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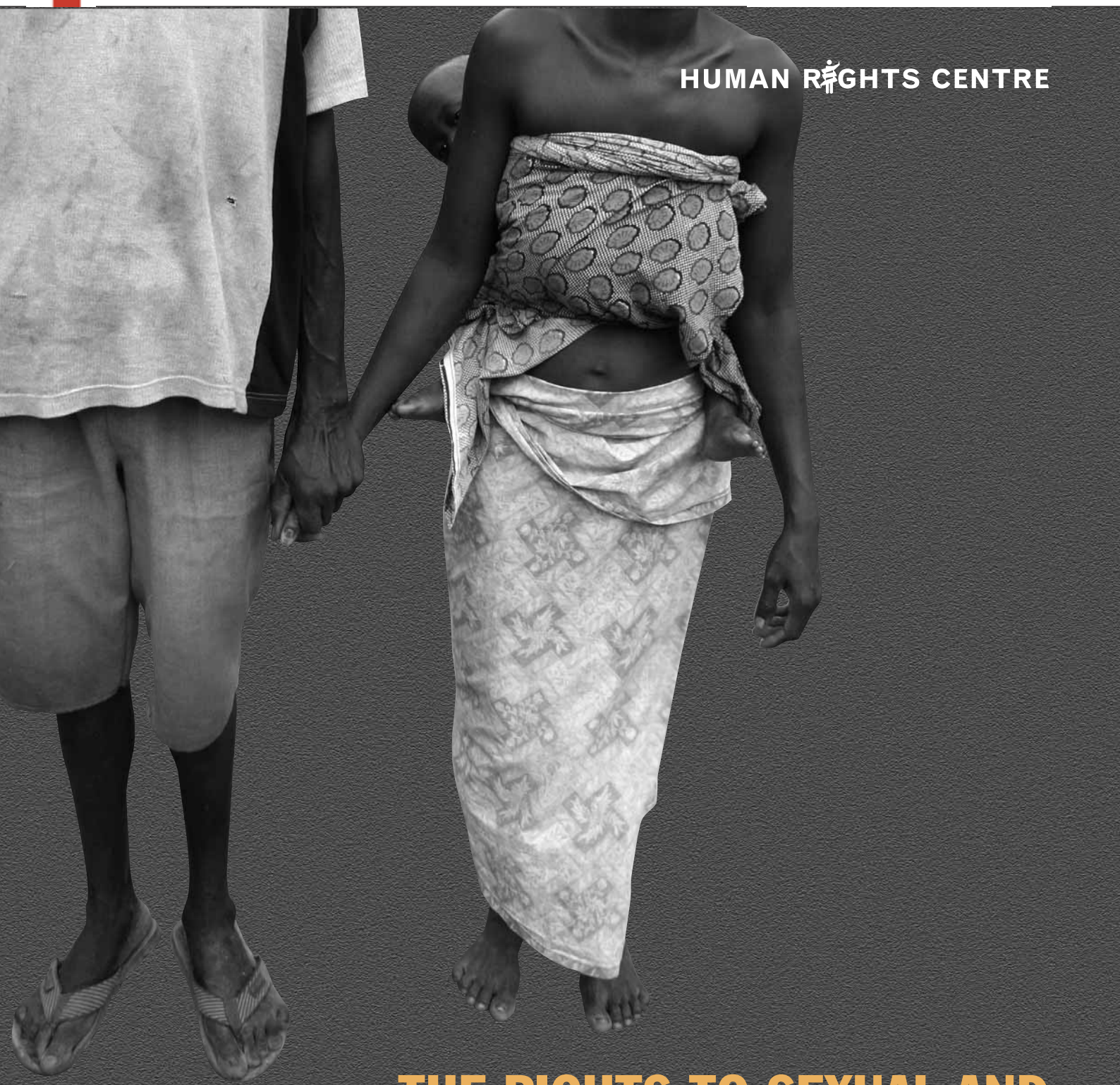
HUMAN RIGHTS CENTRE



# THE RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH

PAUL HUNT AND JUDITH BUENO DE MESQUITA

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## PREFACE

In 2002, the Commission on Human Rights, the then principal political body dealing with human rights in the United Nations (UN) system, decided to appoint a Special Rapporteur to focus on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ('the right to health' or 'right to the highest attainable standard of health'). A Special Rapporteur is an independent expert appointed to monitor, examine and report on either a particular human rights issue or the human rights situation in a particular country or territory.

In 2002, the Commission on Human Rights appointed Paul Hunt, a New Zealand national, as Special Rapporteur for a period of three years. In 2005, the Special Rapporteur's mandate was extended by a further three years.

The Special Rapporteur was requested to submit annual reports to the Commission on Human Rights and the General Assembly. He now submits an annual report to the Human Rights Council, which replaced the Commission in 2006, as well as to the General Assembly.

This briefing is closely based on a report which the Special Rapporteur submitted to the Commission on Human Rights in 2004, and which focused on sexual and reproductive health rights. The report was part of the Special Rapporteur's contribution to the tenth anniversary of the International Conference on Population and Development, held in Cairo in 1994.

The report observes that sexual and reproductive health – among the most sensitive and controversial issues in international human rights law – are integral elements of the right to health. The report also begins to develop an analytical framework for the right to health, drawn from General Comment 14 of the United National Committee on Economic, Social and Cultural Rights, as well as other relevant norms and standards.[2] This framework is then applied in the context of sexual and reproductive health rights.

Some minor changes have been made in this briefing to the text of the original report submitted by the Special Rapporteur to the Commission. While no changes have been made to substance, the language has been modified to make it more accessible to its target audience of policy makers and civil society organisations. The briefing aims to establish the right to health foundations for detailed, practical programmes on SRHR, although it does not provide a blueprint for operationalising these programmes.

This briefing is the first of a series focusing on sexual and reproductive health rights produced by the Special Rapporteur and the Right to Health Unit, Human Rights Centre, University of Essex. The briefings are aimed at national and international policy makers, as well as civil society organisations, working on sexual and reproductive health issues. The briefings series is supported by a grant to the Special Rapporteur by the European Commission.

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# INTRODUCTION

The International Conference on Population and Development (ICPD), held in Cairo in 1994, was a landmark event because participating States recognised that sexual and reproductive health is fundamental to individuals, couples and families, as well as to the social and economic development of communities and nations. The Conference signalled a move away from narrowly focused family planning programmes, placed women at the centre of an integrated approach to reproduction, and recognised that human rights have a crucial role to play in relation to sexual and reproductive health. The following year, this new approach was reaffirmed at the Fourth World Conference on Women held in Beijing.[3]

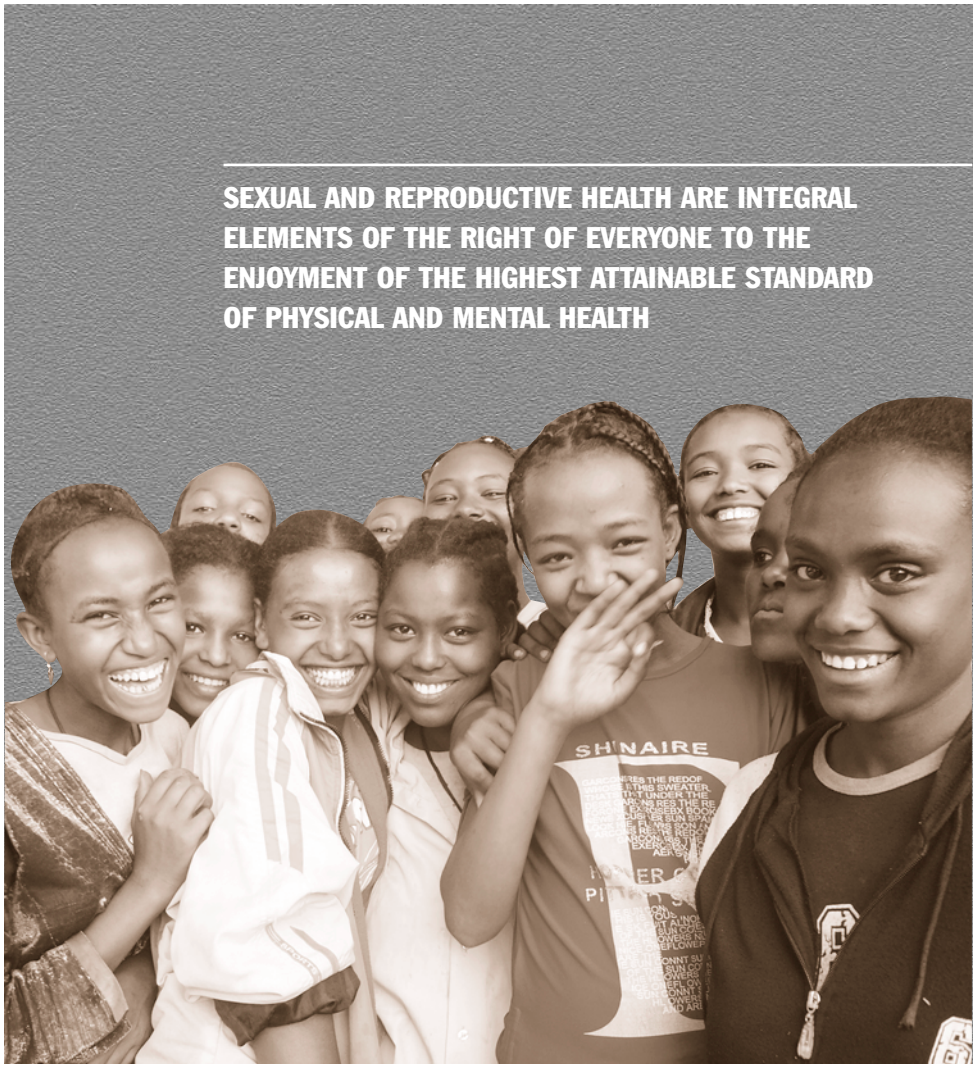
Sexual and reproductive health are among the most sensitive and controversial issues in international human rights law, but they are also among the most important. Their sensitivity and importance is reflected in the Millennium Development Goals that derive from the Millennium Declaration. On the one hand, the Goals do not expressly refer to sexual and reproductive health;[4] on the other hand, at least three of the eight Goals – on maternal health, child health and HIV/AIDS – are directly related to sexual and reproductive health.[5] Sexual and reproductive health issues have a vital role to play in the global struggle against poverty.

In 2003, the Commission on Human Rights confirmed that:

"Sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[6]

The implications of this crucial proposition were examined in the Special Rapporteur's report by drawing upon world conference outcomes, in particular ICPD, the Fourth World Conference on Women and their respective five-year reviews, as well as international human rights instruments, including the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC). The following discussion is also informed by the key principles that shape human rights, in particular non-discrimination, equality and privacy, as well as the integrity, autonomy, dignity and well-being of the individual.

Not only are sexual and reproductive health issues sensitive, controversial and important, they are also large and complex. The following observations are not comprehensive. However, they contribute to a deeper appreciation of one of the achievements of ICPD: the recognition that human rights have an indispensable role to play in relation to sexual and reproductive health. Crucially, ICPD, the Fourth World Conference on Women and the United Nations human rights system represent mutually reinforcing norms and processes.



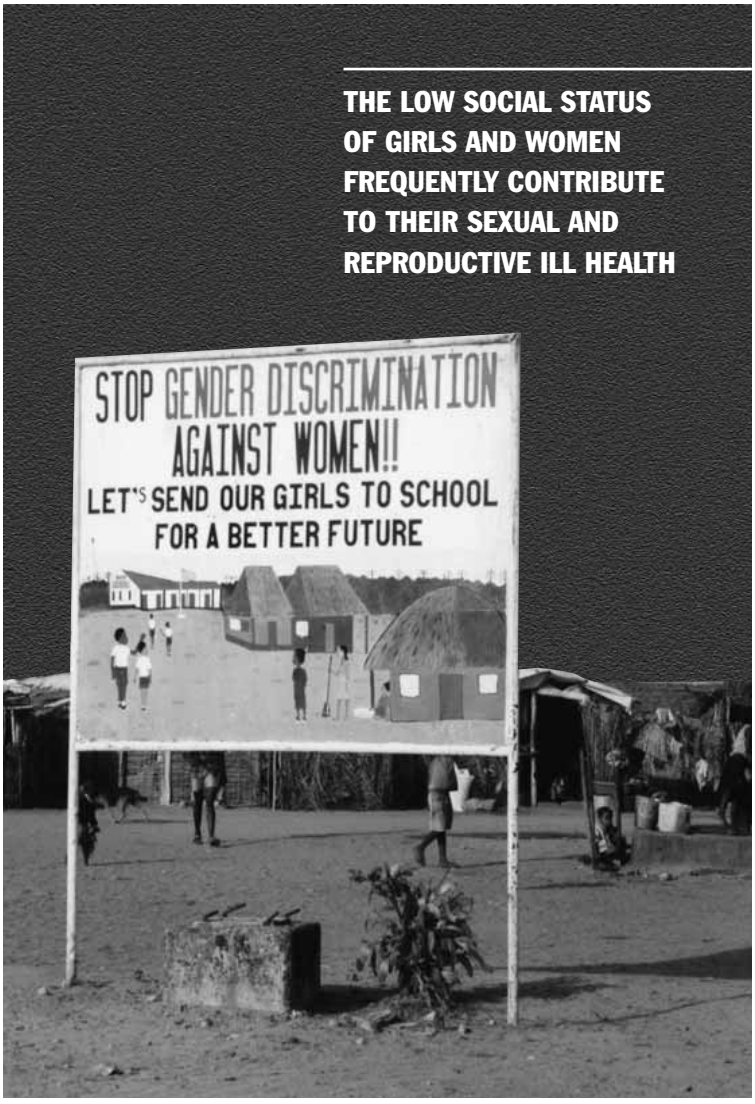

*Photograph © Netsanet Assaye, courtesy of Photoshare. Genet, Tsiyon, and their friends are happy because they are the first generation in Kembata, Durame Woreda, Ethiopia, who do not have to undergo female genital cutting at their young age.*

# I. THE MAGNITUDE OF THE CHALLENGE

Sexual and reproductive ill health gives rise to nearly 20 per cent of the global burden of ill health for women and 14 per cent for men.[7] In 2000, an estimated 529,000 women died from pregnancy-related causes, most of which were avoidable; 99 per cent of maternal deaths occur in developing countries. In States in transition and developing countries, more than 120 million couples are not using any contraception despite their wish to avoid or space children. About 80 million women annually experience unintended pregnancies, some 45 million of whom have abortions. Of this number, some 19 million women undergo unsafe abortions, resulting in 68,000 deaths, i.e. 13 per cent of all pregnancy-related deaths.[8] Apart from mortality, unsafe abortion also gives rise to high rates of morbidity.

In addition, 340 million new cases of largely treatable sexually transmitted bacterial infections occur annually. Many are untreated. Millions of mostly incurable viral infections occur each year, including 5 million new HIV infections of which 600,000 are mother-to-child. Six thousand young people aged 15-24 years become infected with HIV daily. In sub-Saharan Africa and South Asia, about 65 per cent of young people living with HIV/AIDS are female.

Photograph © P. Delargy, courtesy of UNFPA. Stop Gender Discrimination Against Women, Liberia.




**THE LOW SOCIAL STATUS OF GIRLS AND WOMEN FREQUENTLY CONTRIBUTE TO THEIR SEXUAL AND REPRODUCTIVE ILL HEALTH**

Of course, not all sexual and reproductive ill health represents a violation of the right to health or other human rights. Ill health constitutes a human rights violation when it arises, in whole or in part, from the failure of a duty-bearer – typically a State – to respect, protect or fulfil a human rights obligation. Obstacles stand between individuals and their enjoyment of sexual and reproductive health. From the human rights perspective, a key question is: are human rights duty-bearers doing all in their power to dismantle these barriers?

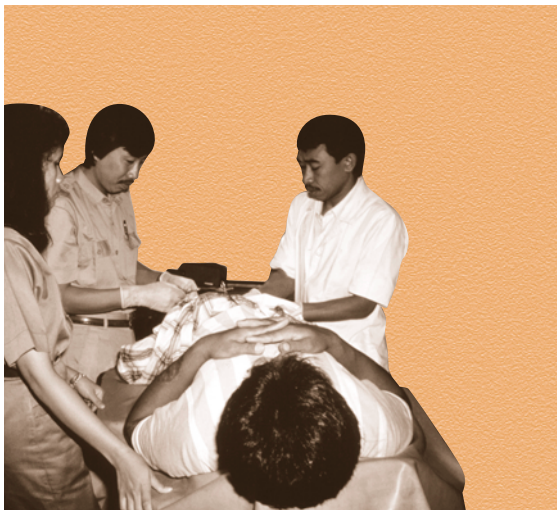
Many of the numerous obstacles to sexual and reproductive health are interrelated and entrenched. They operate at different levels: clinical care, the level of health systems, and the underlying determinants of health.[9] In addition to biological factors, social and economic conditions play a significant role in determining women's sexual and reproductive health. The low social status of girls and women frequently contribute to their sexual and reproductive ill health. Many women experience violence during pregnancy, which may give rise to miscarriage, premature labour and low birth weight. Some traditional views about sexuality are obstacles to the provision of sexual and reproductive health services, including reliable information, and these views have an especially damaging impact upon adolescents.[10] Poverty is associated with inequitable access to both health services and the underlying determinants of health. Too often, improvements in public health services disproportionately benefit those who are better off.

Applying human rights to these questions can deepen analysis and help to identify effective, equitable and evidence-based policies to address these complex problems. Crucially, human rights law places obligations on duty-bearers to do all they can to dismantle the barriers to sexual and reproductive health. In relation to sexual and reproductive health, human rights norms have the potential to inform and empower vulnerable individuals and disadvantaged communities.

Before considering these issues further in the particular context of the right to health, some observations are required about the approaches of ICPD and the Fourth World Conference on Women to human rights and sexual and reproductive health.

# II. CAIRO: SOME KEY DEFINITIONS

Adopted by consensus, the International Conference on Population and Development Programme of Action [11] includes some principles and definitions that were ground-breaking in the context of sexual and reproductive health. They remain highly relevant today.



Photograph © Chieko Ishikawa, courtesy of UNFPA. Vasektomy at Mobile Family Planning Unit, Jakarta, Indonesia.

Chapter II confirms 15 principles that guided – and "will continue to" guide – participants at Cairo. Principle 1 begins: "All human beings are born free and equal in dignity and rights." According to principle 8: "Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. 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."

Principle 3 confirms: "The right to development is a universal and inalienable right and an integral part of fundamental human rights." Several other principles refer explicitly to other human rights. In short, the principles provide a human rights framework upon which to construct sexual and reproductive health laws, policies, programmes and projects.[12] Chapter VII – which, significantly, is entitled "Reproductive rights and reproductive health" – is a key chapter, encapsulating very important definitions of reproductive health and reproductive rights *(see Box 1)*.

**Box 1: The outcome document of the International Conference on Population and Development includes the following important definitions of reproductive health, and reproductive rights:**

"Reproductive health is 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. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in the last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth, and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases" *(paragraph 7.2)*.

"Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning" *(paragraph 7.3)*.[13]

The following year, the Fourth World Conference on Women adopted, also by consensus, identical provisions on reproductive health and rights in the Beijing Platform for Action.[14] In Beijing, however, the outcome document included an important affirmation of the right of women to have control over their sexuality *(see Box 2)*.

The Cairo and Beijing consensus confirms important aspects of the relationship between sexual and reproductive health and human rights, including that:

a) In relation to sexual and reproductive health there are a number of interrelated and complementary human rights, such as those set out in paragraphs 7.2 and 7.3 of the ICPD Programme of Action, e.g. "the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice";

b) The most encompassing of these rights is the "right to attain the highest standard of sexual and reproductive health", which also resonates with principle 8;

c) While there is obviously an intimate relationship between sexual health and reproductive health, ICPD and the Fourth World Conference on Women recognise that sexual health and reproductive health are also different and distinct dimensions of human well-being.

**Box 2: The outcome document of the Fourth World Conference on Women includes an important affirmation of the right of women to have control over their sexuality**

"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. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences" *(paragraph 96)*.

**STATES HAVE AN OBLIGATION TO ENSURE REPRODUCTIVE HEALTH AND MATERNAL AND CHILD HEALTH SERVICES**

Photograph © 2004 Rachel Hoy, courtesy of Photoshare. Marthe, an "accoucheuse traditionnelle", or traditional midwife, displays the reproductive health diagrams that she colored during a training at the Lagdo District Hospital in the Northern Province of Cameroon.

# III. EVOLVING STANDARDS AND OBLIGATIONS

General Comment 14 on the right to the highest attainable standard of health outlines the scope of the international right to health by drawing upon existing norms and concepts such as freedoms, entitlements, immediate obligations and international assistance and cooperation.[15] As well as being applicable to the right to health in general, these approaches can be applied to integral elements of the right to health, such as sexual and reproductive health.[16] The relevant jurisprudential and policy insights provided by United Nations human rights treaty bodies in the light of their experience examining States parties' reports over many years provide interpretational guidance, as do the Cairo and Beijing consensus, and their respective five year reviews.[17]

## FREEDOMS

The right to health, including sexual and reproductive health, encompasses both freedoms, such as freedom from discrimination, and entitlements.

In the context of sexual and reproductive health, freedoms include a right to control one's health and body. Rape and other forms of sexual violence, including forced pregnancy, non-consensual contraceptive methods (e.g. forced sterilisation and forced abortion), female genital mutilation/cutting (FGM/C), and forced marriage all represent serious breaches of sexual and reproductive freedoms, and are fundamentally and inherently inconsistent with the right to health.

Some cultural practices, including FGM/C, carry a high risk of disability and death. Where the practice exists, States should take appropriate and effective measures to eradicate it and other harmful practices, in accordance with their obligations under the Convention on the Rights of the Child. Early marriage, which disproportionately affects girls, is predominantly found in South Asia and sub-Saharan Africa, where over 50 per cent of girls are married by the age of 18. Among other problems, early marriage is linked to health risks including those arising from premature pregnancy. In the context of adolescent health, States are obliged to set minimum ages for sexual consent and marriage.[18]

Although subject to progressive realisation and resource constraints, the international right to health imposes various obligations of immediate effect.[19] These immediate obligations include a duty on the State to respect an individual's freedom to control his or her health and body. For example, there is an immediate obligation on a State not to engage in forced sterilisation and not to engage in discriminatory practices. In other words, the freedom components of sexual and reproductive health are subject to neither progressive realisation nor resource availability.

## ENTITLEMENTS

The right to health includes an entitlement to a system of health protection, including health care and the underlying determinants of health, which provides equality of opportunity for people to enjoy the highest attainable level of health.[20] For example, women should have equal access, in law and fact, to information on sexual and reproductive health issues.

Thus, States have an obligation to ensure reproductive health and maternal and child health services, including appropriate services for women in connection with pregnancy, granting free services where necessary.[21] More particularly, States should improve a wide range of sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information. They should also ensure access to such vital health services as voluntary testing, counselling and treatment for sexually transmitted infections, including HIV/AIDS, and breast and reproductive system cancers, as well as infertility treatment.

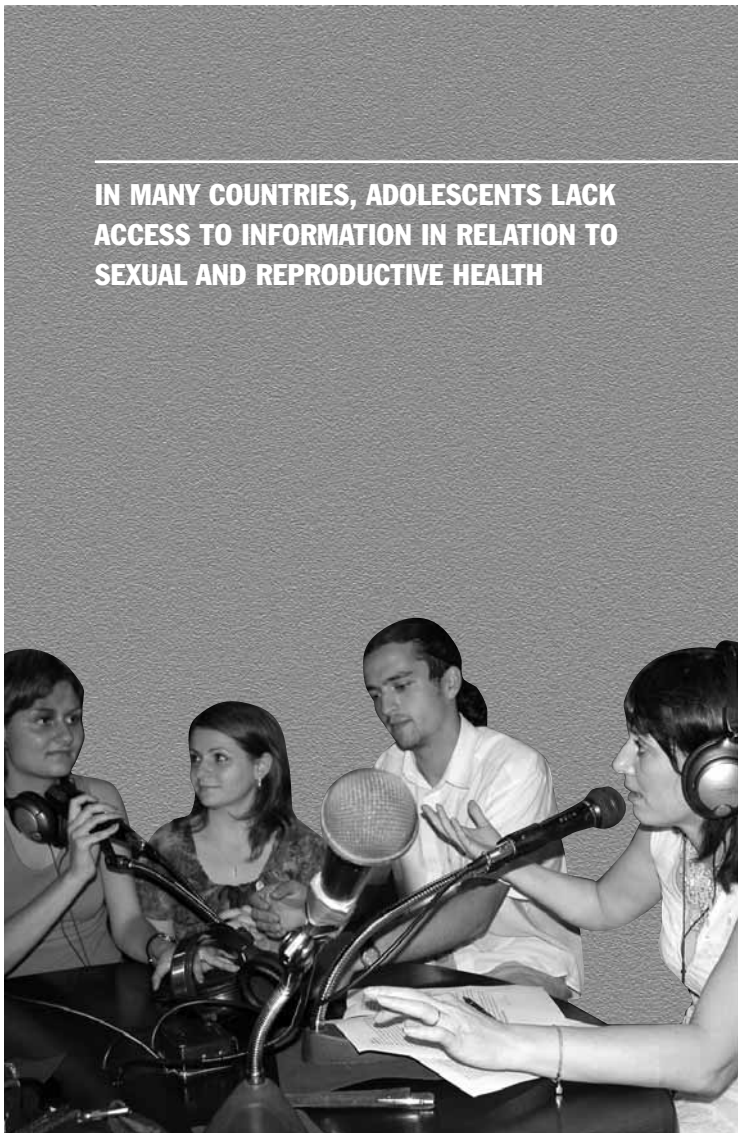
Unsafe abortions kill some 68,000 women each year, a right to life and right to health issue of enormous proportions.[22] Women with unwanted pregnancies should be offered reliable information and compassionate counselling, including information on where and when a pregnancy may be terminated legally. Where abortions are legal, they must be safe: public health systems should train and equip health service providers and take other measures to ensure that such abortions are not only safe but accessible.[23] In all cases, women should have access to quality services for the management of complications arising from abortion. Punitive provisions against women who undergo abortions must be removed.

Even when resources are scarce, States can achieve major improvements in the sexual and reproductive health of their populations. For example, Sri Lanka has made significant advances over the last decades in relation to sexual and reproductive health by improving education, increasing female literacy, enhancing the quality of health-care services, and making them more available and accessible.[24]

## VULNERABILITY, DISCRIMINATION AND STIGMA

International human rights law proscribes discrimination in access to health care and the underlying determinants of health, and to the means for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social or other status that has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.[25]

Nonetheless, discrimination and stigma continue to pose a serious threat to sexual and reproductive health for many groups, including women, sexual minorities, refugees, people with disabilities, rural communities, indigenous persons, people living with HIV/AIDS, sex workers, and people held in detention. Some individuals suffer discrimination on several grounds e.g. gender, race, poverty and health status.[26]




Photograph © 2005 Don Hinrichsen, courtesy of UNFPA. Young people producing a weekly radio programme that educates its audience about reproductive health issues, including HIV and AIDS, broadcasting from Chisinau, Moldova.

### Gender and HIV/AIDS

Discrimination based on gender hinders women's ability to protect themselves from, and respond to the consequences of, HIV infection. The vulnerability of women and girls to HIV and AIDS is compounded by other human rights issues including inadequate access to information, education and services necessary to ensure sexual health; sexual violence; harmful traditional or customary practices affecting the health of women and children (such as early and forced marriage); and lack of legal capacity and equality in areas such as marriage and divorce.

Stigma and discrimination associated with HIV/AIDS may also reinforce other prejudices, discrimination and inequalities related to gender and sexuality. The result is that those affected may be reluctant to seek health and social services, information, education and counselling, even when those services are available. This, in turn, contributes to the vulnerability of others to HIV infection.

### Adolescents

Adolescents and young people under 25 years of age are especially vulnerable in the context of sexual and reproductive health. Adolescence is a period characterised by sexual and reproductive maturation. Yet in many countries adolescents lack access to essential and relevant information and services in relation to sexual and reproductive health. Their need is acute. An estimated 16 per cent of all new HIV infections occur among those under age 15, while 42 per cent of new infections occur among those aged 15-24. Every year there are 100 million new, largely curable, reported cases of sexually transmitted infections among adolescents.

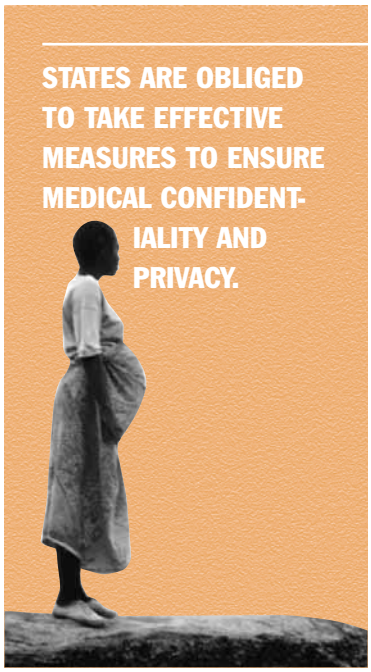
The Convention on the Rights of the Child provides important protections for adolescents, including their right to "access information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well being and physical and mental health";[27] respect of privacy and confidentiality, including in relation to medical information of adolescents;[28] and protections against all forms of abuse, neglect, violence and exploitation.[29] The Convention on the Rights of the Child includes a number of cross-cutting principles which have an important bearing on adolescents' sexual and reproductive health, namely: the survival and development of the child, the best interests of the child, non-discrimination, and respect for the views of the child.[30]

### Sexual orientation

Discrimination on the grounds of sexual orientation is impermissible under international human rights law. The legal prohibition of same-sex relations in many countries, in conjunction with a widespread lack of support or protection for sexual minorities against violence and discrimination, impedes the enjoyment of sexual and reproductive health by many people with lesbian, gay, bisexual and transgender identities or conduct.[31] Criminalization can also impede programmes which are essential to promoting the right to health and other human rights. For example, the Human Rights Committee, in *Toonen v. Australia*, observed: "Criminalization of homosexual activity ... would appear to run counter to the implementation of effective education programmes in respect of HIV/AIDS prevention." [32]

### Non-discrimination, equality and sexual and reproductive health – other remarks

Arising from their obligations to combat discrimination, States have a duty to ensure that health information and services are made available to vulnerable groups. For example, they must take steps to empower women to make decisions in relation to their sexual and reproductive health, free of coercion, violence and discrimination. They must take action to redress gender-based violence and ensure that there are sensitive and compassionate services available for the survivors of gender-based violence, including rape and incest. States should ensure that adolescents are able to receive information, including on family planning and contraceptives, the dangers of early pregnancy and the prevention of sexually transmitted infections including HIV/AIDS, as well as appropriate services for sexual and reproductive health.




Photograph © 1988 Media for Development International, courtesy of Photoshare. Rita is expelled from school in "Consequences," a film that demonstrates the consequences of unwanted pregnancy for an African adolescent audience.

Consistent with *Toonen v. Australia* and numerous other international and national decisions, they should ensure that sexual and other health services are available for men who have sex with men, lesbians, and transsexual and bisexual persons. It is also important to ensure that voluntary counselling, testing and treatment of sexually transmitted infections are available for sex workers.

Finally, in the context of sexual and reproductive health, breaches of medical confidentiality may occur. Sometimes these breaches, when accompanied by stigmatisation, lead to unlawful dismissal from employment, expulsion from families and communities, physical assault and other abuse. Also, a lack of confidentiality may deter individuals from seeking advice and treatment, thereby jeopardising their health and well-being. States are obliged to take effective measures to ensure medical confidentiality and privacy.

## AVAILABLE, ACCESSIBLE, ACCEPTABLE AND GOOD QUALITY

Analytical frameworks or tools can deepen our understanding of economic, social and cultural rights, including the right to health.[33] One framework that is especially useful in the context of policy-making is that health services, goods and facilities, including the underlying determinants of health, shall be available, accessible, acceptable and of good quality.

This analytical framework encompasses sexual and reproductive health. For example, sexual and reproductive health services, goods and facilities must be: available in adequate numbers within the jurisdiction of a State; accessible geographically, economically (i.e. be affordable) and without discrimination; culturally acceptable to, for example, minorities and indigenous peoples, as well as sensitive to gender and life-cycle requirements, and respectful of confidentiality; and scientifically and medically appropriate and of good quality.

When this framework is applied to sexual and reproductive health, it is clear that the key elements of availability, accessibility and so on are frequently absent. For example, in many countries, information on sexual and reproductive health is not readily available and, if it is, it is not accessible to all, in particular women and adolescents. Sexual and reproductive health services are often geographically inaccessible to communities living in rural areas. These services are sometimes not provided in a form that is culturally acceptable to indigenous peoples and other non-dominant groups. Lastly, services, and relevant underlying determinants of health, such as education, are often of substandard quality.

## RESPECT, PROTECT AND FULFIL

Another useful analytical framework is that States have specific obligations under international law to respect, protect and fulfil the right to health.[34] While the framework outlined in the preceding paragraphs (availability, etc.) is especially helpful in the context of policy-making, the respect, protect and fulfil framework is especially useful as a way of sharpening legal analysis of the right to health, including sexual and reproductive health.

The obligation to respect requires States to refrain from denying or limiting equal access for all persons to sexual and reproductive health services, as well as the underlying determinants of sexual and reproductive health. For example, it requires them to refrain from denying the right to decide on the number and spacing of children. The obligation to protect means that States should take steps to prevent third parties from jeopardising the sexual and reproductive health of others, including through sexual violence and harmful cultural practices. For example, countries such as Burkina Faso, Ghana, Senegal and the United Kingdom of Great Britain and Northern Ireland have enacted laws that specifically prohibit female genital cutting. The obligation to fulfil requires States to give recognition to the right to health, including sexual and reproductive health, in national political and legal systems. Health systems should provide for sexual and reproductive health services for all, including in rural areas, and States should carry out information campaigns to combat, for example, HIV/AIDS, harmful traditional practices and domestic violence.

## INTERNATIONAL ASSISTANCE AND COOPERATION

In addition to obligations at the domestic level, developed States have a responsibility to provide international assistance and cooperation to ensure the realisation of economic, social and cultural rights in low-income countries. This responsibility arises from recent world conferences, including the Millennium Summit, as well as provisions of international human rights law.[35]

Thus, States should respect the right to health in other countries, ensure that their actions as members of international organisations take due account of the right to health, and that they pay particular attention to helping other States give effect to minimum essential levels of health. The donor community provides important funding for sexual and reproductive health care in many low-income countries. Donors' funding should promote access to a wide range of services needed for the enjoyment of the right to sexual and reproductive health, including services and information that reduce the incidence of unsafe abortions. Adopting a human rights-based approach to their policies and programmes can help donors, and others, ensure that programmes protect sexual and reproductive health rights.

Increasingly, bilateral and multilateral donors are providing health-budget – rather than project-specific – support. Broadly speaking, these sector-wide approaches can be extremely beneficial. However, it is of the first importance that sexual and reproductive health are not marginalised in a sectoral approach. There is a high risk of marginalisation because of the sensitivities associated with some sexual and reproductive health issues. This makes it important that all actors recognise explicitly the indispensable role of sexual and reproductive health in the struggle against poverty. Explicit recognition is important because what is unnamed is more likely to be unsupported.

## PARTICIPATION

The right to health requires that health policies, programmes and projects are participatory. The active and informed participation of all stakeholders can broaden consensus and a sense of "ownership", promote collaboration and increase the chances of success. Since sexual and reproductive health are integral elements of the right to health, it follows that all initiatives for the promotion and protection of sexual and reproductive health must be formulated, implemented and monitored in a participatory manner.

## ACCOUNTABILITY

The right to health also demands accountability. Without mechanisms of accountability, the obligations arising from the right to health are unlikely to be fully respected. This applies equally to the integral elements of sexual and reproductive health. Thus the promotion and protection of sexual and reproductive health demands effective, accessible and transparent mechanisms of accountability in relation to all duty-bearers.

# CONCLUSION

Photograph © Don Hinrichsen, courtesy of UNFPA. Youth for Youth volunteers pass out information on reproductive health and sexuality at the Polytechnical University of Bucharest.

The preceding section considered sexual and reproductive health in the light of the right to health and the consensus adopted at Cairo and Beijing. The Cairo conference was a landmark event with notable achievements. However, as part of a 10-year review, it is timely to examine ICPD critically. The following observations should be understood in this context.[36]

First, the two conferences confirmed that:

a) Numerous human rights have a direct bearing upon sexual and reproductive health;[37]

b) There are "reproductive rights";[38]

c) There is a "right to attain the highest standard of sexual and reproductive health";[39]

d) Sexual health and reproductive health are intimately related, but distinct, dimensions of human well-being.[40]

Second, while they recognised sexual health as distinct from reproductive health, they did not explicitly and unequivocally recognise sexual rights as distinct from reproductive rights.[41]

Third, they provided a short definition of sexual health: "the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases".[42] A fuller definition of sexual health is a state of physical, emotional, mental and social well-being related to sexuality, not merely the absence of disease, dysfunction or infirmity; sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Fourth, sexuality is a characteristic of all human beings. It is a fundamental aspect of an individual's identity. It helps to define who a person is. Central principles that have shaped international human rights law since 1945 include privacy, equality, and the integrity, autonomy, dignity and well-being of the individual. At Cairo and Beijing, States have already recognised important principles related to sexuality. In these circumstances, the correct understanding of fundamental human rights principles, as well as existing human rights norms, leads ineluctably to the recognition of sexual rights as human rights. Sexual rights include the right of all persons to express their sexual orientation, with due regard for the well-being and rights of others, without fear of persecution, denial of liberty or social interference.

Fifth, it is essential that increased attention be devoted to a proper understanding of sexual health and sexual rights, as well as reproductive health and reproductive rights.[43] The contents of sexual rights, the right to sexual health and the right to reproductive health need further attention, as do the relationships between them. Since many expressions of sexuality are non-reproductive, it is misguided to subsume sexual rights, including the right to sexual health, under reproductive rights and reproductive health. Given the nature of the mandate of the Special Rapporteur on the right to health, the focus of this publication (and the report to the Commission on which it is based) has a particular concern with the rights to sexual and reproductive health. These rights, however, have to be understood in a broader human rights context that includes sexual rights.

Finally, considered together, the rights to sexual and reproductive health have an indispensable role to play in the struggle against intolerance, gender inequality, HIV/AIDS and global poverty.

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2 The Special Rapporteur has further developed this analytical framework in his subsequent reports on a range of issues, and countries. See, for example, his report focusing on mental disabilities and the right to health, E/CN.4/2005/51.

3 The new approach was reaffirmed at the respective five-year follow-up review conferences.

4 At the World Summit in 2005, and after the publication of the Special Rapporteur's report in 2004, Heads of State and Government committed to achieve universal access to reproductive health for all by 2015 (A/RES/60/1, para. 57(g)). The Secretary General of the United Nations subsequently recommended that this commitment should become a new target under Millennium Development Goal 5 (A/61/1, para. 24).

5 Other Millennium Development Goals concern the underlying determinants of health, e.g. those on extreme poverty and gender equality. For an examination of the health-related goals through the lens of the right to health, see A/59/422.

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

7 For various reasons, sexual and reproductive ill health is severely underestimated and so statistics fail to capture the full burden of such ill health. Nonetheless, data give some indications of the magnitude of the problem.

8 An unsafe abortion is a procedure for terminating an unwanted pregnancy performed either by persons lacking the necessary skills, or in an environment lacking the minimal medical standards, or both.

9 Examples of the underlying determinants of health are indicated in E/CN.4/2003/58, para. 23. In summary, they are social, economic and other conditions that bear upon health status, such as access to adequate sanitation, workplace conditions and education.

10 See *Making 1 Billion Count: Investing in Adolescents' Health and Rights*, United Nations Population Fund, 2003.

11 A/CONF.171/13, chap. I, sect. 1.

12 For one way in which the framework could be strengthened, see paragraph 54 of this report.

13 Para. 7.3 continues with some important sentences which have not been reproduced here because of the shortage of space.

14 A/CONF.177/20/Rev.1, chap. I, sect. I. Paragraphs 7.2 and 7.3 of the ICPD Programme of Action are replicated in paragraphs 94 and 95 of the Beijing Platform for Action.

15 This conceptual framework was also discussed in the preliminary report of the Special Rapporteur to the Commission on Human Rights, E/CN.4/2003/58, paras. 22 to 36.

16 Commission on Human Rights resolution 2003/28.

17 In particular, the Committee on the Elimination of Discrimination against Women, General Recommendation 24; the Committee on the Rights of the Child, General Comments 3 and 4; and the Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14.

18 Committee on the Rights of the Child, General Comment 4 on adolescent health and development, paras. 9 and 19.

19 CESCR General Comment 14, para. 30.

20 E/CN.4/2003/58, para. 23. On underlying determinants of health, see endnote 6.

21 In relation to free services and pregnancy, see in particular the Convention on the Elimination of Discrimination against Women, art. 12.2.

22 Unsafe abortion also gives rise to high rates of morbidity.

23 *Safe Abortion: Technical and Policy Guidance for Health Systems*, World Health Organization, 2003.

24 Women's Health in South Asia, WHO Country Profile, Sri Lanka, available at http://w3.whosea.org/nhd/pdf/61-64.pdf.

25 CESCR General Comment 14, para. 18.

26 See E/CN.4/2003/58, para. 62.

27 CRC, art. 17.

28 CRC, art. 16 and the Committee on the Rights of the Child, General Comment 4, para. 11.

29 CRC, arts. 19, 32-36 and art. 38.

30 CRC, arts. 2, 3, 5, 6, 12. Also Committee on the Rights of the Child, General Comment 4, para. 12.

31 Other Special Rapporteurs have documented violence and discrimination based on sexual orientation. See, for example, report of the Special Rapporteur on extrajudicial, arbitrary or summary executions (E/CN.4/2001/9), paras. 48-50 and report of the Special Rapporteur on the question of torture (A/56/156), paras. 17-25.

32 Human Rights Committee, *Toonen v. Australia*, 4 April 1994, (CCPR/C/50/D/488/1992), para. 8.5.

33 E/CN.4/2003/58, paras. 33-36.

34 See E/CN.4/2003/58, para. 35.

35 See E/CN.4/2003/58, para. 28 and A/58/427, paras. 30-34.

36 Of course, these observations relate to very few of the many issues in ICPD.

37 Cairo Programme of Action, para. 7.3.

38 Cairo Programme of Action, chapter VII.

39 Cairo Programme of Action, para. 7.3.

40 Cairo Programme of Action, para. 7.2.

41 Although note paragraph 96 of the Beijing Platform for Action.

42 Cairo Programme of Action, para. 7.2, the Beijing Platform for Action, para. 94.

43 There is growing academic literature on this subject. An excellent place to start is R. Cook, B. Dickens and M. Fathalla, *Reproductive Rights and Human Rights: Integrating Medicine, Ethics, and Law*, Clarendon Press, 2003. On sexual rights, see A. Miller, "Sexual but not Reproductive: Exploring the Junction and Disjunction of Sexual and Reproductive Rights", Health and Human Rights: An International Journal, vol. 4, No. 2.

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