Rights of the Child (in force 2 September 1990); International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (in force 31 October 2003); the Convention on the Rights of Persons with Disabilities (in force May 2008). They are all derived from the Universal Declaration of Human Rights, agreed to in 1948.

to participation in public life. Many of these rights are guaranteed in more than one of the treaties. The right to non-discrimination, for instance, appears in all of the treaties.

When governments ratify international human rights treaties, they are bound to ensure that their national laws, policies and practices do not conflict, and are consistent, with their obligations under international law. Evidence suggests that in many countries, laws, policies and regulations may not always be consistent with human rights obligations and this can present barriers to women and men achieving sexual and reproductive health.

An example of such barriers are laws that prohibit certain groups of people – such as adolescents or unmarried people – from accessing family planning services. Barriers may also include:

- Policies that require payment where there are no social insurance or alternative schemes to ensure that women who have no money can still access health services.
- A lack of policies to promote women's access to information about the signs of pregnancy.
- Policies that require a married woman to obtain her husband's authorization to access health services for herself or her child/ren – in contradiction to human rights commitments.
- The exclusion of various groups – a particularly discriminatory barrier – whether for reasons of ethnicity, social status, health status, nationality, sexual orientation or age, from being able to access health services, thus rendering them even more vulnerable. Sometimes such exclusion is present in a law, but more often in a policy, spoken or unspoken, and frequently translated into practice.

Recognizing and overcoming these sorts of barriers requires the engagement of people who work not only in health, but also in other sectors of government and civil society such as education, transport, finance, justice and women's affairs.

Experience gained from using the Module in different countries demonstrates that referring to human rights standards helps lift discussions out of sometimes entrenched positions – on contentious topics such as sex work, abortion and adolescents' access to information and services – to focus on the human rights and public health standards most relevant to the issues at hand.

How does the Module work?

The Module is for application to all elements and issues related to sexual and reproductive health, covering all population groups, and comprises this document and a series of companion documents.

Main document:

- User Guide and Introduction to the Module
- Data Compilation Instrument
- Analysis Methodology

Annexes:

- Sample documents for use in the Module process

  - Protocol
  - Terms of Reference (for project coordinators, researchers and national project teams)
  - Model agendas for workshops
  - Introductory sample slide presentation on the Module
- Monitoring and Evaluation questionnaires (at the start and end of the project)

Companion documents:

- Question and Indicator Guide (QIG)
- Human Rights Sources documents, international and regional

The generic instrument focuses on sexual and reproductive health in its entirety. The instrument could be adapted to focus on specific elements (e.g. family planning), or used with other ongoing processes, such as the WHO Strategic Approach or other assessments (further details are given below).

A participatory, multi-stakeholder process

Following human rights principles, the process of using the Module is participatory in nature, involving many stakeholders. Such a process has the advantage that multiple perspectives generate broad-based support for, consensus for, and ownership of proposed actions. Including a wide spectrum of viewpoints helps make problem identification and prioritization transparent and open. When the involvement of stakeholders is genuine, barriers that prevent access to appropriate services can be determined and solutions identified. The opinions of health workers and community representatives, including affected vulnerable groups contribute to the understanding of barriers limiting effective service delivery beyond what governments may already know and may help in defining possible solutions that reflect local priorities. The participation of other sectors and government ministries, such as education, planning, finance and justice, helps to ensure that adequate resources are allocated to sexual and reproductive health, and its incorporation into national policies, legislation, development plans and budgets. Involving a variety of stakeholders builds legitimacy for sexual and reproductive health being a goal for national development and human rights across all sectors.

The process is intended to be led by the ministry of health (or other project initiator) with technical assistance from WHO and/or other partners familiar with human rights, and legal and policy issues related to health. It is to be undertaken as an exercise to examine, reflect on, and strengthen, a government's own sexual and reproductive health programmes. In countries with a federal system and/or a decentralised political system, the Module might usefully be applied at both national and sub-national levels.

The process of using the Module consists of three phases (described in more detail below), each with a number of steps. The initial phase involves introduction of the Module to a wide range of potential stakeholders to establish interest in, and commitment to, carrying out the project. These would include those involved in improving sexual and reproductive health, as well as government sectors responsible for laws and policies that have an impact on sexual and reproductive health, even though they may not consider it their primary domain. A national project team, including human rights and public health researchers, is then set up to coordinate the project. The second phase consists of an adaptation workshop with the national project

team, following which the data compilation instrument is adapted to the national context, and a data compilation and analysis workshop is undertaken. In the third phase, stakeholders assess the analysis, make recommendations for actions to be taken by specific sectors, prepare and disseminate a final report and, finally, evaluate the project in its entirety and take required follow-up action. On average, the three phases take approximately twelve months to complete, depending upon individual country circumstances and conditions.

Phase 1: Initiating the process

Establishing commitment and leadership

In any given country, the project may be initiated by the ministry of health with technical assistance from WHO and/or other partners familiar with human rights, or by a national human rights ombudsman, parliamentarians' forum, etc. First, project initiators identify appropriate representatives of the different stakeholder groups, then they introduce the project to them and seek commitment from them for the entire process. Stakeholders should represent both governmental institutions and non-governmental actors, some to be involved in the national project team and others to be invited to the final analysis workshop. They should include representatives of:

- government ministries including as appropriate, those responsible for health, education, social welfare, justice, youth, women's welfare, transportation, labour, religion and finance;
- professional associations, including doctors, obstetrician-gynaecologists, midwives, paediatricians, nurses, etc.;
- academics conducting research in sexual and reproductive health, and in law;
- civil society organizations, including women's health advocates, youth groups, service users and communities; and
- relevant United Nations and donor agencies working to improve sexual and reproductive health and advance human rights.

Although the Module encourages partnerships with donor and international agencies, it places responsibility for decision-making and implementation in the hands of country participants, with appropriate support from external partners. At this initial stage, a protocol needs to be established as a contractual basis for the project. This must lay out the details of the process, the partners involved, and the timeline and the budget. The process of introducing the Module to all potential stakeholders usually allows for the parallel identification of potential national project team members.

Establishing the national project team

The national project team should include designated staff from the health ministry, WHO staff (and other partner agency), researchers, non-governmental organization (NGO) representatives and national experts on. Experience indicates that a team of about eight people is a workable size. The national project team will assist the health ministry to convene all meetings, work with the researchers to adapt the instrument to the national context, oversee data compilation and analysis, prepare the final report, help disseminate the results and if possible, implement prioritized actions at the

conclusion of the project. The health ministry is responsible for convening the national project team meetings.

Engaging the researchers

The health ministry or other initiator of the project should contract the researchers, who should be independent from the government. There should be two researchers (or teams of researchers), one with expertise in sexual and reproductive health and a knowledge of human rights, and another with legal and human rights expertise with a knowledge of sexual and reproductive health. The role of the researchers is to assist in the adaptation of the instrument to the local context, collect information, analyse it using the methodological framework provided, help facilitate the stakeholder workshop, help prepare the final report, and provide information for monitoring and evaluation.

The researchers should regularly inform the national project team about the progress made. They must respect the confidentiality of the data compilation, analysis and process. The results and findings are owned by the health ministry. Any publications resulting from the use of the Module can be owned jointly, for example by the researchers and the ministry of health, but this must be approved in advance by the national project team.

Engaging the project coordinator

Most national project teams find it makes sense to have a project coordinator who is responsible for all administrative and logistical arrangements, and is answerable to the national project team.

Introductory workshop

The researchers need to be introduced to the human rights framework of the Module to understand the data compilation and analysis methodology. It is also advisable that all members of the national project team receive an introduction to the human rights framework of the Module. The workshop can also involve discussion on how the generic data compilation instrument may be adapted (see Phase 2 below).

Phase 2: Data compilation instrument, adaptation and analysis

The instrument

The Module uses a data compilation instrument designed to bring together data relating to laws, regulations and policies on the one hand, and health systems and health outcomes on the other. Readily available and reliable sources are used, rather than the collection of new data. Laws and policies, for example, are nearly always published and available in government services. Health data can usually be extracted from national statistics and population surveys, augmented by published studies. Special attention should be paid to disaggregation by characteristics such as sex, ethnicity, age, and educational and social status, in order to assist in the identification of vulnerable groups.

The instrument is composed of three parts:
Part 1: Human rights and legal context

Part 2: Cross-cutting human rights principles
Part 3: Core sexual and reproductive health issues.

Part 1 brings together information about which human rights treaties a country has ratified, both international and regional, together with information about reports the country has submitted concerning progress on implementing the treaties and other human rights consensus documents, and any concluding observations or comments by treaty monitoring bodies. The information required includes dates of ratification, status of reservations, participation in consensus documents, and short summaries of the relevant documents. Also included are questions regarding the country's legal system, and mechanisms for protecting human rights. The information gathered is used as an introduction to the final report.

Part 2 covers eight cross-cutting human rights principles: non-discrimination and equality, accessibility, that for the purpose of the use of this Module includes availability, acceptability and quality of sexual and reproductive health services; access to information; informed consent; respecting the best interests, evolving capacities and views of the child; privacy and confidentiality; education; and use of available resources. Responses to the questions in this part will provide information on how these cross-cutting principles are reflected in national laws and regulations. The information gathered is also to be used in the human rights analysis.

Part 3 concerns the five core health issues related to sexual and reproductive health, taken from the WHO Global Reproductive Health Strategy adopted by the World Health Assembly in May 2004. They are: maternal health; family planning (including infertility); prevention of abortion; sexually transmitted infections including HIV and reproductive morbidities; and sexual health.

In Part 3, an introduction to each issue presents the "rationale" or reasons why each is important, from both a public health and human rights point of view. This rationale should guide researchers (and the national project team) in their choices of which questions to focus on and which to leave out during the adaptation process (see below). The text of the rationale is also likely to be useful in the final report and can even be reproduced, with some modification to the specific country context.

Part 3 contains questions on specific public health-related issues, on laws, regulations and policies, and on related human rights considerations. The public health indicators are drawn from WHO or other established sources. All the questions and indicators are explained in the accompanying Question and Indicator Guide (see section on data compilation). Before data compilation begins, the researchers and the national project team need to decide which sources of laws, regulations, policies and health data are to be used.

Adaptation of the instrument

The data compilation instrument is presented in a generic form. For the most part, its use in countries will require some adaptation to specific national (or sub-national) contexts. Through the adaptation process, the national project team will be able to:

- select questions in the instrument to be developed further for specific issues (e.g. female genital mutilation), or for specific contexts (e.g. refugee camps);
- amend or add (but not delete) questions in the instrument, due to lack of data availability on some topics, or a need to examine some topics in more detail.

In countries with a federal governmental structure and/or a decentralized health system, the instrument may need to be further adapted to the particular context. Nonetheless, it is recommended that all information is collected at national level first, and then, as appropriate, collected or disaggregated at a sub-national level. This will allow for the examination of the relative concordance (or not) between national and sub-national efforts to address or improve sexual and reproductive health. In some countries, it may also be necessary or desirable to add questions relevant to the national context. For example, a question about access to family planning for unmarried people was added in one adaptation of the instrument. If questions are added, an addition should be made to the numbering system, such as a word or letter, to keep the numbering of the generic instrument intact, because the Question and Indicator Guide (see below) follows the numbering of the generic instrument. Some countries may wish to use the Module to focus specifically on one sexual and reproductive health issue, such as family planning or abortion. This can be done, but care must be taken to include all relevant questions, and not just extract the chapter on the issue of interest. For example, if the adaptation is to focus on sexual health, a selection of questions from each of the other core issue areas should still be included, as they are likely to be relevant.

As the instrument has been carefully constructed to reflect both accepted public health indicators and corresponding international human rights standards, the format of the instrument should be kept intact, particularly the balance between the questions under "health considerations" and those under "laws, regulations and policies". If this internal coherence is not adhered to, the human rights analysis is likely to be affected or difficult to undertake, thus affecting both the implementation and the outcomes of the Module. Amendments should therefore be limited, as far as possible, to what is essential for making the instrument country-appropriate.

Before data complication begins adolescents should be defined bearing in mind the definitions put forth by the Committee on the Rights of the Child and the World Health Organization. The definition should also take into account the age ranges used by major sources of national data such as census agencies and government ministries, which may not correspond with each other. In such cases, it may be necessary for researchers to establish multiple definitions and to note which definition is being used in each instance.

To assist countries in the adaptation of the instrument, the Question and Indicator Guide (QIG), a companion document, provides the definition and significance of each question and indicator included in the instrument (see below).

Data compilation

Data compilation is carried out by the research team with facilitation by the ministry of health and the national project team. The ministry of health should make available, or facilitate access to, the legal, regulatory, policy and health information both within the ministry of health and in other ministries as required by the instrument. Data compilation should be done by both the legal and health data researchers simultaneously. Regular communication and dialogue between the researchers will allow them to share information and resolve any questions arising. The researchers should regularly report on progress to the national project team.

Completing the data compilation instrument must be done in conjunction with the QIG. This provides the definition and significance of each question and indicator included in the instrument, suggests possible sources where the data can be found, and provides, in many cases, alternative questions or indicators that may be substituted if data for a specific indicator is not collected or is otherwise unavailable. For some questions and indicators, no alternative is provided. If no data are available on the indicator or its proxies, the question should not be deleted, but left blank as the lack of data on any issue is usually significant in itself and needs to be highlighted. The QIG also provides information on which laws might address the issues, and where they might be found.

Workshop and analysis

After the data compilation has been completed, a workshop of the national project team should be held, in which members review the completed instrument, and the analysis methodology is introduced and discussed. Agreement should be reached on the issues to be highlighted and developed. The analysis is carried out through examining the legal, policy and public health data alongside the country's human rights commitments. The latter consist of international and regional human rights treaties ratified, the relevant General Comments to those treaties, and country-specific concluding observations of the treaty monitoring bodies, as well as the country's own national constitutions and human rights laws. Most of these data are collected in Parts 1 and 2 of the instrument.

Starting from a definition of the public health problem as revealed by the data compiled e.g. a high rate of unwanted pregnancies among adolescents combined with low contraceptive prevalence and a high rate of coerced first sex, the analysis consists of examining the relevant laws, regulations and policies to establish any aspects that are not in agreement with international, regional or national human rights law. For example, given unmet needs and vulnerability of adolescents, the country's human rights obligations may require that adolescents have access to sexual health education and services without parental authorization. Thus, any laws or policies that require parental authorization are likely to present a barrier, as well as being in contradiction with obligations under the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of Discrimination against Women (CEDAW), which both call for respecting the best interests of the child and his/her evolving capacities, and for providing access to adolescent sexual and reproductive health services. The analysis might also reveal that although the state has a commitment to eliminating violence against women, it has not developed appropriate legal or policy frameworks to bring a rapid response, and there are no data to indicate the extent of the problem, or show which groups of women are most affected.

Without a human rights analysis that looks at the health situation in the context of the legal framework and in light of human rights commitments and obligations, these kinds of gaps are unlikely to be systematically identified, and the imperative for effectively addressing them is likely to be lacking. The completed analysis will provide a comprehensive picture of how national laws, regulations and policies are supporting, or hindering, the achievement of universal access to sexual and reproductive health. A chapter at the end of the instrument explains in more detail how the analysis is to be conducted.

After the workshop, the researchers conduct the analysis in detail. Once the analysis is completed, it is advisable to have a further national project team workshop to go over the analysis, and prepare what is to be presented at the stakeholder workshop.

Phase 3: Planning for action and implementation

The final phase of the process involves the participation of the different stakeholders in reviewing the findings of the analysis and the recommendations made by the national project team, and drawing up an action plan. On the basis of the stakeholder review, a final report should be prepared and presented to a wider audience. The whole process should then be evaluated.

Stakeholder workshop

The stakeholder workshop should be convened by the national project team under the leadership of the ministry of health. Its purpose is to allow the different stakeholders to review and discuss the analysis of the findings, and reach consensus on recommendations for actions and identify key stakeholders to implement them. The workshop can usually be conducted in one day. To ensure transparency, the research team should make available the full completed instrument, as well as any summaries they have made, for the stakeholders to review if they so choose.

A wide range of recommendations made by the stakeholder group are likely to emerge for the development of, or changes to, law and policy, programme interventions and necessary research. Given available human and financial resources in a country, it is unlikely that all of the recommendations made by the stakeholders can be acted upon immediately. The stakeholders should be asked to prioritize those actions that can be undertaken immediately, those that can be performed in the short to medium term, and those that require more systemic, long-term efforts for the health and non-health sectors. Participants should be encouraged to identify actions that they can take themselves or help in implementing, and those that can be taken in partnership across different sectors. For instance, actions related to recording cases of violence against women usually require close collaboration between the health and justice ministries. The workshop should result in a list of prioritized actions for improving the legal, policy and practice situations related to sexual and reproductive health for health sector and non-health sector actors.

After the stakeholder workshop, the national project team should meet again to decide on actions to take and how to follow up on the recommendations made at the workshop.

The final report

The results of the analysis and the recommendations made at the multi-stakeholder workshop should be summarized into a report, prepared by the national project team with the assistance of the researchers. The report should be a published document that aims to publicly demonstrate the extent of the government's efforts to support the improvement of sexual and reproductive health, while also promoting and protecting human rights. The report should include:

- a brief introduction to the sexual and reproductive health situation in the country and why the government chose to engage in this review process; this background section should include the country's recognized human rights obligations and development indices as reported in Part 1 of the instrument;
- a brief explanation of the methodology used, and acknowledgement of gaps and limitations of the review;
- a summary of the findings, including a description of the national recognition of human rights, the key health issues of concern and how the government has attempted to address them through the legal and policy framework; this should be followed by a description of the legal, regulatory and policy barriers to sexual and reproductive health within a human rights perspective that the analysis revealed. Discrepancies and gaps are also to be highlighted;
- based on the above, proposals for action, and the identification of relevant stakeholders to implement them.

The final report is where further or different emphasis can be given to certain issues. For instance, if the exercise is focused on adolescent sexual and reproductive health, the team may wish to place the section on promoting sexual health before the discussion on early marriage/early pregnancy, or before family planning. There is no set order in which the core topics of sexual and reproductive health should be addressed. Rather, the report should accurately reflect the priorities and concerns arising from the analysis undertaken by the national project team and stakeholders.

This report should be written in an easily accessible language, and an executive summary or short version should accompany the longer version to facilitate public dissemination and understanding of the issues. The report should be approved by the national project team, and published by the ministry of health.

Public dissemination

Disseminating the findings from using the Module gives stakeholders an opportunity to share their collective findings and recommendations with colleagues and the broader public alike. Public dissemination reinforces the participatory nature of the Module, and emphasizes the continuum between the assessment and prioritization exercises, and use of the findings and recommendations in programme, policy and action planning.

Public dissemination of the report and recommendations from the stakeholders can take many forms. The ministry of health may choose to hold a public hearing or a press conference to announce the results of the exercise and their action plans. It may convene a national dissemination workshop with participants from provinces and districts, to discuss the findings and allow them to express their views on the prioritization of recommendations and action planning. Whatever dissemination strategy is employed, it is important that the Module results be shared with as a wide an audience as possible to create awareness of, and implement action to improve, sexual and reproductive health and ensure the human rights of all people are respected, protected and fulfilled.

Monitoring and evaluation

An evaluation methodology accompanies the Module and is intended to: (1) determine whether use of the Module increases non-health sector involvement in sexual and reproductive health, and why; and (2) whether use of the Module increases government efforts to explicitly address human rights issues such as non-discrimination, participation and accountability – in their laws, regulations, policies and other governance mechanisms.

Data collected related to whether human rights issues are directly addressed in past and existing laws, regulations and policies should be recorded. After completion of the project, a subsequent review can be carried out to determine whether use of the Module, and in particular implementation of the recommendations from the stakeholders, resulted in increased efforts by both the health and non-health sectors of government to improve sexual and reproductive health, with special attention to human rights dimensions. Sample evaluation questionnaires are included in the set of documents for use of the Module.

Follow-up

The Module is intended to be a self-assessment by countries to strengthen existing efforts. It is expected to highlight the need for action both within the health sector and beyond it, and with other partners. The Module is not intended to provide the type of data necessary to make scientifically robust associations. Neither can it capture the broader factors that influence governments' actions, such as donor policies or global economic structures. It can, however, be linked to other initiatives supported by WHO and other partners. Thus, the results of this process should not and cannot be seen in isolation from other activities of the ministry of health, and its partners, related to improving sexual and reproductive health. For example, the findings may point to the need to strengthen certain interventions, such as revision of guidelines for health workers on service delivery to improve the quality of care. This could be carried out by using the WHO Standards for Sexual and Reproductive Care. If the findings highlight some aspect of community-level participation that needs strengthening, WHO and other partners have tools and guidance that can be employed through various country-support mechanisms.

The results of the Module should ultimately be measured by the degree to which newly prioritized actions to reduce barriers are implemented. Implementation, like use of the Module itself, requires sustained commitment, interest and political will. Strong leadership from the ministry of health, with support from WHO or other international partners, and the serious engagement of all stakeholders involved in this process can strengthen the links between human rights and sexual and reproductive health, and contribute to national level achievement of the highest attainable standard of health.

Further reading

Gruskin S, Cottingham J, Martin Hilber A, Kismodi E, Lincetto O, Roseman MJ. Using human rights to improve maternal and neonatal health: history, connections and a proposed practical approach. *Bull World Health Organ* 2008;86:589-93.

Cottingham J, Kismodi E, Martin Hilber A, Lincetto O, Stahlhofer M, Gruskin S. Using human rights for sexual and reproductive health: improving legal and regulatory frameworks. *Bull World Health Organ* 2010;88:551-5.

B. Data compilation instrument

Introduction

The Sexual and Reproductive Health and Human Rights Module of which this Instrument is an essential part, provides a method for countries to use a human rights framework to identify and address legal, policy and regulatory barriers to people's access to sexual and reproductive health, and to the provision of quality services. See the 'User Guide and Introduction to the Module for more information.

The Instrument is comprised of three parts:
Part 1: Human rights and legal context
Part 2: Cross-cutting human rights principles
Part 3: Core sexual and reproductive health issues.

Part 1 provides information about which human rights treaties – both international and regional – a state has ratified; information about reports the state has made available concerning progress on implementing the treaties and other human rights consensus documents; and any relevant concluding observations or comments by treaty monitoring bodies. Included also are questions about the country's legal system and mechanisms for protecting human rights.

Part 2 deals with the human rights principles that are enshrined in international human rights treaties and must be recognized and applied across all sexual and reproductive health issues raised in the Instrument. Eight principles relevant to sexual and reproductive health are presented: non-discrimination and equality; accessibility (including availability, acceptability and quality) of sexual and reproductive health services; access to information; informed consent; respecting the best interests, evolving capacities and views of the child; privacy and confidentiality; education; and use of available resources. Part 2 contains questions on whether, and how, national laws and policies integrate these principles.

Part 3 deals with the five core sexual and reproductive health issues. These issues are drawn from the WHO Global Reproductive Health Strategy, adopted by the World Health Assembly in May 2004. They are: pregnancy and childbirth; family planning (including infertility); safe abortion; sexually transmitted infections including HIV and reproductive morbidities; and sexual health. An introduction to each issue presents the importance of the topic from both a public health and human rights point of view. Part 3 contains questions on specific health-related issues, on laws, regulations and policies, and on related human rights considerations.

Question and Indicator Guide

Completing the Data Compilation Instrument **must** be done in conjunction with the *Question and Indicator guide* (QIG), a companion document that provides the definition and significance of each question and indicator included in the instrument, and suggests possible sources where answers to them can be found.

The health indicators were drawn from the key documents used by the United Nations, the World Health Organization and other United Nations agencies, or other highly-regarded sources. Details of these are provided in the QIG.

The legal, policy and human rights questions were derived from recognized international or regional human rights treaties and related documents, after consideration of which laws, regulations and policies are known or likely to have an impact on the health question under review.

Analysis methodology

A method for conducting the analysis is included at the end of the instrument. The aim of the analysis is to provide a basis for national stakeholders to make recommendations for improving the legal, regulatory and policy framework to support sexual and reproductive health. The analysis will also provide a basis for the draft report presented to the stakeholders, and for the final report.

Terminology used in headings and instructions

Most terms contained in the questions are explained in the QIG. A number of terms used in headings and instructions in the Instrument, and in the Analysis methodology, may require further explanation and are presented here:

Adolescent. The World Health Organization defines adolescents as people aged 10–19, and this definition is widely reflected in health statistics for the age ranges 10–14 and 15–19, although not all relevant health statistics use these age ranges. From a legal point of view, adolescents below the age of 18 (minors), are recognized as holders of all human rights, specifically enshrined in the Convention on the Rights of the Child, and elaborated in General Comment No. 4 on Adolescent Health and Development of the Committee on the Rights of the Child. Adolescents below the age of 18 are entitled to special protection measures and, according to their evolving capacities, they can progressively exercise their rights.

Barriers. The term "barrier" is used in the Module to designate a problem area identified in the laws, regulations or policies. Human rights are used to identify where and how laws, regulations and policies may not be consonant with human rights obligations and commitments, while the health data serve to highlight those areas of laws, regulations or policies that are not well adapted to addressing the problem. In some cases these will be actual barriers in the law such as the legal requirement for a third party signature for a woman to receive contraception, which not only violates her rights to privacy and access to health services without discrimination, but is also bad for her health. In other cases there may be a gap in the legal framework where, for example, domestic violence is not recognized as a crime, thus denying women their right to legal redress as well as posing barriers to their ability to seek health services if subjected to violence within the family. The term "barriers" is used to cover such a broad variety of cases.

Disaggregation. See "Vulnerable groups".

Discrepancies. A discrepancy is an inconsistency or incompatibility. In the case of this Module, discrepancies may become clear either during data collection or the analysis phase. Discrepancies may exist between national laws, or between a national law and a state's international human rights commitments through the treaties it has ratified. For instance, a national law on domestic violence may condemn rape within marriage, while the criminal code may not recognize – or have provisions for penalising – rape

within marriage, while the Convention on the Elimination of All Forms of Discrimination against Women, which the state has ratified, clearly condemns such rape.

Human rights are the rights people are entitled to simply because they are human beings, irrespective of their sex, age, race, citizenship, nationality or any other status. Human rights become enforceable when they are codified in international treaties, national constitutions and laws. Human rights, such as the right to non-discrimination, have been embodied in all national constitutions, and national laws often reflect a state's human rights commitments. At the international level, human rights were first elaborated in 1948 through the Universal Declaration of Human Rights, which has since been transformed into international law through the various international covenants and conventions such as the International Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Discrimination against Women, and the Convention on the Rights of the Child (nine treaties in all). There are also a number of regional treaties on human rights, which are relevant sources for countries of those regions (Africa, the Americas and Europe). (See complete list of international and regional human rights treaties in the QIG.)

The ratification of any treaty confers upon states the obligation to: *respect* rights (i.e. refrain from interfering with the enjoyment of rights e.g. withdrawing health care from specific populations); *protect* rights (i.e. prevent violations of human rights by third parties such as private companies, individual citizens); and *fulfil* rights (i.e. take appropriate governmental measures towards the full realisation of rights such as allocating resources for, and setting in place, quality health services). The existence of a national constitution may also confer these obligations. Monitoring and enforcement of human rights commitments can happen through international, regional and national mechanisms such as treaty monitoring bodies, courts and special procedures.

Implementation of a law, regulation or policy is a demonstration of it being put into practice. In the text of the law, for example, there might be an elaboration of the necessary steps to be taken to implement the measure, but this is not always the case. Implementation might be demonstrated through the promulgation of a strategy or plan, in which case the existence of, say, a plan on maternal mortality reduction may be evidence of implementation of the law on maternal health. The development, publication and distribution of a plan, strategy or protocol may be evidence of implementation. Evidence of implementation may also be found in the creation of mechanisms for the administration, allocation, appropriation, spending and oversight of necessary funds, and published news reports of the activity. Use of the term "implemented" in the law and policy questions does not imply a methodical or systematic examination of implementation.

Key provisions refer to the intent and purpose of the law, regulation or policy, and the strategic focus of the law, regulation or policy, which should also provide a sense of what groups are the focus of action. Key provisions also refer to the date when a law, regulation or policy came into force and whether it has been subsequently amended.

Laws are considered to be official acts and include provisions in the constitution. Laws and statutes are rules of conduct or action prescribed or formally recognized as binding, or enforced by a controlling authority that governs the behaviour of actors (including people, corporations, associations, government agencies and so on). They are adopted or ratified by the legislative branch of government and may be formally recognized in the constitution. Laws governing sexual and reproductive health are not necessarily contained in one law.

Policies are considered to be high-level plans embracing the general goals and acceptable procedures of governmental bodies. Policies can be targeted towards a sector, such as health, education, transportation, public service or the advancement of women; and they can be national or local in scope. They generally do not have the force of law. Policies can be compatible with laws but they can also be in conflict with the law. Institutions such as hospitals and schools may have their own policies. Policies establish a course or method of action selected from among alternatives, and in light of given conditions, to guide and determine priorities for present and future decisions.

Regulations are considered to be executive, ministerial or other administrative orders or decrees. They can be issued by any number of authorities: national, ministerial, sub-ministerial, provincial, district and communal. At the municipal level, regulations are sometimes called ordinances. Regulations and ordinances issued by governmental entities have the force of law, although circumscribed by the level of the issuing authority. Public institutions such as hospitals and schools also issue their own governing regulations, rules of procedure and redress; corporations issue regulations called by-laws. Associations such as those that govern health professions issue rules and regulations that govern the conduct of their professionals, often called deontological or ethical codes.

Restrictions may refer to exclusion of certain individuals on the basis of their belonging to a racial, ethnic, gender or other group. For example, a policy on family planning may require that only married individuals can use the service. This kind of information may be found in grey literature sources such as articles, governmental inquiries, NGO reports etc. Other restrictions may include "third party" restrictions – requiring spousal, familial or parental authorization/consent for specific services to be accessed or utilized. For women, services that may require spousal authorization include, among others, family planning, abortion, and maternal health care information and services.

Vulnerable groups. Vulnerable groups may include adolescents, migrants, minorities, rural dwellers etc. Vulnerable groups can be identified through health information that is disaggregated or reports on specific groups or topics. Key categories for disaggregation are: sex, age, place of residence, ethnicity, socioeconomic status (or proxies such as level of education), marital status and health status. From a human rights perspective, it is important to disaggregate data to look for patterns of discrimination. For example, disaggregating by age might reveal that certain age groups disproportionately experience some health-related problems or have limited access to some health-related resources. Whenever possible, data should be reported in accordance with how countries disaggregate the data, typically by age, sex, place of residence (urban/rural) and socioeconomic status. Other suggested categories of disaggregation include ethnicity, marital status, health status and educational level. Researchers should use their judgement in reporting on additional types of disaggregation that might provide insight into issues of significance in particular settings. For example, in a country where ethnic minorities are thought to be widely denied key health-related rights, it may be desirable to present data disaggregated by ethnicity, to the extent that such information is available. Lack of disaggregated data points to a need for further information gathering. Laws, regulations and policies may or may not include provisions relating to any of the vulnerable groups identified. During the analysis, with the help of such information, other groups may also be identified such as children, indigenous people, people who are trafficked, people with disabilities or people who are institutionalized.

Part 1: Human rights and the legal context

Complete the following questions, citing key provisions and restrictions. Refer to dates of ratification, status of reservations, and participation in consensus documents. Note that details of state reports and concluding observations should be provided under questions on 'human rights considerations' in Part 3. After answering all the questions, write a two–three page summary.

1.1 International and regional commitments

1.1.1 Has the State ratified the following international treaties? If so, indicate ratification dates, and any reservations entered.

- 1.1.1.1 International Covenant on Economic, Social and Cultural Rights (ICESCR).
- 1.1.1.2 Optional Protocol to the International Covenant on Economic, Social and Cultural Rights.
- 1.1.1.3 International Covenant on Civil and Political Rights (ICCPR).
- 1.1.1.4 Optional Protocol to the International Covenant on Civil and Political Rights.
- 1.1.1.5 Second Optional Protocol to the Covenant on Civil and Political Rights, aiming at the abolition of the death penalty.
- 1.1.1.6 International Convention on the Elimination of All Forms of Racial Discrimination (CERD).
- 1.1.1.7 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).
- 1.1.1.8 Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women.
- 1.1.1.9 Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).
- 1.1.1.10 Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
- 1.1.1.11 Convention on the Rights of the Child (CRC).
- 1.1.1.12 Optional protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography.
- 1.1.1.13 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICRMW).
- 1.1.1.14 Convention on the Rights of Persons with Disabilities.
- 1.1.1.15 Optional Protocol to the Convention on the Rights of Persons with Disabilities.

1.1.2 For each treaty ratified, review the latest report submitted by the State to the relevant UN human rights treaty monitoring body. List any sexual and reproductive health issues that are covered in the report, and note the date of the report being cited.

1.1.3 For each treaty ratified, review concluding comments and observations provided by the relevant UN human rights treaty monitoring body to the State in regard to sexual and reproductive health issues, and note the date of the concluding comments and observations being cited.

1.1.4 Has any international human rights court, tribunal or treaty monitoring body issued decisions or communications based on complaints by individuals and/or groups in regard to sexual and reproductive health issues? List the sexual and reproductive health issues considered in the communication, and note the date of the communication being cited.

1.1.5 Have any Special Procedures (e.g. Special Rapporteurs) written reports on the country? List any sexual and reproductive health issues considered in the report, and note the date of the report being cited

1.1.6 When was the State last considered under the Universal Periodic Review process? Provide a list of sexual and reproductive health issues considered in (a) the national report, and (b) the report of the Working Group (c) list of recommendations.

1.1.7 Has the State ratified the relevant regional treaties? If so, indicate ratification dates and any reservations entered.

1.1.8 For each regional treaty ratified, review the latest report submitted by the State to the relevant regional treaty monitoring bodies. List any sexual and reproductive health issues considered in the report, and note the dates of the report being cited.

1.1.9 Has any regional human rights court or commission issued decisions based on complaints by individuals and/or groups in regard to any sexual and reproductive health issues? List the sexual and reproductive health issue considered and note the date of the decision being cited.

1.1.10 For each regional treaty ratified, describe the response of the relevant regional treaty monitoring mechanism to the latest report submitted by the State in regard to any sexual and reproductive health issues, and note the date of the response.

1.1.11 Have any other regional human rights procedures, such as regional Special Rapporteurs in the Americas and Africa, written reports on the State? List any sexual and reproductive health issues covered in the report and note the date of the report being cited.

1.1.12 Has the State signed the consensus documents adopted at the following international conferences? If so, indicate signing dates and any reservations related to sexual and reproductive health.

- 1.1.12.1 Programme of Action adopted at the International Conference on Population and Development (ICPD, 1994), and its follow-up reviews.
- 1.1.12.2 Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women (FWCW, 1995) and its follow-up reviews.
- 1.1.12.3 United Nations Millennium Declaration adopted at the General Assembly Millennium Summit (MDG, 2000).
- 1.1.12.4 Declaration of Commitment on HIV/AIDS adopted at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS on HIV/AIDS, 2001).
- 1.1.12.5 'A World Fit for Children' resolution adopted at the United Nations General Assembly Special Session on Children (UNGASS on Children, 2002).

Write a two-three page summary.

1.2 Mechanisms for promoting and protecting human rights

Address the following issues, noting any special implications for sexual and reproductive health.

1.2.1 Describe the procedure for adapting international and regional human rights laws into the national legal system.

1.2.2 Describe the legal system (e.g. hierarchy of law, centralized/decentralized/federal legal structure).

1.2.3 What is the relationship of customary and/or religious law practice to the formal legal system.

1.2.4 Identify all human rights that are relevant to sexual and reproductive health enshrined in the national constitution and in laws (e.g. the right to life; the right to be free from inhumane and degrading treatment; the right to health; the right to decide freely and responsibly the number and spacing of children), and cite key provisions.

1.2.5 Identify mechanisms for the protection of human rights, including avenues for judicial, quasi-judicial, political and administrative recourse (e.g. constitutional court, supreme court, ombudspersons, human rights commissions, patient rights representatives, parliamentary committees, administrative review processes).

1.2.6 Identify mechanisms for the participation of civil society in law, policy and programme development and implementation (e.g. nongovernmental organizations, women's groups, adolescents and young people).

Summarize the legal/policy provisions relating to mechanisms for promoting and protecting human rights.

1.3 Population and demographic laws, policies and goals

1.3.1 Are there national laws, regulations or policies regarding population issues?

1.3.2 Has the State established demographic goals?

Summarize the legal/policy provisions relating to population and demography.

1.4 Status of women

1.4.1 Summarize briefly the status of women in the State, e.g. in political, economic, social and cultural arenas.

Part 2: Cross-cutting human rights principles

The human rights principles enshrined in international human rights treaties must be recognized and applied across all sexual and reproductive health issues raised in the instrument. Eight principles relevant to sexual and reproductive health are presented in Part 2:

2.1 Non-discrimination and equality
2.2 Availability, accessibility, acceptability and quality of sexual and reproductive health services
2.3 Access to information
2.4 Informed consent
2.5 Respecting the best interests, evolving capacities and views of the child
2.6 Privacy and confidentiality
2.7 Education
2.8 Use of available resources

These core human rights principles may not be specifically related to sexual and reproductive health in national laws and regulations, but they can be applied to such issues in courts and in implementation. The information provided in Part 2 is intended to document how the cross-cutting principles appear in national laws and regulations. Their specific application and enforcement to sexual and reproductive health, however, is addressed in Part 3. Thus, if a national law addresses non-discrimination generally, for example, the law should be described in the subsection of Part 2 that is about non-discrimination. If a national law about family planning services, for example, contains a provision on non-discrimination, the law should be described in the subsection of Part 3 that is about family planning.

2.1 Non-discrimination and equality

Human rights and public health rationale

The human rights principle of non-discrimination obliges states to guarantee that human rights are exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, national, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation.[5]

Discrimination poses a serious threat to sexual and reproductive health for many people, including women, sexual minorities, refugees, people with disabilities, rural communities, indigenous persons, people living with HIV/AIDS, sex workers, and people held in detention.[6] The legal or social restrictions on women and girls to take decisions regarding their sexual and reproductive health and lives, is a manifestation of discrimination on the basis of sex, and often contributes to poor physical and mental health. People who live in rural areas may not have access to the same sexual and reproductive health services as people in urban areas, thus being discriminated against on the grounds of place of residence. Discrimination on the grounds of age or other

[5] *General comment No 20: Non-discrimination in economic, social and cultural rights*. New York, United Nations. Committee on Economic, Social and Cultural Rights. 2009. (E/C.12/GC/20). Article 2(2), paragraph 27–35.

[6] *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report of the Special Rapporteur, Paul Hunt.* New York, United Nations Commission on Human Rights. 60th Session, 2004. (E/CN.4/2004/49). Paragraph 33.

status is manifested through, for instance, the fact that adolescents may be denied services at family planning clinics because of their age, and others may be denied health services because they are HIV-positive. Some individuals suffer discrimination on multiple grounds e.g. gender, race, socio-economic and health status.[7]

As part of their human rights commitments, states must strive to eliminate all forms of discrimination and to promote equality by ensuring that vulnerable groups have access to information and services. Meeting this obligation may require them to make special efforts. Although national constitutions often guarantee the right to non-discrimination, laws and policies are often discriminatory. Examples of this are laws that stipulate a different marriage age for girls and boys, or policies that do not support certain people (such as migrants) to access health services. Human rights agreements obligate states to review all legislation and to amend or revoke legislation that infringes on the right of all people to non-discrimination.[8]

National laws, regulations and policies

Provide a summary and cite key provisions, including restrictions, of laws, regulations and policies that are relevant to the following points. Summarize all relevant supreme court or constitutional court jurisprudence.

2.1.1 Are non-discrimination and equality included in national laws, regulations or policies? If yes, are all possible grounds for non-discrimination, as enshrined in international human rights law, recognized?

Provide a summary of legal/policy provisions relating to non-discrimination.

2.2 Availability, accessibility, acceptability and quality of sexual and reproductive health services

Human rights and public health rationale

The right to the highest attainable standard of health implies that sexual and reproductive health services must be available, accessible, acceptable and of quality.[9] Availability of services requires that a state ensures that functioning public health and health care facilities, goods and services and essential drugs, including those needed for sexual and reproductive health, are available in sufficient quantity.[10] Accessibility of services comprises the dimensions of: non-discrimination (health services must be accessible to all, especially the most vulnerable or marginalized, in law and in fact, without discrimination); physical accessibility (services must be within safe physical reach for all parts of the population including vulnerable groups); economic accessibility (services must be affordable for all); and services must include information that is accessible to all.[11] Accessibility also requires health-care providers to ensure

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7 *General comment no. 20: non-discrimination in economic, social and cultural rights.* New York, United Nations. Committee on Economic, Social and Cultural Rights. 2009. (E/C.12/GC/20). Paragraph 17.

8 *General recommendation no. 24: women and health*. New York, United Nations, Committee on Elimination of all forms of Discrimination against Women, 1999.

9 *General comment no. 14: the right to the highest attainable standard of health.* New York, United Nations, Committee on Economic, Social and Cultural Rights, 2000 (E/C.12/2000/4). Paragraph 12.

10 General comment no. 14: the right to the highest attainable standard of health. New York, United Nations, Committee on Economic, Social and Cultural Rights, 2000 (E/C.12/2000/4). Paragraph 12

11 *General comment no. 14: the right to the highest attainable standard of health*. New York, United Nations, Com-

that needed services are provided; thus, those who invoke "conscientious objection" to providing certain services such as contraception or safe abortion must refer patients to facilities that will provide such services and provide services such as post-abortion care in case of emergency.[12] Acceptability requires that health services are ethically and culturally appropriate, as well as being designed to respect confidentiality and improve health status.[13] Quality requires that health facilities and the services offered must be scientifically and medically appropriate, and be provided by skilled medical personnel, with scientifically approved and unexpired drugs and hospital equipment.[14] Quality health services are those that keep rigorous health records, based on which statistics and data on health, including sexual and reproductive health, of the population can be generated, disaggregated at a minimum by age and sex.

Each of these four aspects must be considered in regard to the wide array of health services important to sexual and reproductive health. The scope of these services includes the prevention and treatment of STIs and HIV/AIDS (including voluntary testing, post-exposure prophylaxis and access to anti-retroviral therapies); contraception, including condoms and emergency contraception; antenatal and delivery care, and abortion services.

National laws, regulations and policies

Provide a summary and cite key provisions, including restrictions, of laws, regulations and policies that are relevant to the following points. Summarize all relevant supreme court or constitutional court jurisprudence. After responding to the questions under this heading, prepare a summary of legal, jurisprudential and policy provisions relating to accessibility of sexual and reproductive health services.

2.2.1 Do national laws, regulations, or policies guarantee universal access to primary health care?

2.2.2 Do national laws, regulations, or policies guarantee the availability, accessibility, acceptability and quality of sexual and reproductive health goods and services?

2.2.3 Are there national laws, regulations or policies relating to conscientious objection to providing services?

2.2.4 Are there national laws, regulations or policies relating to data collection on sexual and reproductive health, including requirements for disaggregation by at least age and sex?

Provide a summary of legal/policy provisions relating to accessibility of sexual and reproductive health services.

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mittee on Economic, Social and Cultural Rights, 2000 (E/C.12/2000/4). Paragraph 12.

[12] See, for example, General recommendation no. 24: women and health. New York, United Nations, Committee on the Elimination of Discrimination against Women, 1999 (A/54/38/Rev.1). Paragraph 11.

[13] General comment no. 14: the right to the highest attainable standard of health. New York, United Nations, Committee on Economic, Social and Cultural Rights, 2000 (E/C.12/2000/4). Paragraph 12.

[14] General comment no. 14: the right to the highest attainable standard of health. New York, United Nations, Committee on Economic, Social and Cultural Rights, 2000 (E/C.12/2000/4). Paragraph 12.

2.3 Access to information

Human rights and public health rationale

Lack of information denies people the opportunity to develop their potential to the fullest and realise the full range of their human rights. Individual personality, political and social identity, and economic capability are all shaped by the information that is available to each person and to society at large. Thus all people need access to information about, for example, family planning and contraceptives, the dangers of early pregnancy, HIV/AIDS and other sexual and reproductive health issues.

The right to freedom of expression is guaranteed in international human rights treaties and includes the right of all people to seek as well as impart information and to hold opinions without interference.[15] Human rights treaties also highlight the need for access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.[16] The duty to enable people to have access to information rests with the state and encompasses two aspects: enabling citizens to access information upon request; and proactively disseminating important information.[17] Laws that prohibit or restrict information about various aspects of sexual and reproductive health are likely to contribute to people's ill-health, and obstruct their right to seek and receive information. States therefore have a duty to make such information available and accessible. This may involve either direct provision of information by the state, or through the state' facilitating others such as civil society organisations and international organisations to provide such information. The information should be available, through various means,[18] to all, regardless of marital status or age, and minors should be allowed to access it without obtaining parental authorization.[19]

National laws, regulations and policies

Provide a summary and cite key provisions, including restrictions, of laws, regulations and policies that are relevant to the following points. Summarize all relevant supreme court or constitutional court jurisprudence. After responding to the questions under this heading, prepare a summary of legal, jurisprudential and policy provisions relating to access to information.

2.3.1 Are there national laws, regulations or policies ensuring that all individuals have access to health information, including sexual and reproductive health information?

2.3.2 Are there national laws, regulations or policies concerning the provision of information on sexual and reproductive health through the mass media?

Provide a summary of legal/policy provisions relating to universal access to information.

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[15] *See, for example, International Covenant on Civil and Political Rights. New York, United Nations, 1966. Article 19.2; Convention on the Rights of the Child. New York, United Nations, 1989. Article 13.1.*

[16] *Convention on the Elimination of All Forms of Discrimination against Women.* New York, United Nations, 1979, Article 10(h)

[17] *Right to information.* Commonwealth Human Rights Initiative. At: www.humanrightsinitiative.org/programs/ai/rti/rti/what.htm#_edn5.

[18] *Programme of action adopted at the International Conference on Population and Development*, Cairo, 5–13 September 1994. New York, United Nations Population Fund, 1994. Paragraph 7.48.

[19] *General comment no 4: adolescent health and development.* New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/4). Paragraph 28.

2.4 Informed consent

Human rights and public health rationale

Individuals have the right to be fully informed about any treatment, intervention or other health services they may seek out or undergo. Informed consent derives from the right to seek, receive and impart information as well as the right to self-determination and the right to the highest attainable standard of health.[20] In order to give free and fully informed consent, the individual concerned must be competent to consent and be in possession of all relevant facts (benefits, risks, alternatives) at the time consent is given. Consent is only valid if it is provided voluntarily, meaning without coercion, undue influence or misrepresentation. [21]

Informed consent may be recognized in national laws, and often in medical ethical codes, but many states' laws or policies fails to explicitly recognize it. Nonetheless, states have the legal duty to ensure that services are provided in a way that presents information in a clear and understandable fashion, including likely benefits and potential adverse effects of proposed procedures and available alternatives,[22] so that patients or clients can make a choice, including refusing a proposed intervention or treatment. In the fields of sexual and reproductive health, this may include fully understanding and accepting (or declining) a contraceptive method, a diagnostic test for an STI, or a particular intervention during pregnancy, or an intervention such as sterilization, for instance.[23]

National laws, regulations and policies

Provide a summary and cite key provisions, including restrictions, of laws, regulations and policies that are relevant to the following points. Summarize all relevant supreme court or constitutional court jurisprudence. After responding to the questions under this heading, prepare a summary of legal, jurisprudential and policy provisions relating to informed consent.

2.4.1 Are there national laws, regulations or policies that recognize a person's right to freely decide whether or not to accept health services?

2.4.2 Are there national laws, regulations or policies requiring someone other than the patient to provide authorization to seek and receive health services? If yes, in what circumstances? Whose authorization is required? What procedures are followed?

Provide a summary of legal/policy provisions relating to informed consent.

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[20] *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report of the Special Rapporteur, Anand Grover.* New York, United Nations General Assembly. 64th Session, 2009. (A/64/272). Paragraph 18.

[21] *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report of the Special Rapporteur, Anand Grover.* New York, United Nations General Assembly. 64th Session, 2009. (A/64/272). Paragraph 10,13 and 15.

[22] *General recommendation no. 24: women and health.* New York, United Nations, Committee on the Elimination of Discrimination against Women, 1999. (A/54/38/Rev.1). Paragraph 22.

[23] See, for example, Communication 4/2004, A. S. v. Hungary. New York, United Nations, Committee on the Elimination of Discrimination against Women, 2006. (CEDAW/C/36/D/4/2004).

2.5 Respecting the best interests, evolving capacities and views of the child

Human rights and public health rationale

The principle of considering the child's best interests, and evolving capacities and views are stipulated in the Convention on the Rights of the Child (CRC),[24] and apply to all actions taken concerning children, including children and adolescents, up to the age of 18. States, as well as public and private bodies, must ascertain the impact of their actions on children and adolescents, including actions in the health field, in order to ensure that the child' s best interests are a primary consideration. This principle should be expressed in all laws, policies and practices that impact directly or indirectly on the health and well-being of children including adolescents. Children's best interests should also be a primary consideration in sexual and reproductive health-related budgeting and allocation of resources at all levels, as well as in the design and implementation of health services.

Adolescence is a period of transition from childhood into adulthood. It is marked by dramatic physical, psychological and social changes.[25] The concept of evolving capacities relates to the adolescent's acquisition of sufficient maturity and understanding to make informed decisions on matters of importance, without the authorization of their parents or guardians. In the context of sexual and reproductive health, this implies that states must systematically consider the adolescent's evolving capacities, and should ensure that appropriate services are made available to them on their own. States should also develop, implement, monitor and evaluate related laws, regulations and policies to foster availability of such services. There should be no discrimination in the recognition of acquired sufficient maturity and understanding the state's legislation (e.g. different treatment of boys and girls). Health-care providers should be trained to provide information and services to adolescents according to these principles.[26]

Adolescents need to be recognized in their family environment as active rights-holders. The right to express views freely and have them duly taken into account is fundamental in realizing adolescents' right to health and development.[27] Adolescents can be entrusted to gradually take on adult responsibilities by participating in decisions that affect their lives and by making contributions to their families and communities. Taking into consideration the views of adolescents in all actions aimed at improving their health and development, including sexual and reproductive health, provides states an opportunity to tailor laws, policies and strategies, as well as programmes and services, to the specific needs and rights of adolescents, taking their views into account.

National laws, regulations and policies

Provide a summary and cite key provisions, including restrictions, of laws, regulations and policies that are relevant to the following points. Summarize all relevant supreme court or constitutional court jurisprudence. After responding to the questions under this heading, prepare a summary of legal, jurisprudential and policy provisions relating to universal access to respecting the best interests, evolving capacities and views of the child.

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[24] *Convention on the Rights of the Child*. New York, United Nations, 1989. Articles 3.1, 5 and 12.1.

[25] *General comment no. 4: adolescent health and development*. New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/4). Paragraph 2.

[26] *Adolescent friendly health services: an agenda for change*. Geneva, World Health Organization, 2002.

[27] *General comment no. 4: adolescent health and development*. New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/4). Paragraph 8.

2.5.1 Do national laws, regulations and policies relating to the age of majority apply to all children equally and in respect to all behaviours and activities?

2.5.2 Are the following principles enshrined in national laws, regulations or policies? (a) The best interests of the child as a primary consideration; (b) the evolving capacities of the child; and (c) respect for the views of the child.

2.5.3 Do national laws, regulations or policies reflect the general principle that once a child has acquired "sufficient maturity and/or understanding" in relation to a particular decision on an important matter, he or she is entitled to make the decision independently?

2.5.4 Are there national laws, regulations or policies concerning training for health-care providers on provision of information and services for adolescents?

2.5.5 Are there national laws, regulations or policies pertaining to children's participation in judicial or administrative proceedings that affect their health?

Provide a summary of legal/policy provisions relating to respecting the best interests, evolving capacities and views of the child.

2.6 Privacy and confidentiality

Human rights and public health rationale

The right to privacy means that individuals should not be subject to interference with their privacy and should enjoy protection of the law in this respect.[28] Sexual and reproductive health includes many sensitive issues that are not widely discussed in families or communities, and health-care workers are often entrusted with such private information by their patients. Confidentiality, which implies the duty of providers to keep secret or private the medical information they receive from patients, and the protection of an individual's privacy have an important role to play in sexual and reproductive health. If an individual feels that confidentiality and privacy are not guaranteed in the health-care environment, she or he may decide not to seek treatment,[29] thus jeopardizing their own health and potentially that of others. This is often the case for vulnerable groups such as adolescents.[30] For example, sexually active adolescents may decide not to seek counselling from health services that would help them to avoid STIs and pregnancy, for fear that their parents will be informed. People in same-sex relationships or women seeking an abortion may avoid going to public health services for fear of disclosure and even legal reprisals.[31] Privacy is also key to protecting the rights, including in relation to sexual and reproductive health, of groups who are stigmatized on the basis of their sexuality, sexual identity or sexual practices, such as gay, lesbian, bisexual, transgender and intersex people, as well as sex workers.

National laws and regulations may not specifically guarantee the right to privacy and confidentiality, but in line with human rights commitments, and in order to promote the health and development of all, states are encouraged to respect strictly the right to

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[28] International Covenant on Civil and Political Rights. New York, United Nations, 1966. Article 17.

[29] General recommendation no. 24: women and health. New York, United Nations, Committee on the Elimination of Discrimination against Women, 1999 (CEDAW/GC/1999/24). Paragraph 12(d).

[30] General comment no. 3: HIV/AIDS and the rights of the child. New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/03). Paragraph 20.

[31] Cook RJ, Dickens BM, Fathalla MF. Reproductive health and human rights: integrating medicine, ethics and law. Oxford, Clarendon Press, 2003.

privacy and confidentiality, including with respect to advice and counselling on sexual and reproductive health matters.[32] Health-care providers have an obligation to keep medical information confidential, both written records and verbal communications. Such information may only be disclosed with the consent of the patient/client. States should also provide training for health personnel about protecting adolescents' privacy and confidentiality,[33] and enact laws and regulations to ensure that confidential advice and treatment is provided to adolescents.

National laws, regulations and policies

Provide a summary and cite key provisions, including restrictions, of laws, regulations and policies that are relevant to the following points. Summarize all relevant supreme court or constitutional court jurisprudence. After responding to the questions under this heading, prepare a summary of legal, jurisprudential and policy provisions relating to privacy and confidentiality.

2.6.1 Are there national laws, regulations or policies that recognize the right to privacy and confidentiality?

2.6.2 Are there national laws, regulations or policies concerning confidentiality of medical records?

2.6.3 Are there national laws, regulations or policies concerning confidentiality of health status?

Provide a summary of legal/policy provisions relating to privacy and confidentiality.

2.7 Education

Human rights and public health rationale

Universal primary education has a key role to play in relation to sexual and reproductive health through, among others, improving literacy. The provision of education on sexual and reproductive health, including gender sensitivities, reproductive choices and responsibilities, and sexually transmitted infections including HIV/AIDS is most effective if it begins in primary school.[34]

International human rights treaties recognize the right to education.[35] The achievement of universal primary education by 2015 is also the third Millennium Development Goal (MDG 3). States thus have the obligation to make primary education free and compulsory[36] to all without discrimination of any kind, irrespective of a child's or *his or her parent's or legal guardian's race, colour, sex, language, religion, political or* other opinion, national, ethnic or social origin, property, disability, birth or other status. National laws and policies should reflect these human rights commitments.

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[32] General comment no. 4: adolescent health and development. New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/4). Paragraph 11; General comment no.15: right of the child to the enjoyment of the highest attainable standard of health, 2013 (CRC/C/GC/15).

[33] Adolescent friendly health services: an agenda for change. Geneva, World Health Organization, 2002.

[34] Programme of action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994. New York, United Nations Population Fund, 1994. Paragraph 11.9.

[35] For example, International Covenant on Economic, Social and Cultural Rights. New York, United Nations, 1966. Article 13; Convention on the Rights of the Child. New York, United Nations, 1989. Article 28.

[36] For example, International Covenant on Economic, Social and Cultural Rights. New York, United Nations, 1966. Article 13(2)(a); Convention on the Rights of the Child. New York, United Nations, 1989. Article 28(1)(a).

Secondary and higher education create opportunities for the promotion and protection of sexual and reproductive health for adolescents and young people, including through the provision of sex and sexuality education, and because children – and in particular girls – attending secondary and higher education are more likely to delay marriage and childbearing. Deriving from their right to education obligations, states must make secondary education in its different forms generally available and accessible to all by every appropriate means.[37]

National laws, regulations and policies

Provide a summary and cite key provisions, including restrictions, of laws, regulations and policies that are relevant to the following points. Summarize all relevant supreme court or constitutional court jurisprudence. After responding to the questions under this heading, prepare a summary of legal, jurisprudential and policy provisions relating to education.

2.7.1 Are there national laws, regulations or policies regarding primary education? Is primary education free and compulsory? Note any differences for different populations.

2.7.2 Are there national laws, regulations or policies regarding secondary and higher education? Note any differences for different populations.

Provide a summary of legal/policy provisions related to education.

2.8 Use of available resources

Human rights and public health rationale

Access to sexual and reproductive health services may be affected by a range of formal and informal financing arrangements provided for in national laws, regulations and policies, including insurance schemes, payment exemptions, informal systems for accessing and using and/or paying for sexual and reproductive health services, and user fees.

The right to the highest attainable standard of health requires states to devote maximum available resources to the realization of the right to health, including sexual and reproductive health. States must take budgetary, economic and other measures to the maximum extent of their available resources with a view to guaranteeing this human right.[38]

Financial support for the provision of specific sexual and reproductive health services in developing countries may be provided in whole or in part through international cooperation. International cooperation is recognized as essential to provide developing countries with appropriate means and facilities to foster their comprehensive development; and states have a duty to cooperate with each other in ensuring development and eliminating obstacles to economic, social and cultural rights, through

[37] For example, *International Covenant on Economic, Social and Cultural Rights*. New York, United Nations, 1966. Article 13(2)(b); Convention on the Rights of the Child. New York, United Nations, 1989. Article 28(1)(b).

[38] *International Covenant on Economic, Social and Cultural Rights.* New York, United Nations, 1966. Article 2(1); Convention on the Rights of the Child. New York, United Nations, 1989. Article 4; General recommendation no. 24: women and health. New York, United Nations, Committee on the Elimination of Discrimination against Women, 1999 (A/54/38/Rev.1). Part III, Chapter 6, Section 2, paragraph 17.

national efforts and international cooperation.[39] Donor priorities have an impact on the nature and extent of the services provided. Likewise, a state's engagement with international development mechanisms such as sector-wide approaches, is likely to affect the finance flows to sexual and reproductive health services.

National laws, regulations and policies

Provide a summary and cite key provisions, including restrictions, of laws, regulations and policies that are relevant to the following points Summarize all relevant supreme court or constitutional court jurisprudence. After responding to the questions under this heading, prepare a summary of legal, jurisprudential and policy provisions relating to use of available resources.

2.8.1 Are there national laws, regulations or policies that provide national financing mechanisms for sexual and reproductive health?

2.8.2 Are there sexual and reproductive health programmes/services provided by international and/or bilateral agencies? If yes, name the agencies and describe the programmes/services.

Please provide a summary of legal/policy provisions related to use of available resources.

Part 3: Core sexual and reproductive health issues

Part 3 contains questions on the five core health issues related to sexual and reproductive health concerns. These issues are drawn from the WHO Global Reproductive Health Strategy, adopted by the World Health Assembly in May 2004. They are: maternal health; family planning; abortion; sexually transmitted infections including HIV and reproductive morbidities; and sexual health. An introduction to each issue presents the "rationale" or reasons why, from both a health and human rights point of view, the topic is important. The rationale highlights a number of subtopics that are reflected in the subheadings of the section. The subsequent questions are grouped, for each issue, by: health considerations; national laws, regulations and policies; and human rights considerations.

3.1 Pregnancy and childbirth

Human rights and public health rationale

Maternal mortality is unacceptably high. About 800 women die from pregnancy- or childbirth-related complications around the world every day. In 2010, an estimated 287 000 women died during and following pregnancy and childbirth.[40] Almost all of these deaths occurred in low-resource settings, and most could have been prevented. Almost all maternal deaths (99%) occur in developing countries. More than half of

[39] *Declaration on the right to development.* New York, United Nations General Assembly, 1986. Article 4(2); Universal declaration of human rights. New York, United Nations General Assembly, 1948. Article 22.

[40] *WHO, UNICEF, UNFPA, the World Bank. Trends in maternal mortality: 1990 to 2010. Geneva, World Health Organization, 2012.*

these deaths occur in sub-Saharan Africa and almost one third occur in South Asia. The maternal mortality ratio (i.e. the number of maternal deaths per 100 000 live births) in developing countries is 240 per 100 000 births versus 16 per 100 000 in developed countries. There are large disparities between countries, with few countries having extremely high maternal mortality ratios of 1000 or more per 100 000 live births. The high number of maternal deaths in some areas of the world reflects inequities in access to health services, and highlights the gap between rich and poor. There are also large disparities within countries, between people with high and low income and between people living in rural and urban areas. The risk of maternal mortality is highest for adolescent girls under 15 years old. Complications in pregnancy and childbirth are the leading cause of death among adolescent girls in most developing countries.[41]

Improving maternal health is one of the eight Millennium Development Goals (MDGs) adopted by the international community in 2000. Under MDG5, countries committed to reducing maternal mortality by three quarters between 1990 and 2015. Since 1990, maternal deaths worldwide have dropped by 47%.In sub-Saharan Africa, a number of countries have halved their levels of maternal mortality since 1990. In other regions, including Asia and North Africa, even greater headway has been made. However, between 1990 and 2010, the global maternal mortality ratio declined by only 3.1% per year. This is far from the annual decline of 5.5% required to achieve MDG5.[42]

Women's right to life has been recognized in international human rights law as applying to pregnancy and childbirth – women should not die from preventable, pregnancy-related causes.[43] The promotion and protection of other rights, such as the right to health, non-discrimination, privacy, information and an identity, are also key to ensuring the survival and health of mothers and neonates. The UN Human Rights Council, and UN treaty monitoring bodies have recognized states' obligations to reduce maternal and infant mortality[44] and states have made commitments to foster women's empowerment and gender equality and to expand Safe Motherhood programmes on numerous occasions – including the UN General Assembly Special Session (UNGASS) on Children in 2002, and the Global Strategy on Women's and Children's Health in 2010. Achieving this goal requires increased attention to improved health care for women and neonates, including high-quality emergency obstetric care, as well as a greater commitment to respect, protect and fulfil women's human rights. Laws and policies can specifically support the reduction of maternal and perinatal mortality in a number of different ways.

Antenatal, childbirth and postpartum care

Most maternal deaths are caused by four major complications of pregnancy: severe bleeding, infections, unsafe abortion, and hypertensive disorders (pre-eclampsia and eclampsia).[45] Neonatal deaths and stillbirths stem from poor maternal health,

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41 *Maternal mortality, Fact Sheet N° 348. Geneva, World Health Organization, 2012*

42 *Ibid.*

43 *Reduction of maternal mortality: a joint WHO/UNICEF/UNFPA/World Bank statement*. Geneva, World Health Organization, 1999; General recommendation no 24: women and health. New York, United Nations, Committee on the Elimination of Discrimination against Women, 1999 (A/54/38/Rev.1). Paragraph 27.

44 UN Human Rights Council Resolution 11/8 (2009); *Technical Guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity*, UNOHCHR, 2012 (A/HRC/21/22).

45 10 Facts on Maternal Health, World Health Organization, 2013.

inadequate care during pregnancy and childbirth, inappropriate management of complications during pregnancy and delivery, poor hygiene during delivery and the first critical hours after birth , and lack of newborn care. Neonatal tetanus has been, and remains, a common cause of neonatal death in settings where lack of hygiene at birth and inadequate cord care are prevalent, and malaria and syphilis are also contributing factors. Nearly all of these deaths can be prevented through good quality health care.[46]

Access to good quality antenatal, perinatal and postpartum care has been widely recognized – by both the international health community and human rights bodies – as being essential to ensuring a healthy pregnancy and a healthy start for newborns.[47] Essential components of this care have been elaborated by WHO and other partners, and have been shown to dramatically reduce maternal and perinatal mortality. However, services staffed by adequately trained personnel and supplied with essential medicines and equipment are not always available and accessible to the population.[48] It is critical that laws, regulations and policies are developed and implemented to support the goal of universal access to maternal and newborn health services. An essential component of these laws and policies concerns the provision of information and privacy for antenatal, perinatal and postpartum care. All pregnant women and adolescents have the right to seek, receive and impart the information necessary for their health and the health of their infants.[49] Furthermore, in all health services, including those relating to pregnancy, women and adolescents have a right to privacy and confidentiality.

As with many health interventions, vulnerable population groups such as rural dwellers, migrants, those who have little or no resources or who have a pre-existing health condition, are often those who do not reach or have easy access to the services they need. Special efforts have to be made by states to reach such populations, including through the legal and policy framework, to ensure affordable access to services without discrimination.

Early marriage and early pregnancy

Early marriages can have a serious impact on girls' health and rights by increasing their risk of becoming pregnant too early, thus exposing them to severe health consequences such as obstetric fistula and the higher risk of death. Pregnancy-related deaths are the leading cause of death for adolescent girls in developing countries.[50] Evidence from a study of over 850 000 women in Latin America and the Caribbean, for instance, shows that mothers aged under 16 years were four times more likely to die

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46 UNICEF, WHO, the World Bank, UN Population Division, UNECLAC. Levels and trends in child mortality. Report 2013. New York, United Nations Children's Fund, 2013.

47 *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets.* Geneva, World Health Organization, 2004. Paragraph 36. General comment No 14: The right to the highest attainable standard of health. New York, United Nations, Committee on Economic, Social and Cultural Rights, 2000. (E/C.12/2000/4). Paragraph 14.

48 *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets*. Geneva, World Health Organization, 2004. Paragraph 26.

49 *Convention on the Elimination of All Forms of Discrimination against Women*. New York, United Nations, 1979. Article 10(h).

50 Patton GC. Global patterns of mortality in young people: a systematic analysis of population health data. *Lancet* 2009;374(9693):881–92.

of maternal causes than mothers aged 20–24.[51] Early marriage may also increase girls' risks of being infected by HIV through lack of ability to negotiate condom use.[52]

In many countries, the legal age of marriage is lower than the internationally recommended 18 years, and is often different for boys and girls, with the age being younger for girls. This is not only discriminatory but exposes girls to early pregnancy and all its attendant risks. In some countries, girls, and particularly younger girls, are not asked for their consent, but coerced into marriage. Where these situations exist, states should elaborate and implement laws and policies aiming to eliminate early marriage and prevent early childbearing. Furthermore, the Committee on the Elimination of All Forms of Discrimination against Women, the Committee on the Rights of the Child and other treaty monitoring bodies have called on states to eliminate child marriages and to stipulate that the legal minimum age for marriage should be 18 for both man and woman, to prevent discrimination.[53]

In many societies, adolescents – both boys and girls – are ill-prepared for parenthood. Adolescent parents may need special support because of their age or economic situation and should have access to services that are sensitive to their needs. Pregnant adolescents are more likely to leave school,[54] which compromises the fulfilment of their right to education. To reduce the risk of becoming pregnant very young, adolescents have the right to information on the dangers of early marriage and early pregnancy, and on ways to protect themselves from unintended pregnancy and sexually transmitted infections.

HIV/AIDS and pregnancy

As access to antiretroviral therapy improves globally, greater numbers of HIV positive women are living longer, healthier lives. Consequently, women with HIV are contending with an increasing range of decisions related to pregnancy and childbearing. Issues of concern include women's experience during contraception, testing and counselling, treatment during pregnancy and after delivery, as well as access to safe abortion services.[55] Mother-to-child transmission is responsible for the majority of infant HIV infections. As a part of protecting children's rights to life and health, the Committee on the Rights of the Child has urged states to take steps to prevent infection including the provision of essential drugs and ensuring voluntary counselling and testing is available to pregnant women.[56] States have made commitments at the UNGASS on AIDS and at other conferences to reduce mother-to-child transmission of HIV. Even as the focus of these programmes is on preventing infection among neonates, the care and treatment that women need to cope with their own disease, before, during and after childbirth must be given attention.

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[51] Conde-Agudelo A, Belizán JM, Lammers C. Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: Cross-sectional study. *Am J Obstet Gynecol.*, 2005;192(2):342–9.

[52] Clark S. Early marriage and HIV risks in sub-Saharan Africa. *Stud Fam Plan*, 2004;35(3):149–60.

[53] *General recommendation 21: equality in marriage and family relations*. New York, United Nations, Committee on the Elimination of Discrimination against Women, 1994. Paragraph 36.

[54] *Why is giving special attention to adolescents important for achieving Millennium Development Goal 5?* Fact sheet. Geneva, World Health Organization, 2008.

[55] *The pregnancy intentions of HIV-positive women: forwarding the research agenda. Conference report, 17–19 March 2010*. Boston, MA (USA), Harvard School of Public Health, 2010.

[56] *General comment no. 3: HIV/AIDS and the rights of the child.* New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/03). Paragraph 26.

Pregnancy, education and employment

Girls who become pregnant while still at school may face being expelled and/or being unable to continue their education once they are mothers. This truncating of their education has repercussions on their development and on their health. School regulations or policies that expel pregnant girls from schools are in direct contradiction to the right to education guaranteed by international human rights treaties and often protected by a country's constitution. Various United Nations human rights treaty monitoring bodies and courts have stressed the importance of equal opportunities for girls and boys in education, that married and pregnant girls should not be forced to leave school,[57] and that states must take steps to provide opportunities for them to return to school after giving birth, and provide alternative solutions for them to finish schooling.[58]

Women in the workforce face particular challenges with regard to pregnancy. For instance, women may be asked to prove that they are not pregnant in order to secure a job, and others may be asked to leave their jobs as soon as they become pregnant. The Human Rights Committee has noted that a woman's right to privacy is compromised when an employer requests a pregnancy test before hiring her. CEDAW and the International Labour Organization have stressed the need to eliminate such discriminatory practices by employers, and ensure that women are provided with adequate maternity leave and breaks for breastfeeding.[59]

Birth registration

Having a legal identity is critical to health and the enjoyment of human rights, especially those related to access to health services, education, inheritance and protection from trafficking. The lack of a birth certificate may prevent a child from receiving health care, nutritional supplements and social assistance, and from being enrolled in school, and these effects can continue over the life course.[60] The right to a name and nationality is recognized both by the Covenant on Civil and Political Rights and the Convention on the Rights of the Child. The UN Human Rights Council,[61] the Committee on the Rights of the Child[62] and the United Nations General Assembly Special Session on Children[63] have noted the importance of developing systems to ensure registration of every child as soon as possible after birth. Birth registration should therefore be required by national laws and implemented by relevant actors.

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[57] See, for example, *Report of the Committee on the Elimination of Discrimination against Women. Chapter IV.B.5: Chile.* New York, United Nations, Committee on the Elimination of Discrimination against Women, 2006 (A/61/38). Paragraph 311.

[58] *General comment no. 4: adolescent health and development.* New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/4). Paragraph 31.

[59] *Convention on the Elimination of All Forms of Discrimination against Women.* New York, United Nations, 1979. Article 11(2); Maternity Protection Convention C183. Geneva, International Labour Organization, 2000.

[60] *The 'Rights' start to life: a statistical analysis of birth registration.* New York, UNICEF, 2005.

[61] UN Human Rights Council, Resolution 22/7 (2012).

[62] *General comment no. 7: implementing child rights in early childhood.* United Nations, Committee on the Rights of the Child, 2006 (CRC/C/GC/7/Rev.1). Paragraph 25.

[63] *A world fit for children.* New York, United Nations General Assembly, 2002 (A/RES/S-27/2). Paragraph 44.

3.1.1 Health considerations

Provide data in answer to the following questions or indicators, using the most authoritative sources available. If there are no data relating to a particular indicator, these gaps should be noted. Include disaggregated data to the extent possible and any information on vulnerable groups.

After answering the questions under this heading, prepare a summary describing the state of maternal health nationally, based on the data provided in the answers. In the summary you may draw on additional, qualitative data about the health situation, such as that contained in sociological studies and governmental, NGO and United Nations reports. Describe trends over the past ten years where possible. The summary should be approximately three–five pages and include references.

Maternal, perinatal and neonatal mortality

- 3.1.1.1 Maternal mortality ratio
- 3.1.1.2 Proportion of maternal deaths by five leading causes
- 3.1.1.3 Perinatal mortality rate
- 3.1.1.4 Neonatal mortality rate
- 3.1.1.5 Percentage of live births of low birth weight

Antenatal, childbirth and postpartum care

- 3.1.1.6 Are there five emergency obstetric care facilities per 500 000 population, with at least one offering comprehensive care
- 3.1.1.7 Percentage of population living within one hour of travel time to an emergency obstetric care facility
- 3.1.1.8 Percentage of women who attended antenatal care at least four times during pregnancy
- 3.1.1.9 Percentage of women of reproductive age (15–49 years), screened for haemoglobin levels, who are anaemic
- 3.1.1.10 Percentage of pregnant women screened for syphilis, with a positive syphilis serology, who are treated appropriately
- 3.1.1.11 Percentage of pregnant women who receive tetanus vaccination during pregnancy
- 3.1.1.12 Percentage of births attended by skilled health personnel
- 3.1.1.13 Caesarean sections as percentage of all live births
- 3.1.1.14 Percentage of women who receive postpartum family planning counselling
- 3.1.1.15 Percentage of women and newborns who receive at least one postnatal visit by skilled health personnel within two days of birth
- 3.1.1.16 Percentage of women breastfeeding at three months post-partum
- 3.1.1.17 Percentage of women with obstetric fistula who received surgical treatment

Early marriage and early pregnancy

- 3.1.1.18 Average age at first marriage
- 3.1.1.19 Percentage of women and men aged 18–24 years who became parents before they were 18 years old

HIV/AIDS and pregnancy

3.1.1.20 Percentage of pregnant women aged 15–24 years attending antenatal clinics whose blood tested positive for HIV

3.1.1.21 Percentage of HIV-infected pregnant women receiving antiretroviral (ARV) drugs for prevention of mother-to-child transmission of HIV (PMTCT), in accordance with WHO PMTCT guidelines

3.1.1.22 Percentage of infants of HIV-infected mothers receiving ARV drugs at birth.

Pregnancy, education and employment

3.1.1.23 Percentage of employed women who are ensured paid maternity leave.

Birth registration

3.1.1.24 Proportion of children aged 0–4 whose births are reported registered

Summary description of the maternal health situation nationally.

3.1.2 National laws, regulations and policies

Complete the following questions, citing key provisions and restrictions. Refer to the name and date of any laws, regulations and policies, and provide information, if available, on whether they are actually implemented. Also summarize all relevant supreme court or constitutional court jurisprudence. After responding to all the questions, write a two–three page summary of legal, jurisprudential and policy provisions relating to maternal health.

Maternal and perinatal mortality; antenatal, perinatal and postpartum care

3.1.2.1 Are there national laws, regulations or policies concerning maternal mortality reduction?

3.1.2.2 Are there national laws, regulations or policies regulating routine performance of maternal, perinatal and neonatal death audits and reviews?

3.1.2.3 Are there national laws, regulations or policies regulating access to, and provision of, maternal health services?

3.1.2.4 Are there national laws, regulations or policies regulating data collection relating to maternal and perinatal mortality?

Early marriage and early pregnancy

3.1.2.5 Are there national laws, regulations or policies concerning the elimination of early marriage and early pregnancy?

3.1.2.6 Are there national laws, regulations or policies regulating the minimum age of marriage?

3.1.2.7 Are there national laws, regulations or policies regulating the registration of marriages?

HIV/AIDS and pregnancy

3.1.2.8 Are there national laws, regulations or policies regulating HIV testing for pregnant women?

3.1.2.9 Are there national laws, regulations or policies concerning the prevention of mother-to-child transmission of HIV?

3.1.2.10 Are there national laws, regulations or policies concerning treatment, care and support for HIV-infected women beyond pregnancy and childbirth?

Pregnancy, education and employment

3.1.2.11 Are there national laws, regulations or policies concerning maternity protection?

3.1.2.12 Are there national laws, regulations or policies regulating access to schooling for pregnant girls and adolescent mothers (and fathers)?

Birth registration

3.1.2.13 Are there national laws, regulations or policies regulating birth registration?

Summary description of the state of the law concerning maternal health.

3.1.3 Human rights considerations

Complete the following questions, citing key provisions. After responding to all the questions, write a two–three page summary.

3.1.3.1 Have any of the human rights treaty monitoring bodies provided concluding comments or observations to the State in regard to the issues in this section?

3.1.3.2 Has any international human rights court, tribunal or treaty monitoring body issued decisions or communications based on complaints by individuals and/or groups in regard to the issues in this section? If so, provide summary of key decisions.

3.1.3.3 Have any Special Procedures (e.g. Special Rapporteurs) been used to examine the human rights situation in the State? If so, are any topics related to the issues in this section addressed in the report?

3.1.3.4 Has the State been considered under the Universal Periodic Review process? If so, are any topics related to the issues in this section addressed in the report?

3.1.3.5 Has any regional human rights court or commission issued decisions or communications based on complaints by individuals and/or groups in regard to the issues in this section?

3.1.3.6 Have any of the relevant regional treaty monitoring bodies provided a response to the State report on any topics related to the issues in this section?

3.1.3.7 Have any other regional human rights procedures, such as regional Special Rapporteurs in the Americas and Africa, been used to examine the human rights situation and issued reports on the State? If so, are any of the issues in this section addressed in the report?

3.1.3.8 Has the State ratified the ILO C183 Maternity Protection Convention 2000?

Summary description of the human rights considerations concerning maternal health.

3.2 Contraception and family planning

Human rights and public health rationale

Need for contraception, and family planning information and services

Over the past three decades, contraceptive use has increased the world over. Despite these increases, however, an estimated 222 million women who want to avoid a

pregnancy are not using an effective method of contraception.[64] Serving all women in developing countries who currently have an unmet need for modern methods would prevent an additional 54 million unintended pregnancies, including 21 million unplanned births, 26 million abortions (of which 16 million would be unsafe) and seven million miscarriages; this would also prevent 79,000 maternal deaths and 1.1 million infant deaths.[65]

To exercise their right to decide freely and responsibly on the number and spacing of their children – which has been recognized through human rights conventions and conferences for many years – people need access to high quality family planning services. Respect for the human rights to health, information, privacy and non-discrimination can contribute to the provision of better family planning services for adults and adolescents, and help guard against the negative impact of practices such as forced sterilization and coercive population policies.[66]

A woman's right to choose if and when she has children depends on her being able to access a full range of family planning services and information, including on the benefits of contraception. States have set the deadline of 2015 for reducing unmet need for contraception.[67] Nonetheless, women (and men) may face a number of restrictions or barriers, which prevent them from realizing this right. Through their laws and policies, states may limit the availability of particular contraceptives such as emergency contraception, or they may not assure regular stocks and distribution of contraceptives at an affordable price throughout the country. States and the international donor community may not have invested adequate resources to put in place good quality family planning services (i.e. offering a full range of methods, with appropriately trained staff to provide information and counselling about both family planning and protection against STIs) within easy reach of the entire population. Training for family planning service providers may be inadequate and restrictive practices such as not serving unmarried women or adolescents may be condoned by superiors. These practices have been found to be discriminatory and contrary to women's right to health.[68] In other cases, the law may require a woman to obtain authorization from her husband, which is not only discriminatory but violates her privacy and may prevent her from seeking the contraceptive services she needs.[69] Thus, states have an obligation to review and revise any such laws or policies in order to meet their human rights obligations on family planning. In various international meetings, states have stressed the importance of promoting longer birth intervals through information, education and counselling about appropriate family planning methods. They have also agreed on the need to foster linkages between family planning services and STI/HIV services.[70]

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[64] Singh SD, JE. Adding it up: the costs and benefits of investing in family planning and newborn and maternal health. Estimates for 2012. New York City: Guttmacher Institute, 2012.

[65] *Ibid.*

[66] See, for example, Kim YM, Kols A, Mucheke S. Informed choice and decision-making in family planning counselling in Kenya. *Int Fam Plann Perspect* 1998;24/1:4–11.

[67] Through the Millennium Development Goals, target 5B: universal access to sexual and reproductive health. See: http://www.un.org/millenniumgoals/.

[68] *General recommendation no. 24: women and health.* New York, United Nations, Committee on the Elimination of Discrimination against Women, 1994. (CEDAW/GR/1999/24). Paragraph 14.

[69] *Ibid.*

[70] *Strategic considerations for strengthening the linkages between family planning and HIV/AIDS policies, programs and services.* Geneva, World Health Organization, USAID and Family Health International, 2009.

Indigenous and minority women in a number of countries have been coerced into using long-term or permanent family planning methods, which not only violates the rights to life and health but can be a form of both gender and racial discrimination.[71] One type of coercive family planning is forced sterilization, a serious breach of women's human rights including the rights to health, to decide on the number and timing of children, to information, to non-discrimination and to be free from inhumane and degrading treatment.

Adolescents are particularly vulnerable to having unwanted pregnancies because they are more likely to be subject to coerced sex and often lack the information, and the services, needed to protect themselves.[72] Pregnant adolescents face significant health risks, especially if they resort to unsafe abortions. Human rights conventions and treaty monitoring bodies have clearly stated that adolescents should have access to family planning services and information.[73] However, many adolescents face legal and policy obstacles to receiving these services including age restrictions, parental consent requirements or restrictions because of their marital status. These barriers have been found to be discriminatory on the grounds of age and sex;[74] they also interfere with adolescents' privacy. To best ensure adolescents rights and health, states have been urged to develop programmes for family planning, specifically designed for the needs of adolescents.[75]

Infertility information and services

While some women may seek to prevent pregnancies, others may find they have trouble getting pregnant. In 2002, more than 186 million ever-married women aged 15–49 in developing countries (excluding China) were infertile because of primary infertility (inability to bear children) or secondary infertility (inability to bear a child after having an earlier birth).[76] When states set the goal of universal access to reproductive health by 2015, it was specified that this should include services and information for the prevention and appropriate treatment of infertility. Very often, such information and services with the necessary skilled personnel are not available or accessible to people, particularly those in resource-poor settings. The use of assisted reproductive technologies and other methods, including surrogacy, while available and regulated in some countries, still poses a number of unresolved ethical and legal questions, not least of which is the high cost that puts the technologies out of reach of the large majority of infertile people.[77] Adoption is also an important means of coping with childlessness, yet this possibility is not easily accessible, especially to those with

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[71] *General recommendation no.19: violence against women.* New York, Untied Nations, Committee on the Elimination of Discrimination against Women, 1992. Paragraph 22.

[72] *Why is giving special attention to adolescents important for achieving Millennium Development Goal 5?* Factsheet. Geneva, World Health Organization, 2008.

[73] For example, *General comment no. 4: adolescent health and development.* New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/4). Paragraphs 10, 28 and 31.

[74] *General comment no. 4: adolescent health and development.* New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/4). Paragraph 28; *General comment no.15: right of the child to the enjoyment of the highest attainable standard of health*, 2013 (CRC/C/GC/15),

[75] *General comment no. 4: adolescent health and development*. New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/4). Paragraph 28.

[76] Rutstein SO, Shah IH. *Infecundity, infertility, and childlessness in developing countries*. Comparative Reports No. 9. Calverton, Maryland, USA, ORC Macro and Geneva, World Health Organization, 2004.

[77] Vayena E, Rowe PJ, Griffin PD (eds). *Medical, ethical and social aspects of assisted reproduction. Current practices and controversies in assisted reproduction: report of a WHO meeting*. Geneva, World Health Organization, 2002.

limited resources, and the law may not allow adoption by certain groups of people, including people who are HIV positive.[78]

3.2.1 Health considerations

Provide data in answer to the following questions or indicators using the most authoritative sources available. If there are no data relating to a particular indicator, these gaps should be noted. Include disaggregated data to the extent possible and any information on vulnerable groups.

After answering the questions under this heading, prepare a summary describing the state of family planning nationally, based on the data provided in the answers. In the summary you may draw on additional, qualitative data about the health situation, such as that contained in sociological studies and governmental, NGO and United Nations reports. Describe trends over the past ten years where possible. The summary should be approximately three–five pages and include references.

Access to contraception/family planning information and services

3.2.1.1 Total fertility rate.
3.2.1.2 Contraceptive prevalence (a) modern methods (b) all methods.
3.2.1.3 Adolescent birth rate (age-specific fertility rate for ages 15-19 years).
3.2.1.4 Unmet need for family planning.
3.2.1.5 Births within the last 3 or 5 years of children born after an interval of less than 24 months.
3.2.1.6 Percentage of primary health care facilities providing family planning services.
3.2.1.7 Number of family planning service delivery points per 500,000 population.
3.2.1.8 Percentage of service delivery points prepared (with stocks and trained providers) to provide at least three family planning methods.
3.2.1.9 Percentage of women and men in union who know about contraceptive methods (traditional or modern).
3.2.1.10 Percentage of births that are unintended.
3.2.1.11 Percentage of family planning service delivery points offering counselling, diagnosis and treatment or referrals for STIs.
3.2.1.12 Percentage of family planning service delivery points offering voluntary HIV counselling and testing.

Infertility information and services

3.2.1.13 Prevalence of infertility on women.
3.2.1.14 Percentage of primary health care facilities offering infertility care services.

Summary description of the health situation related to family planning nationally.

3.2.2 National laws, regulations and policies

Complete the following questions citing key provisions and restrictions. Refer to the name and date of any laws, regulations and policies, and provide information, if available, on whether they are actually implemented. Also summarize all relevant supreme court or constitutional court jurisprudence. After responding to all the questions, write a two–three page summary of legal, jurisprudential and policy provisions relating to family planning.

[78] Global Commission on HIV and the law: risks, rights and health. New York: UNDP, 2012. Page 71.

Access to contraception/family planning information and services

3.2.2.1 Are there national laws, regulations or policies regulating the provision of contraception and of family planning information, counselling and services?

3.2.2.2 Are contraceptives, including emergency contraception, on the national essential medicines list?

3.2.2.3 Are there national laws, regulations or policies regulating the manufacturing, importing, selling and publicizing of approved contraceptive methods?

3.2.2.4 Are there national laws, regulations or policies regulating female or male sterilization?

Infertility information and services

3.2.2.5 Are there national laws, regulations or policies regulating infertility information and services?

3.2.2.6 Are there national laws, regulations or policies regulating maternal surrogacy?

3.2.2.7 Are there national laws, regulations or policies regulating adoption?

Summary description of the state of the law concerning family planning and infertility

3.2.3 Human rights considerations

Complete the following questions, citing key provisions. After responding to all the questions, write a two–three page summary.

3.2.3.1 Have any of the human rights treaty monitoring bodies provided concluding comments or observations to the State in regard to the issues in this section?

3.2.3.2 Has any international human rights court, tribunal or treaty monitoring body issued decisions or communications based on complaints by individuals and/or groups in regard to the issues in this section? If so, provide summary of key decisions.

3.2.3.3 Have any Special Procedures (e.g. Special Rapporteurs) been used to examine the human rights situation in the State? If so, are any topics related to the issues in this section addressed in the report?

3.2.3.4 Has the country been considered under the Universal Periodic Review process? If so, are any topics related to the issues in this section addressed in the report?

3.2.3.5 Has any regional human rights court or commission issued decisions or communications based on complaints by individuals and/or groups in regard to the issues in this section?

3.2.3.6 Have any of the relevant regional treaty monitoring bodies provided a response to the State report on any topics related to the issues in this section?

3.2.3.7 Have any other regional human rights procedures, such as regional Special Rapporteurs in the Americas and Africa, been used to examine the human rights situation, and issued reports on the State? If so, are any of the issues in this section addressed in the report?

Summary of human rights considerations related to family planning and infertility.

3.3 Safe abortion

Human rights and public health rationale

Abortion and unsafe abortion

Approximately 42 million induced abortions are estimated to take place each year, 22 million safely and 20 million unsafely.[79] Unsafe abortion is defined as "a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both."[80] Each year, an estimated 47 000 women die from complications from unsafe abortion, which include haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus and abdominal organs, and many other women are left with significant health problems such as reproductive tract infections, pelvic inflammatory diseases and infertility.[81] Although this figure represents a decline over the estimate for 2003 (56 000) and 2009 (69 000), deaths due to unsafe abortion remain close to 13% of all maternal deaths.[82] Unsafe abortions are preventable, but they continue to pose great risks to a woman's health and may endanger her life.

A restrictive legal environment, poverty, a lack of adequate family planning services, and pregnancy resulting from violence are just some of the reasons women may resort to unsafe abortions. The number of induced abortions declined worldwide between 1995 and 2003, from nearly 46 million to approximately 42 million. However, the decline was greater in developed countries, where nearly all abortions are safe and legal (from 39 to 26 abortions per 1000 women aged 15–44,) than in developing countries, where more than half are unsafe and illegal (from 34 to 29 abortions per 1000 women aged 15–44).[83]

In consideration of their human rights commitments, governments at the United Nations International Conference on Population and Development review and appraisal process agreed that "in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health".[84] In order to protect women's health and human rights, human rights bodies have recommended that States should make all efforts to ensure that women do not have to undergo life-threatening clandestine abortion.[85]

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79 *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*. Sixth edition. Geneva, World Health Organization, 2011.

80 *The prevention and management of unsafe abortion. Report of a technical working group*. Geneva, World Health Organization, 1992 (WHO/MSM/92.5).

81 *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008.* Sixth edition. Geneva, World Health Organization, 2011.

82 *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*. Sixth edition. Geneva, World Health Organization, 2011.

83 Shah I, Ahman E. Unsafe abortion: global and regional incidence, trends, consequences, and challenges. J *Obstet Gynaecol Can* 2009:1149–58.

84 *Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development, adopted by the twenty-first special session of the General Assembly.* New York: United Nations, 1999.

85 *Safe Abortion : technical and policy guidance for health systems*. Second Edition. Geneva: World Health Organization, 2012

Legal status of abortion

Legal restrictions on abortion do not result in fewer abortions nor do they result in significant increases in birth rates. Conversely, laws and policies that facilitate access to safe abortion do not increase the rate or number of abortions. The principle effect is to shift previously clandestine, unsafe procedures to legal and safe ones.[86]

Restricting legal access to abortion does not decrease the need for abortion, but it is likely to increase the number of women seeking illegal and unsafe abortions, leading to increased morbidity and mortality. Legal restrictions also lead many women to seek services in other countries/states, which is costly, delays access and creates social inequities. Restricting abortion, with the intent of boosting population has been well documented in several countries. In each case, abortion restrictions resulted in an increase of illegal and unsafe abortions and pregnancy-related mortality, with insignificant net increase in the population. Evidence increasingly shows that, where abortion is legal on broad socioeconomic grounds and on a woman's request, and where safe services are accessible, both unsafe abortion and abortion-related mortality and morbidity are reduced.[87]

Fifty-seven countries, representing almost 40% of the world's women, allow abortion upon request of the pregnant woman and approximately 20% of the world's women live in countries that have laws that allow abortion based on a woman's social and economic circumstances. In several countries' criminal or penal codes abortion throughout pregnancy, or up to a set gestational limit, is no longer subject to criminal regulation, and has been removed as a distinct offence. Nonetheless, about 40% of women of childbearing age live in countries that have highly restrictive laws, and/or where abortion, even when lawful, is neither available nor accessible.

Over the past 15 years, human rights have been increasingly applied by international and regional human rights bodies and national courts, including the United Nations treaty monitoring bodies in the context of abortion. The respect, protection and fulfilment of human rights require, among others: the amendment of laws that criminalize medical procedures only needed by women, and that punish women who undergo those procedures, the provision of legal abortion in cases of sexual assault, rape, incest,[88] and where the continued pregnancy endangers the health or the life of the woman.[89] In addition, forcing a woman or girl to carry a foetus to term when the fetus is non-viable is considered cruel and inhuman treatment.[90]

The legal grounds, and the scope of their interpretation, are only one dimension of the legal and policy environment that affects women's access to safe abortion. Health system and service-delivery barriers may also be codified in laws, regulations, policies and practices. These may include: prohibiting access to information on legal abortion

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86 *Safe Abortion : technical and policy guidance for health systems.* Second Edition. Geneva: World Health Organization, 2012.

87 *Safe Abortion : technical and policy guidance for health systems.* Second Edition. Geneva: World Health Organization, 2012.

88 See, for example, *Conclusions and recommendations of the Committee against Torture: Peru.* New York, United Nations, Committee against Torture, 2006 (CAT/C/PER/CO/4). Paragraph 23.

89 See, for example, *Concluding observations of the Human Rights Committee: Chile.* New York, United Nations, Human Rights Committee, 2007 (CCPR/C/CHL/CO/5). Paragraph 8.

90 *Safe Abortion : technical and policy guidance for health systems.* Second Edition. Geneva: World Health Organization, 2012.

services, requiring third-party authorization, restricting available methods of abortion, restricting the range of health-care providers and facilities that can safely provide services, e.g. to physicians in inpatient facilities with sophisticated equipment; failing to assure referral in case of conscientious objection; requiring mandatory waiting periods; censoring, withholding or intentionally misrepresenting health-related information; excluding coverage for abortion services under health insurance and failing to guarantee confidentiality and privacy. These barriers contribute to unsafe abortion because they deter women from seeking care and providers from delivering services within the formal health system; cause delay in access to services, which may result in denial of services due to gestational limits on the legal grounds; create complex and burdensome administrative procedures; increase the costs of accessing abortion services and limit the availability of services and their equitable geographic distribution.[91]

In some instances, women and girls have been forced to undergo abortions against their will.[92] Women who belong to ethnic minorities, are HIV positive, or who are disabled are particularly vulnerable to forced abortion. While forced abortion may not necessarily be unsafe abortion, it is nonetheless a serious violation of a woman's rights to found a family, decide on the number and spacing of her children, and to be free from discrimination. This may not be in a law, regulation or policy, but may occur in practice.

Safe abortion services

Almost all the deaths and complications from unsafe abortion are preventable. Procedures and techniques for early induced abortion are simple and safe. When performed by trained health-care providers with proper equipment, correct technique and sanitary standards, abortion is one of the safest medical procedures.[93] Access to safe abortion services therefore saves women's lives.

Human rights bodies recommend that abortion facilities and trained providers are available in sufficient quantity and equitably distributed; and that States should ensure timely and affordable access to good quality health services, which should be delivered in a way that ensures that a women gives her informed consent, be treated with respect and dignity, guarantees her confidentially, and is sensitive to her needs and perspectives.[94,95]

Post abortion Care

Women who have undergone unsafe abortion often need emergency obstetric care to stop bleeding or infection. States have an obligation to ensure that such post-abortion

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[91] *Safe Abortion : technical and policy guidance for health systems.* Second Edition. Geneva: World Health Organization, 2012.

[92] *Concluding observations of the Committee on Economic, Social and Cultural Rights: China.* Geneva, Office of the High Commissioner for Human Rights, Committee on Economic, Social and Cultural Rights, 2005 (E/C.12/1/Add.107). Paragraph 36.

[93] *Safe abortion: technical and policy guidance for health systems.* Second edition. Geneva: World Health Organization, 2012.

[94] *General comment no. 14: the right to the highest attainable standard of health.* New York, United Nations, Committee on Economic, Social and Cultural Rights, 2000 (E/C.12/2000/4). Paragraphs 12 and 36; *Protocol on the Rights of Women in Africa, African Charter on Human and Peoples' Rights.* Addis Ababa, Organization of African Union, 2003. Article 14.2.

[95] *Safe abortion: technical and policy guidance for health systems.* Second edition. Geneva: World Health Organization, 2012.

care is available and accessible to women, regardless of the legality of abortion, a commitment made at international conferences such as ICPD and the Fourth World Conference on Women.[96] This requires states to put services in place and ensure that they are staffed by trained practitioners, and that women receiving post-abortion care are counselled and offered family planning. The Committee against Torture found that a situation in which emergency medical care was denied to a woman suffering from complications from unsafe abortion unless she named the person who had performed the illegal abortion, constituted cruel and inhuman treatment.[97]

3.3.1 Health considerations

Provide data in answer to the following questions or indicators using the most authoritative sources available. If there are no data relating to a particular indicator, these gaps should be noted. Include disaggregated data to the extent possible and any information on vulnerable groups.

After answering the questions under this heading, prepare a summary describing the state of abortion nationally, based on the data provided in the answers. In the summary you may draw on additional, qualitative data about the health situation, such as that contained in sociological studies and governmental, NGO and United Nations reports. Describe trends over the past ten years where possible. The summary should be approximately three–five pages and include references.

Abortion and unsafe abortion

3.3.1.1 Abortions per 1000 live births.
3.3.1.2 Percentage of induced abortions, by gestational age.
3.3.1.3 Percentage of obstetric and gynaecological admissions owing to abortion.
3.3.1.4 Percentage of maternal deaths attributed to abortion.
3.3.1.5 Hospitalization rate for unsafe abortion per 1000 women.

Legal status of abortion

3.3.1.6 Percentage of health personnel with correct knowledge of legal status of abortion.
3.3.1.7 Percentage of the population with correct knowledge of legal status of abortion.

Safe abortion services

3.3.1.8 Number of facilities offering safe abortion services per 500,000 population.
3.3.1.9 Percentage of basic emergency obstetric care services offering abortion.
3.3.1.10 Percentage of service delivery points using WHO recommended methods for induced abortion and for management of abortion complications.
3.3.1.11 Percentage of health care providers trained to provide safe abortion services to the full extent of the law.

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[96] *Programme of action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994*. New York, United Nations Population Fund, 1994. Paragraph 8.25; Report of the Fourth World Conference on Women, Beijing, 4–15 September 1995. New York, United Nations, 1996. Paragraph 106(k).

[97] *Conclusions and recommendations of the Committee against Torture: Peru.* Geneva, United Nations, Committee against Torture, 2006 (CAT/C/PER/CO/4). Paragraph 23.

3.3.1.12 Percentage of the population living within two hours of travel time to a facility providing safe abortion services.

Post-abortion care

3.3.1.13 Percentage of service delivery points providing post-abortion care services.

3.3.1.14 Percentage of the population living within two hours of travel time to a facility providing post-abortion care services.

3.3.1.15 Percentage of health-care providers trained in post-abortion care.

Summary description of the health situation related to abortion nationally.

3.3.2 National laws, regulations and policies

Complete the following questions citing key provisions and restrictions. Refer to the name and date of any laws, regulations and policies, and provide information, if available, on whether they are actually implemented. Also summarize all relevant supreme court or constitutional court jurisprudence. After responding to all the questions, write a two–three page summary of legal, jurisprudential and policy provisions relating to safe abortion.

Legal status of abortion

3.3.2.1 Are there national laws, regulations or policies that regulate termination of pregnancy?

Safe abortion services

3.3.2.2 Are there national laws, regulations or policies that regulate information provided to the public on safe abortion services?

3.3.2.3 Are there national laws, regulations or policies regulating the provision of safe abortion services?

3.3.2.4 Are there national laws, regulations or policies regulating medical abortion?

Post-abortion care

3.3.2.5 Are there national laws, regulations or policies that regulate the provision of post-abortion care?

Summary description of the state of the law concerning abortion.

3.3.3 Human rights considerations

Complete the following questions, citing key provisions. After responding to all the questions, write a two–three page summary.

3.3.3.1 Have any of the human rights treaty monitoring bodies provided concluding comments or observations to the State in regard to the issues in this section?

3.3.3.2 Has any international human rights court, tribunal or treaty monitoring body issued decisions or communications based on complaints by individuals and/or groups in regard to the issues in this section? If so, provide summary of key decisions.

3.3.3.3 Have any Special Procedures (e.g. Special Rapporteurs) been used to examine the human rights situation in the State? If so, are any topics related to the issues in this section addressed in the report?

3.3.3.4 Has the State been considered under the Universal Periodic Review process? If so, are any topics related to the issues in this section addressed in the report?

3.3.3.5 Has any regional human rights court or commission issued decisions or communications based on complaints by individuals and/or groups in regard to the issues in this section?

3.3.3.6 Have any of the relevant regional treaty monitoring bodies provided a response to the State report on any topics related to the issues in this section?

3.3.3.7 Have any other regional human rights procedures, such as regional Special Rapporteurs in the Americas and Africa, been used to examine the human rights situation and issued reports on the State? If so, are any of the issues in this section addressed in the report?

Summary description of the human rights considerations concerning abortion.

3.4 Sexually transmitted infections, including HIV, and reproductive morbidities

Human rights and public health rationale

Sexually transmitted infections (STIs) and HIV

The World Health Organization estimates that more than 1 million people acquire STIs every day and each year an estimated 500 million new cases STIs.[98] In developing countries, STIs and their complications rank in the top five disease categories for which adults seek health care. The majority of STIs (such as syphilis, gonorrhoea, chlamydia and trichomoniasis) are curable, but untreated, STIs can lead to acute symptoms, chronic infection and serious delayed consequences such as infertility, ectopic pregnancy, cervical cancer and the untimely death of infants and adults.[99] Other STIs are viral infections, like the human immunodeficiency virus (HIV) that causes AIDS, and the human papillomavirus (HPV), for which there is no cure.[100]

UNAIDS estimates that at the end of 2013, there were between 32.2 and 38.8 million people living with HIV (the human immunodeficiency virus), that between 1.9 and 2.7 million people became newly infected with HIV in 2013 (a decline of 33% in the number of new infections in 2001), and an estimated 1.6 million people died from AIDS in 2013, down from 2.3 million in 2005.[101] Knowing that the presence of another sexually transmitted infection can increase the risk of contracting HIV, preventing and treating all STIs is vital to achieving the Millennium Development Goal of halting and reversing the spread of HIV.

For people to be able to protect themselves from STIs and HIV, their rights to information and education and to the highest attainable standard of health must be respected, protected and fulfilled. Because HIV and other STIs are so often stigmatised, the right to be free from discrimination – which is recognized in all human rights treaties – is particularly important. Discrimination against people living with HIV has been widespread around the world, and gender-based discrimination may also increase women's vulnerability to HIV infection.[102] Historically this was also true of

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98 *Sexually transmitted infections.* Fact sheet No 110. Geneva, World Health Organization, 2013.

99 *Sexually transmitted infections.* Fact sheet No 110. Geneva, World Health Organization, 2013.

100 *Sexually transmitted infections.* Fact sheet No 110. Geneva, World Health Organization, 2013.

101 *Global report: UNAIDS report on the global AIDS epidemic 2013.* Geneva, Joint United Nations Programme on HIV/AIDS (UNAIDS), 2013.

102 *Integrating gender into HIV/AIDS programmes in the health sector: a tool to improve responsiveness to women's needs.* Geneva, World Health Organization, 2009.

people suffering from syphilis and common STIs such as gonorrhoea. Various human rights treaty monitoring bodies have stressed the importance of states eliminating all forms of discrimination including discrimination based on the HIV status of individuals, parents, families and communities.[103] Some groups may be particularly vulnerable to stigma and discrimination in the context of HIV/AIDS, such as sex workers, intravenous drug users and men who have sex with men. The criminalization of HIV transmission has been found not only to be ineffective in controlling the spread of the epidemic, but also severely stigmatising and discriminatory.[104]

Experience with programmes to address the HIV/AIDS pandemic has demonstrated the importance of a multi-faceted approach to HIV and other STIs including prevention, confidential counselling and testing, and access to treatment and care.[105]

Prevention programmes

Consistent with their obligations under the right to health and information, states are required to establish prevention and education programmes for adults and adolescents regarding behaviour-related health concerns such as sexually transmitted infections, including HIV/AIDS. Because adolescents are particularly vulnerable to contracting an STI, their right to acquire the necessary information and skills to protect themselves as they become sexually active is especially critical.[106] In respecting this right, states should ensure that accurate information is available to all adolescents, regardless of marital status.[107] Prevention strategies include formal education programmes, as well as mass-media campaigns in the general population, and the provision and widespread availability of condoms at an affordable price.[108] Such strategies should adequately address the differing needs and vulnerabilities of diverse groups, including women and adolescents.[109] In keeping with human rights principles, these programmes should be developed without discrimination and with the full participation of the relevant communities (e.g. adolescents, migrants and people living with HIV).[110]

Recognizing that education plays an important role in providing children and adolescents with information on HIV, and the fundamental right of all children to education, the Committee on the Rights of the Child (CRC) has stressed that states must ensure that primary education is available to all children, regardless of their HIV status, or that of their families.[111]

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[103] See, for example, *Concluding comments of the Committee on the Elimination of Discrimination against Women: Jamaica*. New York, United Nations, Committee on the Elimination of Discrimination against Women, 2006 (CEDAW/C/JAM/CO5). Paragraph 36.

[104] Jürgens R, Cohen J, Cameron E, Burris S, Clayton M, Elliott R et al. Ten reasons to oppose the criminalization of HIV exposure or transmission. *Reprod Health Matters*, 2009, 17(34):163–72.

[105] *Declaration of commitment on HIV/AIDS*. New York, United Nations General Assembly, 2001. Resolution A/RES/S-26/2.

[106] *General comment no. 3: HIV/AIDS and the rights of the child*. New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/3). Paragraph 16.

[107] *Sexual transmission of HIV*. Geneva, Joint United Nations Programme on HIV/AIDS (UNAIDS), 2011. Website: www.unaids.org/en/AboutUNAIDS/PolicyAndPractice/Prevention/IECbehaviChange/default.asp.

[108] *Condoms and HIV prevention: position statement*. Geneva, Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organization and United Nations Population Fund, 2004, updated 2009.

[109] *General recommendation No 24: Women and health*. New York, United Nations, Committee on the Elimination of Discrimination against women, 1999 (CEDAW/GC/1999/24). Paragraph 20(q).

[110] *Non-discrimination in HIV responses*. 26th meeting of the UNAIDS Programme Coordinating Board. Geneva, Joint United Nations Programme on HIV/AIDS (UNAIDS), 2010.

[111] *General comment no. 3: HIV/AIDS and the rights of the child*. New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/3). Paragraph 19.

Confidential voluntary testing and counselling

The need for voluntary counselling and testing for HIV has been called for by many UN human rights bodies and consensus declarations as an integral part of comprehensive sexual and reproductive health services.[112] The WHO–UNAIDS standards for provider-initiated testing and counselling adhere to human rights standards and recommend that all HIV testing must be voluntary, confidential, and undertaken with the patient's consent, and in no case may the services be coercive.[113] When implementing provider-initiated HIIV testing and counselling, equal efforts must be made to ensure that a supportive social, policy and legal framework is in place to maximize positive outcomes and minimize potential harms to patients.[114]

Access to care and treatment for STIs including HIV

In the International Conference on Population and Development (ICPD) Programme for Action in 1994, states agreed that reproductive health services should be universally accessible to adults and adolescents.[115] This position, supported by other international consensus documents such as the Declaration of Commitment on HIV/AIDS[116], emphasized that reproductive health services including counselling, information, education and services for the treatment of reproductive tract infections and STIs including HIV/AIDS, should be made universally available. To ensure that young people have equal access to care and treatment, states should pay special attention to developing youth-friendly services.

In relation to care and treatment for HIV, including access to essential medicines, in the Declaration of Commitment on HIV/AIDS, states agreed to develop comprehensive care strategies for HIV, including the provision of antiretroviral medication.[117] The Human Rights Committee has recognized the right of access to HIV treatment,[118] and in several prominent cases national courts ruled that under the rights to health and life, states are responsible for providing HIV treatment. Health service providers must be trained to provide appropriate counselling, testing, treatment and care, and services must be equipped with blood screened for HIV.[119,120]

Reproductive morbidities

Infection with certain types of human papillomavirus can lead to the development of genital cancers, particularly cervical cancer in women. Cervical cancer causes

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[112] See, for example, General comment no. 3: HIV/AIDS and the rights of the child. New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/3). Paragraph 20; *Declaration of commitment on HIV/AIDS.* New York, United Nations General Assembly, 2001 (A/RES/S-26/2). Paragraph 52.

[113] *Guidance on provider-initiated HIV testing and counselling in health facilities.* Geneva, World Health Organization and he Joint United Nations Programme on HIV/AIDS (UNAIDS), 2007.

[114] *Ibid.*

[115] *Programme of action adopted at the International Conference on Population and Development, Cairo, 5–13 Ibid. September 1994.* New York, United Nations Population Fund, 1994. Paragraphs 7.6 and 7.7.

[116] *Declaration of commitment on HIV/AIDS*. New York, United Nations General Assembly, 2001 (A/RES/S-26/2). Paragraph 55.

[117] *Declaration of commitment on HIV/AIDS.* New York, United Nations General Assembly, 2001 (A/RES/S-26/2). Paragraph 55.

[118] Concluding observations of the Human Rights Committee: Uganda. Geneva, United Nations, Human Rights Committee, 2004 (CCPR/CO/80/UGA). Paragraph 14.

[119] *Guidance on provider-initiated HIV testing and counselling in health facilities.* Geneva, World Health Organization and Joint United Nations Programme on HIV/AIDS (UNAIDS), 2007. Page 32.

[120] *Blood safety and HIV.* UNAIDS Technical update. Geneva, Joint United Nations Programme on HIV/AIDS (UNAIDS), 1997.

approximately 275 000 deaths among women every year, the majority of which occur in developing countries.[121] Cervix uteri cancer is the number one cause of cancer deaths among women in Africa and South-East Asia.[122] Breast cancer is the most common cancer in women globally, resulting in deaths of 458 000 women worldwide.[123] Prostate cancer is detected in more than a million men annually, and is the sixth cause of cancer deaths among men globally, but the leading cause of cancer deaths among men in the African region[124]

About one-third of the cancer burden could be decreased if cases were detected and treated early.[125] With the recent availability of the HPV vaccine, strategies for appropriate introduction of this vaccine are being promoted as an important prevention measure.

While not specifically mentioned in human rights treaties and related documents, reproductive cancers and morbidities require similar inputs and efforts as for STIs and HIV on the part of states and other actors, in order for people's sexual and reproductive health and related human rights to be protected and promoted.

3.4.1 Health considerations

Provide data in answer to the following questions or indicators using the most authoritative sources available. If there are no data relating to a particular indicator, these gaps should be noted. Include disaggregated data to the extent possible and any information on vulnerable groups.

After answering the questions under this heading, prepare a summary describing the state of STIs including HIV and reproductive morbidities nationally, based on the data provided in the answers. In the summary you may draw on additional, qualitative data about the health situation, such as that contained in sociological studies and governmental, NGO and United Nations reports. Describe trends over the past ten years where possible. The summary should be approximately three–five pages and include references.

STIs and HIV

3.4.1.1 Percentage of relevant population groups with self-reported or diagnosed symptoms of bacterial or viral STIs and RTIs, classified by disease and by sex.

3.4.1.2 Percentage of women and men with secondary infertility.

3.4.1.3 Percentage of men aged 15-49 years reporting at least one episode of urethral discharge in the last 12 months.

3.4.1.4 Estimated HIV prevalence among the population aged 15-49.

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[121] Cancer. Fact sheet 297. World Health Organization website. At: http://www.who.int/mediacentre/factsheets/fs297/en/index.html..

[122] Globocan 2012: estimated cancer incidence, mortality and prevalence worldwide in 2012. Lyon, WHO International Agency for Research on Cancer. At: http://globocan.iarc.fr/Pages/bar_site_sel.aspx. (Accessed 21 January 2014)

[123] Cancer. Fact sheet 297. World Health Organization website. At: http://www.who.int/mediacentre/factsheets/fs297/en/index.html.

[124] Globocan 2012: estimated cancer incidence, mortality and prevalence worldwide in 2012. Lyon, WHO International Agency for Research on Cancer. At: http://globocan.iarc.fr/Pages/bar_site_sel.aspx. (Accessed 21 January 2014)

[125] *Cancer.F Fact sheet 297*. World Health Organization website. At: www.who.int/mediacentre/factsheets/fs297/en/index.html.

3.4.1.5 Percentage of men who have sex with men, people who inject drugs and sex workers who are HIV-infected.
3.4.1.6 Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission
3.4.1.7 Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse
3.4.1.8 Percentage of STI services offering family planning services.
3.4.1.9 Percentage of primary health care facilities providing case management for symptomatic STIs.
3.4.1.10 Percentage of primary health care services offering voluntary counselling and testing for HIV, including advice on condoms.

Reproductive morbidities

3.4.1.11 Prevalence of cervical cancer.
3.4.1.12 Prevalence of breast cancer.
3.4.1.13 Proportion of primary health care service delivery points that offer (a) cervical cancer screening and (b) treatment or referral for treatment.
3.4.1.14 Percentage of women screened for cervical cancer within the past five years.
3.4.1.15 Percentage of women screened for breast cancer within the past five years.
3.4.1.16 Percentage of adolescent girls who have been vaccinated against HPV.

Summary description of the STI, HIV and reproductive morbidities situation nationally.

3.4.2 National laws, regulations and policies

Complete the following questions citing key provisions and restrictions. Refer to the name and date of any laws, regulations and policies, and provide information, if available, on whether they are actually implemented. Also summarize all relevant supreme court or constitutional court jurisprudence. After responding to all the questions, write a two–three page summary of legal, jurisprudential and policy provisions relating to STIs including HIV, and reproductive morbidities.

STIs and HIV

3.4.2.1 Are there national laws, regulations or policies concerning prevention, control and treatment of STIs?
3.4.2.2 Are there national laws, regulations or policies concerning prevention, control and treatment of HIV?
3.4.2.3 Are there national laws, regulations or policies to protect people living with HIV, and other vulnerable sub-populations, from discrimination? If so, provide summary of key decisions.
3.4.2.4 Are there national laws, regulations or policies that criminalize the transmission of HIV or any other STIs?
3.4.2.5 Are antiretroviral drugs included on the national essential medicines list?
3.4.2.6 Are there national laws, regulations or policies concerning the training and accreditation of health professionals and others in any of the following areas: HIV counselling, HIV prevention activities, or HIV care and treatment?

Reproductive morbidities

3.4.2.7 Are there national laws, regulations or policies concerning a national cancer control programme including provisions for cervical and breast cancer screening?

3.4.2.8 Are there national laws, regulations or policies concerning the provision of information on HPV and the HPV vaccine to adolescent girls?

Summary description of the state of the law concerning STI, HIV and reproductive morbidities.

3.4.3 Human rights considerations

Complete the following questions, citing key provisions. After responding to all the questions, write a two–three page summary.

3.4.3.1 Have any of the human rights treaty monitoring bodies provided concluding comments or observations to the State in regard to the issues in this section?

3.4.3.2 Has any international human rights court, tribunal or treaty monitoring body issued decisions or communications based on complaints by individuals and/or groups in regard to the issues in this section?

3.4.3.3 Have any Special Procedures (e.g. Special Rapporteurs) been used to examine the human rights situation in the State? If so, are any topics related to the issues in this section addressed in the report?

3.4.3.4 Has the State been considered under the Universal Periodic Review process? If so, are any topics related to the issues in this section addressed in the report?

3.4.3.5 Has any regional human rights court or commission issued decisions or communications based on complaints by individuals and/or groups in regard to the issues in this section?

3.4.3.6 Have any of the relevant regional treaty monitoring bodies provided a response to the State report on any topics related to the issues in this section?

3.4.3.7 Have any other regional human rights procedures, such as regional Special Rapporteurs in the Americas and Africa, been used to examine the human rights situation and issued reports on the State? If so, are any of the issues in this section addressed in the report?

Summary description of the human rights situation regarding STI, HIV and reproductive morbidities.

3.5 Sexual health

Human rights and public health rationale

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality, not merely the absence of disease, dysfunction or infirmity; sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free

of coercion, discrimination and violence.[126] For sexual health to be attained and maintained, the human rights of all persons must be respected, protected and fulfilled. Human rights related to sexuality and sexual health include the rights to identity, to self-determination, privacy, autonomy and physical integrity with due regard for the well-being and rights of others, without fear of persecution, denial of liberty or social interference.[127] The ability of individuals or couples to pursue a fulfilling and safe sex life is central to achievement of sexual health.

Age of sexual consent

The age at which societies consider adolescents of sufficient maturity to embark upon sexual relations varies across countries, regions and cultures, ranging from 12 to 21 years, with lower ages for girls than for boys in a number of cases, highlighting different gender standards. In some countries there is no specific age stipulation, but a requirement to be married. Evidence shows, however, that almost everywhere, sexual activity begins for most men and women between the ages of 15 and 19 years (except where early marriage is the norm, when sexual intercourse will start at lower ages for girls).[128] Setting a minimum age of sexual consent has an important role in protecting a range of human rights of children including their rights to health and education, as well as in relation to the prohibition of violence, exploitation and harmful practices including early marriage. The Committee on the Rights of the Child has urged states to set a minimum age of sexual consent, taking account of the principles of non-discrimination (i.e. it should be the same for girls and boys), evolving capacity, age and maturity of the child.[129]

Sex and sexuality information, education and services

Access to information about sexual health is considered essential in order for individuals to lead "a satisfying and safe sex life" as agreed upon in the ICPD Programme of Action.[130] Often the appropriate information, as well as the services to support the information, is not available, thus leaving people in ignorance and without the support needed for them to safeguard their sexual health. Adolescents in particular often lack the ability or support to resist pressure to have unwanted sexual relations or negotiate safer sex;[131] young girls have a higher risk of unplanned pregnancies, and young people are more likely to contract an STI than adults.[132] In most countries, taboos and norms about sexuality (including practices such as child marriage, female genital mutilation

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[126] *Defining sexual health. Report of a technical consultation on sexual health 28–31 January 2002.* Geneva, World Health Organization, 2006. Available at: www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/index.html.

[127] Defining sexual health. Report of a technical consultation on sexual health 28–31 January 2002. Geneva, World Health Organization, 2006. Available at: www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/index.html.

[128] Wellings K, Collumbien M, Slaymaker E, Singh S, Hodges Z, Patel D et al. Sexual behaviour in context: a global perspective. Lancet 2006;368(9548):1706-28.

[129] General comment no. 4: adolescent health and development. New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/4). Paragraph 9.

[130] *Programme of action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994*. New York, United Nations Population Fund, 1994. Paragraph 7.2.

[131] Jejeebhoy SJ, Shah I, Thapa S (eds). *Sex without consent: young people in developing countries*. London, Zed Books, 2005.

[132] *Why is giving special attention to adolescents important for achieving Millennium Development Goal 5?* Fact sheet. Geneva, World Health Organization, 2008.

and early sexual initiation) pose strong barriers to providing the information, sexual and reproductive health services, and other forms of support that young people need to be healthy. In some countries, such taboos and norms are codified in laws and policies.

States are required to establish programmes for sexual and reproductive health, including information and guidance on healthy lifestyle choices regarding relationships and sexual behaviour.[133] Programmes for adolescent health, in particular, should strive to eliminate gender-based discrimination which can, in addition to being a violation of rights and having a negative impact on health generally, increase boys' and girls' risk for HIV.[134] To ensure access to needed services and information for all young people, programmes should be directed at youth both in and out of school. Adolescents also have the right to services that are sensitive to their particular needs, including having more flexible hours and specially trained staff. At the ICPD, states agreed to provide appropriate youth-friendly services to adolescents and to remove barriers to adolescents seeking reproductive health information and care.[135] Extensive reviews of programmes and interventions in developing countries provide strong evidence that sex education (including HIV education) interventions do not increase adolescents' sexual activity and that a substantial percentage of interventions significantly decrease one or more types of sexual activity,[136] thus contributing to their health.

The extent to which minors have the legal ability to consent to a range of health-care services – including sexual and reproductive health care – is likely to have an impact on their sexual health. In some countries there is recognition that, while parental involvement in minors' health care decisions is desirable, this cannot be required by the law as many minors will not avail themselves of important services if they are forced to involve their parents.[137] Rather, laws should require providers and others to take into consideration the best interests and evolving capacity of adolescents who request services on their own. Addressing sexual health requires a legal, policy and regulatory environment where the human rights of all people are upheld.[138]

Consensual sexual activity, sexual orientation, gender identity and expression

Sexual activity is strongly regulated in virtually every society. In many countries laws prohibit a variety of sexual behaviour between consenting adults in private. This includes sex outside of marriage, same-sex sexual behaviour, sexual activity in exchange for money, specific sexual acts deemed "unnatural" such as anal intercourse, and sex within prisons. Criminalization of consensual, private sexual behaviour among

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[133] *General comment no. 4: adolescent health and development.* New York, United Nations, Committee on the Rights of the Child, 2003. (CRC/GC/2003/4). Paragraph 16.

[134] *Young people: health risks and solutions. Fact sheet No 345*. Geneva, World Health Organization. 2010. At: www.who.int/mediacentre/factsheets/fs345/en/.

[135] *Programme of action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994.* New York, United Nations Population Fund, 1994. Paragraph 7.45.

[136] Kirby D, Obasi A, Laris BA. The effectiveness of sex education and HIV education interventions in schools in developing countries. In: Ross D, Dick B, Ferguson J (eds). *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries*. Geneva, World Health Organization, 2006.

[137] *An overview of minors' consent laws.* State policies in brief. New York, Guttmacher Institute, 2009.

[138] *New tools for strengthening national legal and policy frameworks to improve child and adolescent health.* Geneva, World Health Organization, 2008. At: www.who.int/child_adolescent_health/news/archive/2008/24_11/en/.

adults has many consequences for sexual health. Persons whose sexual behaviour is deemed a criminal offence strive to hide their behaviour and relationships from agents of the state and others, not availing themselves of sexual health services. Research has documented that those engaged in sexual behaviour deemed criminal evade or do not take full advantage of HIV and STI services for prevention and treatment of disease, fearing compromised medical privacy or doubting health providers' respect for confidentiality.[139] These consequences are often exacerbated by other characteristics of the person such as disfavoured sex, gender, race, ethnicity or national status, which renders them more vulnerable to abuse by authorities under the criminal law. Many legal systems fail to create remedies that reach both the underlying basis for abuse (race, national status, sex or gender) and the immediate barriers (sexual stigma through criminalization). However, criminalization of consensual sexual behaviour between consenting adults in private has been successfully challenged at international, regional and national courts during the past decades.[140]

Being able to determine, and live according to, one's deeply felt, individual experience of gender is being recognized as matter of human dignity, self-determination, privacy, non-discrimination. Because transgender, gender variant and intersex people do not necessarily conform to socially-accepted forms of identities and expressions of maleness and females, in nearly all societies they are often stigmatized and discriminated against and experience high levels of violence from police, gangs, family members, health care providers and others. Stigmatization, discrimination and legal, economic, social marginalization and exclusion occur in accessing necessities such as appropriate and quality health care, social welfare, housing as well as in education and in employment. Their gender expression in many countries is being criminalized and they are subjected to compulsory medical interventions without informed decision making and choice. Such stigma, discrimination, violence, marginalization and exclusion have a grave impact on their overall health and well-being in general and sexual health in particular, in various ways. In addition, not being able to live according to one's self-defined gender is likely to be a source of distress exacerbating other forms of ill-health.[141,142]

UN human rights treaty monitoring bodies recognize that sexual orientation and gender identity are prohibited grounds for discrimination,[143] and that States have an obligation to provide effective protection against violence and discrimination based on sexual orientation[144] and gender identity. They also have an obligation to ensure

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[139] Gruskin S, Ferguson L. Government regulation of sex and sexuality: in their own words. *Reprod Health Matters* 2009;17(24):108–18.

[140] See, for examples, Communication No. 488/1992: Australia. (Toonen v. Australia). New York, United Nations, Human Rights Committee, 1994 (CCPR/C/50/D/488/1992). Paragraphs 8.1–8.7; Dudgeon v. the United Kingdom. Application no. 7525/76. Strasbourg, European Court of Human Rights, 1981; and National Coalition for Gay and Lesbian Equality and Another v, The Minister of Justice and Others. Pretoria, Constitutional Court of South Africa, 1998 (CCT11/98).

[141] Hill DB. Genderism, transphobia, and gender bashing: A framework for interpreting anti-transgender violence. In: Wallace B, and Carter R, eds. A multicultural approach for understanding and dealing with violence: A handbook for psychologists and educators. Thousand Oaks, California: Sage Publishing, 2001.

[142] *Discussion Paper: Transgender health and human rights.* New York, United Nations Development Programme, 2013.

[143] *General comment no. 14: the right to the highest attainable standard of health*. New York, United Nations, Committee on Economic, Social and Cultural Rights, 2000. Paragraph 18.

[144] *Concluding observations of the Human Rights Committee: El Salvador.* New York, United Nations, Human Rights Committee, 2003 (CCPR/CO/78/SLV). Paragraph 16.

that national laws provide protection for such groups and foster their access to health information and services.[145,146,147]

A major concern for people with intersex condition is that sex "normalizing" surgery is often undertaken during infancy and childhood, to alter the infant's or child's body, particularly sexual organs, to conform to gendered physical norms, including through (repeated) surgeries, hormonal interventions, and other measures. As a result, such children may be subjected to irreversible interventions that may have lifelong consequence for their physical and mental health, including irreversible termination of all or some of their reproductive and sexual capacity. Human rights bodies and health professional organization increasingly recommend the delay of surgery except for life-threatening conditions. They also recommend involving children in any decision about any intervention affecting their physical and mental wellbeing, bodily integrity and gender expression and identity. Provision of comprehensive information, counselling and support are the main interventions that are recommended instead.[148, 149,150]

Sex work

Sex work, or prostitution, is extremely widespread throughout the world. In many countries the selling of sex is criminalised and in a few the purchase of sex is criminalised. Criminalisation puts sex work underground and prevents workers from seeking health services or other help they might need as they fear denunciation to the police.[151] Sex workers the world over routinely face violence from their clients as well as the police, and are rarely able to use the legal system to their benefit.[152]

State health controls, through measures purportedly serving a public health purpose, are a frequent source of violations of sex workers' rights and undermine public health efforts: mandatory testing for STIs and HIV; routine infringements of confidentiality regarding HIV test results and other medical information; and mandatory health identity cards, which must be displayed to authorities on demand. In some places, even possession of condoms – promoted as part of HIV-related information and services – may be used by police as "proof" that a person is a sex worker, thus hampering their ability to protect themselves against STIs and HIV.[153]

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[145] *General comment No. 20: Non-discrimination in economic, social and cultural rights* (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights). Geneva, United Nations Committee on Economic, Social and Cultural Rights, 2009. (E/C.12/GC/20)

[146] *Discussion Paper: Transgender health and human rights*. New York, United Nations Development Programme, 2013.

[147] Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity. New York, United Nations General Assembly, 2011. (UN Doc A/HRC/19/41)

[148] Lee PA, Houk CP, Ahmed SF, Hughes IA; International Consensus Conference on Intersex organized by the Lawson Wilkins Pediatric Endocrine Society and the European Society for Paediatric Endocrinology.. Consensus statement on management of intersex disorders. International Consensus Conference on Intersex. *Pediatrics,* 2006; 118: e488–500.

[149] Intersex Society of North America. Website: http://www.isna.org/faq/what_is_intersex.

[150] United Nations General Assembly. *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez.* New York, United Nations, 2013 (UN Doc A/HRC/22/53).

[151] *Gruskin S, Ferguson L. Government regulation of sex and sexuality: in their own words.* Reprod Health Matters 2009;17(24):108–18.

[152] *Ibid.*

[153] *Documenting human rights violations of sex workers in Kenya*. Nairobi, Federation of Women Lawyers Kenya, 2008.

The health status of many people in sex work is often relatively low, in part related to insecurity of income, food and housing for the most vulnerable persons in sex work, and because of the difficulty of accessing appropriate and respectful health services for prevention or treatment. The barriers to care and accurate information are proportionate to socially discriminatory attitudes and legal barriers.[154]

Human rights bodies increasingly recognise the violations of sex workers' human rights and find that discrimination, violence and harassment that such workers suffer clearly constitute human rights violations and point to needed action on the part of states to provide protections.[155] Individuals who do sex work need information and access to appropriate services in order to protect themselves, their health and that of their clients. States thus have an obligation to ensure that national laws and policies are supportive rather than punitive, and that appropriate, accessible health services are in place.[156]

Violence as it is relevant to sexual health and sexuality

Violence against women takes many forms including physical, sexual and emotional abuse. It occurs throughout the world and is more often than not perpetrated by an intimate partner or husband.[157] It is closely associated with a wide range of effects on women's health including: inability to protect oneself against unwanted sex, increased unwanted pregnancies and abortions, increased incidence of gynaecological disorders and mental health problems, and lower self-esteem than women who have not experienced violence.[158] Specific forms of sexual violence include rape, coerced sex, child sexual abuse, female genital mutilation (FGM), so-called honour crimes, and sexual exploitation, including trafficking into forced prostitution. Sexual violence can be – and is – directed at women, men, girls and boys, and at any group in a position of vulnerability, though available evidence suggests higher incidence of sexual violence directed against women and girls.[159]

Coerced sex is a common occurrence, particularly for girls: evidence from DHS and other surveys show that up to 23% of married women aged 15–24 in selected developing countries have experienced non-consensual sex.[160,161] Global prevalence figures indicate that 35% of women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime.[162] Coerced sex can lead to many health problems including unwanted pregnancy, sexually transmitted

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154 *UNAIDS Guidance note on HIV and sex work*. Geneva, Joint United nations Programme on HIV/AIDS (UNAIDS), 2009.

155 *Violence against sex workers and HIV prevention: information sheet.* Geneva, World Health Organization. 2005.

156 *UNAIDS Guidance note on HIV and sex work*. Geneva, Joint United nations Programme on HIV/AIDS (UNAIDS), 2009.

157 *WHO Global and Regional Estimates on Violence Against Women,*. Geneva, World Health Organization, 2013.

158 *WHO Global and Regional Estimates on Violence Against Women,*. Geneva, World Health Organization, 2013.

159 *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Geneva, World Health Organization, 2010.

160 Jejeebhoy S, Santhya KG. *Forced sex within marriage among young women: Evidence from South Asia*. New Delhi, Population Council, 2003.

161 Moore AM, Awusabo-Asare K, Madise N, John-Langba J, Kumi-Kyereme A. Coerced first sex among adolescent girls in Sub-Saharan Africa: prevalence and context. *Afr J Reprod Health*, 2007, 11[3]:62–82.

162 Violence against women. Fact sheet N° 239. Geneva: World Health Organization, 2013. At: http://www.who.int/mediacentre/factsheets/fs239/en/index.html. (Accessed 21 January 2014)

infections and sexual dysfunction as well as emotional sequelae such as depression, feelings of worthlessness and mental health problems.[163]

States must take steps to protect women and children from sexual coercion and violence, including engaging in public education about these issues, and ensuring that health services are accessible and able to provide appropriate care and referral for adolescents and women suffering violence.[164] Trafficking and sexual exploitation of women and children are forms of violence that require specific attention both because of the health consequences and the violation of rights (e.g. to health and to be free from inhuman and degrading treatment) that they cause.[165]

Harmful practices can include a variety of customs that violate human rights including: female genital mutilation, early or forced marriage and son preference. Women and girls who undergo FGM can suffer serious health consequences. The immediate complications include severe pain, haemorrhage and sepsis among others. There are multiple long-term effects including severe scarring, which make urinating and menstruation difficult, cause pain during sexual intercourse and complications during pregnancy and childbirth. A number of human rights treaty monitoring bodies have highlighted the violation of rights, such as that to be free from cruel, inhuman and degrading treatment, or the right to bodily integrity, that FGM represents.[166] While many countries have enacted laws banning FGM, the practice still continues in some parts of the world.

Cultural traditions favouring sons may lead to discriminatory practices such as sex selective abortion, female infanticide and/or preferential feeding which violate girls' right to life and health.[167] Likewise, so called "honour crimes", which disproportionately affect women and girls, threaten their right to life. International human rights treaty monitoring bodies, including the Human Rights Committee, the Convention on the Rights of the Child, the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women[168] have all ruled that states must take steps to eliminate harmful practices that violate human rights.

3.5.1 Health considerations

Provide data in answer to the following questions or indicators using the most authoritative sources available. If there are no data relating to a particular indicator,

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[163] Jejeebhoy S, Bott S. *Non-consensual sexual experiences of young people: a review of the evidence from developing countries.* New Delhi, Population Council, 2003.

[164] *Report of the Fourth World Conference on Women, Beijing, 4–15 September 1995*. New York, United Nations, 1996. Paragraph 283.

[165] *General comment no. 4: adolescent health and development*. United Nations, Committee on the Rights of the Child, 2003. (CRC/GC/2003/4). Paragraph 10; *Programme of action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994.* New York, United Nations Population Fund, 1994. Paragraph 7.39

[166] World Health Organization. Eliminating female genital mutilation. An interagency statement. Geneva, WHO, 2008.

[167] ICPD+5, Key Actions for the Further Implementation of the Programme of Action, 1999, Paragraph 48.

[168] *General comment no 28: equality of rights between men and women.* New York, United Nations, Human Rights Committee, 2000 (CCPR/C/21/Rec.1/Add.10) Paragraph 11; *General comment no 14: the right to the highest attainable standard of health*. New York, United Nations, Committee on Economic, Social and Cultural Rights, 2000 (E/C.12/2000/4). Paragraph 35; *Convention on the Rights of the Child.* New York, United Nations, 1989. Article 24(3). General *recommendation no. 24: women and health*. New York, United Nations, Committee on the Elimination of Discrimination against Women, 1999 (CEDAW/GC/1999/24). Paragraph 18.

these gaps should be noted. Include disaggregated data to the extent possible and any information on vulnerable groups.

After answering the questions under this heading, prepare a summary describing the state of sexual health nationally, based on the data provided in the answers. In the summary you may draw on additional, qualitative data about the health situation, such as that contained in sociological studies and governmental, NGO and United Nations reports. Describe trends over the past ten years where possible. The summary should be approximately three–five pages and include references.

Adolescent sexual activity,

3.5.1.1 Percentage of adolescents who have ever had sexual intercourse.
3.5.1.2 Percentage of individuals aged 15-24 years who have had sex before 15 years of age.
3.5.1.3 Percentage of sexually active adolescents who used contraception at first or last sex.
3.5.1.4 Percentage of sexually active, unmarried adolescents who consistently use condoms.

Sexual health information, education and services

3.5.1.5 Percentage of adolescents who have received comprehensive sexual and reproductive health education in schools.
3.5.1.6 Percentage of health care providers trained to work with or provide services to adolescents.
3.5.1.7 Percentage of health providers trained in sexual health counselling.

Consensual sexual relations, sexual orientation and gender identity

3.5.1.8 Percentage of people who have had same-sex sexual experiences.
3.5.1.9 Percentage of people who live, or name themselves, differently from their assigned sex at birth.
3.5.1.10 Proportion of children born with reported intersex conditions in the last year.

Sex work

3.5.1.11 Percentage of male and female sex workers reporting the use of a condom during penetrative sex with their most recent client
3.5.1.12 Percentage of men aged 15-49 reporting sex with a sex worker in the last 12 months who used a condom during last paid sexual intercourse.

Violence as relevant to sexual and reproductive health and sexuality

3.5.1.13 Percentage of women and men who have experienced sexual abuse as a child
3.5.1.14 Percentage of sexually active adolescents who have experienced non-consensual or forced first sex.
3.5.1.15 Proportion of women aged 15-49 who ever experienced physical or sexual violence from an intimate partner.
3.5.1.16 Number of incidents of sexual violence reported to law enforcement or health professionals in the past five years.
3.5.1.17 Percentage of health facilities that have a protocol in place for the clinical management of rape survivors.
3.5.1.18 Existence of harmful practices.

Summary description of the state of sexual health.

3.5.2 National laws, regulations and policies

Complete the following questions, citing key provisions and restrictions. Refer to the name and date of any laws, regulations and policies, and provide information, if available, on whether they are actually implemented. Also summarize all relevant supreme court or constitutional court jurisprudence. After responding to all the questions, write a two–three page summary of legal, jurisprudential and policy provisions relating to sexual health.

Adolescent sexual activity

3.5.2.1 Are there national laws, regulations or policies that regulate the age of sexual consent?

Sexual health education, information and services

3.5.2.2 Are there national laws, regulations or policies that regulate the provision of sexuality education in primary, secondary and higher education institutions, and for adolescents not enrolled in school?

3.5.2.3 Are there national laws, regulations or policies that regulate information and expression related to sexuality and sexual health?

3.5.2.4 Are there national laws, regulations or policies that regulate training of health providers in sexual health and sexuality counselling?

Consensual sexual relations, sexual orientation and gender identity

3.5.2.5 Are there national laws, regulations or policies that regulate consensual sex outside of marriage?

3.5.2.6 Are there national laws, regulations or policies that regulate consensual sexual relations in institutions (e.g. in prisons or detention facilities, hospitals or psychiatric institutions)?

3.5.2.7 Are there national laws, regulations or policies that prohibit discrimination on the grounds of sexual orientation and gender identity?

3.5.2.8 Are there national laws, regulations or policies criminalizing consensual same-sex activity?

3.5.2.9 Are there national laws, regulations or policies regulating civil status, identity and access to health services for transgender and intersex people?

Sex work

3.5.2.10 Are there national laws, regulations or policies regulating sex work?

3.5.2.11 Are there national laws, regulations or policies regulating access to sexual and reproductive health information and services for sex workers?

Violence as relevant to sexual health and sexuality

3.5.2.12 Are there national laws, regulations or policies criminalizing sexual activity with a child below the age of sexual consent?

3.5.2.13 Are there national laws, regulations or policies concerning sexual violence?

3.5.2.14 Are there national laws, regulations or policies concerning hate crimes relating to sexuality, sexual orientation and gender identity?

3.5.2.15 Are there national laws, regulations or policies concerning sexual exploitation?

3.5.2.16 Are there national laws, regulations or policies concerning harmful practices?

Summary description of the state of the law concerning sexual health.

3.5.3 Human rights considerations

Complete the following questions, citing key provisions. After responding to all the questions, write a two–three page summary.

3.5.3.1 Have any of the human rights treaty monitoring bodies provided concluding comments or observations to the State in regard to the issues in this section?

3.5.3.2 Has any international human rights court, tribunal or treaty monitoring body issued decisions or communications based on complaints by individuals and/or groups in regard to the issues in this section? If so, summarise key decisions.

3.5.3.3 Have any Special Procedures (e.g. Special Rapporteurs) been used to examine the human rights situation in the State? If so, are any topics related to the issues in this section addressed in the report?

3.5.3.4 Has the State been considered under the Universal Periodic Review process? If so, are any topics related to the issues in this section addressed in the report?

3.5.3.5 Has any regional human rights court or commission issued decisions or communications based on complaints by individuals and/or groups in regard to the issues in this section?

3.5.3.6 Have any of the relevant regional treaty monitoring bodies provided a response to the State report on any topics related to the issues in this section?

3.5.3.7 Have any other regional human rights procedures, such as regional Special Rapporteurs in the Americas and Africa, been used to examine the human rights situation and issued reports on the State? If so, are any of the issues in this section addressed in the report?

Summary description of human rights considerations concerning sexual health.

C. Analysis methodology

1. Introduction

The review and analysis is carried out by examining the legal/policy and health data alongside the country's human rights commitments. Once researchers have compiled all data, a workshop should be held for the national project team, where team members review the completed data compilation instrument and are introduced to the Analysis Methodology. Agreement should be reached on the issues to be highlighted and developed. Following the workshop, the researchers conduct the analysis. Starting from a definition of the health problem as revealed by the data compiled, the analysis consists of examining the relevant laws, regulations and policies to establish any aspects that do not appear to be addressing the health problem and/or that are not consonant with international, regional or national human rights law. Then, a second workshop should be conducted for the team to go over the completed analysis and make modifications where necessary. Based on this analysis, a draft report is presented to the multi-stakeholder group (see *Users' guide*).

The aim of the analysis is to provide a basis for national stakeholders to make recommendations that improve the legal, regulatory and policy framework to support sexual and reproductive health.

The analysis will also provide a basis for the draft report presented to the stakeholders, and for the final report.

2. Process

Review, analysis and reporting of the data are conducted in four phases:

i. The researchers prepare a summary of the data for presentation to the national project team at the initial analysis workshop. The summaries, which should be based on those at the end of each subsection in the data compilation instrument, may be in the form of a PowerPoint presentation and should include:

- information about human rights commitments made by the country (Part 1 of the data compilation instrument);
- how cross-cutting principles relating to sexual and reproductive health are recognized in national laws (Part 2 of the data compilation instrument);
- the health and legal situation for each sexual and reproductive health topic area, including the situation of vulnerable groups (Part 3 of the data compilation instrument).

These summaries will be further developed during (iii) below, as described in the Methodology.

ii. The ministry of health organizes an initial analysis workshop for the national project team, where the researchers present their review of the completed data compilation instrument in the form of the above-mentioned summaries. The Analysis Methodology is then presented to the team by the researchers (or others familiar with the methodology) and discussed with reference to these initial findings. The discussion should lead to agreement on the issues to be highlighted and developed by the researchers in the analysis.

iii. The researchers conduct the analysis following the steps outlined in the methodology below, and prepare a draft report.

iv. The draft report is presented to the national project team for discussion at the second analysis workshop. On the basis of comments and agreements during this workshop, draft recommendations are made and the researchers then revise the report for presentation to the stakeholder workshop. (For details of conducting the workshop and steps beyond the analysis, see the *Users' guide*.)

3. Methodology

The researchers should take the following steps.

Step 1. Summarize the country's human rights commitments and basic information about the legal context

Expanding on the brief summaries made for the initial analysis workshop, develop summaries of the information contained in Part 1 of the data compilation instrument, including the human rights commitments the state has made, how the national constitution and other laws recognize human rights related to sexual and reproductive health, and what mechanisms are in place for the protection and enforcement of these rights in the country. The summary should also provide a brief overview of population and demographic laws and the overall status of women (or, for the Adolescent Sexual and Reproductive Health Module, the overall status of adolescents) in the country.

This information is essential for the subsequent analysis as it outlines what human rights commitments the country has made related to sexual and reproductive health and relevant basic information about the country. This information will help the national project team (and later the stakeholders) to understand the broad range of accountability mechanisms that the state has put in place to ensure that it promotes and protects human rights related to sexual and reproductive health.

Example. Of the seven international human rights treaties, country X has ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights (ICCPR), the International Convention on Torture, and the international Convention on the Elimination of all forms of Racial Discrimination. All of these treaties call on governments to eliminate discrimination of any kind and some of them specifically condemn discrimination against women in all its forms. This includes adopting appropriate legislative and other measures, and modifying or abolishing existing laws, regulations, customs and practices which constitute discrimination. … The Government of country X has submitted a number of reports, most notably to the Committee on the Rights of the Child and the CEDAW Committee, and has received recommendations from the Committees. These recommendations are incorporated into the analysis in this report. For instance, the CEDAW Committee expressed its concern at "the existence of laws that are not in accordance with the provisions of the Convention. It notes that discrimination against women exists in laws regarding family and marriage, including polygamy, age of marriage, divorce, economic rights including health and other benefits in the labour sector, health including the requirement that the wife obtain her husband's consent with regard to sterilization or abortion, even when her life is in danger."

The Government of country X has also made a commitment to major international consensus documents and development goals (including the ICPD Programme of Action,[169] the Beijing Platform for Action,[170] the Millennium Development Declaration,[171] the United Nations General Assembly Special Session on HIV/AIDS[172] and the Special Session on Children[173]) all of which recognize that reproductive health cannot be improved without the respect and protection of reproductive rights.

The Constitution of country X and several national laws such as the Law on Human Rights, the Law on Child Protection and the Law on Domestic Violence have adopted the principles of international human rights treaties and commitments, setting a clear national framework for their protection.

The summary can later be used as an introduction to the draft report to be presented to the stakeholders, as well as an introduction for the final report.

Step 2. Analyse the national recognition of cross-cutting principles relating to sexual and reproductive health

Prior to starting, read the "Human rights and public health rationale" boxes under each principle of Part 2 of the data compilation instrument, to understand the orientation of this section. Based on the summaries given in Part 2, provide a brief description of whether, and if so how, national laws, regulation and policies incorporate internationally recognized human rights principles related to sexual and reproductive health. Also note whether any of them are not recognized, as this may be an important barrier to be addressed.

International human rights treaties contain a number of key, universal principles that must be recognized and applied across areas of concern including health and development. The analysis undertaken here will contribute to the national project team's (and later the stakeholders) understanding of how the state has incorporated these cross-cutting principles into relevant national legislation. For example, if the evolving capacity of children is not recognized in national legislation or jurisprudence, this presents a potential barrier to minor adolescents gaining access to health services. Or, the laws and policies may perfectly reflect the human right principles, but be inadequately implemented.

Example. The field-test of the Module in country Z revealed an impressive range of laws and policies that guarantee the crucial norm of respecting the best interests of the child. For instance, the Constitution refers to the State's obligation to "promote with special care the interests of the children and youth to ensure their full development and protection from exploitation and discrimination." Country Z adopted the Children's Charter, a policy document that includes a provision on the best interests of the child.

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169 *Programme of action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994*. New York, United Nations Population Fund, 1994.

170 *Beijing declaration and platform for action*. Resolution adopted at the Fourth World Conference on Women, 15 September 1995, New York, United Nations, 1995 (A/CONF.177/20).

171 *United Nations Millennium Declaration.* Resolution adopted by the General Assembly, 8 September 2000. New York, United Nations, 2000 (A/RES/55/2).

172 *Declaration of commitment on HIV/AIDS*. Resolution adopted by the General Assembly, 2 August 2001. New York, United Nations, 2001 (A/RES/S-26/2).

173 *A World fit for children*. Resolution adopted by the United Nations General Assembly. New York, United Nations, 2002 (A/RES/S-27/2).

Fifteen years later, the ICCPR Act incorporated the language from the Convention on the Rights of the Child (article 3): "the best interests of the child must be paramount in all matters concerning children". The country also has a range of laws and policies that conform to international standards concerning a child's evolving capacity, and recognizing the importance of hearing the voice of children and adolescents.

However, there is no procedure to ensure that the right is exercised or the standards implemented in practice. The absence of a checklist and guidelines, for instance, is a major gap in implementing the standard of respecting best interests and evolving capacity; neither is there a clear procedure for ensuring that the child's views are heard. The Natural Disaster Act is the first legislation to address this problem by providing for a checklist on foster care placement. Even this legislation has no procedure for ensuring that the child or young person is consulted and consent is obtained. This situation also has an impact on children's and adolescents' ability to access health services, including those for sexual and reproductive health.

In order to complete this part of the analysis, it will be important to use the chapter on cross-cutting principles in the Human rights standards documents (international and regional). These standards documents provide citations of international and regional human rights provisions under each principle that can be taken as a benchmark for analysing the national recognition of international human rights standards.

This analysis can later be used as part of the introduction of the draft report to be presented to the stakeholders, as well as for the final report. It can also be a stand-alone chapter in the report.

Step 3. Analyse the health situation including identification of vulnerable groups

The analysis draws on the information gathered in Part 3 of the data compilation instrument: health considerations. Each of the five health topics should be dealt with in turn.

Expanding on the summary at the end of each subsection on public health considerations in Part 3 of the data compilation instrument, provide information on both positive and negative aspects, as follows:

(a) Based on trend data for the past few years, indicate improvements in, for instance, mortality ratios, contraceptive prevalence, decreases in sexually transmitted infections, etc.

For example, in country B it was reported that "Contraceptive prevalence in country B has greatly increased over the past 30 years, and contraceptive methods are being used for both postponing and spacing births by around 60% of married women. Knowledge of at least one contraceptive method is almost universal among men and married women."

(b) Indicate the continuing problems in the health topic, such as inadequate decrease in mortality ratios, increases in STI or HIV prevalence etc.

In country B, it was found that the unmet need for contraception was 8.6%, that among women giving birth nearly 17% either would have preferred the pregnancy at a later time or not at all, and there was a serious lack of data concerning the access of unmarried people, particularly adolescents, to information and services for contraception.

This section on continuing problems should focus most on vulnerable groups, i.e. those who appear to be particularly affected by the health condition or access to services. This may be related to age, sex, geographical residence, educational status, race, colour, etc. For instance, if there are large differences between rural and urban adolescents in accessing services, or there are higher rates of certain conditions for a particular age group this should be noted here. Any obvious gaps in data, which do not allow researchers to fully describe the situation, should also be noted here, as this may constitute an important barrier to be addressed.

This information will help the national project team (and later the stakeholders) to focus on specific aspects of sexual and reproductive health, and will be used to examine how laws and policies are addressing the identified health topic.

This analysis can later be used as part of the findings in the draft report to be presented to the stakeholders, and in the final report.

Step 4. Conduct a human rights analysis of the laws, regulations and policies related to the different aspects of sexual and reproductive health, and elaborate proposed recommendations for action

Step 4.1 Analyse the health information together with the legal, regulatory and policy information, identify positive aspects as well as barriers or discrepancies

The human rights analysis consists of taking the health information described in Step 3 and examining whether the laws, regulations and policies appear to be adequate in two fundamental ways, which are closely linked:

1. Are the existing laws, regulations and policies appropriately targeted to the health problem at hand? If so, how do they address the problem? If not, what is lacking, or what is the barrier or shortcoming? This question must be addressed by examining the summaries given at the end of each grouping of law and policy questions in Part 3 of the data compilation instrument.
2. Do these laws, regulation and policies comply with international, regional and national human rights standards? Do they take into consideration the crosscutting human rights principles? If so, how? If not, in what way – what is the barrier, discrepancy or shortcoming? These questions must be addressed by examining the summaries developed in Steps 1 and 2 above.

The answer to either question may be yes, in which case this reflects the government's effort to both address the problem through its legal and policy framework, and to fulfil its human rights commitments.

The answer to either question may be no, in which case it will be important to pinpoint the precise problem both in health terms and in human rights terms.

Most often, the answer to these questions is both yes and no. Laws, regulations and policies of many countries are geared, at least in part, to addressing a particular social and development issue affecting the population. Yet often there are restrictions, or sometimes even a lack of a law or policy, which can have a negative effect. In the analysis, therefore, it is important to separate what is positive and what is negative. (See examples below.)

As will be clear from the examples, in order to conduct the human rights analysis, the researchers must make themselves familiar with the international, regional and national human rights standards related to the different aspects of sexual and reproductive health. This is best done before starting the analysis by looking at the following parts of the Module:

- "Human rights and public health rationale" text in the data compilation instrument, under each of the cross-cutting principles and each core sexual and reproductive health topic.
- The information collected in the data compilation instrument in answer to the questions under the sub-headings "Human rights considerations" in each health topic. Answers to the "Human rights considerations" questions reveal how international, regional and national human rights bodies have applied human rights to the specific topic, thus making explicit what the human rights standards related to the specific sexual and reproductive health issue actually are in relation to the state in question.
- The Human rights standards documents (international, and regional where applicable).
- The process of examining the laws and policies in relation to the public health problem identified, and applying the human rights standards should be continued for each of the health issues emerging.

Step 4.2 Identify common legal, regulatory and policy discrepancies or barriers across the different health topics

Look at the summaries conducted on the five different health topic areas. If common or recurring themes emerge, you may wish to pull out those issues and combine them.

Grouping may be by topic or by human rights principle. For instance, adolescents' access to services may be a recurring problem under each topic area, whether for family planning, STIs, abortion, etc. On the other hand, the protection of privacy and confidentiality may be a problem in the delivery of all sexual and reproductive health services regardless of topic. These topics could then be the focus of a separate subject area for the draft report. As a result, the topics for the report may be different from the five topic areas of Part 3 of the data compilation instrument. Some of the field tests of the Module revealed the following common issues:

- limited access of adolescents to sexual and reproductive health services;
- lack of privacy and confidentiality for all in sexual and reproductive health services;
- lack of respect for the best interests and the evolving capacity of the child in providing sexual and reproductive health services;
- lack of adequate financing mechanisms for assuring different sexual and reproductive health services.

Example 4 below demonstrates how this kind of common issue can be dealt with.

Step 4.3 Elaborate proposed recommendations for action

Propose recommendations for action for each barrier identified and/or for strengthening a state's effort/activity that is already under way in order to improve the

legal, regulatory and policy framework and its implementation. Identify actors who should take responsibility for such actions (e.g. ministry of health, ministry of justice, professional associations, parliament).

It is likely that there will be many recommendations. The stakeholders meeting, at which the findings of the analysis are presented, is more likely to be successful if participants do not feel overwhelmed by too many recommendations. It is therefore strategic to choose two or three priority issues for which short-term strategies and actions can be effective, and two or three issues for which a longer-term strategy will be needed.

The examples below demonstrate how such an analysis works in practice. Notice that the analysis starts with a statement of the public health situation, goes on to describe the positive aspects of the legal, regulatory and policy framework, continues with identification of barriers or shortcomings and the human rights considerations applied to those barriers, and ends with recommendations for addressing the barriers. Provisional recommendations for action should be made for each barrier identified in order to improve the legal, regulatory and policy framework and its implementation. The recommendations will be discussed and finalised at the stakeholders workshop, which will also identify actors who should take responsibility for such actions (ministry of health, ministry of justice, professional associations, parliament).

Example 1: Violence against women (Country Y)

Public health situation. In country Y, there is no systematic collection of data on violence against women at the national level. However, reports from women's crisis centres, police stations, health facilities and some other institutions (courts, psychological services etc.) indicate that violence against women is increasing. Available data indicate that 72% of women reporting violence are married and that the perpetrator is nearly always their husband. This is confirmed by additional data showing that for the majority – 80% – of women reporting to crisis centres, the perpetrators are husbands, former husbands, boyfriends, relatives or parents. This indicates that being married is not necessarily a protection for women. On the contrary, it is married women who are identified as the vulnerable group, along with adolescents, as 4.5% of the women reporting were under 18 years old. A significant number of women victims of violence suffered reproductive health problems.

Legal, regulatory and policy framework. Following the State's ratification of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1984 and active participation in both the International Conference on Population and Development in 1994 and the Fourth World Conference on Women in 1995, a Presidential decree was issued, leading to the establishment of the National Commission of Violence Against Women. This Commission has been acting on various levels, including collecting data on different aspects of violence against women, conducting public awareness campaigns, publishing reports and supporting women's crisis centres. Few years back a National Action Plan on Elimination of Violence against Women was elaborated by the Ministry of Women's Empowerment, resulting from a multi-stakeholder collaboration started in 1999. It is being implemented in seven sectors including law and justice, military, education, religion and culture, health care, employment and the media. Finally, in 2004 a law on the elimination of domestic violence was enacted, making it clear that "the Government is responsible for making every effort to prevent domestic violence". The Law imposes sanctions depending

on the severity and type of domestic violence act. The Government later issued a regulation regarding the implementation and cooperation on the recovery of victims of domestic violence. The Criminal Code also has provisions on violence, including some that specifically criminalize violence against women, depending on the nature and severity of the criminal act.

Legal, regulatory and policy barriers. Country Y has ratified nearly all the international human rights treaties, including CEDAW, which it has adopted integrally into a national law. Violence against women has been clearly recognized as a violation of the rights and fundamental freedoms of women, including the right to non-discrimination, the right to be free from inhuman and degrading treatment, the right to health and, in severe cases, the right to life. The Committee on the Rights of the Child has expressed its concern about the high number of child victims of abuse, including sexual abuse.

While the Government has made significant efforts to provide legal protection for women by adopting a law on domestic violence, which encompasses all forms of violence against women irrespective of marital status, two articles of the Criminal Code still do not recognize sexual violence within marriage. When available data clearly indicate that the majority of women experience violence at the hands of their husband, the fact that sexual violence and rape within marriage are not recognized as crimes, means that the Criminal Code contradicts the human rights commitments and obligations of the State. Women experiencing marital rape are currently unable to seek either appropriate health services or legal redress.

In addition, despite the recognition of rape as a serious crime in both the Criminal Code and the Law on Domestic Violence, the Health Law and regulations do not allow women to deal with the possible consequences of rape, as access to safe abortion services is prohibited when the pregnancy is a result of rape or incest. The lack of legal regulation on provision of safe abortion services for women who are victims of rape or incest can result in serious harm to the physical and mental health of the victim, and thus appears to constitute a violation of international human rights standards as enshrined in international human rights treaties ratified by country Y, as well as in the Constitution and various national laws.

Although some data are available, they are inadequate. The CEDAW Committee has urged the Government to collect, as a matter of priority, data on the extent, causes and consequences of the problem of violence against women in country Y. Without comprehensive national and provincial level data on the prevalence of violence against women, it is very difficult to precisely assess the magnitude of the problem and thus to plan exactly how best to tackle the problem. In order to do so, a population-based survey would allow a more scientifically-based estimate of the prevalence. The reporting system would also need to be expanded and improved. For example, knowing whether the prevalence varies from one province to another would allow the Government to focus training of law enforcement officers and health workers in areas where there is most need.

National stakeholder recommendations:

- The Criminal Code and the Law on Domestic Violence should be harmonized and immediate action should be taken to ensure that the revised Criminal Code takes into account the existing Law on Domestic Violence with regards to marital rape.

- The on-going process of amendment of the Health Law no 23/92 should be accelerated to ensure the provision of safe abortion services in cases of rape and incest.

Those potentially responsible: Ministry of Law and Human rights; Ministry of Health; Ministry of Women's Empowerment; Ministry of Social Affairs, Chief of Police Department; the Judiciary.

- National and provincial data on violence against women should be systematically collected through different means.
- The domestic violence law and its implementation should be socialized to all with special attention to law enforcers.
- Measures should be put in place to ensure that cases of violence against women are properly recorded and monitored in all health facilities.
- All health personnel should receive in-service training on violence against women and be able to record cases of violence against women. Pre-service training curricula should also incorporate the topic.
- Measures should be taken to ensure that the cause of death of every woman suspected to be a victim of violence is appropriately documented.
- Socialization of the existing policy on Zero Tolerance on violence against women should be reinforced at all levels of the bureaucracy.

Those potentially responsible: Ministry of Health; Ministry of Women's Empowerment; Ministry of Social Affairs; Chief of Police Department.

Example 2: Unsafe abortion (Country A)

Public health situation. Unsafe abortion is the second leading cause of pregnancy-related mortality in country A, accounting for 18% of all maternal deaths, and is the leading cause of obstetric complications (24–30%). Country A has a low contraceptive prevalence rate (41%), high unmet need for contraception (28%), high total fertility rate (6.0) and large numbers of mistimed or unwanted pregnancies (40% of births in the five years preceding the 2004 Demographic & Health Survey). Country A women most commonly seek abortion services from private clinics or traditional healers, or attempt to self-induce abortion using unsafe methods.

The age of sexual consent is 13 in country A; the minimum age for marriage is 18, or 15 with parental consent. Country A youth initiate sexual activity and childbearing at a young age: 37% of adolescent girls and 60% of adolescent boys 15–19 years old have had sexual intercourse, and one in three young women under 20 has begun childbearing. Approximately a third of adolescents aged 15–19 years report having a close friend who tried to end a pregnancy, as did a fifth of those aged 12–14. Inadequate knowledge of sexual and reproductive health, reluctance to access health services, early marriage and sexual debut, and low rates of contraceptive use make country A teens particularly vulnerable to sexual and reproductive health problems, including complications of unsafe abortion.

Legal, regulatory and policy framework. Country A current law regulating abortion, a vestige of the antiquated British Offences against the Person Act 1861, imposed under British rule (1891–1964), allows abortion only for preservation of a woman's life. In practice, the endorsement of two independent obstetricians is required before

abortion can be performed, and spousal consent is necessary. According to the law, any attempt to procure an abortion is punishable by 7–14 years of imprisonment.

The Ministry of Health developed an Essential Health Package in 2001 consisting of 11 cost-effective interventions responding to country A burden of disease. Although the package included reproductive health, treatment of abortion complications and family planning, it was resource-driven rather than need-driven, and thus was never expected to achieve the targets set by the Millennium Development Goals (MDGs). A recent evaluation of the Package and sector-wide approach determined that services for treatment of complications of abortion in country A need to double to meet demand.

To accelerate attainment of all MDGs, country A has implemented the Growth and Development Strategy 2006–2011, which is expected to provide a broad base for poverty reduction, with specific policies to address provision of social services such as health and education, including the 2007 Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity (Road Map). The Road Map aims to decrease maternal mortality by increasing availability, accessibility, utilization and quality of skilled obstetric care during pregnancy, childbirth and the postnatal period, as well as avoidance of unintended pregnancy and unsafe abortion with family planning. Importantly, the Road Map acknowledges unsafe abortion as a major cause of maternal mortality. The National Sexual and Reproductive Health and Rights Policy 2009 (SRHRP) provides a rights-based framework for the provision of comprehensive sexual and reproductive health services in accordance with the ICPD Programme of Action. Its goal is to promote, through informed choice, safer reproductive health practices by men, women and young people, including use of good quality, accessible reproductive health services. It calls for the provision of abortion services to the full extent of the law, prevention of unsafe abortion and management of any complications with high quality postabortion care services, including counselling, family planning and use of manual vacuum aspiration as appropriate. Safe abortion services are not discussed in any national policy.

Legal, regulatory and policy barriers. Country A ratified and signed a number of regional and international human rights treaties and consensus documents, which have a bearing on abortion. The most important of these include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),[174] the Protocol to the African charter on human and peoples' rights on the rights of women in Africa (Maputo Protocol),[175] and the Maputo Plan of action on sexual and reproductive health and rights.[176] Like country A SRHRP, these agreements call for minimization of unsafe abortion and the prompt treatment of complications from unsafe abortion. The Maputo Plan of Action and the Maputo Protocol, Article 14(2)(c), specifically call for the enactment of policies and legal frameworks to reduce incidence of unsafe abortion and the provision of safe abortion on broad-based legal grounds, including "in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother".Country A`s current abortion law is at odds with

[174] *Convention on the Elimination of All Forms of Discrimination against Women*. New York, United Nations General Assembly, 1979.

[175] *Protocol to the African charter on human and peoples' rights on the rights of women in Africa*. Maputo, African Commission on Human and Peoples' Rights. Second Ordinary Session of the Assembly of the Union, 2003. Article 14, Health and reproductive rights.

[176] *Plan of action on sexual and reproductive health and rights.* Special Session of the African Union Conference of Ministers of Health. Maputo, 18–22 September 2006.

these human rights standards. In their most recent review of implementation of CEDAW by country A, the CEDAW Committee reiterated its concern regarding country A high maternal mortality, particularly from unsafe abortions. The Committee called for more attention to complications from unsafe abortion, and recommended that country A review its abortion laws.

National stakeholder recommendations:

- Review and harmonize country A restrictive abortion law with its international commitments, including of the Maputo Protocol, by, among others, including additional legal grounds to facilitate adolescents' access to safe abortion.
- Initiate evidence-driven, national discussion on unsafe abortion, its contribution to maternal mortality and implications for reforming the current abortion law.
- Strengthen the national family planning programme and eliminate administrative barriers and ensure continuous procurement and distribution of contraceptives in all public health facilities.
- Address the sexual and reproductive health needs of young people of country A , including revising the Life skills curriculum to address issues of unintended pregnancy, STIs, and abortion and adequately trained health-care providers in the provision of adolescent and youth friendly services.
- Strengthen and expand postabortion care services including the replacement of sharp curettage with manual vacuum aspiration (MVA) equipment for treatment of incomplete abortion.

Example 3: Sexuality education (Country K)

Public health situation. The general trend towards a lower age of initiation of sexual relations combined with an increase in the age at marriage in country K means that a greater number of young people are in need of contraceptive information and services, as well as of access to information and counselling regarding sexuality and sexual health. An evaluation study of young people's knowledge, attitudes and practices in 2005 revealed that the average age of first sexual intercourse is 16 years, with those in urban areas initiating sexual relations much earlier than those in rural areas. Sex education is not systematically taught in schools, and there are no data available on the proportion of adolescents who have received some form of sexuality education. There is also a lack of youth-friendly health services with trained staff.

Legal, regulatory and policy framework. To address the issue of access to information and education on sexuality and sexual health, in 2004 the Government initiated the development of a curriculum and training materials for "Life skills education", which included information about different types of violence. About 3000 teachers were trained. Initially, this subject was a compulsory part of the school curriculum, but after only two months it was transformed into an optional subject due to opposition from some quarters, including some parents and the church.

Regarding the promotion of sexual health in reproductive health services, two different laws guarantee the right of each person to information, education and services necessary for a normal sexual life and reproductive health, and these must be provided by public and private health-care institutions licensed for this type of activity.

In 2005, country K adopted a Strategy for Reproductive Health (2005–2015) for the improvement of the sexual and reproductive health of teenagers, and established a Health Services Network for Teenagers (2005). These initiatives were praised by the UN Committee on the Rights of the Child in 2009.

Legal, regulatory and policy barriers. Country K has ratified all major international human rights treaties. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) provides for equal rights to specific education aimed at ensuring the health and the welfare of the population, including to information and counselling on family planning. The right to health, guaranteed in different international and regional human rights conventions, also includes access to information and education on health, including sexual and reproductive health. The Committee on the Rights of the Child has underlined that the states must ensure the access of all adolescents, boys and girls, both within and outside the school system, to information concerning the protection of health and development, as well as on healthy behaviours, including information on safe and respectful behaviours towards their partner.[177]

International human rights treaty monitoring bodies have repeatedly recommended that the country K introduce and intensify education for sexual and reproductive health in school curricula, in professional schools, and for the general population in order to protect health, especially that of women and adolescents. The Committee on the Rights of the Child has expressed its concern about the "absence of an effective adolescent health promotion strategy and a comprehensive child and adolescent mental health policy", particularly in the context of high rates of teenage pregnancies and abortions as well as suicides. The Committee went on to recommend the extension of the Health Services Network for Adolescents, the initiation of a comprehensive study on the nature and extent of adolescents' health problems, with their full participation, and the strengthening of efforts in adolescent sexual and reproductive health education to reduce the number of teenage pregnancies, and develop child-friendly programmes to assist teenage mothers and their children.

The education of young people about sexuality and sexual health within the compulsory education system is not provided to all young people in a systematic and comprehensive way. The initiative of the Ministry of Education of 2004 to introduce the "Life skills education" curriculum in the compulsory education system has not been reactivated and the promotion of a healthy lifestyle is being carried out sporadically. Vulnerable groups, such as teenagers outside the school system, those with psychological disorders, people in rural areas not attending any education institution etc. are not provided with sexuality education. The failure to ensure the sexual education of young people and other vulnerable groups can be considered a failure on the part of the state to fulfil its obligation to ensure everyone's access to education, including sexual health education.

National stakeholder recommendations:

- Strengthen the regulatory, institutional and policy framework for the purpose of including sexuality education of adolescents in compulsory and vocational public education.

[177] *General comment No 4: adolescent health and development.* New York, United Nations, Committee on the Rights of the Child, 2003 (CRC/GC/2003/4). Paragraph 26.

- In the medium term, the Ministry of Education and the Ministry of Health may reconsider the introduction of the "Life skills education" programme in compulsory public education throughout the country, and including vocational schools.
- In the medium term, the Ministry of Education, Ministry of Health and the Ministry of Labour, Social Protection and Family, in collaboration with trade unions and NGOs, may initiate a range of education programmes for sexual and reproductive health for the general population as a measure of public health protection, especially of women and adolescents. Special sexual and reproductive health protection measures might be implemented for adolescents outside the school system, those with psychological disorders and people in rural areas not attending any education institution, etc.

Example 4: Vulnerable groups: adolescents (Country D)

Public health situation. The review of health-related data revealed some recurring patterns incountry D with regard to vulnerable groups, as described under the specific health issues. Common patterns found across all health topics concerned, among others, young women. Young girls and young women are particularly vulnerable in nearly all dimensions of reproductive health in country D. Firstly, child/early marriage is still practised in parts of the country (particularly the rural areas), exposing young girls and adolescents to early sexual relations and pregnancy, which often leads to health problems, including maternal morbidity and mortality. Additionally, unmarried women, particularly young women, do not have access to family planning services because of the restrictive provisions of the Population Law, thus exposing them to the risk of unwanted pregnancy. Young girls are also vulnerable because they may be subjected to female genital mutilation. Furthermore, despite improvements in educational enrolment of girls and boys, there are still twice as many girls as boys who are not enrolled in primary school.

Legal, regulatory and policy framework. The Law on Marriage sets the marriageable age at 19 for men and 16 for women. The Law on Marriage requires parental consent to marry for those who have not reached 21 years, while the Child Protection Law considers people below the age of 18 to be children. As governed by the Population Law, the family planning programme makes services available for married couples only. The adolescent reproductive health programme for unmarried young people aged 10–24 years focuses only on moral issues and abstinence.

Legal, regulatory and policy barriers. The right to non-discrimination based on age is commonly violated in connection with sexual and reproductive health. Young people are often refused information and services related to sexuality and reproduction. This takes on a heightened significance in light of the increased risk that premature pregnancy brings.

The Convention on the Rights of the Child, ratified through a Presidential decree, and the Child Protection Law, define a child as a human being below the age of 18 years. Both the Convention and the Law on Child Protection further declare that "the state shall respect and ensure the rights set in the Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national ethnic or social origin, property, disability, birth or other status". This non-discrimination clause is accordingly applicable, among others, to Article 24(1) of the Convention that declares that "states parties shall strive to ensure that no child is deprived of his or her right of access to … health care services."

Furthermore, the Law on CEDAW stipulates that the state shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning. The Convention on Economic, Social and Cultural Rights, ratified by country Din 2005, calls for the provision of the right to health without discrimination, and the prohibited grounds specifically include age.

Laws and clinical policies and practices that set chronological age limits for types of care, and deny to adolescents the sexual and reproductive health information and services that they are able and competent to request according to their evolving capacities, are contradictory to international human rights treaties ratified by the state and national laws that protect the right to health without discrimination.

National stakeholder recommendations:

- The existing Law on Marriage should be revised in order to eliminate early marriage and early pregnancy by defining the minimum legal age of marriage as 18 for both women and men.
- Both the Law on Population and the Law on Health should be amended and revised to make comprehensive reproductive health services including contraceptive services available, accessible and affordable for unmarried women and men, including adolescents.
- The accessibility and affordability of contraceptive services for unmarried people has to be assured as an integral part of the amendment of the Health Law.
- Access to family planning services for the unmarried should be ensured and be integrated into the ongoing process of the amendment of the Population Law.
- Local schools should be forbidden by law to expel pregnant girls and young women from school.
- Regulations to ensure budget allocation for the education of girls and young women should be issued.

Step 5. Prepare the draft report to be presented to the national project team

Based on the analysis, the researchers prepare the draft report to be presented and discussed by the national project team at the second analysis workshop. The draft report may be structured as follows:

Chapter 1: Introduction

Chapter 2: Cross-cutting human rights principles

Chapter 3: Main sexual and reproductive health issues
- Section 1: Health considerations
- Section 2: Legal, regulatory and policy framework
- Section 3: Legal, regulatory and policy barriers
- Section 4: National stakeholder recommendations

Chapter 3 should be organized around the topic areas emerging from the analysis. As a result the topics for the report may be different from the five topic areas of Part 3 of the data compilation instrument. As noted above, the grouping may be by topic or by human rights principles. They may be the same topics as those identified under Step 3.

After discussion and amendments made during the second analysis workshop, the national project team will present the draft report to the stakeholders' workshop. The researchers should finalize the report, based on the comments received from the stakeholders (see section A, Users' Guide).

Sources

Using human rights for maternal and neonatal health: a tool for strengthening laws, policies and standards of care. A report of the Indonesia field test analysis. Jakarta, World Health Organization and Ministry of Health of the Republic of Indonesia, 2006. Pages 5–7.

Using human rights to advance sexual and reproductive health of youth and adolescents in Sri Lanka. Colombo, Ministry of Health, Draft report, 2010.

Strategic assessment and human rights analysis on issues related to unsafe abortion in Malawi. Lilongwe, Malawi, Ministry of Health, 2011.

Annexes

Annex 1 sample document

Declaration of collaboration

between

the Ministry of Health (or other national institution), of (name of Country)

and

(name of collaborating institution e.g. World Health Organization)

The Ministry of Health, with technical and financial support from (collaborating institution) will conduct the application of the WHO Module entitled "Module 1: Sexual and Reproductive Health".

1. Main hypothesis

Despite government efforts to achieve improvements in the accessibility, utilization and quality of sexual and reproductive health services, legal, policy and practice barriers exist, both within and outside the health sector, that constrain or impede progress. Applying human rights principles, the health sector and their partners can identify and address these barriers, specifically for the poor and vulnerable populations with the greatest need.

2. Description of the Module

Using human rights has been recognized as a major way to advance all fields of development, and has been the focus of increased attention over the past few years. In answer to the United Nations Secretary-General's call in 1997 for integrating human rights across the entire United Nations system, nearly all the United Nations agencies now have explicit policies or strategies for applying human rights to their field of intervention. Within WHO, a number of initiatives are being undertaken to use human rights to advance health. This Module is one such initiative.

The Module was developed by the Department of Reproductive Health and Research at the World Health Organization (WHO), in collaboration with the Human Rights Programme at Harvard University's School of Public Health.

The purpose of the Module is to help countries to use a human rights framework to identify and address legal, policy and regulatory barriers to people's access to, and use of, sexual and reproductive health-care information and services, and to the provision of quality services. Using human rights complements the public health approach by enabling (a) a systematic application to policies and programming of human rights principles such as non-discrimination, participation and accountability; and (b) examination of laws and policies to ensure they are supportive of, rather than a barrier to, the achievement of sexual and reproductive health, as well as being in line with a state's human rights obligations.

The objectives of the Module are to assist countries to:

- review and document government efforts to put in place a supportive legal and policy framework related to sexual and reproductive health;
- identify legal, policy and regulatory barriers to sexual and reproductive health, and make recommendations to overcome these barriers;
- engage health sector, as well as non-health sector, actors to help eliminate barriers to sexual and reproductive health;
- identify specially vulnerable groups and examine government effort to address their needs.

Because the Module consists of a process that follows human rights principles, it is participatory in nature, and must involve many different stakeholders.

3. Methodology

3.1 Study site and implementation team

The application of the Module will be conducted at the national (and/or subnational level), primarily through a desk review.

It will be carried out by selected researchers, and guided by a national working group, under the supervision of the national coordinator.

3.2 Module validity

The Module will be considered valid if:

- the ministry of health demonstrates leadership and commitment to the process throughout the life of the project;
- different stakeholders remain involved throughout the life of the project;
- legal and policy barriers and/or gaps are identified, particularly in relation to vulnerable groups;
- there is increased understanding of human rights related to sexual and reproductive health on the part of the stakeholders;
- possible actions are proposed for implementation.

3.3 Expected outcomes

Successful use of the Module will result in:

- a comprehensive overview of the legal and policy environment affecting sexual and reproductive health;
- identification of legal and policy barriers and/or gaps;
- recommendations for overcoming the barriers and gaps;
- increased awareness among stakeholders of the content of human rights related to sexual and reproductive health and the value of applying a human rights framework to sexual and reproductive health law and policy development.

3.4 The process

To use the Module in countries, a process has been elaborated that is participatory and country led. The process is intended to be undertaken by the ministry of health as an exercise to examine, reflect on and strengthen its laws, policies and programmes relating to sexual and reproductive health, with technical assistance from collaborating institutions, e.g. WHO and/or other partners familiar with human rights and legal and policy issues related to health.

To use the Module, three distinct groups with separate roles and responsibilities will need to be established: a national working group, a research group and a multi-stakeholder group.

3.4.1 Establishing the groups

The national working group (7–10 people)

The national working group will facilitate the project, under the coordination of the ministry of health. The national working group will consist of representatives of the ministry of health, possibly other ministries, independent national experts in the field of law, human rights and sexual and reproductive health, nongovernmental organizations and youth representatives of the collaborating institution. The coordinator from the ministry of health will be responsible for convening all workshops and overseeing the use of the Module, dissemination of results and, if possible, implementation of prioritized actions at the conclusion of the project.

The research team

The national working group will oversee and facilitate the work of the researchers, which should be independent from the government, as far as possible. The role of the research team is to collect the information, fill in the Module, conduct a preliminary analysis, assist in the facilitation of the stakeholder analysis workshop, and prepare the final report. The researchers should include people with expertise in law, human rights, sexual and reproductive health, and health systems. They should be familiar with the subject matter and specificities of the country and local context.

The multi-stakeholder group (around 30)

The members of this group (in addition to the national working group) should represent relevant units within the ministry of health and other governmental institutions/ministries, such as women's affairs, education, social welfare, justice, labour, religion and finance ministries. They should also include nongovernmental actors, as well as representatives of United Nations agencies and bilateral agencies. They should include health programme managers, health service providers, professional associations, academic institutions and researchers, human rights commissions, youth groups, sexual and reproductive health advocates, religious groups, and other organizations dedicated to improving sexual and reproductive health and advancing human rights. Although the Module encourages partnerships with donor and international agencies, it places responsibility for decision-making and implementation in the hands of country participants, with appropriate support from partners.

3.4.2 Orientation and adaptation of the Module

A three-day orientation and adaptation workshop will be conducted for the national working group members and for researchers. The objectives of the workshop are to:

- provide an orientation on human rights and sexual and reproductive health;
- introduce the Module and explain how to use it;
- adapt the Module for national use.

Adaptation of the Module will allow the country to amend, and if necessary change, questions or indicators to better match national data sources. It will also provide countries with the possibility of adding strategic focus on country-specific issues and priorities. It does not, however, allow countries to significantly change the Module (delete indicators, etc.). As mentioned in the previous section, the questions and indicators have been selected based on their connection to sexual and reproductive health and human rights. Significant amendment or alteration of the Module has the potential to lose the focus of the rights-based methodology. Despite the flexibility of the assessment process and the importance of making the Module country appropriate, modification and/or expansion of the questions and indicators affects both the implementation and the outcomes of the Module.

3.4.3 Data compilation

The data compilation and analysis will cover 3 months. Data compilation will be done by the researchers, with facilitation by the ministry of health and the national working group. Data compilation will be done by both the legal and health data researchers simultaneously. Researchers will communicate regularly with the national working group on progress made, and to discuss any difficulties encountered.

3.4.4 Data analysis

The analysis of the collected data will by done by the researchers, together with the national working group, using the analysis methodology provided in the Users' guide. A summary of the analysis will be used for drafting the final report and for the presentation to the stakeholder workshop.

3.4.5 Preparation of the draft report

The research team, in consultation with the national working group, will prepare the draft report based on the data analysis, and this will include proposed conclusions and recommendations. In addition, a separate report on the process and validity of the Module will be prepared by the researchers.

3.4.6 Stakeholders' workshop

The final phase of the process involves the participation of the national multi-stakeholder group to review the draft report, conclusions and recommendations made by the national working group. The stakeholders' workshop will be run by the ministry of health and the research team, with assistance from the collaborating institution and other partners. The workshop will result in consensus on conclusions and recommendations for improving the legal, regulatory and policy situation related to sexual and reproductive health, for both the health sector and non-health sector actors at the national level. It will also provide the government with a review of its efforts to respect, protect and fulfil human rights related to sexual and reproductive health.

3.4.7 Final report and dissemination

Following the multi-stakeholder workshop, the report of findings and recommendations will be finalized by the national working group. Public dissemination of the report and recommendations can take many forms. The ministry of health may choose to hold a public hearing or a press conference to announce the results of their findings and recommendations. It may convene a national dissemination workshop. Whatever dissemination strategy is employed, it is important that the Module results be shared with as a wide an audience as possible, to create awareness and action for ensuring that the sexual and reproductive health and human rights of all people are respected, protected and fulfilled.

3.4.8 Monitoring and evaluation

Monitoring and evaluation activities will relate to both elements of the process and use of the Module. To determine the usefulness of the Module, an evaluation methodology has been developed to determine:

- whether use of the Module increases non-health sector involvement in improving sexual and reproductive health and why;
- whether use of the Module increases government effort to address explicitly human rights issues such as non-discrimination, participation and accountability in their policies, plans, strategies and other governance mechanisms.

4. Duration of the project

The Module divides the project into three phases, with tasks itemised as in the table below.

	Timetable in months											
Actions	1	2	3	4	5	6	7	8	9	10	11	12
Phase 1: Initiating the process												
Establishment of political commitment in country	x	x										
Establishment of the multi-stakeholder group	x	x										
Identification and contracting of the researchers		x										
Translation of documents		x	x									
Preparation and holding of orientation workshop			x									
Phase 2: Data compilation instrument, adaptation and analysis												
Adaptation of the Module, training			x									
Data compilation				x	x	x						
Preliminary analysis							x	x				
Phase 3: Planning for action and implementation												
Preparation and multi-stakeholder analysis workshop									x			
Preparation of the final report										x		
Publication of findings, public dissemination activity											x	x

5. Links with other projects

The use of the Module will link up with, and contribute to, current government efforts to respond to the sexual and reproductive health needs of all people.

6. Study ownership and publication

The results will be used for publication. Publications will have involvement of the ministry of health, the researchers and collaborating institutions. Results from the country study will be co-owned by the ministry of health and the researchers.

Agreement

1. Title

Application of the WHO Module entitled **"Sexual and reproductive health " : a Module for examining laws, regulations and policies"**

2. National coordinator for the field test

Name

Institution

E-mail

Postal address:

Telephone:

3. Partners collaborating with the coordinator/ministry of health

- National working group (to be established)
- Relevant ministries
- WHO and other United Nations partners
- National and international nongovernmental organizations
- Consultants/experts

To be completed by the national coordinator

4. Duration of project

Earliest starting date (if applicable):

Total (months):

5. Declaration of collaborating institutions

We confirm that the application of the WHO Module will be conducted by the Ministry of Health, and with technical and financial support of the collaborating institution.

Name and initials (please print)	Name and initials (please print)
Title	Title
Ministry of Health (and/or other state entity)	Collaborating institution (name)
Date	Date
Signature	Signature

Annex 2 sample document

Terms of reference

National coordinator

The coordinator from the ministry of health (or other state institution) will be responsible for convening all meetings of those involved in the Module field test and overseeing the use of the Module, dissemination of results and, if possible, implementation of prioritized actions at the conclusion of the field test.

Tasks of the coordinator include:

- convening the national working group;
- ensuring that the project is on track, including adherence to the timeline;
- providing feedback and resolving any difficulties that may arise;
- convening the multi-stakeholder workshop;
- communicating regularly with collaborating institutions on progress made and difficulties encountered;
- overseeing the preparation and delivery of (a) the report of the findings from the Module.

ANNEX 3 sample document

Terms of reference

National working group

The national working group will facilitate the application of the Module, under the coordination of the ministry of health (or other state institution). The national working group will consist of representatives of the ministry of health and possibly other ministries, independent national experts in the field of law, human rights and sexual and reproductive health, nongovernmental organizations, and members of collaborating institutions.

The national working group will be responsible for the following tasks:

- identifying the members of the multi-stakeholder group;
- working with the researchers to adapt the Module to the national context;
- overseeing and facilitating the work of the researchers;
- participating in the preliminary analysis of findings;
- contributing to the drafting of the final report;
- facilitating the stakeholder workshop;
- participating in the public dissemination activities;
- bringing recommendations for follow-up actions to the relevant decision-makers;
- providing information for monitoring and evaluation of the process.

ANNEX 4 sample document

Terms of reference

Public health researcher

Assisting in the implementation of the WHO Module: "Module 1: Sexual and Reproductive Health".

The public health researcher is appointed by the coordinator of the ministry of health (or other state institution) and partner institutions, with the agreement of the national project team and is tasked to assist in facilitating the national adaptation of the data compilation instrument, to compile and analyse legal data indicated by the Module, to assist in the conduct of the stakeholders' workshop and to prepare the final report.

The researcher must respect the confidentiality of the information collected. Any publications resulting from the use of the Module can be owned jointly but must be approved by the ministry of health and partner institutions.

Duties and tasks

Under the direction of a ministry of health (or state institution) and the national project team, the researcher will have the following duties and tasks:

- working with the national project team on the adaptation of the instrument to the national context;
- collecting the data and filling in the health considerations section of the instrument;
- meeting regularly with the legal researcher(s) and the national project team to discuss progress regarding the data compilation process;
- in collaboration with the legal researcher(s), presenting the completed instrument to the national project team and incorporating amendments;
- conducting the analysis of findings in collaboration with the legal researcher(s), using the analysis methodology provided;
- in collaboration with the legal researcher(s), presenting the initial findings of the analysis to the national project team and incorporating amendments;
- in collaboration with the legal researcher(s) and in consultation with the national project team, preparing the draft report;
- in collaboration with the legal researcher(s), presenting the draft report at the stakeholders' workshop;
- in collaboration with the legal researcher(s), finalizing the report on the basis of feedback from the stakeholders and the national project team;
- assisting in the public dissemination of the report;
- filling in the monitoring and evaluation questionnaire at the beginning and end of the process.

Competencies required

- Demonstrated knowledge about and experience in using and analysing demographic, epidemiological and health service delivery data related to sexual and reproductive health
- Familiarity with human rights (if possible)
- Ability to work in collaboration with other researchers, as well as with government and civil society organizations

ANNEX 5 sample document

Terms of reference

Legal researcher

Assisting in the implementation of the WHO Module: "Module 1: Sexual and Reproductive Health"

The legal researcher is appointed by the coordinator of the ministry of health (or other state institution) and partner institutions, with the agreement of the national project team, and is tasked to assist in facilitating the national adaptation of the data compilation instrument, to compile and analyse legal data indicated by the Module, to assist in the conduct of the stakeholders workshop and to prepare the final report.

The researcher must respect the confidentiality of the information collected. Any publications resulting from the use of the Module can be owned jointly but must be approved by the ministry of health and partner institutions.

Duties and tasks

Under the direction of a ministry of health (or other state institution) and the national project team, the researcher has the following duties and tasks:

- working with the national project team on the adaptation of the instrument to the national context;
- collecting the data and filling in parts I and II in their entirety and the sections on national laws, policies and regulations, and human rights considerations in part III of the instrument;
- meeting regularly with the public health researcher(s) and the national project team to discuss progress regarding the data compilation process;
- in collaboration with the public health researcher(s), presenting the completed instrument to the national project team and incorporating amendments;
- conducting the analysis of findings in collaboration with the public health researcher(s), using the analysis methodology provided;
- in collaboration with the public health researcher(s), presenting the initial findings of the analysis to the national project team and incorporating amendments;
- in collaboration with the public health researcher(s) and in consultation with the national project team, preparing the draft report;
- in collaboration with the public health researcher(s), presenting the draft report at the stakeholder workshop;
- in collaboration with the public health researcher(s), finalizing the report on the basis of feedback from the stakeholders and the national project team;
- assisting in the public dissemination of the report;
- filling in the monitoring and evaluation questionnaire at the beginning and end of the process.

Competencies required

- Demonstrated knowledge about national laws and policies related to sexual and reproductive health
- Demonstrated knowledge about international, regional and national human rights standards related to health/sexual and reproductive health
- Experience in using and analysing legal data together with epidemiological and health service delivery data related to health/sexual and reproductive health (desirable)
- Ability to work in collaboration with other researchers, as well as with government and civil society organizations

ANNEX 6 sample document

Monitoring and evaluation at the start of the project

Introduction

These questions should be answered before and during the beginning of phase 1. Answers to these questions will provide a baseline against which to measure progress resulting from this initiative.

Overall, the objectives of the evaluation of the sexual and reproductive health Module are to assess the extent to which using the Module results in:

- a review of national laws and policies related to sexual and reproductive health from a human rights perspective;
- a comprehensive and good quality report that documents government efforts to respect, protect and fulfil human rights, especially with regard to vulnerable groups; and identifies regulatory and policy barriers or discrepancies related to sexual and reproductive health and recommendations for overcoming the barriers identified;
- the engagement of health and non-health sector stakeholders in identifying rights-related barriers to sexual and reproductive health and arriving at a consensus list of priority areas for action, through a participatory process;
- an increased understanding of the interconnection of laws and policies with sexual and reproductive health and human rights standards;
- strengthened capacity of the national project team in analysing laws and policies from a rights perspective, and in coming up with solutions to address legal, policy and regulatory barriers to sexual and reproductive health;
- creation of mechanisms for implementing action in the priority areas identified.

Questions for the national working group and researchers

Please fill in as much information as you can. Please note that all information will be treated as confidential and is being gathered strictly for the purpose of monitoring and evaluation. Names or other identifying characteristics will not be shared or otherwise disseminated. Please write your responses in the spaces provided underneath the questions. If you need more space, continue your answers on a separate sheet of paper and attach it to your questionnaire before handing it in.

I. Personal details (optional)

Name: _____

First *Middle* *Last*

Place of work: _____

_____

_____

_____

Please be as specific as possible. For example, if you work for the government, please provide the name of the ministry, and your department. If you work for a nongovernmental organization (NGO), please provide the name and a brief description of what the NGO does:

Job title: _____

Which of the following best describes your engagement with this project (please circle the appropriate answer)?

(a) The national projects team
(b) The research team
(c) Other (please explain)

II. Prior knowledge/experience in human rights and related sexual and human rights issues

For questions in this section, feel free to be as specific as you wish. Please indicate if you have had any previous training or experience with these issues, and how knowledgeable you feel about them.

(1) Are you familiar with sexual and reproductive health concerns in your country? Please explain briefly.

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(2) Are you familiar with the Millennium Development Goals, other international consensus documents and international human rights treaties relevant to sexual and reproductive health in your country? Please explain briefly.

(3) Do you understand the links between human rights and sexual and reproductive health? If you do, please describe what you understand to be some of these links.

(4) Do you think your capacity in any of the areas mentioned above can usefully be improved through participation in this initiative? If yes, which capacities in particular are you interested in improving?

(5) In your work, do you collaborate with people with expertise in fields other than your own? (Please specify: never, sometimes, frequently, always; and specify the expertise/discipline of those people.)

(6) Does the mandate of your ministry/organization/institution include sexual and reproductive health concerns? If yes, what activity/activities is your ministry/organization/institution engaged in that are relevant?

(7) Does the mandate of your ministry/organization/institution include attention to human rights related to sexual and reproductive health? If yes, what activity/activities is your ministry/organization/institution engaged in that relate(s) to human rights related to sexual and reproductive health?

III. State efforts in the area of sexual and reproductive health

(8) Are any state institutions and/or sectors of the government (both health and non-health sectors) currently engaged in activities to identify and address health sector barriers to sexual and reproductive health (e.g. lack of adolescent-friendly health services, lack of skilled doctors and nurses, lack of health supplies, etc.)? If yes, which institutions/sectors are engaged in these activities? To the best of your knowledge, what exactly do these activities entail?

(9) Are any state institutions and/or sectors of the government (both health and non-health sectors) currently engaged in activities to identify and address non-health sector barriers to sexual and reproductive health (e.g. education, law, labour, transportation, etc.)? If yes, which state institutions/sectors are engaged in these activities? To the best of your knowledge, what exactly do these activities entail?

(10) Are you familiar with the laws and policies in your country that relate directly or indirectly to vulnerable groups? If so, do they have a negative or positive impact on the sexual and reproductive health of these groups? Please give specific examples.

(11) Do you know of any laws, policies, regulations or other governance mechanisms in place to explicitly address human rights issues related to sexual and reproductive health pertaining to vulnerable groups (e.g. ensuring non-discrimination and access to services, and/or their participation in policy-making activities that impact on their lives, health and well-being)?

(12) Do you know of any accountability mechanisms the state has in place to ensure they can receive feedback from affected communities about the impacts of their laws, policies and practices?

IV. Participation of nongovernmental organizations and marginalized groups

(13) Are there group(s) representing the concerns of individuals and groups affected by sexual and reproductive health issues in this country (NGOs)? Please list any such groups.

(14) Do you think any of these groups should be part of this initiative? If yes, how should they be involved, and at what stages? If no for some, why not?

(15) When it comes to sexual and reproductive health, who, in your opinion, are the main vulnerable/marginalized groups in the country?

(16) Do you think the representatives of these vulnerable/ marginalized groups should be part of this initiative? If yes, how should they be involved, and at what stages? If not, why not?

V. Challenges

(17) Are there any important challenges that you foresee might occur as this initiative continues? If so, what suggestions do you have for how can they be pre-empted?

Annex 7 Sample document

Monitoring and evaluation at the end of the project

Introduction

The questions in this document are for use upon completion of the process. Answers to these questions will provide a reflection on the successes and challenges of implementing the process and data compilation instrument and will provide a measure of progress related to this initiative.

Overall, the objectives of the evaluation of the sexual and reproductive health Module are to assess the extent to which using the Module results in:

- a review of national laws and policies related to sexual and reproductive health from a human rights perspective;
- a comprehensive and good quality report that documents government efforts to respect, protect and fulfil human rights, especially with regard to vulnerable groups; and identifies regulatory and policy barriers or discrepancies related to sexual and reproductive health and recommendations for overcoming the barriers identified;
- the engagement of health and non-health sector stakeholders in identifying rights-related barriers to sexual and reproductive health and arriving at a consensus list of priority areas for action, through a participatory process;
- an increased understanding of the interconnection of laws and policies with sexual and reproductive health and human rights standards;
- strengthened capacity of the national project team in analysing laws and policies from a rights perspective, and in coming up with solutions to address legal, policy and regulatory barriers to sexual and reproductive health;
- creation of mechanisms for implementing action in the priority areas identified.

Questions for the national working group and researchers

Please fill in as much information as you can. Please note that all information will be treated as confidential and is being gathered strictly for the purpose of monitoring and evaluation. Names or other identifying characteristics will not be shared or otherwise disseminated. Please write your responses in the spaces provided underneath the questions. If you need more space, continue your answers on a separate sheet of paper and attach it to your questionnaire before handing it in.

I. Personal details (optional)

Name:

First *Middle* *Last*

Place of work:

Please be as specific as possible. For example, if you work for the government, please provide the name of the ministry, and your department. If you work for a nongovernmental organization (NGO), please provide the name and a brief description of what the NGO does:

Job title:

Which of the following best describes your engagement with this project (please circle the appropriate answer)?

(a) The national projects team
(b) The research team
(c) Other (please explain)

II. Knowledge/experience in human rights and related sexual and human rights issues

For questions in this section, feel free to be as specific as you wish. Please indicate if you have had any previous training or experience with these issues, how knowledgeable you feel about them and whether involvement in this initiative has contributed to your knowledge about the issues noted below.

(1) As a result of this initiative, are you more familiar with sexual and reproductive health concerns in your country?

(2) As a result of this initiative, has your understanding of the Millennium Development Goals, other international consensus documents and international human rights treaties relevant to sexual and reproductive health improved?

(3) As a result of this initiative, do you understand better the links between human rights and sexual and reproductive health? If you do, please describe some of these links.

(4) In those areas where you wanted your capacity improved, did your participation in this initiative contribute? If so, how?

(5) As a result of this initiative, are you collaborating with people with expertise in fields other than your own? (Please specify: never, sometimes, frequently, always; and specify the expertise/discipline of those people.) Are there plans for any future collaborations now that this initiative is over?

(6) As a result of this initiative, has the engagement of your ministry/organization/institution in sexual and reproductive health been strengthened?

(7) As a result of this initiative, has the engagement of your ministry/organization/institution in human rights related to sexual and reproductive health been strengthened?

III. State efforts in the area of sexual and reproductive health

(8) As a result of this initiative, are more state institutions and/or sectors of the government (both health and non-health sectors) engaged in activities to identify and address *health sector* barriers to sexual and reproductive health (e.g. lack of adolescent-friendly health services, lack of skilled doctors and nurses, lack of health supplies, etc.)? Please explain briefly.

(9) As a result of this initiative, are more state institutions and/or sectors of the government (both health and non-health sectors) engaged in activities to identify and address non-health sector barriers to sexual and reproductive health (e.g. education, law, labour, transportation, etc.)? Please explain briefly.

(10) As a result of this initiative, are you more familiar with the laws and policies in your country that relate directly or indirectly to sexual and reproductive health, and whether they have a negative or positive impact on vulnerable groups?

(11) As result of this initiative, are you more familiar with laws, policies, regulations or other governance mechanisms in place to explicitly address human rights issues related to sexual and reproductive health pertaining to vulnerable groups (e.g. non-discrimination and access to services, and/or their participation in policy-making activities that impact on their lives, health and well-being)?

(12) As a result of this initiative, are you more familiar with accountability mechanisms the state has in place to ensure they can receive feedback from affected communities about the impacts of their laws, policies and practices?

IV: Participation of nongovernmental organizations, representatives of marginalized groups and non-health sector representatives of the government

(13) Did members of any group(s) representing the concerns of individuals and groups affected by sexual and reproductive health issues in this country (NGOs) participate in this initiative? Please specify.

(14) As a result of this initiative, has your opinion/knowledge changed with regard to who are the main/vulnerable marginalized groups in the country when it comes to sexual and reproductive health?

(15) Did representatives of these vulnerable/marginalized groups participate in this initiative? Please specify.

(16) Do you feel adequate attempts were made to ensure participation of representatives of NGOs and of marginalized groups in the national project team, the stakeholders' group, or the research team?

(17) Were representatives from non-health sectors of government (such as ministries of justice, transport, education and finance) involved in the national project team or the stakeholders' group? Please specify.

V: Evaluation of the process of this initiative

(18) Did the process of this initiative contribute to identifying legal, policy and regulatory barriers to improving sexual and reproductive health? Please specify.

(19) Did the process of this initiative create a multi-stakeholder discussion and action plan to improve the legal, regulatory and policy framework on sexual and reproductive health in line with human rights? Please explain.

(20) Did the process produce a comprehensive and good quality report that (a) documents governments effort to respect, protect, and fulfil human rights, especially with regard to vulnerable groups; (b) identifies legal, regulatory and policy barriers or discrepancies related to sexual and reproductive health; and (c) provides recommendations to overcoming the barriers?

VI: Next steps

(21) What plans are in place to implement the recommendations? Do these include participation of all identified stakeholders? If not, do you have any suggestions on how they could be included?

(22) Will the recommendations be disseminated to a wide range of actors who may be able to contribute to implementation? If not, do you have any suggestions on how to ensure such a broad base of implementation of recommendations?

VII. Successes and challenges

(23) Please discuss any remaining thoughts you may have with regard to this initiative. Please feel free to elaborate on any successes achieved or challenges faced during the course of process.

(24) Do you feel that this initiative has an overall positive impact on your work? Why or why not?

End of Module 1

- Module 2: Newborn and Child Health (Forthcoming)
- Checklist (Forthcoming)

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