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Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the interim report prepared by the Special Rapporteur of the Human Rights Council on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, in accordance with Human Rights Council resolutions 15/22 and 6/29.

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Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Summary

In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health considers the interaction between criminal laws and other legal restrictions relating to sexual and reproductive health and the right to health. The right to sexual and reproductive health is a fundamental part of the right to health. States must therefore ensure that this aspect of the right to health is fully realized.

The Special Rapporteur considers the impact of criminal and other legal restrictions on abortion; conduct during pregnancy; contraception and family planning; and the provision of sexual and reproductive education and information. Some criminal and other legal restrictions in each of those areas, which are often discriminatory in nature, violate the right to health by restricting access to quality goods, services and information. They infringe human dignity by restricting the freedoms to which individuals are entitled under the right to health, particularly in respect of decision-making and bodily integrity. Moreover, the application of such laws as a means to achieving certain public health outcomes is often ineffective and disproportionate.

Realization of the right to health requires the removal of barriers that interfere with individual decision-making on health-related issues and with access to health services, education and information, in particular on health conditions that only affect women and girls. In cases where a barrier is created by a criminal law or other legal restriction, it is the obligation of the State to remove it. The removal of such laws and legal restrictions is not subject to resource constraints and can thus not be seen as requiring only progressive realization. Barriers arising from criminal laws and other laws and policies affecting sexual and reproductive health must therefore be immediately removed in order to ensure full enjoyment of the right to health.

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I. Introduction

1. Since his previous report to the General Assembly (A/65/255), the Special Rapporteur has undertaken country missions to the Syrian Arab Republic in November 2010 (A/HRC/17/25/Add.3) and Ghana in May 2011. He submitted reports on the right to health and development (A/HRC/17/25) and on the expert consultation on access to medicines as a fundamental component of the right to health (A/HRC/17/43) to the Human Rights Council at its seventeenth session, held in June 2011. He convened an expert consultation and held a public consultation on the right to health of older persons in April 2011, which informed the report submitted to the Council at its eighteenth session in September 2011.

2. The Special Rapporteur has contributed to a number of meetings and conferences on the right to health, including the meeting on human rights and the Global Fund to Fight AIDS, Tuberculosis and Malaria, organized by the Open Society Institute/Joint United Nations Programme on HIV/AIDS (UNAIDS) in New York in March 2011, and the conference on enforcement of the right to health organized by the Central European University in Budapest in June 2011. The Special Rapporteur gave keynote presentations at the Northern Ireland Assembly in September 2010 on the Millennium Development Goals and at the International Drug Policy Consortium seminar, held in London in May 2011, on proportionality in sentencing for drug offences.

3. The Special Rapporteur also held regional civil society consultations in Nairobi, for East Africa; Budapest, for Eastern Europe; and Moscow, the Russian Federation and Central Asia. The consultations allowed the Rapporteur to gather information regarding realization of the right to health in those regions and to disseminate information about the mandate.

II. Background

4. The present report considers the criminalization of certain sexual and reproductive health services, particularly in relation to women, and their impact on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (hereafter, the “right to health”). It also discusses the effect of other legal restrictions and policies affecting conduct and decision-making in the context of sexual and reproductive health. It examines how laws and other legal restrictions are used to regulate abortion, conduct during pregnancy, sexual and reproductive education, and contraception and family planning. It also discusses the negative impact that such criminal laws and other legal restrictions may have on health care, including access to goods, services and information, on the freedoms and human dignity of affected persons, particularly women, and on public health outcomes.

5. The Special Rapporteur decided to address those issues given that the right to sexual and reproductive health is an area in which conduct and decision-making are regulated by the State through a range of criminal laws and other legal restrictions that may violate the right to health.

III. International human rights law and the right to sexual and reproductive health

6. The right to sexual and reproductive health is an integral component of the right to health. The International Covenant on Economic, Social and Cultural Rights emphasizes aspects of the right to sexual and reproductive health in article 12.2 (a). General Comment No. 14 of the Committee on Economic, Social and Cultural Rights states that the right to health includes measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, prenatal and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information (E/C.2/2000/4, para. 14). Moreover, it notes that women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health (ibid., para. 21). The recommendations of the Committee have consistently supported that approach.[1]

7. The Convention on the Elimination of All Forms of Discrimination against Women[2] requires States to take action to ensure that women are afforded broad equality in, inter alia, education, employment and access to health care. The Convention specifically provides for a proper understanding of maternity as a social function, access to family planning information, and the elimination of discrimination against women in marriage and family relations. Furthermore, article 16.1 (e) mandates that women be provided the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise those rights.

8. The Convention on the Rights of the Child provides for the protection of the right to health of young persons under the age of 18. Article 24 of the Convention affirms the right to health as established in the International Covenant on Economic, Social and Cultural Rights, which is especially relevant given the importance of sexual and reproductive health to the lives of young women and men.[3] The Convention urges States to ensure prenatal and post-natal care for mothers, develop family planning education and services and ensure the elimination of traditional practices that are "prejudicial to the health of children".[4]

9. Reproductive health rights also feature prominently in the Programme of Action of the 1994 International Conference on Population and Development, the 1995 Beijing Platform for Action and the Millennium Development Goals, which affirm the rights of women to control all aspects of their health, to respect bodily autonomy and integrity and to decide freely in matters relating to their sexuality and reproduction, free of discrimination, coercion and violence. The Beijing Platform for Action states that States should consider removing punitive measures related to sexual and reproductive health. The relationship between improved sexual and reproductive health for women and poverty reduction is particularly emphasized.

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[1] See E/C.12/1/Add.98, para. 43; E/C.12/1/Add.105 and Corr.1, paras. 53 and 54; E/C.12/BRA/CO/2, para. 29; and E/C.12/COL/CO/5, para. 5.

[2] See in particular articles 5, 10 (h), 11, 12.1 and 16.

[3] See United Nations Population Fund, *Eight Lives: Stories of Reproductive Health* (New York, 2010).

[4] United Nations, *Treaty Series*, vol. 1577, No. 27531, article 24; see also CRC/GC/2003/4, para. 31.

Unfortunately, the *Millennium Development Goals Report 2010*[5] declared that progress in parts of the world in some indicative areas, such as adolescent pregnancy and contraceptive use, had slowed and that aid for family planning as a proportion of total aid to health had declined sharply between 2000 and 2008.

10. General Comment No. 14 of the Committee on Economic, Social and Cultural Rights elaborates the concept of reproductive health, stating that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice and appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth (E/C.12/2000/4, footnote 12). 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".[6] The Programme of Action of the International Conference on Population and Development states that sexual health includes the right to a satisfying and safe sex life as well as the freedom to decide when and how often to reproduce (A/CONF.171/13, para. 7.2). It also states that 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.

IV. Criminal laws and other legal restrictions affecting the right to sexual and reproductive health

11. Criminal laws are enacted by the State to regulate conduct perceived as threatening, dangerous, or harmful to an individual, to other individuals or society. Such laws represent the strongest expression of the State's power to punish and are among its most intentional acts. Criminal laws punish those who engage in prohibited conduct; they are also intended to deter others from similar conduct, incapacitate and rehabilitate offenders, and provide restitution for victims.

12. The use of overt physical coercion by the State or non-State actors, such as in cases of forced sterilization, forced abortion, forced contraception and forced pregnancy has long been recognized as an unjustifiable form of State-sanctioned coercion and a violation of the right to health.[7] Similarly, where the criminal law is used as a tool by the State to regulate the conduct and decision-making of individuals in the context of the right to sexual and reproductive health the State coercively substitutes its will for that of the individual.

13. States also use other legal restrictions, including provisions in civil and administrative laws to restrict or prohibit access and/or availability of sexual and reproductive health services, goods and information.

14. In their application, criminal laws and other legal restrictions may prevent access to certain sexual and reproductive health-care goods, such as contraceptive methods, directly outlaw a particular service, such as abortion, or ban the provision of sexual and reproductive information through school-based education programmes

[5] United Nations publication, Sales No. E.10.I.7.

[6] Paul Hunt and Judith Bueno de Mesquita, *The Rights to Sexual and Reproductive Health* (Colchester, Essex, University of Essex, 2006).

[7] See CRC/C/15/Add.268, para. 46(e); CEDAW/C/CHN/CO/6, para. 32; E/CN.4/2004/49, para. 25.

or otherwise. In practice, these laws affect a wide range of individuals, including women who attempt to undergo abortions or seek contraception; friends or family members who assist women to access abortions; practitioners providing abortions; teachers providing sexual education; pharmacists supplying contraceptives; employees of institutions that are established to provide family planning services; human rights defenders advocating for sexual and reproductive health rights; and adolescents seeking access to contraception for consensual sexual activity.

15. Criminal laws and other legal restrictions on sexual and reproductive health may have a negative impact on the right to health in many ways, including by interfering with human dignity. Respect for dignity is fundamental to the realization of all human rights. Dignity requires that individuals are free to make personal decisions without interference from the State, especially in an area as important and intimate as sexual and reproductive health.

16. Criminal laws and other legal restrictions affecting sexual and reproductive health may amount to violations of the right to health. Although the present report deals predominantly with the impact of these laws and legal restrictions on women and girls, it by no means discounts similar problems faced by men and boys. Women, however, are generally more likely to experience infringements of their right to sexual and reproductive health[8] given the physiology of human reproduction and the gendered social, legal and economic context in which sexuality, fertility, pregnancy and parenthood occur. Persistent stereotyping of women's roles within society and the family establish and fuel societal norms. Many of those norms are based on the belief that the freedom of a woman, especially with regard to her sexual identity, should be curtailed and regulated (see E/CN.4/2002/83, para. 99). Where women transgress these stereotype-driven norms in the pursuit of sexual and reproductive freedom, they are often punished severely,[6] with resultant adverse effects on their health outcomes and violations of their right to health. The criminal laws and other legal restrictions examined in the present report facilitate and justify State control over women's life, such as forcing women to continue unwanted or unplanned pregnancies.

17. The causal relationship between the gender stereotyping, discrimination and marginalization of women and girls and their enjoyment of their right to sexual and reproductive health is well documented (see E/CN.4/2002/83 and E/CN.4/2004/49). Criminalization generates and perpetuates stigma; restricts their ability to make full use of available sexual and reproductive health-care goods, services and information; denies their full participation in society; and distorts perceptions among health-care professionals which, as a consequence, can hinder their access to health-care services. Criminal laws and other legal restrictions disempower women, who may be deterred from taking steps to protect their health, in order to avoid liability and out of fear of stigmatization. By restricting access to sexual and reproductive health-care goods, services and information these laws can also have a discriminatory effect, in that they disproportionately affect those in need of such resources, namely women. As a result, women and girls are punished both when they abide by these laws, and are thus subjected to poor physical and mental health outcomes, and when they do not, and thus face incarceration.

[8] With the exception of men who have sex with men; see A/HRC/14/20.

18. States most frequently cite two grounds for implementing criminal or other restrictive laws in relation to the right to sexual and reproductive health: public health and public morality. Public morality cannot serve as a justification for enactment or enforcement of laws that may result in human rights violations, including those intended to regulate sexual and reproductive conduct and decision-making. Although securing particular public health outcomes is a legitimate State aim, measures taken to achieve this must be both evidence-based and proportionate to ensure respect of human rights. When criminal laws and legal restrictions used to regulate public health are neither evidence-based nor proportionate, States should refrain from using them to regulate sexual and reproductive health, as they not only violate the right to health of affected individuals, but also contradict their own public health justification.

19. Securing the rights of women is crucial to improving health outcomes for both sexes. However, substantial underreporting of reproductive and sexual health problems is a serious challenge and probably arises for a variety of political, social, and cultural reasons. By generating a chilling effect on the open exchange of information and data collection, criminalization further exacerbates the underreporting of important health indicators. As a result, effectively addressing poor health outcomes is rendered impossible, and difficulties faced by the international community in meeting core development goals are compounded. Moreover, development indicators do not capture the full impact of criminalization because they only address specific quantifiable public health data and exclude deprivations of dignity and autonomy.

20. The use by States of criminal and other legal restrictions to regulate sexual and reproductive health may represent serious violations of the right to health of affected persons and are ineffective as public health interventions. These laws must be immediately reconsidered. Their elimination is not subject to progressive realization since no corresponding resource burden, or a *de minimis* one, is associated with their elimination.

Impact of criminal laws and other legal restrictions on sexual and reproductive health

1. Criminalization and other legal restrictions related to abortion

21. Criminal laws penalizing and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realization of women's right to health and must be eliminated. These laws infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health. Moreover, such laws consistently generate poor physical health outcomes, resulting in deaths that could have been prevented, morbidity and ill-health, as well as negative mental health outcomes, not least because affected women risk being thrust into the criminal justice system. Creation or maintenance of criminal laws with respect to abortion may amount to violations of the obligations of States to respect, protect and fulfil the right to health.

22. The Committee on the Elimination of Discrimination against Women has strongly disapproved of restrictive abortion laws, especially those that prohibit and criminalize abortion in all circumstances (see CEDAW/C/CH/CO/4, para. 19). It has also confirmed that such legislation does not prevent women from procuring unsafe

illegal abortions and has framed restrictive abortion laws as a violation of the rights to life, health and information.[9] The Committee on the Rights of the Child is also concerned about the impact of highly restrictive abortion laws on the right to health of adolescent girls.[10] The Committee against Torture has further stated that punitive abortion laws should be reassessed since they lead to violations of a woman's right to be free from inhuman and cruel treatment.[11] The Human Rights Committee concluded that equality between men and women required equal treatment in the area of health and the elimination of discrimination in the provision of goods and services and addressed the need to review abortion laws to prevent rights violations (see CCPR/C/21/Rev.1/Add.10, paras. 20, 28 and 31). The former Special Rapporteur on the right to health called for removal of punitive measures against women who seek abortions (see E/CN.4/2004/49, para. 30).

23. In States where abortion is criminalized, particular grounds for seeking an abortion may be exempt from criminalization. In the most severe cases, however, abortion is completely criminalized without exception — a situation that exists in only a handful of States — or allowed only to save the life of the woman. Approximately 25 per cent of the world's population lives under legal regimes that prohibit all abortions except for those following rape or incest, as well as those necessary to save a woman's life. Slightly less restrictive legal regimes permit abortion on a number of physical health, mental health and socio-economic grounds, such as poverty and number of children. Finally, abortion is unrestricted on any grounds in 56 States, though limits still exist with respect to how late in pregnancy an abortion will be permitted.[12]

24. Other legal restrictions also contribute to making legal abortions inaccessible. Conscientious objection laws create barriers to access by permitting health-care providers and ancillary personnel, such as receptionists and pharmacists, to refuse to provide abortion services, information about procedures and referrals to alternative facilities and providers.[13] Examples of other restrictions include: laws prohibiting public funding of abortion care; requirements of counselling and mandatory waiting periods for women seeking to terminate a pregnancy; requirements that abortions be approved by more than one health-care provider; parental and spousal consent requirements; and laws that require health-care providers to report "suspected" cases of illegal abortion when women present for post-abortion care, including miscarriages. These laws make safe abortions and post-abortion care unavailable, especially to poor, displaced and young women. Such restrictive regimes, which are not replicated in other areas of sexual and reproductive health care, serve to reinforce the stigma that abortion is an objectionable practice.

25. The World Health Organization (WHO) has confirmed that legal grounds largely shape the course for women with an unplanned pregnancy towards a safe or an unsafe abortion.[14] As legal restrictions primarily influence whether abortion is

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[9] See A/53/38/Rev.1, para. 337; and A/54/38/Rev.1, part I, paras. 56, 228 and 393.

[10] CRC/C/15/Add.107, para. 30; CRC/C/CHL/CO/3, para. 55; and CRC/C/URY/CO/2, para. 51.

[11] CAT/C/PER/CO/4, para. 23; CAT/C/NIC/CO/1, para. 16; and CAT/C/CR/32/5, para. 7.

[12] R. Boland, "Second trimester abortion laws globally: actuality, trends and recommendations", *Reproductive Health Matters*, vol. 18, No. 36 (2010), pp. 67-89.

[13] Louise Finer and Judith Bueno de Mesquita, *Conscientious Objection: Protecting Sexual and Reproductive Health Rights* (Colchester, Essex, University of Essex, 2010).

[14] WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, 6th ed. (Geneva, 2011), p. 2.

safe or not,[15] more unsafe abortions are likely to occur in legal regimes that are more restrictive of abortion. The rate of unsafe abortions and the ratio of unsafe to safe abortions both directly correlate to the degree to which abortion laws are restrictive and/or punitive.[16] Unsafe abortions are estimated to account for nearly 13 per cent of all maternal deaths globally.[14] A further 5 million women and girls suffer short- and long-term injuries due to unsafe abortions,[17] including haemorrhage; sepsis; trauma to the vagina, uterus and abdominal organs; cervical tearing; peritonitis; reproductive tract infections; pelvic inflammatory disease and chronic pelvic pain; shock and infertility.

26. The conditions under which unsafe abortions occur include: limited access to information, particularly concerning when and how legal abortions may be obtained; abortion induced by an unskilled provider in unhygienic conditions or by a health-care worker outside of appropriate facilities; abortion induced by the woman herself or a traditional medical practitioner through insertion of an object into the uterus, drinking of a hazardous substance or violent massage; and incorrectly prescribed medicine with no follow-up or further information provided.[18] Criminalization of abortion creates and perpetuates these unsafe conditions. In more liberal regimes, women are able to legally seek service and treatment through professional health-care providers under safe and medically appropriate circumstances, including the use of medical abortion pills, which allow for safe, self-induced early abortions.

27. Criminal prohibition of abortion is a very clear expression of State interference with a woman's sexual and reproductive health because it restricts a woman's control over her body, possibly subjecting her to unnecessary health risks. Criminal prohibition also requires women to continue unplanned pregnancies and give birth when it is not their choice to do so. States are obliged to ensure that women are not denied access to necessary post-abortion medical services, irrespective of the legality of the abortion undertaken.

28. States are also obliged to protect against infringement of the right to health by third parties. In States where abortion is prohibited, public health and safety regulations regarding abortion, such as provisions for the training and licensing of health-care workers, cannot exist, thus increasing the potential for unsafe abortion practices. Decriminalization, coupled with appropriate regulation and the provision of accessible, safe abortion services, is the most expeditious method of fully protecting the right to health against third-party violations. Additionally, States should take measures to protect those who provide abortions and related services from harassment, violence, kidnappings and murder perpetrated by non-State actors (religiously motivated or otherwise).

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[15] Axel I. Mundigo, "Determinants of unsafe induced abortion in developing countries", in Ina K. Warriner and Iqbal H. Shah, eds., *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action* (New York, Guttmacher Institute, 2006), pp. 51-54.

[16] WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems* (Geneva, 2003), p. 86.

[17] Lori Ashford, "Hidden suffering: disabilities from pregnancy and childbirth in less developed countries" (Washington, D.C., Population Reference Bureau, 2002). Available from: http://www.prb.org/pdf/HiddenSufferingEng.pdf.

[18] Michael Vlassoff and others, "Estimates of health care system costs of unsafe abortion in Africa and Latin America", *International Perspectives on Sexual and Reproductive Health*, vol. 35, No. 3 (2009), pp. 114-121.

29. States must take measures to ensure that legal and safe abortion services are available, accessible, and of good quality. Safe abortions, however, will not immediately be available upon decriminalization unless States create conditions under which they may be provided. These conditions include establishing available and accessible clinics; the provision of additional training for physicians and health-care workers; enacting licensing requirements; and ensuring the availability of the latest and safest medicines and equipment.

30. Women are entitled to equal health protection afforded by the State as part of the right to health. Regardless of the legal status of abortion, women are entitled to receive access to goods, services and information related to sexual and reproductive health. In particular, they are entitled to have access to quality health services for the management of complications, including those arising from unsafe abortions and miscarriages. Such care must be unconditional even where the threat of criminal punishment is present, and it should not be contingent on a woman's cooperation in any subsequent criminal prosecution, or used as evidence in any proceeding against her or the abortion providers. Laws must not require health-care personnel to report women for abortion-related care to law enforcement or judicial authorities.

31. Absolute prohibition under criminal law deprives women of access to what, in some cases, is a life-saving procedure. Even where a clandestine abortion can be performed in a relatively safe, hygienic setting, it may be financially inaccessible for the most vulnerable women. Poor and marginalized women may instead turn to unsafe, self-induced abortions. Where narrow exceptions to the criminalization of abortion exist, such as to save the life of a woman, criminalization may effectively block access to information about legal abortion services. Women often remain unaware of these exceptions because the stigma surrounding the issue of abortion prevents dissemination and discussion of such necessary information. Legal restrictions on the availability of information relating to abortions also exist because criminal laws often include explicit provisions prohibiting the production and distribution of the information.

32. The provision of health-care goods and services that are of poor quality is a major problem arising from legal regimes criminalizing abortion. In these circumstances, the lack of State and professional regulation of medical practices means that abortions are performed by unskilled practitioners, in unhygienic conditions, in order to evade law enforcement.[19] On the contrary, when performed by trained health-care providers under appropriate conditions, abortion is one of the safest medical procedures available.[20] Criminalization further prevents practitioners from accessing accurate health information and, where exceptions to criminalization exist, the chilling effect created by its associated stigma may prevent health-care workers from seeking training and information on abortion. Health-care workers who choose to perform abortions under these circumstances may accordingly be uninformed and untrained on appropriate abortion procedure and post-abortion care, reducing the quality and availability of legal abortions.

33. Health-care workers have, on occasion, denied women access to legally available sexual and reproductive health services or simply refused to treat women suffering from complications resulting from a clandestine abortion performed

[19] WHO, *Unsafe Abortion: Global and Regional Estimates*, p. 7 (see footnote 14 above).
[20] WHO, *Safe Abortion: Technical and Policy Guidance*, p. 14 (see footnote 16 above).

elsewhere. Owing to the stigma surrounding abortion, health-care workers have also provided erroneous information to women, such as stating that a woman may have only one legal abortion.

34. The marginalization and vulnerability of women as a result of abortion-related stigma and discrimination perpetuate and intensify violations of the right to health. Abortion-related stigma prevents women from seeking abortions and prevents those who undergo abortions from requesting treatment for resulting medical complications. The gross underreporting of abortion — only 35 to 60 per cent are reported — is one indicator of the magnitude of the stigma attached to abortion. Although many social and cultural factors generate and exacerbate the stigma attached to abortion, criminalization of abortion perpetuates discrimination and generates new forms of stigmatization. For example, a woman's infertility may be misunderstood to be the result of a previous abortion, placing "culpability" on the woman as a result of the stigma associated with abortion rather than acknowledging that her infertility may be due to various unrelated health conditions.

35. The stigma resulting from criminalization creates a vicious cycle. Criminalization of abortion results in women seeking clandestine, and likely unsafe, abortions. The stigma resulting from procuring an illegal abortion and thereby breaking the law perpetuates the notion that abortion is an immoral practice and that the procedure is inherently unsafe, which then reinforces continuing criminalization of the practice.

36. The criminalization of abortion also has a severe impact on mental health. The need to seek illegal health services and the intense stigmatization of both the abortion procedure and women who seek such procedures can have deleterious effects on women's mental health.[21] In some cases, women have committed suicide because of accumulated pressures and stigma related to abortion.[22] In jurisdictions where rape is not a ground for termination of pregnancy, women and girls who are pregnant as a result of rape but who do not wish to continue their pregnancy are either forced to carry the pregnancy to term or seek an illegal abortion. Both options can cause enormous anguish. In electing to pursue either option, the overarching threat of being investigated, prosecuted and punished within the criminal justice system has significant negative impacts on the emotional health and well-being of both those who seek abortions and those who do not. Moreover, while the psychological impact of seeking an illegal abortion or carrying an unwanted pregnancy to term is well documented, no corresponding evidence supports the existence of long-term mental health sequelae resulting from elective abortion.[23]

2. Control over and criminalization of conduct during pregnancy and delivery

37. Maternal health, prenatal and post-natal care, and access to information, are all elements of the right to health elaborated under General Comment No. 14. Additionally, article 10.2 of the International Covenant on Economic, Social and Cultural Rights provides that special protection should be accorded to mothers. The Convention on the Elimination of All Forms of Discrimination against Women also recognizes that women should be provided with appropriate services in connection

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[21] WHO, *Mental Health Aspects of Women's Reproductive Health* (Geneva, 2008), p. 54.

[22] Ibid, p. 52.

[23] Vignetta E. Charles and others, "Abortion and long-term mental health outcomes: a systematic review of the evidence", *Contraception*, vol. 78, No. 6 (December 2008), p. 436.

with pregnancy. In chapter VII.A., the Programme of Action of the International Conference on Population and Development observes that reproductive health includes access to services that enable women to go through pregnancy and childbirth safely.[24] Despite these positive obligations to support women during pregnancy and post-birth, certain States have proposed or enacted criminal laws or other legal restrictions prohibiting certain forms of conduct, which infringe the right to health of affected women.

38. In certain jurisdictions, pregnant women have been prosecuted for various types of conduct during pregnancy. A number of prosecutions have occurred in relation to the use of illicit drugs by pregnant woman, including under pre-existing laws relating to child abuse, attempted murder, manslaughter and criminally negligent homicide. Criminal laws have also been used to prosecute women for other conduct, including alcohol use during pregnancy, the birth of stillborn babies or the miscarriage of a foetus (see A/HRC/17/26/Add.2, para. 68), failing to follow a doctor's orders, failing to refrain from sexual intercourse, and concealment of the birth.

39. In some instances, civil legislation related to child welfare has been expanded to include punitive sanctions for prenatal drug exposure, where such exposure may provide a ground for the termination of parental rights and the removal of the child upon birth. A pregnant woman's positive toxicology report or clinical signs of drug exposure in newborns, may be regarded as proof of child abuse or neglect under these legislative schemes. In some jurisdictions, health professionals are required to test pregnant women or newborns for drug exposure or may do so provided the woman is given notice. Others have enacted legislation authorizing the institutionalization of women who have used drugs during pregnancy. Health professionals may also be obliged to report positive drug-screening results to the Government.

40. Some States have also criminalized perinatal HIV transmission. For example, in one jurisdiction, a person infected with HIV (and aware of the fact) must "'take all reasonable measures and precautions to prevent the transmission of HIV to others and in the case of pregnant women, the foetus', with criminal sanctions imposed for failure to do so" (see A/HRC/14/20, para. 67). In this case, no exception or defence is allowed in relation to unavailability or lack of access to preventive health-care goods, services and information. Statutes from other jurisdictions, which criminalize HIV transmission generally, may also be applied to perinatal transmission.

41. Criminalization of conduct during pregnancy impedes access to health-care goods and services, infringing the right to health of pregnant women. Where women fear criminal prosecution, they may be deterred from accessing health services and care, as well as pregnancy-related information. For example, women may not seek antenatal services if they are faced with the risk of prosecution from transmitting HIV, which poses a risk to their health and the health of the foetus. This undermines public health objectives related to HIV, because women may refuse testing entirely if they face criminal penalties for transmission.

42. While public health goals can justify some degree of interference with personal freedoms, it has been well documented that the public health goals are not

[24] United Nations, *Treaty Series*, vol. 1249, No. 20378, article 12.

realized through criminalization; rather, they are often undermined by it (see A/HRC/14/20, para. 51). The application of criminal law to regulate conduct such as alcohol consumption during pregnancy is a disproportionate response and an ineffective deterrent. A number of professional medical associations oppose use of the criminal law as a means to address substance abuse by pregnant women, on the grounds of ineffectiveness and disproportionality.[25] In order to realize public health outcomes effectively and simultaneously promote the right to health of women, States should not criminalize such conducts during pregnancy, but rather ensure the provision of health-care goods, services and information that promote health throughout pregnancy and childbirth.

43. Certain criminal laws effectively shift the burden of realizing the right to health away from States onto pregnant women, punishing women for the lack of effective provision of health-care goods, services and education by the Government. For instance, where a woman living with HIV must take all reasonable measures and precautions to prevent the transmission of HIV to the foetus but there is limited or no access to health-care services and antiretroviral treatment, the State fails to provide what is needed for a woman to avoid criminal prosecution. The Special Rapporteur has observed that "where the right to access to appropriate health services … is not ensured, women are simply unable to take necessary precautions to prevent transmission, which could place them at risk of criminal liability" (see A/HRC/14/20, para. 66). As availability of, and access to, health-care goods and services is the responsibility of States, it is particularly perverse that the criminal law has the potential to punish women for the inadequacy of the Government in this respect.

3. Contraception and family planning

44. WHO defines family planning as a process that allows people to attain their desired number of children and determine the spacing of pregnancies which is achieved through use of contraceptive methods and the treatment of infertility.[26] Use of family planning methods is an integral component of the right to health. Contraception is a method of fertility control by which family planning is affected. Some forms can also be used for the prevention of sexually transmitted infections, primarily through physical barrier methods of contraception such as condoms. Various other forms of contraception exist, ranging from surgical sterilization to pharmaceutical methods, such as the oral contraceptive pill, which do not protect against sexually transmitted infections.

45. Family planning empowers women to make autonomous and informed choices about their sexual and reproductive health. It reduces maternal mortality by delaying pregnancies in young women who would otherwise face an increased risk of health problems and death from early childbearing. Evidence shows that access to voluntary family planning can reduce maternal deaths by between 25 and 40 per cent.[27] Family planning also reduces the number of unsafe abortions and the perinatal transmission of HIV. Condom use not only results in lower incidences of

[25] National Advocates for Pregnant Women, "What's wrong with making it a crime to be pregnant and to have a drug problem?" (9 March 2006).

[26] WHO, Family Planning, Fact sheet No. 351 (April 2011).

[27] World Bank, "Population issues in the 21st century: the role of the World Bank", Health, Nutrition, and Population (Washington, D.C., April 2007).

sexually transmitted infections but, when used correctly and consistently, male condoms are 98 per cent effective toward preventing pregnancy.[26]

46. The global unmet need for family planning remains a significant barrier to achieving rights-related and development goals. WHO estimates that 200 million couples in developing countries would like to delay or stop childbearing but are not using any method of contraception.[26] In 2009, 24 per cent of women of reproductive age in the least developed countries, who were married or in a union, reported not wanting any more children or wanting to delay the birth of their next child.[28] Reasons for the global unmet need included limited access to contraception; limited choice of contraceptive methods; fear or experience of side-effects; cultural or religious opposition; poor quality of available services; and gender-based barriers.

47. Family planning allows women to choose whether and when to reproduce and is thus integral to development and the full participation of women in society. In parts of sub-Saharan Africa, contraceptive use is four times higher among women with a secondary education than among those with no education, and is almost four times higher among women in the richest households than those in the poorest households.[29] One cross-national survey suggests that the percentage of women in the labour force is directly related to national birth rates.[30] Strong links have also been observed between contraception use by women and opportunities to work outside of the home; in one country, the average income growth for women with one to three pregnancies was twice that of women who had been pregnant more than seven times.[30]

48. Criminal laws and other legal restrictions that reduce or deny access to family planning goods and services, or certain modern contraceptive methods, such as emergency contraception, constitute a violation of the right to health. The Convention on the Elimination of All Forms of Discrimination against Women calls upon States to ensure access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning, as well as access to adequate health-care facilities, including information, counselling and services in family planning.[31] In General Comment No. 14, the Committee on Economic, Social and Cultural Rights calls upon States to take measures to "improve child and maternal health, sexual and reproductive health services, including access to family planning … and access to information, as well as to resources necessary to act on that information" (see E/C.12/2000/4, para. 14).

49. In chapter II, principle 8, of the Programme of Action of the International Conference on Population and Development confirms that States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. It also stresses the need for participation and notes that family planning programmes are most successful when women are fully involved in the design, provision, management and evaluation of services. It further adds that Governments should remove all unnecessary legal,

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[28] *World Contraceptive Use 2010* (POP/DB/CP/Rev2010), available from http://www.un.org/esa/population/publications/WCP_2010/Data.html.

[29] *Millennium Development Goals Report 2010* (United Nations publication, Sales No. E.10.I.7), p. 37.

[30] World Bank, "Population issues", p. 26 (see footnote 27 above).

[31] United Nations, *Treaty Series*, vol. 1249, No. 20378, articles 10 (h), 14 (b).

medical, clinical and regulatory barriers to information and to access to family-planning services and methods. In paragraph 96, the Beijing Platform for Action declares that the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

50. However, in many States access to family planning goods and services is severely curtailed by criminal laws and other legal restrictions. In these jurisdictions, women and men (especially the poor) lack access to safe and effective contraception and are denied the freedom to decide whether or not to reproduce.

51. For example, some States have criminalized the distribution and use of emergency contraception,[32] justifying such laws with claims that emergency contraception is abortifacient. WHO, however, confirms that emergency contraception is a valid form of contraception.[33] Women who carry an unplanned pregnancy to term as a result of such laws also might face adverse physical and mental health outcomes.[34] At the same time, women who lack access to emergency contraception as a result of criminal prohibitions may ultimately be forced to seek clandestine abortions, thus exposing themselves to the associated health risks.

52. Restricting access to surgical methods of contraception also contravenes the obligations of States to ensure that quality services are available and accessible. For instance, tubal ligation, a safe and effective sterilization procedure for women, is prohibited by law in some countries except under narrow circumstances where the procedure is therapeutically necessary. Read in conjunction with laws criminalizing violence causing permanent damage to a limb, this law exposes health professionals who perform the procedure to criminal liability, thus restricting women's access to this method of contraception. Women may instead seek tubal ligation procedures in unlicenced health facilities, potentially placing them at the risk of experiencing health complications and effectively denying access to poor women who cannot afford such procedures.

53. Other laws restricting access to family planning and contraception include a city-wide de facto ban on so-called "artificial" contraception in one jurisdiction, which created significant difficulty for women in accessing reliable forms of birth control (see A/HRC/14/20/Add.1). A total of 70 per cent of the affected population, a majority of whom were poor and marginalized, depended on Government providers for services including female sterilization, oral pills, intrauterine devices and injectables (ibid.). The ban resulted in the absolute deprivation of access to family planning services and contraception for many women and men. In other instances, States require women to obtain their husband's consent and adolescents to obtain parental consent before acquiring various forms of contraception. Other jurisdictions allow pharmacists, and in some cases pharmacies, to refuse to dispense emergency contraception, which is otherwise legally available. These laws directly infringe upon the right of women and girls to make free and informed choices about their sexual and reproductive health and reflect discriminatory notions of women's roles in the family and society.

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[32] Eileen Kelly, "Crisis of conscience: pharmacist refusal to provide health care services on moral grounds", Employee Responsibility Rights, vol. 23, No. 1 (2011), 37-54.

[33] WHO, Emergency contraception, Fact Sheet No. 244 (revised October 2005). Available from http://www.who.int/mediacentre/factsheets/fs244/en/index.html.

[34] WHO, *Mental health*, p. 55 (see footnote 21 above).

54. Women are also entitled to participate in all decisions affecting their sexual and reproductive health at all levels of decision-making. Community-level participation concerning use of contraception has been shown to increase a woman's autonomy and capacity to freely choose to use condoms, not only providing her with a means of controlling fertility but also protecting her own health in preventing sexually transmitted infections.[35]

55. The obligation to respect the right to health requires that States abstain from limiting access to contraceptives and other means of maintaining sexual and reproductive health. States should therefore remove criminal laws and other legal restrictions, including parental consent laws and other third party authorizations, to ensure access to family planning and contraceptive goods, services and information. The obligation to protect requires States ensure that neither third parties nor harmful social or traditional practices interfere with access to prenatal and post-natal care and family-planning (see E/C.12/2000/4, para. 35), or curtail access to some or all contraceptive methods. Finally, the obligation to fulfil includes adopting and implementing a national public health strategy, which includes the provision of "a wide range of sexual and reproductive health services, including access to family planning (...) and access to information (see E/CN.4/2004/49, para. 29)".

4. Education and information on sexual and reproductive health

56. The provision of comprehensive education and information on sexual and reproductive health is an essential component of the right to health and to the realization of other rights, such as the right to education and access to information. Criminal and other laws restricting access to comprehensive education and information on sexual and reproductive health are thus incompatible with the full realization of the right to health and should be removed by States (see E/C.12/2000/4, para. 11). Both women and men are adversely affected by these barriers. Women, however, are disproportionately impacted.

57. General Comment No. 14 places emphasis on access to information because it is a critical component of the right to health (ibid; footnote 8), and particularly guarantees access to sexual and reproductive health information. States are additionally required to provide adequate resources and refrain "from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information (see E/C.12/2000/14, para. 14)". The Committee on the Elimination of Discrimination against Women has recommended that a comprehensive understanding of the content of sexual and reproductive education encompass the topics of reproductive rights, responsible sexual behaviour, sexual and reproductive health, prevention of sexually transmitted infections including HIV/AIDS, prevention of teenage pregnancies, and family planning,[36] and stressed that education campaigns are urgently needed to combat harmful practices such as female genital mutilation.[37] Comprehensive education and information on sexual

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[35] For example, in Kolkata, India, the rate of condom use among sex workers rose from 3 to 90 per cent over the course of seven years as a result of a community-led structural intervention called the Sonagachi Project. See T. Ghosea and others, "Mobilizing collective identity to reduce HIV risk among sex workers in Sonagachi, India: the boundaries, consciousness, negotiation framework", *Social Science Medicine*, vol. 67, No. 2 (2008), pp. 311-320.

[36] See A/56/38, para. 224; A/56/38, para. 303; A/53/38, para. 349; CEDAW/C/PHI/CO/6, para. 28.

[37] See E/C.12/1/Add.78, para. 31; and E/C.12/1/Add.62, para. 39.

and reproductive health is also useful in reducing knowledge gaps between men and women on these issues.[38]

58. The International Guidelines on Sexuality Education of the United Nations Educational, Scientific and Cultural Organization (UNESCO) describe optimal sexual education as "an age-appropriate, culturally sensitive and comprehensive approach … that include programmes providing scientifically accurate, realistic, non-judgmental information".[39] Moreover, comprehensive sexual and reproductive health education and information should provide "opportunities to explore one's own values and attitudes and to build decision-making, communication, and risk reduction skills about all aspects of sexuality".[39] The Special Rapporteur on the right to education has further emphasized that a comprehensive curriculum requires sensitivity to sexual diversity and a gendered perspective (see A/65/162, para. 23).

59. Laws restricting information about sexual and reproductive health and which censor discussions of homosexuality in the classroom fuel stigma and discrimination of vulnerable minorities.[40] For example, laws and policies that promote abstinence-only education reduce sexual education to images and stereotypes of heteronormativity, given their focus on procreation; some of these programmes even contain explicitly discriminatory content on gender and sexual orientation.[41] In certain instances, teachers have been suspended or threatened with lawsuits for engaging in discussions on "inappropriate" sexual matters with their students when discussing sexual and reproductive health issues in the classroom. In other cases, pursuant to abstinence-only and anti-obscenity policies, school districts, courts and legislators have prohibited civil society organizations from meeting in public schools. Such laws and policies perpetuate false and negative stereotypes concerning sexuality, alienate students of different sexual orientations and prevent students from making fully informed decisions regarding their sexual and reproductive health.

60. Even in jurisdictions where sexual and reproductive health education is permitted in some form, its quality and effectiveness can be severely diminished by policy prescriptions. States have assisted in the dissemination of misinformation on condom use either by distributing materials that contain inaccurate information or by remaining silent on the topic, which allows for the proliferation of contradictory and inaccurate information.[42] Similarly, abstinence-only campaigns that focus only on abstaining from sexual intercourse as a means to avoid sexually transmitted infections and unintended pregnancies provide a narrow and incomplete rather than a comprehensive perspective. Such programmes, which often lack accurate and evidence-based information, have been shown to have a minimal or no effect on reducing the transmission of sexually transmitted infections.

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[38] UNAIDS, *Global Report on the AIDS Epidemic 2008* (Geneva, 2008).

[39] UNESCO, *International Guidelines on Sexuality Education: An Evidence Informed Approach to Effective Sex, Relationships and HIV/STI Education* (Paris, 2009), p. 61.

[40] See the International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia; Human Rights Watch, Rights at Risk, Executive Summary (2011); and BBC, "Brazil sex education material suspended by President" (25 May 2011). Available from http://www.bbc.co.uk/news/world-latin-america-13554077.

[41] See A/65/162, paras. 68 and 69; and A/HRC/14/20/Add.3, para. 25.

[42] UNESCO, "Review of sex, relationships and HIV education in schools" (2007), pp. 16 and 17.

61. Studies have shown that while few young people have accurate knowledge about HIV/AIDS,[43] women are generally even less well informed than men. In a UNAIDS study of 147 countries, whereas more than 70 per cent of young men were found to recognize that condoms can protect against HIV, only 55 per cent of young women identified condoms as an effective strategy for HIV prevention.[44] Women and girls are disproportionally impacted by legal restrictions to comprehensive sexual and reproductive health education and information, which both reinforces and exacerbates the gender inequalities that the figures demonstrate. The existence of legal restrictions on access to sexual and reproductive health information and education lead to the provision of inaccurate information through informal sources that are often inaccurate and may reinforce negative gender stereotypes. As a result, young women are less prepared for their sexual and reproductive lives, leaving them vulnerable to coercion, abuse and exploitation, as well as to an increased risk of unintended pregnancy, unsafe abortion, maternal mortality, HIV/AIDS and other sexually transmitted infections.[45]

62. In jurisdictions where aspects of sexual and reproductive health are criminalized, the availability and accessibility of related information is greatly restricted. For example, penal codes may contain specific provisions that prohibit dispensing information on the prevention or interruption of pregnancies, or materials that supposedly conflict with notions of morality or decency. Punishments can range from fines to imprisonment. Moreover, the restriction of information relating to health can be an unintended result of laws relating to other information, such as pornography laws, which can also extend to criminalize sexual and reproductive health materials.[46] Thus, public health and empowerment programmes and activities that rely on such information — educational campaigns on HIV/AIDS and sexually transmitted infection prevention, family planning, domestic violence, gender discrimination, female genital mutilation, sexual diversity, overall sexual and reproductive health — are effectively prohibited. Women and girls are most likely to be affected by this gap in available services and programming because they are exposed to a higher risk of HIV/AIDS and sexually transmitted infections, maternal mortality, unsafe abortion and unwanted or unplanned pregnancies.

63. Adequate knowledge about sexual and reproductive health has repeatedly proved to be effecting in lowering rates of maternal mortality; preventing unintended pregnancies, unsafe abortion, HIV/AIDS and other sexually transmitted infections; delaying the onset of sexual intercourse; increasing knowledge about family planning options; and protecting against gender-based violence (see E/C.12/2000/4, para. 21). Empowering women through comprehensive education and information on sexual and reproductive health is also imperative since young women often have less power or control in their relationships, which make them disproportionately vulnerable to coercion, abuse and exploitation.[47] As a tool for empowerment and means to critically examine gender inequalities and stereotypes, comprehensive education and information also becomes a way of eroding deeply entrenched systems of patriarchy; such systems perpetuate violations of women's

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[43] UNAIDS, *Global Report 2008*, p. 98 (see footnote 38 above).

[44] Ibid.

[45] UNESCO, *International Guidelines on Sexuality Education*, p. 2 (see footnote 39 above).

[46] Amnesty International, *Left Without a Choice: Barriers to Reproductive Health in Indonesia* (London, 2010).

[47] See UNESCO, *International Guidelines on Sexuality Education*, p. 20 (see footnote 39 above).

rights, including their right to health (see A/65/162, paras. 7-9). Providing women with knowledge and skills relating to their sexual and reproductive health, related education and information enhances their freedom in making informed health-related decisions, and promotes their equal participation in society.

64. States that implement and enforce criminal or other laws to restrict access to sexual and reproductive health information actively reduce access to information and therefore do not meet their obligation to respect the right to health. As a consequence of such laws and the stigma they generate, third parties, such as teachers, publishers, or booksellers may also deny women and girls access to necessary sexual and reproductive health materials. The obligation of States to fulfil the right to health requires that they develop strategies to ensure that comprehensive sexual and reproductive health education and information is provided to everyone, especially women and young girls.

V. Recommendations

65. **In applying a right-to-health approach, States should undertake reforms toward the development and implementation of policies and programmes relating to sexual and reproductive health as required by international human rights law. In that context, the Special Rapporteur calls upon States to:**

(a) **Formulate public health policies and programmes that disseminate evidence-based information regarding sexual and reproductive health, as well as the prevention of perinatal HIV transmission;**

(b) **Develop comprehensive family planning policies and programmes, which provide a wide range of goods, services and information relating to contraception and are available, accessible and of good quality;**

(c) **Decriminalize the supply and use of all forms of contraception and voluntary sterilization for fertility control and remove requirements for spousal and/or parental consent;**

(d) **Take steps to ensure the availability, accessibility and quality of a full range of contraceptive methods, including both pharmaceutical and surgical contraceptive methods;**

(e) **Decriminalize the provision of information relating to sexual and reproductive health, including evidence-based sexual and reproductive health education;**

(f) **Formulate policies to ensure that existing criminal laws, such as those concerning pornography, are not applied to restrict access to, or punish those who provide, evidence-based sexual and reproductive health information and education;**

(g) **Take steps to standardize national curricula to ensure that sexual and reproductive education is comprehensive, evidence-based, and includes information regarding human rights, gender and sexuality;**

(h) **Decriminalize abortion, including related laws, such as those concerning abetment of abortion;**

(i) **Consider, as an interim measure, the formulation of policies and protocols by responsible authorities imposing a moratorium on the application of criminal laws concerning abortion, including legal duties on medical professionals to report women to law enforcement authorities;**

(j) **Ensure safe, good quality health services, including abortion, using services, in line with WHO protocols;**

(k) **Establish policies and programmes to ensure the accessibility and availability of safe, reliable and good quality services for abortion-related complications and post-abortion care, in line with WHO protocols, particularly in jurisdictions where abortion is criminalized;**

(l) **Ensure that accurate, evidence-based information concerning abortion and its legal availability is publicly available and that health-care providers are fully aware of the law related to abortion and its exceptions;**

(m) **Ensure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider;**

(n) **Suspend/abolish the application of existing criminal laws to various forms of conduct during pregnancy, such as conduct related to treatment of the foetus, most notably miscarriage, alcohol and drug consumption and HIV transmission.**