SUBSTANTIVE EQUALITY AND REPRODUCTIVE RIGHTS

A BRIEFING PAPER ON ALIGNING DEVELOPMENT GOALS WITH HUMAN RIGHTS OBLIGATIONS

CENTER FOR REPRODUCTIVE RIGHTS

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International human rights norms have recognized that reproductive rights are women's rights, clarifying that violations of reproductive rights are primarily manifestations of discrimination, poverty, and violence. Where women's rights to equality and non-discrimination are not fulfilled, women's ability to access reproductive health services and make meaningful choices about their reproductive lives is limited. In addition, where women are unable to access reproductive health services, the inequalities and discrimination women face are exacerbated due to the differentiated impact that childbearing has on women's health and lives, including in the spheres of education and employment. Gender inequalities create gender-specific barriers to the realization of women's rights, including historical and systemic discrimination; gender stereotypes about women as mothers, caregivers, and child-bearers; and traditional and cultural beliefs about the role of women in society.[1]

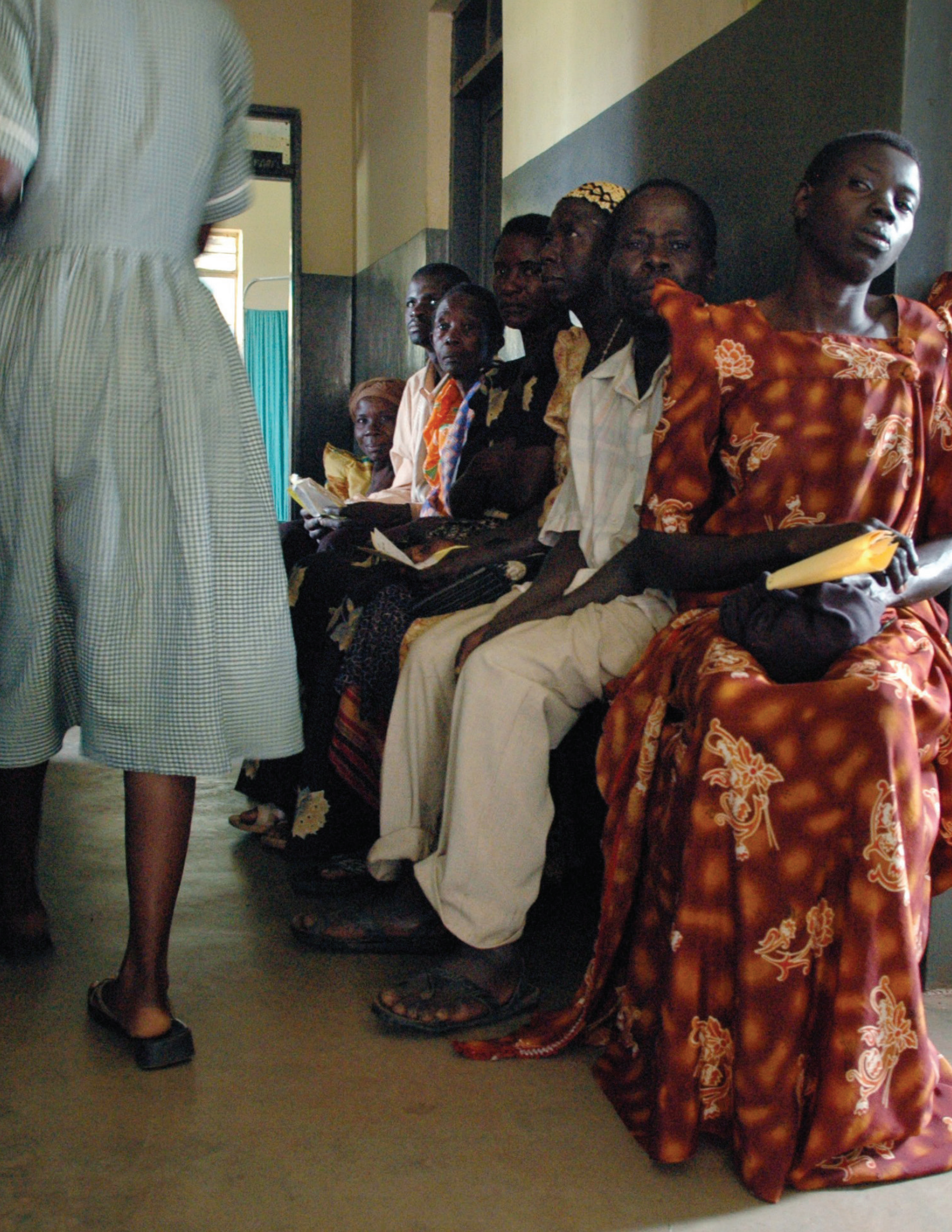
The principle of substantive equality provides a framework by which to effectively recognize and address inequalities faced by women. At its core, substantive equality requires states to identify the root causes of discrimination, such as power structures and social and economic systems reinforced by gender stereotypes and socialized gender roles, which lead to inequalities. Substantive equality also requires states to acknowledge that people experience inequality differently not only because of who they are as individuals but also because of the groups to which they belong. Finally, substantive equality requires that states measure progress on addressing inequalities by looking at outcomes of results for all persons, including the most marginalized, and ensuring equality of results, which may require enacting practices and policies targeting particular marginalized groups.

Achieving equality, particularly gender equality, has been articulated as one of the main goals of both international development programs and international human rights law. Development programs, however, have been largely unsuccessful to date in eliminating the root causes of the inequalities women face, which create gender-specific barriers to the realization of women's rights due to the lack of a substantive equality approach.

Over the next two years, states have an opportunity to address the root causes of gender inequality by ensuring that reproductive rights, including the equality aspects of reproductive rights, are reflected in development goals and programs. In particular, states must ensure there are specific targets and indicators on reproductive rights and gender equality in the Post-2015 Development Agenda (Post-2015 Agenda), as the Post-2015 Agenda will guide a significant amount of the world's development funding during the next 20 years. The Post-2015 Agenda also provides an opportunity for states to change their laws and policies at the national level to proactively promote gender equality and reproductive rights. At the international level, states will be able to demonstrate their commitment to achieving gender equality and realizing reproductive rights, including through the development of a set of sustainable development goals (SDGs) that respect, protect, and fulfill all human rights.

This briefing paper is intended to provide guidance on how to incorporate the principles of substantive equality into the Post-2015 Agenda. Specifically, when considering reproductive rights and gender equality in these programs, states should take the following steps:

- **Ensure that human rights guide and are present in all goals, targets, and indicators.**
  - Ensure that the core principles of human rights—including the need for states to respect, protect, and fulfill rights, ensure equality for all, and promote accountability for rights violations—are mainstreamed throughout the new framework.
  - Use the principle of substantive equality to address underlying causes of gender inequality and other bases for discrimination such as race, disability, migration status, age and others that manifest as reproductive rights violations.
  - Use the framework provided by international human rights law concerning the right to health (Accessibility, Availability, Acceptability, Quality (AAAQs)) to guide implementation of all goals, targets, and indicators on health.
  - Ensure that women are able to meaningfully access effective administrative or judicial remedies for violations of reproductive rights, including access to information and comprehensive services, and that states promptly implement these decisions.



GENDER EQUALITY AND REPRODUCTIVE RIGHTS

A. An Overview of Gender Equality

Since their first articulation in the Universal Declaration of Human Rights (UDHR), international human rights principles have recognized women's right to equality.[2] Two models of equality, formal equality and substantive equality, have emerged as the primary modes by which human rights mechanisms and courts have sought to address inequalities.[3]

Formal equality, which is often referred to as "de jure" equality, requires that states provide equality in law and in treatment for all groups, including men and women. This model of equality emphasizes the need for states to eliminate distinctions in laws and policies based on group characteristics, such as race or gender.[4] As such, this model of equality has tried to eliminate stereotypes and discrimination by attempting to create a world where the law treats everyone the same.[5] In particular, formal equality provides a basis through which states can protect individuals from state and private intrusions into their liberty.[6]

Formal equality principles have been useful in addressing persistent gender inequalities but have not on their own achieved the goal of overcoming gender stereotypes and ending discrimination against women. By ignoring group characteristics, formal equality has not addressed the disadvantage that comes with historically and socially entrenched gender stereotypes and roles. Furthermore, formal equality may envisage a model of human rights where the state's main role is to respect and protect—rather than fulfill—human rights. This is because of formal equality's emphasis on equality in law, as opposed to in practice, thus requiring states to refrain from and prosecute acts of discrimination but not necessarily requiring states to take positive measures to promote equality.[7]

To confront the historical and socialized discrimination and barriers faced by women and other marginalized groups, such as racial minorities, international human rights bodies have established the principle of substantive equality, or "de facto" equality. For women, substantive equality seeks to remedy entrenched discrimination by requiring states to take positive measures to address the diverse inequalities women face. Substantive equality demands the recognition of the various ways discrimination plays out in women's lives. It requires recognition and analysis of discriminatory power structures—including historical and socialized roles of women, gender stereotypes, and laws and policies—and how these structures affect the ways in which individuals and groups experience discrimination. It further calls on states to ensure they are taking the necessary steps to proactively address these impacts and change the context in which discrimination arises.[8]

International human rights treaties make clear that ensuring gender equality is a human rights obligation that states must respect, protect and fulfill. The three foundational human rights instruments—the UDHR, the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social, and Cultural Rights (ICESCR)—require non-discrimination in the application of all rights as well as equal enjoyment of rights for both men and women.[9] The Convention on the Elimination of all forms of Discrimination against Women (CEDAW) then provides a comprehensive framework for addressing gender discrimination and inequality.

CEDAW AND EQUALITY

- **Article 1** defines discrimination against women to include "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."[10]
- **Article 2** describes the general methods by which states should eliminate discrimination, including by ensuring equality between men and women in law and by respecting, protecting, and fulfilling women's rights through legislation and other means in both the public and private spheres.[11]
- **Article 5** addresses social structures, including the family, that may hinder women's development and affect women's equality. It requires that states take an active role in breaking down women's socialized roles, redefining relationships between men and women, and eliminating stereotypes.[12]

B. Substantive Equality and Reproductive Rights

Reproductive rights lie at the heart of human rights for women. Because reproductive health services are services that primarily women need, due to their different reproductive capacities, ensuring access to reproductive health services such as contraception, abortion, and maternal health services is essential to ensuring that women can equally exercise their human rights.[13] Upholding reproductive rights is essential to ensuring gender equality for women, so that women are able to exercise autonomy and make meaningful choices about their lives, not limited by discrimination or lack of opportunities or possible results and without undue influence or coercion. Substantive equality can then also play an important role in analyzing and addressing reproductive rights violations, because substantive equality empowers women to make choices about their own reproductive health and lives while also requiring states to address the historical causes of health-related gender inequalities.

As states develop a Post-2015 Agenda that will guide development programs and seek to ensure better lives for all people, they must keep in mind the gender inequalities that stem from and are reinforced by reproductive rights violations. Human rights norms provide guidance to states about how to overcome gender inequality and ensure substantive equality, particularly with respect to reproductive rights.

Reproductive rights are explicitly included in two articles of the CEDAW Convention. Article 12 concerns equality in the right to health, providing that "States Parties 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."[14] Article 12 then goes on to enumerate special protections for women during pregnancy, confinement, and the post-natal period, "granting free services where necessary."[15]

The provision of reproductive health services must conform to the international human rights framework concerning the general right to health—namely, the state obligations to ensure availability, accessibility, acceptability, and quality (AAAQs) of health facilities, goods, services, and information on a basis of non-discrimination.[16]

THE AAAQS AND THE RIGHT TO HEALTH

- **Availability:** There must be an adequate number of functioning health care facilities, services, goods and programs to serve the population,[17] including essential medicines such as contraception and emergency contraception.[18]
- **Accessibility:** Health facilities and services must be accessible to the population without discrimination, meaning that they must be accessible to all, in law and in practice, particularly the most marginalized groups.[19] Health facilities and services must also be physically accessible, including for people with physical disabilities, and affordable, ensuring that impoverished families and individuals do not bear a disproportionate burden of health costs.[20] Finally, information must be accessible, meaning that individuals and groups must be able to seek, receive, and disseminate unbiased, clear, and scientifically accurate information on reproductive health issues.[21]
- **Acceptability:** Health facilities, services, and goods must be culturally appropriate and should take into account the interests and needs of marginalized groups, including racial and ethnic minorities, indigenous populations, persons with disabilities, and different genders and age groups.[22]
- **Quality:** Health services must be scientifically and medically appropriate, which requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.[23]

Reproductive rights are also explicitly recognized in Article 16 of the CEDAW Convention, which provides a right to decide on the number and spacing of children. This article protects the autonomy of women in decisions about their reproductive rights, including guaranteeing access to information, and requires states to eliminate discrimination and ensure equality for women in marriage and family relations.[24]

Many of the norms surrounding reproductive rights and equality also stem from international consensus documents, including a groundbreaking set of political commitments made in Cairo in 1994, the International Conference on Population and Development (ICPD) Programme of Action, and in Beijing in 1995, the Beijing Platform for Action.

THE ICPD PROGRAMME OF ACTION AND THE BEIJING PLATFORM FOR ACTION

At the ICPD in 1994, 179 countries adopted a Programme of Action in which they agreed that population policies must be aimed at empowering couples and individuals—especially women—to make decisions about the size of their families, and that states must provide them with the information and resources to make such decisions. For the first time in an international consensus document, states agreed that reproductive rights are human rights that are already recognized in domestic and international law, and that reproductive health should be an essential aspect of development programs.

The ICPD Programme of Action recognizes that realizing reproductive rights is a critical part of ensuring development. The ICPD Programme of Action broadly defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."[25] Reproductive health implies that people are able to have a safe and satisfying sex life; the ability to reproduce; and the right to decide if, when, and how frequently to reproduce.[26] Governments also recognized the inherent link between sustainable development, the eradication of poverty, and gender equality, and committed to address these issues in tandem.[27] Furthermore, states agreed that coercive laws, policies, and practices that do not respect individuals' autonomy and decision making must be eliminated.[28] In adopting the ICPD Programme of Action, states committed to take legal, policy, budgetary, and other measures to effectuate the principles and rights enshrined in this document.

In 1995, states came together in Beijing on a similar mission: to more fully define and commit to ensuring equality for women in all aspects of their lives. The Beijing Platform for Action brought states together to agree that "[e]quality between women and men is a matter of human rights and a condition for social justice and is also a necessary and fundamental prerequisite for equality, development and peace."[29] The Beijing Platform for Action specifically acknowledges the role that health, particularly sexual and reproductive health, plays in women's equality.[30] It also relates reproductive health back to women's human rights, including the rights to decide on the number and spacing of children, to attain the highest standard of physical and mental health, and to be free from discrimination and violence, and recognizes that government action to promote reproductive health should be based on these rights.[31]

With the principles of substantive equality and the framework of reproductive rights in mind, human rights institutions have provided the following guidance to states about overcoming discriminatory power structures, recognizing differences between men and women and among women, and achieving equality of results in the area of reproductive rights.

Overcoming Discriminatory Power Structures

Discriminatory power structures, which perpetuate negative ideas about the role of women in society— such as stigma, stereotypes, and traditional beliefs about women—and laws and policies that reinforce traditional gender roles, are some of the main factors contributing to lack of access

to reproductive health services for women, reinforcing power disparities that limit women's opportunities for equality. These structures can include the legal system, state administered social and economic programs, educational institutions, hospitals, employers, etc. In the context of reproductive rights, these discriminatory power structures maintain gender stereotypes which assign a primary role to women as mothers and caregivers as well as the laws and policies that stem from those stereotypes, which may limit women's access to reproductive health services and undermine women's reproductive autonomy.

Both the Beijing Platform for Action and the ICPD Programme of Action recognize the power imbalances that lead to poor health outcomes for women.[32] Indeed, the Beijing Platform for Action addresses the fact that "[h]ealth policies and programmes often perpetuate gender stereotypes…and may not fully take account of the lack of autonomy of women regarding their health."[33] The Platform explains that poor reproductive health outcomes for women result from "discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives," among other factors.[34] Additionally, the ICPD Programme of Action recognizes that women should be able to make reproductive decisions "free of discrimination, coercion and violence, as expressed in human rights documents."[35] Indeed, the Programme of Action emphasizes the reinforcing nature of promoting women's empowerment and breaking down the power structures that limit their autonomy, stating that "improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction."[36]

As Article 5 of the CEDAW Convention recognizes, ensuring equality for women requires states to address entrenched discrimination against women, including discrimination based on gender stereotypes.[37] In the context of reproductive rights, gender stereotypes that reinforce the traditional role of women as mothers and caregivers often mean that women are denied needed reproductive health services. The CEDAW Committee's decision in *L.C. v. Peru* provides guidance on a state's obligation to eliminate gender stereotypes of women as mothers and caregivers in the context of ensuring their reproductive equality.

GENDER STEREOTYPES AND ABORTION: L.C. V. PERU

L.C. was 13 years old when she became pregnant as a result of sexual abuse. She attempted to commit suicide by jumping off a building, resulting in serious spinal injuries that required urgent surgery. Nonetheless, doctors refused to provide her with the necessary medical care to correct the spinal injuries because they were concerned that the surgery would pose risks to the fetus. It was not until after L.C. experienced a miscarriage nearly three months later that she received the medical care she required, and as a result she continues to experience a severe physical disability. The CEDAW Committee found that Peru had violated L.C.'s rights to equality and non-discrimination, her right to health, and her right to be free from gender stereotyping because the state's laws and policies effectively denied her access to needed medical care because of her pregnancy.[38] The CEDAW Committee, based on Article 5, used a substantive equality framework to determine violations of the right to be free from gender stereotyping, noting that "the decision to postpone the surgery due to the pregnancy was influenced by the stereotype that protection of the fetus should prevail over the health of the mother."[39]

Additionally, gender stereotypes about women as mothers and caregivers may lead states to implement policies that make certain reproductive health services unaffordable for women. In some instances, reproductive health services, including contraception and abortion, may be excluded from coverage by public health insurance or be denied subsidization by the state, limiting access to those services particularly for poor and marginalized women. Human rights bodies have consistently called on states to ensure that reproductive health services, including abortion and contraception, are affordable for all women, covered by public health insurance when available, and included on government lists of subsidized medicines.[40]

Some of the most powerful structures that impede women's reproductive equality are restrictions, in law or in practice, on their exercise of reproductive autonomy. Substantive equality for women is commonly linked to reproductive rights and the autonomy of women to determine the course of their lives.[41] As the CEDAW Committee has noted, restrictions such as high fees, third-party authorization for services, distance from health facilities, inability to access or control family finances, and lack of affordable transport are all issues that can prejudice women's reproductive autonomy.[42] Where women are not able to exercise reproductive autonomy, because of legal, cultural, social, structural, or economic restrictions, they face inequalities in their health outcomes and in many other aspects of their lives.

In particular, women may be denied reproductive health services because of legal provisions that require a third party such as a judge, a doctor, a spouse, or a parent to provide authorization for the service. Third party authorization requirements are found in some laws regulating access to abortion or contraception or may be required for adolescents accessing health services. Third party authorization requirements undermine women's autonomy by placing the decision about reproductive health, and as a result, many other aspects of women's lives, in the hands of others. This system reinforces the gender-based stereotype that women are not competent or responsible decision-makers. Human rights bodies have recognized that, as a means of achieving equality and ensuring that women are free from discrimination and can exercise their autonomy, states must eliminate third party authorization requirements for reproductive health services, including for adolescents, and ensure that health care providers do not impose these requirements.[43]

BARRIERS TO CONTRACEPTIVE ACCESS IN SLOVAKIA

Gender stereotypes and discriminatory traditional beliefs have limited access to contraceptives for women in Slovakia through the influence of the Catholic Church hierarchy. In rural parts of Slovakia, the Catholic Church hierarchy maintains a strong influence, including through its condemnation of the use of contraceptives. Research conducted by the Center for Reproductive Rights (CRR) in 2011 found that doctors in rural Slovakia, who may be the only providers in their areas, may invoke conscientious objection based on Catholic beliefs to refuse to provide prescriptions for contraception. As a result, women in rural areas who lack access to alternative health service providers may be unable to access contraception.[44] Rural women may also feel more uncomfortable going to providers for contraceptives because of fears that, in a small community, their patient confidentiality may be breached.[45] Additionally, because sexual activity before marriage is stigmatized, girls in rural areas have a more difficult time admitting that they use or would like to use contraceptives.[46]

These discriminatory power structures have also led to state policies that make contraception unaffordable for many women in Slovakia.[47] In 2011, the Slovak government enacted a law that specifically prohibits coverage of contraceptives under public health insurance when used solely for prevention of pregnancy, a medical service that only women need.[48] Women are therefore left to cover the entire cost of most contraceptive methods. Additionally, the Slovak government has refused to regulate the price of contraceptives or subsidize contraceptives.[49] The resulting high price of contraceptives is prohibitive for some women and keeps others from using the method that would be most suitable based on their health, personal circumstances, or preferences.[50] The use of hormonal contraceptives remains low in Slovakia, at 20.5% of women of reproductive age, while use of withdrawal as a family planning method, a traditional method that is likely to fail to prevent pregnancy, is over 30%.[51]

Recognizing Difference

Substantive equality also requires that states recognize differences between groups that are the result of or may result in discrimination and inequalities. In the context of reproductive rights, for instance, states must recognize the biological differences between men and women, including women's ability to become pregnant and bear children, and the resulting different health needs of women, and that traditional gender roles of women as mothers and caregivers may reinforce inequalities.[52] As the Beijing Platform for Action acknowledges. "[w]omen have different and unequal access to and use of basic health resources, including primary health services," and "[w]omen also have different and unequal opportunities for the protection, promotion and maintenance of their health."[53] This means that women may require services that men do not in order for women to achieve equal social and health outcomes.[54]

Substantive equality also requires that states take into account the differences that exist between groups of women, which may result in intersectional discrimination. Human rights institutions have addressed the need to ensure gender equality for women from marginalized groups, recognizing that discrimination can be compounded for women based on both their gender and other identities. Human rights treaties and bodies, for instance, recognize the particular forms of intersectional discrimination targeted at women with disabilities,[55] women migrant workers,[56] and women who are subject to racial discrimination, finding that these women's multiple identities can lead to discrimination that only affects them or affects them in different ways from men.[57] It also means that women may face intersectional discrimination that requires states to take further actions to meet their distinctive health needs and overcome barriers to their access to reproductive health services.[58]

As noted previously, in order to meet their obligations under the right to health, states must ensure that health services are acceptable for all persons. This means that these services must be provided free from discrimination, violence, or coercion. For women with intersectional identities, such as women with disabilities, from racial minorities, with low socioeconomic status, living with HIV, or indigenous women, among others, intersectional discrimination can lead to further inequalities related to their health, and thus must be addressed with the sources of this discrimination in mind.[59] The ICPD Programme of Action recognizes the importance of including marginalized populations in the design, implementation, and monitoring of sexual and reproductive health programs, as means of addressing inequalities.[60]

REPRODUCTIVE HEALTH FOR RURAL WOMEN

Rural women, for example, are more likely than other women to experience poverty and less likely to have formal education or paid employment. Many also face language barriers, which can result in multiple impediments to accessing reproductive health services.[61] Additionally, rural women often live far from health providers, which may require rural women to travel long distances, and have limited access to public transportation.[62] Costs associated with traveling long distances to access services, such as loss of income, transportation, or accommodation costs, can also disproportionately limit rural women's access to reproductive health services, as rural women are more likely to live in poverty.[63] Further, the disparate geographical access to health services means that women may not have another provider or health facility that they can turn to for reproductive health services if their closest provider does not have access to the proper or appropriate medicines or if the provider refuses to administer certain reproductive health services such as in instances of conscientious objection.[64]

Rural women from minority groups may face additional barriers to accessing reproductive health services, due to discrimination and social exclusion. In many states, registration in the state or city where one lives is a prerequisite to accessing other social services, including state-provided health information and services. Romani women in Europe, for example, face discrimination in accessing social services because of barriers they face in registering for social benefits in the town or country where they live, including for those who live in informal settlements, who may travel to different parts of a country throughout the year, or who are not recognized as citizens of the country in which they reside.[65] As a result of these barriers and prevalent gender and racial stereotypes directed at Romani communities, Romani women may not be able to access reproductive health services they need, or they may face severe human right abuses in accessing those services, including forced sterilization.[66]

EQUALITY AND CONTRACEPTIVE ACCESS IN THE PHILIPPINES

Research by CRR provides a glimpse into the impact on all aspects of women's lives of denying women access to contraception, a situation that can have particular consequences for poor women. In the Philippines, for example, a Manila City Executive Order effectively bans all modern contraception provision in public health facilities, an outcome that has a particularly devastating impact on poor communities.[67] This order not only imposes a power structure under which women cannot effectively exercise their reproductive autonomy; it also has a profound impact on many aspects of women's lives, including their health, socioeconomic status, employment, and personal security. Women in Manila City reported mental anguish, including fear and anxiety, at the thought of getting pregnant again because they could not afford unsubsidized contraception outside of the public health facilities.[68] Even where another pregnancy would threaten the life or health of a woman, doctors at public health facilities were powerless to provide contraception, contributing to higher rates of maternal mortality and morbidity.[69] Some women who tried to avoid sex with their husbands because of fear of pregnancy and lack of adequate contraception reported that they were then subjected to sexual violence.[70] Although the Filipino government passed groundbreaking legislation in 2012 to provide universal and free access to contraceptives for all women in the Philippines, as of January 2014 the state had cut all funding for this program, effectively continuing to deny women, particularly poor women, access to needed contraceptive services.

As with other women, girls may face barriers to reproductive equality and autonomy resulting from their age, which may lead parents and providers to exclude them from decision-making about their health or deny them confidential health services.[71] Denying adolescent girls reproductive health services can have implications not only for their health but also for their education and future prospects, perpetuating cycles of poverty for women and girls. Human rights bodies have determined that adolescents should be given the opportunity to participate in decisions about their health, including their reproductive health, in an environment that protects their privacy and is youth-friendly.[72] Both the Beijing Platform for Action and the ICPD Programme of Action address the marginalized situation of adolescents, who "are particularly vulnerable [to abuses of reproductive rights] because of their lack of information and access to relevant services in most countries."[73]

REPRODUCTIVE EQUALITY AND ADOLESCENTS IN TANZANIA

Violations related to reproductive health have a particular impact on the development and lives of adolescent girls and result in discrimination, as early pregnancy is more likely to lead to complications that put girls' health and lives at risk, and unplanned pregnancy can discriminatorily delay or deny girls access to education. In 2013, CRR released a fact-finding report on denial of education to pregnant girls in mainland Tanzania, due solely to their pregnancy. Every year, thousands of adolescent girls in mainland Tanzania undergo the humiliating practice of forced pregnancy testing in school, sometimes as often as once per month. Adolescent girls found to be pregnant are immediately expelled. Over 55,000 female students have been forced out of mainland Tanzanian schools in the past decade, solely because they are pregnant.[74]

When adolescent girls are found to be pregnant, they are often unable to return to school even after giving birth. For example, when Chika was 16 years old, she began a relationship with a 20-year-old man who could help support her by paying for meals during the school day at her school in Dar-es-Salaam—meals she could not otherwise afford. Because she had never been taught how to prevent pregnancy, she became pregnant, which was discovered when she underwent a forced pregnancy test mandated by her school. About a week in advance of the test, the headmistress of the school announced that all of the girls would be taking a trip to the hospital, and when the time of the trip came, she informed the girls that they would undergo pregnancy testing. A nurse palpated Chika's abdomen, causing her pain, and did not ask Chika's consent as she continued to perform tests to determine if Chika was pregnant. When the nurse determined that she was pregnant, Chika was forced to leave school, although she was allowed to take her primary school exams later in the year to allow her to graduate. However, because of her pregnancy, parental responsibilities, and lack of funding from her family, Chika was not able to return for secondary school, a situation that is all too common for girls in mainland Tanzania.[75]

Ensuring Equality of Results

As noted above, substantive equality requires that states ensure equality of opportunities and results for marginalized groups including women, in addition to ensuring non-discriminatory treatment. This requires states to take affirmative measures to address inequalities, which may indicate that states use differential treatment in favor of marginalized groups to address historical and systemic discrimination.[76] As such, key human rights bodies have found that states may need to adopt special measures of a temporary or permanent nature to eliminate discrimination and take positive measures to achieve gender equality.[77]

Ensuring equality of results for women means making sure that women have positive reproductive health outcomes, meeting certain indicators such as low rates of maternal mortality, adolescent pregnancy, unsafe abortion, and unmet need for contraceptives. Indeed, human rights bodies have often called on states to measure and explicitly ensure these positive outcomes for all women as part of their obligations to ensure reproductive rights. [78]

In order to ensure equality of results, states must make high quality reproductive health services available, accessible, and affordable to women. In the context of women's health, equality requires that states first remove barriers to women's access to health care,[79] including by providing services for the specific health needs of women, including particular groups of women, and ensuring that reproductive health services are legal.[80] For instance, human rights bodies have found that in order to ensure women's reproductive rights, a comprehensive range of contraceptives, including emergency contraceptives, must be widely available and affordable, indicating that states must take all necessary measures to ensure contraceptive access for women.[81]

Additionally, ensuring access to reproductive health services for marginalized groups of women requires states to take positive measures tailored to those groups in order to achieve equal health outcomes with other women. The situation of rural women, for instance, may require states to provide free or low-cost services or mobile clinics near their homes with providers who are trained in reproductive health, as well as subsidized transportation to those services. Ensuring access for women with disabilities may require that health care facilities are physically accessible, that information is provided in accessible formats that women with disabilities can understand, and that providers are trained to work with women with disabilities and ensure full respect for their human rights, including their right to make decisions about their reproductive health.[82]

ENSURING MATERNAL HEALTH: *ALYNE DA SILVA PIMENTEL V. BRAZIL*

Maternal mortality violates women's rights to equality and non-discrimination, as maternal mortality often results from denying women access to safe, quality reproductive health services that only they need. Human rights bodies have indicated that ensuring equality of health results—including by lowering the maternal mortality rate—is an important indicator of a state's success in overcoming these reproductive rights violations.[83]

Equality of results was an important part of the CEDAW Committee's analysis in its first case regarding maternal mortality, *Alyne da Silva Pimentel v. Brazil*. Alyne, a pregnant woman of Afro-Brazilian descent, suffered obstetric complications during her sixth month of pregnancy. She went to a nearby health facility with abdominal pain and nausea, but was not provided with the care her symptoms indicated.[84] A few days later, Alyne went back to the clinic and delivered a stillborn baby. A Lack of previous medical care led to further complications affecting Alyne's health, including a delay of 14 hours for a surgery to remove parts of the placenta. Following the stillbirth, as her condition continued to deteriorate, a local private hospital refused to send an ambulance to pick up Alyne at the health facility so that she could receive proper emergency obstetric care. Alyne died of these complications on November 16, 2002.[85]

The CEDAW Committee found that Brazil should have provided Alyne with quality maternal health care in order to prevent her complications and her death, finding that the state had discriminated against her in ensuring the rights to health and life.[86] These violations resulted from a systemic problem concerning health care during pregnancy and delivery in Brazil,[87] a situation that only affects women. In particular, the CEDAW Committee highlighted that the poor quality of care that Alyne received was not only linked to inequalities based on her gender, but also to her race and socio-economic status.[88]

In its decision, the CEDAW Committee highlighted that Alyne was a poor, Afro-Brazilian women. It acknowledged that Brazil had polices in place to provide comprehensive maternal health care to women, but those policies were not implemented so as to achieve equality of health outcomes for all women in Brazil.[89] The CEDAW Committee recommended that Brazil ensure affordable emergency obstetric services, provide trainings to health professionals and judges, implement a national plan on maternal health, and impose sanctions on health care providers who violate women's reproductive rights.[90]

THE POST-2015 AGENDA, REPRODUCTIVE RIGHTS, AND EQUALITY

Taking into account the Beijing Platform for Action, the ICPD Programme of Action, and the many advances in human rights standards that have followed these important documents, the Post-2015 Agenda provides an opportunity for states to fully reflect on, enumerate and implement their reproductive rights obligations, in line with the goal of ensuring gender equality. This section briefly reflects on equality in the Millennium Development Goals (MDGs) and its shortcomings and then provides guidance to states on the measures that should be taken to ensure that gender equality and reproductive rights are fully respected, protected, and fulfilled in the Post-2015 Agenda.

A. The Millennium Development Goals and Equality

As noted below, many of the MDGs contained provisions to tackle gender inequalities and improve reproductive health for women. These goals, however, fell short of expectations because of failure to address the full spectrum of barriers that women face in their daily lives and the inequalities between groups of women in accessing reproductive health services.

Because of these inequalities, women in developing countries are still experiencing a risk of maternal mortality that is 15 times greater than that for women in the developed world.[91] There are persistent and significant inequalities for rural women concerning maternal mortality, and complications from pregnancy remain among the leading causes of death for adolescent girls.[92] Although the world has reached parity in access to primary education for girls and boys, there remain significant gaps in girls' access to secondary education and in access among marginalized groups of girls, while the targets promoting gender equality failed to tackle other gender inequalities, such as persistent gender-based violence, as well as discrimination in access to employment and political participation.[93]

The primary challenge states have faced in achieving full implementation of the MDGs stems from a lack of integration of human rights into the MDG framework. In particular, persistent inequalities, a situation that affects the most marginalized because of entrenched discrimination, were not sufficiently addressed by the MDGs,[94] and as the MDGs were only applicable to developing countries, inequalities that existed in developed states were largely ignored. The MDGs also failed to create an effective system of accountability for states or to utilize existing accountability mechanisms at the local, national, and international level to ensure implementation. The human rights framework could address these problems by providing a set of state obligations by which to guide states, measure progress, and hold all states accountable to human rights and development commitments.

THE MDGS ON GENDER EQUALITY AND MATERNAL HEALTH

MDG 3: Promote Gender Equality and Empowerment of Women

Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

MDG 5: Improve Maternal Health

Target 5.A: Reduce by three quarters the maternal mortality ratio

Target 5.B: Achieve universal access to reproductive health

RECOMMENDATIONS FOR POST 2015

In order for the Post-2015 Agenda to be successful, states will need to adopt a framework that has a meaningful basis in human rights, particularly one that incorporates substantive equality and reproductive rights, in all of its goals, including goals related to health and gender equality. To fully utilize a human rights framework in developing the SDGs, states must ensure that every goal contains measures to respect, protect, and fulfill human rights. **Respecting** human rights requires states to refrain from interfering in the equal enjoyment of rights. **Protecting** human rights requires states to take steps, including by enacting laws and policies, to prevent violations of rights by state and non-state actors. **Fulfilling** human rights requires states to take positive measures to enable people to exercise their rights on an equal basis.

REPRODUCTIVE RIGHTS IN AN SDG ON HEALTH

Under an SDG on health, international human rights norms require targets and indicators that adopt the respect, protect, fulfill framework, promote women's substantive equality, and also reflect the AAAQs that underlie the right to health. With this framework in mind, states should adopt a reproductive rights-specific health target and indicators such as the following:

Target: All women have meaningful access, including financial access, to acceptable, available, and quality sexual and reproductive health information and services.

Indicators:

- Respect: Reproductive health services and information are legal and provided without discrimination.
  - Has the state adopted a national health plan that includes comprehensive reproductive health care services and information? Are these services or information available in all regions, to people of all ages, and in all relevant languages, including accessible formats?
  - Has the state enacted anti-discrimination legislation? If so, has it been implemented/reflected within the national health plan?[95]
  - Has the state enacted regulations on service providers to ensure that comprehensive, medically accurate information is available and accessible to all women and that services are available with informed consent and free from coercion, discrimination or violence? Does the state require third-party authorization for reproductive health services?[96]
- Protect: States have implemented regulations to protect reproductive rights, including by non-state actors.
  - Has the state established a regulatory framework and monitoring mechanism for private health care providers?[97]
  - In particular, does the state regulate private medical insurance providers and private employers to ensure that women are able to access a comprehensive range of reproductive health services for free or at low cost?[98]
- Fulfill: Reproductive health services are accessible, acceptable, available, and of high quality for all women, particularly from marginalized groups.
  - Has the state established a monitoring mechanism that collects data disaggregated by gender, race, ethnicity, age, location, disability, sexual orientation, migration status, and income? If so, has the state used this information to assess parity in access to reproductive health services and information?
  - How many health centers have been established throughout the country? How many of them are in rural areas; in low-income, urban areas; and in areas primarily populated by racial or ethnic minorities? Are the health centers accessible to persons with disabilities? How many of these health centers provide the full range of reproductive health services, including abortion? How many of these health facilities are staffed by personnel trained to provide essential reproductive health care, including emergency maternal health care, contraception, and abortion?
  - Has the state established a process for seeking feedback from women accessing health care services? Has the state established policies to ensure medical services are acceptable to diverse communities?
  - Are women able to seek administrative or judicial remedies for violations of reproductive rights including access to information, and comprehensive services? If so, what is the rate of implementation of these decisions?[99]

REPRODUCTIVE RIGHTS IN AN SDG ON GENDER EQUALITY OR INEQUALITIES

As this paper illustrates, reproductive rights touch on almost every aspect of women's lives, and reproductive rights violations both reinforce gender inequalities and are manifestations of those inequalities. As such, states should include targets and indicators related to reproductive rights not only in an SDG on health but also in any SDGs related to gender equality or inequalities. These targets and indicators should adopt a human rights approach and address the key aspects of equality—overcoming discriminatory power structures, recognizing difference, and ensuring equality of results—such as the following:

Target: Women are able to exercise reproductive autonomy, including in deciding on the number and spacing of their children, free from violence, coercion, or discrimination.

- Respect:
  - Is there a constitutional provision prohibiting discrimination, including gender-based discrimination?
  - Has the state adopted legislation prohibiting violence against women? If so, has it been implemented in national policy?
  - Are women able to act autonomously in their decisions regarding health care, including reproductive health care? Do married women or adolescents require additional permissions to seek information or obtain reproductive health services?
  - Do national laws or policies discriminate against women or reflect gender stereotypes concerning any aspect of their lives, including their access to health services, education, or employment? Is there any differential treatment with regard to the provision of health services for women, including particular groups of women, as compared to men?
- Protect:
  - Does the state regulate the use of conscientious objection in the provision of reproductive health services?
  - Does the state have a mechanism to monitor and protect women from gender-based violence, including in reproductive health care settings, committed by state and non-state actors?
- Fulfill:
  - Has the state taken proactive measures to ensure gender equality by countering the negative impacts of gender-based stereotypes, and violence against women, such as by educating government officials, health care providers, teachers, and the general public on gender stereotypes and violence against women?[100]
  - What percentage of women and girls have access to sexuality education that is comprehensive and scientifically accurate about their reproductive health to inform their reproductive decision-making? What percentage of women and girls have access to comprehensive reproductive health care services? Is this information disaggregated by location, income, race, disability, age, and migration status?
  - In law or practice, are girls removed from school due to pregnancy or sexual activity?
  - Are legal remedies available for gender-based discrimination? If so, what is the rate of implementation of these decisions?

ACCOUNTABILITY

In order to ensure positive development outcomes that comply with states' human rights commitments, it is critical that the Post-2015 Agenda recognize the need for accessible and effective accountability mechanisms. By employing the specific guidance on accountability developed by the international human rights system, the Post-2015 Agenda can ensure that local populations and the global community are provided with the requisite tools and resources to hold states accountable for their development commitments.

Under an SDG on health as applied to reproductive health and an SDG on gender equality, international human rights norms on accountability would require states to:

Target: Women, including from marginalized groups, are able to fully participate in the design, monitoring and implementation of national policies relating to equality and reproductive health and are able to access effective remedies, including adequate compensation, for violations of their rights.

- **Guarantee Meaningful Participation:** Is there a mechanism to facilitate input in the design, monitoring and implementation of national policies related to advancing gender equality? Is there a mechanism to facilitate input in the design, monitoring, and implementation of national policies related to reproductive health? If so, what is the percentage of participation of women from marginalized groups, such as racial or ethnic minorities, women with disabilities, adolescents, and low-income women?[101]

- **Monitor and Evaluate Progress:** Does the state routinely collect disaggregated data on targets and indicators surrounding women's reproductive health? If so, does it have a method for making this data transparent and available?[102] If so, is this data submitted to a body formally charged with overseeing and assessing states' progress?[103] Is this data submitted by the state as part of its review under the Universal Periodic Review process?

- **Provide Remedy and Redress:** Are women able to seek administrative or judicial remedies for discrimination or violations of reproductive rights, including access to information and comprehensive reproductive health care services? If so, what is the rate of implementation of these decisions?[104]

Endnotes

1 Because gender inequality is primarily experienced by women rather than men, this paper will focus on the inequalities that women face and how states should address those inequalities.

2 Universal Declaration of Human Rights, *adopted* Dec. 10, 1948, art. Preamble, G.A. Res. 217A (III), U.N. Doc. A/810 at 71 (1948) [hereinafter Universal Declaration] ("Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom…").

3 Simone Cusack & Lisa Pusey, *CEDAW and the Rights to Non-discrimination and Equality*, 14 Melbourne Journal of International Law, 10-11 (2013).

4 Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, (34th Sess., 2005), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 7, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 16*]; Sandra Fredman, *Providing Equality: Substantive Equality and the Positive Duty to Provide,* 21 S. Afr. J. on Hum. Rts. 163, 163-164, 166 (2005) [hereinafter Fredman (2005)].

5 Catherine Albertyn, Sandra Fredman & Judy Frank, *Introduction: Substantive Equality, Social Rights, and Women: A Comparative Perspective*, 23 S. Afr. J. on Hum. Rts. 209, 209 (2007) [hereinafter Albertyn et al. (2007)].

6 Fredman (2005), *supra* note 4, 166.

7 *Id.*

8 Albertyn et al. (2007), *supra* note 5, 209.

9 Universal Declaration, *supra* note 1, preamble; International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, art. 3, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976); International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 3, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976).

10 Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 1, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

11 *Id.* art. 2.

12 *Id.* art. 5.

13 Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health),* (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 11-12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

14 CEDAW, *supra* note 10, art. 12(1).

15 *Id.* art. 12(2).

16 Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 85, para. 12, U.N. Doc. HRI/GEN/1/Rev.6 (2003) [hereinafter ESCR Committee, *Gen. Comment No. 14*].

17 *Id.* para. 12(a).

18 *Id.*

19 *Id.* para. 12(b)(i).

20 *Id.* paras. 12(b)(ii) & (iii).

21 *Id.* para. 12(b)(iv); *see also* Open Door and Dublin Well Woman v. Ireland, No. 14235/88 Eur. Ct. H.R., para. 80 (1992) (In the case of *Open Door*, in applying a test for necessity and proportionality of restrictions on information related to abortion in Ireland, the European Court of Human Rights recognized that abortion "may be crucial to a woman's health and well-being" and found that the injunction on information about legal abortion services abroad violated Article 10 of the European Convention on Human Rights because it was, among other reasons, over broad and disproportionate. The Court specifically cited the risk to the health of women created by the injunction because they must "seek abortions at a later stage in their pregnancy, due to lack of proper counseling …").

22 *Id.* para. 12(c).

23 *Id.* para. 12(d).

24 CEDAW, *supra* note 10, art. 16(1)(e).

25 Programme of Action of the International Conference on Population and Development, Cairo, Egypt, Sept. 5-13, 1994, para. 7.2, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].

26 *Id.*

27 *Id.* paras. 3.1, 4.1.

28 *Id.* paras. 4.1, 4.24.

[29] *Beijing Declaration and the Platform for Action, Fourth World Conference on Women,* Beijing, China, Sept. 4-15, 1995, para. 1, U.N. Doc. A/CONF.177/20 (1996) [hereinafter *Beijing Declaration and Platform for Action*].

[30] *Id.* para. 92.

[31] *Id.* para. 95.

[32] *Id.* para. 90; *ICPD Programme of Action*, *supra* note 25, para. 4.1.

[33] *Beijing Declaration and Platform for Action*, *supra* note 29, para. 90.

[34] *Id.* para. 95.

[35] *ICPD Programme of Action*, *supra* note 25, para. 7.3.

[36] *Id.* para. 4.1.

[37] *Id.* art. 5; CEDAW Committee, *General Recommendation No. 25, on article 4, paragraph 1, on temporary special measures, in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 282, para. 7, U.N. Doc. HRI/GEN/1/Rev.7 (2004).

[38] L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

[39] *Id.* para. 8.15.

[40] CEDAW Committee, *Concluding Observations: Austria,* para. 39, U.N. Doc. CEDAW/C/AUT/CO/7-8 (2013); *Concluding Observations: Burkina Faso*, para. 276, U.N. Doc. A/55/38 (2000); *Concluding Observations: Cyprus*, para. 29, U.N. Doc. CEDAW/C/CYP/6-7 (2013); *Concluding Observations: Hungary*, para. 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); ESCR Committee, *Concluding Observations: Kenya*, para. 33, U.N. Doc. E/C.12/KEN/CO/1 (2008); *Concluding Observations: Slovakia*, para. 24, U.N. Doc. E/C.12/SVK/CO/2 (2012); CAT Committee, *Concluding Observations: Peru*, para. 15, U.N. Doc. CAT/C/PER/CO5-6 (2013); Human Rights Committee, *Concluding Observations: Poland*, paras. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010).

[41] CEDAW, *supra* note 10, art. 15; Reva Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 Emory Law Journal 815, 816 (2007).

[42] CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, para. 21; United Nations Department of Economic and Social Affairs, *2009 World Survey on the Role of Women in Development: Women's Control over Economic Resources and Access to Financial Resources, including Microfinance* v (2009).

[43] *Id.*; ESCR Committee, *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),* para. 31, U.N. Doc. E/C.12/GC/20 (2009) [hereinafter ESCR Committee, *Gen. Comment No. 20*]; Committee on the Rights of the Child, *General Comment No. 15: The right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, para. 31, U.N. Doc. CRC/C/GC/15 (2013) [hereinafter CRC Committee, *Gen. Comment No. 15*]; Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, (68th Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 179, para. 20, U.N. Doc. HRI/GEN/1/Rev.6 (2003) [hereinafter Human Rights Committee, *Gen. Comment No. 28*]. *See also* World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems, 68 & 95 (2nd ed. 2012).

[44] *See* Center for Reproductive Rights et al., Calculated Injustice: The Slovak Republic's Failure to Ensure Access to Contraceptives 33 (2011) [hereinafter Calculated Injustice].

[45] *Id.* at 21.

[46] *Id.*

[47] *Id.*

[48] Zákon. 363/2011 Z. z. o rozsahu a podmienkach úhrady liekov, zdravotníckych pomôcok a dietetických potravín na základe verejného zdravotného poistenia a o zmene a doplnení niektorých zákonov [Act No. 363/2011 Coll. of Laws on the Scope and Conditions of Drugs, Medical Devices and Dietetic Foods Coverage by Public Health Insurance and on Amending and Supplementing Certain Acts], secs. 16(4)(e)(1) & 37(5)(c)(6) (Slovk.) [hereinafter Act No. 363/2011]

[49] *Id.* sec. 22(3)(b) (Slovk.).

[50] Calculated Injustice, *supra* note 44, at 27.

[51] National Health Information Center, Zdravotnícka ročenka Slovenskej republiky 2011 [Health Statistics Yearbook of the Slovak republic 2011] 96 (2012), *available at* http://www.nczisk.sk/Documents/rocenky/rocenka_2011.pdf; Akbar Aghajanian et al, *Continuing Use of Withdrawal as a Contraceptive Method in Iran*, 34 Canadian Studies in Population 179, 182 (2007).

[52] The ESCR Committee recommends that states adopt a "gender-based approach" to ensuring equality in the right to health that "recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women." ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 20. The CEDAW Committee's General Recommendation No. 24 recognizes that biological differences between men and women as well as socio-economic differences can lead to health

inequalities for women. CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, para. 6. The Convention on the Rights of Persons with Disabilities recognizes that special measures should be taken to ensure the right to health, including reproductive health, for persons with disabilities and that they should on an equal basis with others be able to decide on the number and spacing of their children. Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, art. 6, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., arts. 23 & 25, U.N. Doc. A/61/611, (*entered into force* May, 3 2008) [hereinafter CRPD].

53 *Beijing Platform for Action, supra* note 29, para. 90.

54 CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, para. 12(a).

55 The CRPD recognizes "that women and girls with disabilities are subject to multiple discrimination, and in this regard [states] shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms." CRPD, *supra* note 52, art. 6.

56 The Committee on Migrant Workers (CMW Committee) has recognized the particularly gendered nature of migration for women migrant workers, particularly domestic workers, and the abuses that accompany that work because of their gender, including gender-based violence and poverty. Committee on Migrant Workers, *General Comment No. 1: Migrant Domestic Workers*, paras. 7 & 60, U. N. Doc. CMW/C/GC/1 (2010).

57 Committee on the Elimination of Racial Discrimination, *General Recommendation No. 25: Gender-related dimension of racial discrimination*, (Fifty-sixth session, 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6, at 214, para. 1 (2003).

58 CEDAW Committee, *Concluding Observations: Hungary*, para. 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).

59 CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, para. 6.

60 *ICPD Programme of Action*, *supra* note 25, paras. 6.16, 6.24(a), 6.26.

61 *See, i.e.*, U.N. Secretary-General, *The empowerment of rural women and their role in poverty and hunger eradication, development and current challenge: Rep. of the Secretary-General*, paras. 5-7, U.N. Doc. E/CN.6/2012/3 (2011).

62 *Id.* para. 9.

63 *See* European Monitoring Centre on Racism and Xenophobia, Council of Europe, Breaking the Barriers- Romani Women and Access to Public Health Care 17 (2003) (describing that Roma women throughout Europe face barriers to accessing gynecological services because of transportation issues from their rural communities) [hereinafter Council of Europe, Breaking the Barriers- Romani Women and Access to Public Health Care (2003)].

64 *See* Calculated Injustice, *supra* note 44, at 33; Guttmacher Institute, *Contraception and Unintended Pregnancy in Uganda* (2013), *available at* http://www.guttmacher.org/pubs/FB-Contraception-and-unintended-pregnancy-in-Uganda.html (last visited Sept. 13, 2013).

65 Council of Europe, Breaking the Barriers- Romani Women and Access to Public Health Care (2003), *supra* note 63, at 7.

66 A.S. v. Hungary, CEDAW Committee, Commc'n No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (2006); Center for Reproductive Rights & Poradna pre obcianske a ludské práva (Centre for Civil and Human Rights), Body and Soul: Forced Sterilization and Other Assaults of Romani Women's Reproductive Freedom 13-18 (2002).

67 Center for Reproductive Rights, Imposing Misery: The impact of Manila City's Contraception Ban on Women and Families 24 (2007).

68 *Id.* at 27.

69 *Id.* at 28-30.

70 *Id.* at 31.

71 CRC Committee, *Gen. Comment No. 15*, *supra* note 43, para. 56.

72 *Id.* para. 31; ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 23.

73 *Beijing Platform for Action*, *supra* note 29, para. 95; *ICPD Programme of Action*, *supra* note 25, para. 7.3.

74 Center for Reproductive Rights, Forced Out: Mandatory Pregnancy Testing and the Expulsion of Pregnant Students in Tanzanian Schools (2013).

75 *Id.* at 79.

76 ESCR Committee, *Gen. Comment No. 16*, *supra* note 4, para. 8.

77 ESCR Committee, *Gen. Comment No. 20*, *supra* note 43, para. 9; Human Rights Committee, *Gen. Comment No. 28*, *supra* note 43, para. 3.

78 CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, para. 17; *Concluding Observations: Congo*, para. 35 (f), U.N. Doc. CEDAW/C/COG/CO/6 (2012); *Concluding Observations: Ethiopia*, para. 34(c), U.N. Doc. CEDAW/C/ETH/CP/6-7 (2011); *Report of the Committee on Elimination of Discrimination Against Women: Angola*, para. 162, U.N. Doc. Supplement No. 38 (A/59/38) (2004); *Report of the Committee on Elimination of Discrimination Against Women: Cameroon*, para. 60, U.N. Doc. Supplement No. 38 (A/55/38) (2000).

79 ESCR Committee, *Gen. Comment No. 16*, *supra* note 4, paras. 21 & 29.

80 CEDAW Committee, *Gen, Recommendation No. 24*, *supra* note 13, para. 11.

[81] CEDAW Committee, *Concluding Observations: Cyprus*, para. 29, U.N. Doc. CEDAW/C/CYP/6-7 (2013); *Concluding Observations: Poland*, para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010); *Concluding Observations: Chile*, para. 35(a), U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012).

[82] *See* CRPD, *supra* note 52, arts. 9, 12, 23, & 25; CRPD Committee, *Concluding Observations: Peru*, paras. 34-35, U.N. Doc. CRPD/C/PER/CO/1 (2012).

[83] CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, para. 27.

[84] Alyne da Silva Pimentel Teixeira v Brazil, CEDAW Committee, Commc'n No. 17/2008, para. 3.4, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).

[85] *Id.* para. 2.12.

[86] *Id.* paras. 7.3-7.5.

[87] *Id.* para. 7.6.

[88] *Id.* para. 7.7.

[89] *Id.* para. 7.6

[90] *Id.* para. 8.

[91] United Nations, *Factsheet: Goal 5: Improving Maternal Health* (2013), available at http://www.un.org/millenniumgoals/maternal.shtml (accessed November 12, 2013).

[92] *Id.*; United Nations Population Fund, Motherhood in Childhood: Facing the challenge of adolescent pregnancy 18 (2013).

[93] United Nations, *Factsheet: Goal 3: Promote Gender Equality and Empower Women* (2013), available at http://www.un.org/millenniumgoals/gender.shtml (accessed November 12, 2013).

[94] Report of the United Nations Secretary-General, *A life of dignity for all: accelerating progress towards the Millennium Development Goals and advancing the United Nations development agenda beyond 2015*, para. 6, U.N. Doc. A/68/202 (2013).

[95] CEDAW, *supra* note 10, arts. 1, 2, & 12; ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 34.

[96] CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, para.14; ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 34.

[97] CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, para. 15; Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, para. 7.5, U.N. Doc. CEDAW/C/49/D/17/2008 (2011); ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 35.

[98] ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 12(b); CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, para. 29; ESCR Committee, *Concluding Observations: Kenya*, para. 33, U.N. Doc. E/C.12/KEN/CO/1 (2008); CEDAW Committee, *Concluding Observations: Hungary*, para. 31(b), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).

[99] ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 35; CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, para. 15; CEDAW Committee, *Concluding Observations: Costa Rica*, paras. 32-33, U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011).

[100] CEDAW Committee, *General Recommendation No. 28 on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women,* paras. 17 & 38(e), U.N. Doc. CEDAW/C/GC/28 (2010).

[101] CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, paras. 12 & 31.

[102] *Id.* para 9; Report of the Office of the High Commissioner on Human Rights, *Technical Guidance on Maternal Mortality and Morbidity*, paras. 69-73, U.N. Doc. A/HRC/21/22 (2012).

[103] *See* CEDAW, *supra* note 10, art. 18; CEDAW Committee, Rules of Procedure, Rules 47 & 48, available at http://www2.ohchr.org/english/bodies/cedaw/docs/CEDAW_Rules_en.pdf (accessed Jan. 3, 2014).

[104] ESCR Committee, *Gen. Comment No. 14*, *supra* note 16, para. 35; CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, para. 15; CEDAW Committee, *Concluding Observations: Costa Rica*, paras. 32-33, U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011).

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