Round Table of Human Rights Treaty Bodies on Human Rights Approaches to Women’s Health, with a Focus on Sexual and Reproductive Health and Rights

Summary of Proceedings and Recommendations

sponsored by

United Nations Population Fund
United Nations High Commissioner for Human Rights
United Nations Division for the Advancement of Women
FOREWORD

The promotion of women's rights has always been a major institutional priority for the United Nations Population Fund (UNFPA). Through its advocacy efforts, it has created awareness of the disparity of opportunities between women and men at all stages of their lives and of the urgent need to redress this imbalance if development goals are to be realized. In keeping with the specific focus of its mandate, UNFPA has promoted women's reproductive health as part of the basic right to health.

Strengthening the legal and moral framework for recognizing reproductive and sexual rights as human rights, for securing human rights and for meeting the individual's basic needs constitutes a critical first step in addressing global problems. For this reason, UNFPA, in collaboration with the Office of the United Nations High Commissioner for Human Rights and the United Nations Division for the Advancement of Women, organized the Round Table of Human Rights Treaty Bodies on Human Rights Approaches to Women's Health, with a Focus on Sexual and Reproductive Health and Rights. The Round Table was held in Glen Cove, New York, 9-11 December 1996, and included representatives of the human rights treaty bodies, United Nations specialized agencies and other bodies, and non-governmental and academic organizations.

Today, a carefully constructed framework of human rights exists, built on a strong ethical foundation and drawn from all cultures and traditions. It recognizes that all human beings have the same rights and that women must be free to make choices of their own and make decisions concerning their reproductive and sexual health, free from discrimination, coercion and violence. This framework was affirmed by the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing. The work of the Round Table was intended to help integrate the understandings reached at the Cairo and Beijing conferences into the treaty monitoring process. The human rights treaties hold Governments accountable for neglecting or violating women's rights and ensure that States parties to those Conventions honour the commitments they made at Cairo, Beijing and other international conferences of this decade.

The recommendations from this Round Table have been endorsed by the treaty bodies, which collect information on the observance of reproductive rights in the course of their monitoring responsibilities. Treaty bodies also examine their guidelines for evaluating States' reports to integrate women's health issues more fully into their consideration of these reports. Thus, the Round Table has advanced the ability of the treaty bodies and the entire United Nations system to secure women's rights to health as one of the surest ways of enabling women to realize their full potential in all aspects of their lives and to achieve gender equality. Women's right to health, including reproductive and sexual health, is central for gender equality and women's empowerment.

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United Nations Population Fund
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<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<td>CAT</td>
<td>Committee against Torture</td>
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<td>CEDAW</td>
<td>Committee on the Elimination of All Forms of Discrimination against Women; Convention on the Elimination of All Forms of Discrimination Against Women</td>
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<td>CERD</td>
<td>Committee on the Elimination of All Forms of Racial Discrimination</td>
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<td>DAW</td>
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<td>FGM</td>
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<td>HIV</td>
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<td>International Covenant on Civil and Political Rights</td>
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<td>PFA</td>
<td>Platform for Action (Beijing Conference)</td>
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<td>RTI</td>
<td>Reproductive tract infection</td>
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<td>UDHR</td>
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INTRODUCTION

A. Purpose

The United Nations Population Fund (UNFPA), the United Nations High Commissioner for Human Rights (UNHCHR), and the United Nations Division for the Advancement of Women (DAW), with active support and cooperation from the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), jointly organized the Round Table of Human Rights Approaches to Women’s Health, with a Focus on Sexual and Reproductive Health and Rights. The proposed Round Table was endorsed by the September Meeting of the Chairpersons of the Human Rights Treaty Bodies. The Round Table took place from 9 to 11 December 1996 at the Harrison Conference Center in Glen Cove, New York. The meeting was attended by members of each of the six human rights treaty bodies; persons working in women’s reproductive and sexual health drawn from United Nations specialized agencies and other United Nations bodies; and persons representing non-governmental organizations (NGOs) and academia. (See Annex I for the list of participants and Annex II for the agenda.)

The Round Table was the first occasion on which members of the six human rights treaty bodies met to focus on the interpretation and application of human rights in relation to a specific thematic issue. The purpose of the Round Table was to contribute to the work of the treaty bodies in interpreting and applying human rights standards to issues relating to women’s health and to encourage collaboration in the development of methodologies and indicators for use by both the treaty bodies and the United Nations agencies and other bodies to promote, implement and monitor women’s human right to health, in particular, reproductive and sexual health. It was designed to provide an opportunity for the treaty bodies to consider the gender dimensions of human rights from the perspective of their respective treaties and to take account of the conclusions of recent United Nations conferences in the treaty monitoring process.

The meeting was expected to enhance dialogue among and within United Nations bodies; to examine and potentially enlarge the role of human rights in their programmatic work; enhance the effectiveness of their programmes with respect to the promotion and protection of women’s human rights; and facilitate the greater involvement and contribution of United Nations agencies and other bodies to the work of the treaty bodies, particularly as monitors of State compliance. It was also expected that the NGO and academic participants would contribute both theoretical and practical insights into this process and that the meeting would strengthen working relationships between the three sectors involved.

On the basis of four background papers prepared as reference points (see Annex III for list of background papers), plenary meeting discussions focused on:

- Bringing a gender perspective to the right to health, including reproductive and sexual health;
- Interpreting the treaty norms with respect to sexual and reproductive health as
human rights; and

- Analysing the right to health, including reproductive and sexual health, in the context of the situation of indigenous women and of refugee, migrant and displaced women.

Presentations were made, and discussions followed, on the perspectives of the treaty bodies regarding the human rights approaches to women's health, including reproductive and sexual rights.

Three working groups were formed to analyse issues and rights regarding maternal mortality, adolescent reproductive health, and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), respectively. All three groups also discussed possible modalities to foster the incorporation of human rights dimensions into the actual work of the treaty bodies, United Nations agencies and other bodies, and NGOs.

B. Organization of the Report

This report, the outcome of the deliberations at the Round Table, is divided into five parts.

- Part I sets out the framework that was developed at the recent United Nations conferences for integrating gender concerns in human rights at all levels and for addressing the relationship between human rights and health, in particular, women's sexual and reproductive health. It includes recommendations for action by the treaty bodies, other United Nations bodies and NGOs. A final set of recommendations addresses issues of collaboration between and among treaty bodies, United Nations agencies and other United Nations bodies and NGOs.

- Part II presents the discussions relating to the development of a framework for a human rights approach to issues of women's health and contains a summary of the papers presented by independent specialists in the field of human rights and women's health;

- Part III reviews the steps already taken by treaty bodies, United Nations agencies and other bodies and NGOs to identify the gender dimensions of human rights, to integrate gender concerns in their programmes and policies and to address issues of women's health. It outlines proposed strategies and methods for collaboration between and among the treaty bodies, other United Nations bodies and NGOs on issues of women's health; and

- Part IV presents a proposal for a framework to protect, promote and monitor women's right to health, illustrating, in particular, the utilization of the Conference consensus documents in the development of indicators of human rights protection and progressive implementation.
PART I. THE HUMAN RIGHTS APPROACH TO WOMEN'S HEALTH: BACKGROUND AND RECOMMENDATIONS

A. Framework Developed at Recent United Nations Conferences

The Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) include the right to non-discrimination on the basis on sex. This right is elaborated in the Convention on the Elimination of All Forms of Discrimination against Women (Women's Convention). Nevertheless, violations of women’s human rights were, until recently, largely invisible or marginal in the United Nations human rights system.

During the last decade, however, developments in the jurisprudence of several of the human rights treaty bodies, in national laws and decisions and in the writings of jurists have advanced understanding of the human rights of women, in general, and, more specifically of the human rights dimensions of women’s health, in particular, sexual and reproductive health. At the same time, in a number of the specialized agencies and other United Nations organs, as well as at the State level, programmatic concern with women’s equality and empowerment and, specifically, with women’s health has expanded. These developments were fuelled by and, in turn, fuelled the growth of international, regional and national networks of organizations dealing with women’s health and women’s human rights, which have contributed new analyses and vision to this process. These different streams of work coalesced and crystallized at recent thematic world conferences, particularly:

• The 1993 World Conference on Human Rights (hereinafter, the Vienna Conference);

• The 1994 International Conference on Population and Development (hereinafter, the ICPD or Cairo Conference); and

• The 1995 Fourth World Conference on Women: Action for Equality, Development and Peace (hereinafter, the Beijing Conference).

Recognizing and redressing the marginalization of violations of women’s rights, the world community affirmed that women’s rights are human rights and that women’s right to health -- in particular, sexual and reproductive health -- is a part of such rights.

The 1993 Vienna Conference reaffirmed that women’s rights are an integral and inalienable part of all human rights. The Vienna Declaration and Programme of Action states the need to integrate or mainstream women’s human rights throughout the United Nations human rights system and other United Nations bodies. It specifically recognizes women’s right to the enjoyment of the highest standards of physical and mental health throughout their life span and to accessible and adequate health care and the widest range of family planning services.
The 1994 ICPO focused attention on the relationship between health and human rights and particularly on women's rights to reproductive and sexual health, education and equality. Explicitly rejecting the use of demographic targets in fertility-regulation programmes, the Programme of Action calls for population policies and programmes that reflect the needs of individual women and men and for such programmes and policies to be based upon the principles of gender equality and women's empowerment.7 (See Box 1.)

The Platform for Action (PFA) of the 1995 Beijing Conference notes women's "right to the enjoyment of the highest attainable standard of physical and mental health" and emphasizes the centrality of this right to women's "life and well-being and their ability to participate in all areas of public and private life, as well as of inequality of all kinds as an obstacle to women's enjoyment of their right to health." 8 The PFA reaffirms the ICPO's emphasis on reproductive and sexual health9 and its human rights dimensions, adding:

"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 behavior and its consequences."10

Both the ICPO and the Beijing documents recognize that it is necessary to take programmatic steps and to hold States accountable for ensuring that women enjoy their human rights. In elaborating and embodying the consensus of nations on immediate and progressive steps to be taken in the field of health, the ICPO and Beijing Conference documents clarify and itemize the particular responsibilities of States and intergovernmental and non-governmental actors to protect human rights. The Beijing PFA emphasizes that "international human rights instruments must be applied in such a way as to take more clearly into consideration the systematic and systemic nature of discrimination against women that gender analysis has clearly indicated."11

The Beijing PFA specifically calls for the Platform commitments to be taken into account by the treaty bodies within their respective mandates, and by States parties in their reports to the treaty bodies. While these commitments are technically not binding on States, the documents reflect the official consensus of the world community. As such, they can be seen as contributing to the evolution of customary international law norms and obligations by clarifying the evolving meaning, or progressive development, of human rights norms as well as by indicating widely approved steps or means to further their implementation.

The conference documents identify responsibilities at different levels and emphasize the need for strengthening cooperation and coordination between the treaty bodies and agencies. Agencies can make a valuable contribution to the treaty monitoring process, while their work can itself be informed by the perspectives and needs of the treaty bodies. The role of NGOs in developing and implementing the conference consensus, particularly through participation in the "decision making process and access to power" is also emphasized. Indeed, it has been
Box 1. Definitions of reproductive health and reproductive rights, from the Programme of Action of the International Conference on Population and Development

"7.2 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 this 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.

"7.3 . . . [R]eproductive rights embrace certain human rights that are already recognized 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. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behavior; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed."

widely recognized, in the conference documents and the work of the treaty bodies, that NGOs are key not only to the advancement of the international work to integrate health and human rights but also to the domestic application of such standards, which further contributes to the creation of a culture of human rights at the national and local level.

It was to advance these principles, goals, and commitments that this Round Table was conceived and convened to set the stage for further dialogue among the treaty bodies, United Nations agencies and other programmatic bodies, NGOs and scholars in the field of women’s health and human rights.

B. Perspectives of the Convenors

Ms. Ivanka Corti, Chairperson, Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), and the 1996 Chairperson of the Meeting of the Chairpersons of the Human Rights Treaty Bodies, opened the Round Table by recalling the United Nations conferences which called for the integration of gender concerns into United Nations human rights activities. Ms. Corti emphasized the importance of applying human rights standards to secure women’s health, in particular their sexual and reproductive health.

Underscoring the significance of a system-wide and interdisciplinary approach to the mainstreaming of gender concerns, Ms. Corti noted that the annual general meeting of the chairpersons of treaty bodies has recommended the integration of gender concerns into the work of all treaty bodies and endorsed, at its recent meeting, the participation of members of each of the treaty bodies in this meeting. Collaboration among treaty bodies, United Nations agencies and programmes, NGOs and women’s human rights scholars is of critical importance to the success of this endeavour.

Dr. Nafis Sadik, Executive Director of UNFPA and Secretary-General of the ICPD, emphasized that in many countries, few women are able to exercise their right to reproductive health. Every year, more than 585,000 women die from pregnancy and maternity-related causes; 2 million girls risk undergoing some form of female genital mutilation (FGM); and 25 million women undergo unsafe abortions, of whom 70,000 die as a result. Areas which require urgent attention include the reproductive health of adolescent girls, both married and unmarried, women refugees and others in situations of emergency or armed conflict, including those subjected to systematic rape and sexual assault and other forms of violence against women.

The application of human rights to women’s health offers a means of holding Governments accountable for structural and systemic discrimination against women, and thus of improving women’s health status. A human rights approach is premised on the view that reproductive and sexual health rights are integral to recognized human rights -- in particular, to life, liberty and personal security, and the highest attainable standard of health.

To establish the legal accountability of Governments for neglecting or violating rights to reproductive and sexual health, it is necessary to integrate the consensus developed at the recent conferences into the treaty implementation and monitoring process. Specifically, treaty bodies could refine their standard-setting activities to incorporate reference to women’s health
concerns in their general recommendations or guidelines for reporting. In conjunction with this, United Nations organizations and agencies could develop indicators for monitoring progress towards the goals of the United Nations conferences. Other steps which could be taken include strengthening the complaints mechanisms under the treaty system, for example, the optional complaints protocol to CEDAW, and encouraging the ratification of, and the withdrawal of reservations to, CEDAW.

A human rights approach to women’s health creates an international standard that transcends culture, tradition and societal norms. Although these forces may bind societies together, they cannot justify value systems which perpetuate women’s subordination. The application of human rights standards to women’s health will aid women in their resistance to violence and subordination, which damage their health and minimize their participation in the family, the community and the State. It also complements the steps taken by States to address aspects of women’s health needs within their policies and programmes.

Ms. Angela King, Director, Division for the Advancement of Women (DAW) (now the Senior Adviser to the Secretary-General on Gender and the Advancement of Women), outlined the steps taken following the United Nations conferences to mainstream gender within the United Nations human rights system. At the political level, the General Assembly, the Economic and Social Council, the Commission on Human Rights and the Commission on the Status of Women have each adopted resolutions supporting and encouraging the integration of a gender perspective into the United Nations’ human rights activities.

The Commission on Human Rights appointed the Special Rapporteur on Violence against Women, its Causes and Consequences, and the Commission on the Status of Women initiated the development of an optional protocol to CEDAW. The special rapporteurs and independent specialists have met to discuss methods of incorporating gender concerns into their work. The human rights treaty bodies and special rapporteurs have already begun to reflect a concern with women’s human rights in their guidelines for reports and questions to States parties, general comments, recommendations and concluding observations. Joint work plans have been developed between the UNHCHR/Centre for Human Rights and DAW. New mechanisms have been put into place to ensure the integration of women’s human rights into United Nations system-wide activity. These include the development of a system-wide medium-term plan and the Inter-agency Committee on Women and Gender Equality.

Ms. Helga Klein, Chief, Support Services Branch, Centre for Human Rights, read the statement of Mr. Ayala Lasso, UNHCHR, which noted that the United Nations conference documents had identified new dimensions for the interpretation and implementation of the human rights treaties, particularly by clarifying the interrelationship between human rights and women’s rights and their pertinence to reproductive and sexual health.

The High Commissioner’s statement emphasized the importance of promoting women’s rights and mainstreaming them within the overall human rights regime. The UNHCHR has begun to facilitate the process of integrating gender into the work of the treaty bodies through expert group meetings and joint meetings between particular treaty bodies. These included the 1995 expert group meeting, sponsored by UNHCHR and the United Nations Development Fund for Women (UNIFEM), on the development of guidelines to enable the treaty bodies to solicit gender-specific information from States parties as part of their treaty monitoring activities.
Another such initiative included the joint meeting in November 1996 of the Committee on the Rights of the Child (CRC) and CEDAW. This meeting recommended that gender-sensitive data should be included in the States’ reports. The UNHCHR also expressed an interest in CEDAW’s ongoing work in developing a general recommendation on women’s health.

Sexual and reproductive health rights are interconnected with the realization of rights relating to the provision of information and to human rights education. The treaty bodies should continue to monitor human rights within the framework of the United Nations Decade for Human Rights Education. To increase their effectiveness, treaty bodies require sound data and reliable indicators on women’s health. The efforts of the treaty bodies could be accompanied by system-wide cooperation to develop or identify indicators of progress towards the realization of economic, social and cultural rights -- in particular, women’s health rights.

C. Recommendations

1. Treaty bodies

1. Treaty bodies are urged to review and consider the discussions held and recommendations made at this meeting. Treaty bodies are also encouraged to examine both the guidelines for the preparation of reports of States parties and the general criteria for examining reports as well as specific reports in order to more fully integrate issues of women’s health, particularly the right to reproductive and sexual health, into their consideration of the respective reports.

2. The chairpersons of the treaty bodies are urged to allocate a particular time, for example, one of the five days set aside for their Annual Meeting, for consideration of particular thematic issues, including the right to reproductive and sexual health, and to invite concerned United Nations agencies and NGOs to participate in such thematic discussions.

3. Treaty bodies are encouraged to consider the incorporation of gender dimensions, in particular, women’s health concerns, as appropriate, in the revision of general comments/recommendations and in the preparation of general comments/recommendations and guidelines which deal with one or more themes; emphasis should be given to the obligation of States parties to adopt positive measures to ensure rights.

4. Treaty bodies are encouraged to take into account the Declarations made at the World Conference on Human Rights, the International Conference on Population and Development and the Fourth World Conference on Women, to the extent that they are pertinent to their treaty norms and provide a useful source of indicators and questions for monitoring human rights, including the right to reproductive and sexual health.

5. Treaty bodies should develop their working methods to encourage greater cooperation with United Nations agencies, other United Nations bodies and NGOs, including by identifying and charging a member of each treaty monitoring body, as appropriate, to liaise with United Nations agencies, other United Nations bodies and NGOs on thematic issues, in particular, on women’s health issues, including the right to reproductive and sexual health.

6. Treaty bodies should notify United Nations agencies, other United Nations bodies and
NGOs of their schedule of meetings as soon as possible and also provide them with the reports of States parties as soon as they are received, to allow United Nations agencies and NGOs to analyse and respond to the reports. Dissemination of such information through the Internet should be encouraged.

7. Treaty bodies are urged to consider holding their pre-sessional meetings or to engage in consultations well in advance of their meetings in order to identify issues on which they require information to be provided by States parties, United Nations agencies, other United Nations bodies and NGOs with respect to the reviewing of reports by States parties.

8. The Secretariat should publicize and disseminate through appropriate media, including the Internet, the general comments/recommendations made by each treaty monitoring body. United Nations agencies and NGOs should follow up on such recommendations at a national and regional level.

9. The Secretariat should publicize and disseminate, through appropriate media, including the Internet, the concluding observations made by treaty bodies in respect of reports of States parties. United Nations agencies and NGOs should follow up on such recommendations at a national and regional level.

2. United Nations agencies and other United Nations bodies

1. United Nations agencies and other United Nations bodies are urged to review and consider the discussions held and recommendations made at this meeting. In the meantime, they should examine specific reports by States parties to treaty bodies in order to provide specific information which would allow for fuller integration of issues of women’s health, in particular reproductive and sexual health, in the consideration of the respective reports.

2. United Nations agencies and other United Nations bodies should allocate adequate human and other resources to human rights activities and seriously integrate human rights concerns into all their programmatic work and policy-making, including by the development of in-house expertise on human rights, and in so doing should support and be more actively and effectively involved in the work of the treaty bodies.

3. United Nations agencies and other United Nations bodies should provide training, both to staff at headquarters and field level and to their government and other counterparts, on the application of human rights to their work, and should call upon the expertise of treaty body members and NGOs, where appropriate.

in relation to treaty bodies:

4. United Nations agencies should consult with treaty bodies on their information collection systems, identifying the kinds of information which the agencies could provide to and analyse for the treaty bodies and considering ways to revise the agencies’ processes of information collection and analysis to enhance the capacity of the treaty bodies to monitor human rights.
5. United Nations agencies should provide technical assistance to treaty bodies in understanding and developing standards and processes for monitoring women's health issues, in particular the right to reproductive and sexual health.

6. United Nations agencies should assist the treaty bodies, as appropriate, in elaborating the content of the core minimum obligations of States parties under the respective human rights treaties and the progressive steps which could be taken in realization of particular treaty provisions, and in developing inquiries for States parties regarding the inclusion of, for example, relevant quantitative and qualitative information in their reports.

7. United Nations agencies should identify available information, particularly country-specific information, which would be relevant to consideration of reports of States parties and, where possible, should provide such information to the treaty bodies.

8. United Nations agencies and other United Nations bodies should also co-ordinate efforts to build the capacity of countries to monitor human rights, in particular the right to reproductive and sexual health.

9. Recognizing the obstacles to direct participation in the examination of reports by States parties, United Nations agencies could analyse each treaty and the work of each treaty monitoring body and, where possible, assist the treaty bodies in identifying gaps between the contents of the reports of States parties and specific country situations.

10. United Nations agencies should receive and follow up as pertinent the concluding comments and suggestions of the treaty bodies on reports by States parties and work with countries to implement such recommendations.

In relation to NGOs:

11. While respecting the autonomy of NGOs, United Nations agencies should facilitate and support the work of NGOs, particularly those monitoring the implementation of the Declarations of the United Nations World Conference on Human Rights, the International Conference on Population and Development and the Fourth World Conference on Women, in obtaining and providing training, information and resources to understand and use human rights in their work on the ground, becoming more involved in the human rights treaty monitoring process and increasing their capacity to use information regarding the treaty monitoring process to protect human rights.

3. Non-governmental organizations

1. The NGO participants in this meeting are urged to communicate the discussions and recommendations of this meeting to their constituencies and to other NGOs. In the meantime, they should be aware of the criteria for reporting by States parties as well as the content of specific reports in order to contribute more fully to the integration of issues of women's health, particularly reproductive and sexual health, into the consideration of the respective reports.

2. NGOs are vital to the human rights system because they provide credible and reliable independent information (such as shadow reports), and they can contribute to making United
Nations agencies aware of the human rights dimensions of their work. It is very important that NGOs be able to participate in treaty monitoring and conference implementation processes, and that their autonomy in doing so is respected.

3. NGOs are a source of valuable information which can assist the treaty bodies in developing comments, recommendations and guidelines for reporting, including by identifying meaningful quantitative as well as qualitative criteria and sources of information.

4. NGOs might identify the human rights dimensions of health issues, with a particular focus on women’s reproductive and sexual health, and bring these to the attention of the treaty bodies.

5. NGOs might consider identifying a national focal point for liaison with United Nations agencies regarding the treaty monitoring process.

6. United Nations agencies might provide NGOs with resources, including financial support, for programmes on human rights education and legal literacy at grass-roots levels, as well as for training in the treaty monitoring process and ensure on a local level that they have knowledge of treaty monitoring activities.

7. Donor assistance should be provided to NGOs to assist in their involvement in the treaty monitoring process as well as in the implementation of the conference documents.

4. Treaty bodies, United Nations agencies and non-governmental organizations

1. Further dialogues among treaty bodies, United Nations agencies and NGOs might be held on thematic issues relating to human rights, both internationally, regionally and nationally. Members of treaty bodies should be identified and invited to participate in such dialogues.

2. Dialogues among United Nations agencies, the treaty bodies and NGOs might be held to identify gaps in information collection and to explore different ways of collecting and sharing information which would be useful for identifying indicators for the monitoring of human rights.

3. United Nations agencies and NGOs might assist the treaty bodies in identifying criteria which establish the core minimum obligations of States to comply with the human rights treaties, and in developing guidelines regarding the inquiries to be made of States parties during the reporting process, as well as in developing recommendations and general comments relating to the progressive steps to be taken by States in ensuring compliance with the treaty norms.

4. United Nations agencies might collaborate with NGOs regarding the establishing of national advocacy bodies to promote human rights, and also to assist the treaty bodies in monitoring human rights, while respecting the autonomy of NGOs and recognizing their different role.

5. Treaty bodies, United Nations agencies and NGOs might invite specialists in gender and women’s human rights to assist them in understanding and integrating gender concerns in the interpretation and implementation of their mandates.
PART II. FRAMEWORKS FOR A HUMAN RIGHTS APPROACH TO WOMEN'S HEALTH

A. A Gender Perspective on Health and Human Rights

In the past decade, there has been a sharpened recognition of the need to understand, reconceptualize and implement human rights from the perspective of gender. This involves ensuring that women's rights are fully protected by the United Nations, regional and national human rights systems.

1. Identifying gender dimensions of human rights

Ms. Maria Isabel Plata, Executive Director, PROFAMILIA, in Bogota, Colombia, discussed how women's organizations worldwide have, through their practical work, identified the gender dimensions of human rights. In doing so, they have brought a new perspective to the rights of women and girls to sexual and reproductive health. The application of a human rights approach to women's health makes visible violations of women's rights that are otherwise invisible. This approach involves challenging the assumption of a dichotomy between public and private spheres. This notion of such a dichotomy has tended to shield violations of sexual and reproductive rights -- typically seen as "private" -- from public concern or scrutiny. Challenging the dichotomy has advanced the principle that the responsibility of the State includes an obligation of due diligence to ensure the accountability of private actors for human rights violations.

Violations of women's right to sexual and reproductive health raise questions of special sensitivity. As a result of the operation of a double standard in both law and culture, women are valued predominantly for their reproductive capacity or maternal functions and rendered vulnerable to discrimination, coercion, abuse and violence, particularly in relation to their sexuality. Thus, the development of policies addressing women's health is directly affected by cultural or social barriers. For example, the stereotyping of women in particular roles -- for example, as mothers -- results in policies and programmes which prioritize infant and maternal health over public health issues and leaves unacknowledged the maternal deaths resulting from unsafe abortions. Such policies also ignore the life-cycle health needs of women, including their sexual and reproductive health needs, such as those related to menopause or cancers and other diseases of the reproductive system, or to the sex-specific risks of HIV and other sexually transmitted diseases (STDs).

The realization of women's right to health is impeded by explicit gender-discriminatory laws and policies, as well as by the gender-differentiated impact of ostensibly gender-neutral laws. It is also affected by traditional or cultural practices, including those directed exclusively toward women, such as FGM. The development of gender-sensitive laws needs to be accompanied by greater awareness and education about women's human rights, the empowerment of women and the creation of services which address women's health concerns (see Box 2).
Box 2. Ingredients in a gender-sensitive health policy

A gender-sensitive health policy or programme would recognize that gender-based discrimination contributes to women's ill-health and constitutes an obstacle to women's enjoyment of human rights. It would not only address the relationship between women's empowerment, gender relations and the family but also integrate human rights which enable women to control their own fertility and sexuality. Such rights include, but are not limited to, life, liberty and personal security, equality, and the rights to found a family, to decide freely and responsibly on the number and spacing of children, to have access to information and education, to enjoy a healthy environment and to have access to health care. A gender-sensitive health policy which integrates human rights concerns would thus ensure the quality of care, technical expertise, modern technology, choice of contraceptive methods, full information on available choices and other services to enable women to make decisions about and to protect their own sexuality, fertility and reproductive goals.

2. Designing a methodology for developing a gender perspective on human rights

Ms. Elizabeth Evatt, Member, Human Rights Committee (HRC), the treaty body established under the International Covenant on Civil and Political Rights, outlined a methodology for developing a gender perspective to human rights, with a focus on women's health.

In developing a human rights approach to the issue of health, it is important to focus on securing compliance with rights recognized as legally binding. The documents from the United Nations conferences, in particular the ICPD and the Beijing Conference, are a declaration of objectives and policy goals, and provide a framework for examining the extent to which recognized rights, to which States are already committed, can further such objectives.

Designing a human rights approach to women's health involves identifying each recognized right, analysing its gender dimensions and examining the impact of each right on every aspect of women's health. For example, the application of the right to participation in public life and political decision-making would secure the role of women in the provision of health care, in particular, its gender-specific aspects. The implementation of this right would, thus, lead directly to improvements in women's right to health. Further, the application of the right to life, through the taking of positive measures and affirmative action, could result in the protection of maternal health. An identification of the linkages between health and human rights and a detailed examination of the rights protected by ICCPR and the ICESCR could further the enjoyment of women's right to health in all its dimensions.
To identify the means of developing a human rights approach to health issues, three specific studies could be considered, possibly in conjunction with the treaty bodies:

- An identification of issues relating specifically to women's health;
- An assessment of the impact on women of the denial of their human rights, such as lack of access to information regarding reproductive matters or unequal access to reproductive and other health services; and
- An examination of the improvements to women's health resulting from implementation of their human rights.

Ms. Evatt emphasized that for minority women, it is necessary to identify additional dimensions relevant to the enjoyment of human rights. For example, in cases involving women from racial minorities, the gender dimension is supplemented by a race dimension. Such women, by reason of their vulnerability, may face additional risks to their health, such as forced sterilization or unequal access to health care.

B. The Interrelationship of Gender and Minority Status

The initial discussion of the interrelationship of gender and race in the application of human rights focused, inter alia, on the question of whether each recognized human right necessarily involved a distinct gender dimension as opposed to merely a differential implication for men and women. Participants identified several specific gender dimensions. The gender-selective application of the pass laws in South Africa, which enforced racial segregation, was cited as an example. Such laws compelled men to live away from their families and left women without their spouses. Thus, the laws not only inflicted racial segregation upon women but affected their right to reproductive and sexual health. Another example was that of the gender dimensions of racist propaganda related to ethnic cleansing, such as calls for the rape and forced impregnation of Bosnian-Muslim women during the conflict in the former Yugoslavia. It was also noted that women from racial or ethnic minorities face additional discrimination when seeking access to lawyers or the courts, because of poverty or prejudice, and, in many cases, are prevented by male members of their own families and communities from so doing. Even when women are able to access a court, the gender bias of the judiciary or decision makers -- often amplified, in the case of minority women, by racial and ethnic prejudices -- is likely to prevent their claims from being taken seriously.

The Round Table considered the health and human rights implications for indigenous and refugee women in order to illustrate the need for context-specific consideration by the treaty bodies, United Nations agencies and programmes and NGOs of the human rights dimensions of sexual and reproductive health.

1. Indigenous women

Ms. Charon Asetoyer, Director, Native American Women’s Health Education Resource Centre, South Dakota, United States, discussed the impact on women’s health of the intersection of factors such as race or ethnicity and poverty with gender, focusing on the
experiences of indigenous women in the United States of America and other countries. She noted that the standard of health care available to indigenous women is often inferior to that of the general population. Moreover, poverty not only limits access to health care but compounds the vulnerability of indigenous women to violations of their right to reproductive and sexual health. Coercion in treatment and clinical use is a special concern among poor and indigenous women. Ms. Asetoyer noted the following examples of the vulnerability of indigenous women:

- Tubal ligations, performed on indigenous women in India with insufficient provision of anaesthesia, have led to deaths or other injuries following infection;
- Thousands of indigenous women in the United States were coerced into having permanent tubal ligations, often directly after childbirth, when still under anaesthesia;
- The Indian Health Service, the major health provider for indigenous communities in the United States, continues to have no uniform required protocol or informed consent for the distribution and use of injectable or implantable contraceptives such as Depo-provera or Norplant on indigenous women;
- Indonesian women have been coerced into using Norplant; and
- Financial incentives have been used to induce contraceptive usage among Bangladeshi women.

The delivery of health care is impeded by the lack of information, in particular the absence of information services which are culture- and language-specific. For example, inadequate translation services could deprive indigenous women of relevant information on reproductive health procedures or the side-effects of drugs. The absence of consent forms in local languages has resulted in unauthorized sterilizations and experimentation on indigenous women in the United States.

In rural communities, indigenous women may suffer especially from the degradation of environmental conditions. For example, pollution resulting from mining in the Philippines’ Benguet Province and uranium on the Navajo and Ute reservations in the United States has resulted in miscarriages, birth defects and cancers.

Ms. Asetoyer emphasized the responsibility of the human rights treaty bodies to monitor and take steps within their mandates to prevent these abuses. She also emphasized the significance of the draft Declaration on the Rights of Indigenous Peoples, which is being developed by a working group of the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities.

2. Refugee, migrant and displaced women

Dr. Colette Dehlot discussed the right to reproductive and sexual health of displaced women, including refugees, migrants and the internally displaced, based on her experience in humanitarian aid work in Africa, the site of the world’s most severe crisis of forced
displacement. Women make up the overwhelming majority of the world's refugee and displaced populations.

The gender dimensions of international refugee and humanitarian law and policy have been neglected. Women in conflict situations experience the impact of violence and suffer lifelong social, economic and psychological trauma. During the period of conflict, they are often the target of sexual abuse, rape, abduction, harassment, forced prostitution and military attacks, and are especially vulnerable to anti-personnel land mines. Despite the urgency of the need, they are often unable to access reproductive and sexual health services. There is no attention to the most endemic form of violence against women -- battering and sexual violence by intimate partners, and its resultant effects on women's physical and mental health and survival, which often occurs in refugee situations. The law also fails to recognize women's special need for protection in refugee situations, particularly given their role as child-bearers, caretakers, food providers and heads of household.

Migrant women, other than those moving for reasons of family reunion, are disproportionately represented among refugees and economic migrants. The latter are especially likely to suffer violations of their right to reproductive and sexual health -- in particular, sexual assault. Faced with decreasing income and likelihood of employment, displaced women may be forced into commercial sex work in order to provide for themselves and their families. The dependency situation created in conditions of forced displacement further incapacitates women from making choices, leaving them vulnerable to involuntary servitude and trafficking for marriage, illegal labour and the sex industry. Internally displaced women have little or no access to health services, due to distance, cost and the fear of violence (see Box 3).

Box 3. Women's right to reproductive health in situations of forced displacement

To secure women's right to reproductive and sexual health in situations of forced displacement, it is necessary to ensure their rights to live in a violence-free environment; to express their sexuality and to enjoy a healthy sexual life; to be protected from sexual assault, including FGM and reproductive tract infections (RTIs); to have access to family planning services; to make decisions concerning safe contraception and reproduction; to obtain information and education on reproductive and sexual health; to select safe reproductive technology; to choose the time of pregnancy and carry to term safe motherhood; to obtain quality of care in reproductive health services; to comprehend laws and regulations affecting women's reproductive and health rights; to access economic opportunities to improve their reproductive and health rights; and to advocate for the recognition of women's reproductive and sexual health rights as human rights.
Specific actions to address the health concerns of displaced women need to be identified. These could involve encouraging their participation in the process of national decision-making on gender issues. For many displaced women, the expansion of reproductive and sexual health services would enable them to exercise their right to control child-bearing through safe and reliable contraceptive methods, enhancing their empowerment. Displaced women themselves could become service providers. A programme to empower women concerning their reproductive and sexual health rights could entail setting up a community-based reproductive and sexual health clinic within the host community to ensure access to quality services.

In conclusion, Dr. Dehlot called for the vigorous application of human rights treaties both to provide protection and to determine responsibility for violations under human rights law. The responsibility of Governments and international institutions, assisted by NGOs and the private sector, outlined by the ICPD Programme of Action and the Beijing PFA, includes protection of human rights, in particular, access to reproductive and sexual health services in time of armed conflict and its aftermath. She emphasized that international support for these efforts from the World Bank and other international donors should be directed toward building local talent and capacity rather than being spent largely on foreign technical specialists. A major focus of all such efforts must be to involve displaced women as participants in all aspects of nation-building and reconstruction.

C. An Interdependent Framework for the Application of Human Rights Standards to Women’s Health, with a Focus on Sexual and Reproductive Health

1. Examining the intersection of human rights and the protection of women’s health

Ms. Rhonda Copelon presented a framework for understanding the intersection of the grave human rights concerns involved in the protection of women's health. Her remarks were based on a paper which she co-authored with Sofia Gruskin and Nahid Toubia. The paper suggests a comprehensive, interdisciplinary framework for analysing a particular health problem or response that could engage the respective treaty bodies and the programmatic agencies. It identifies four distinct but interrelated categories -- which the authors describe as “bundles” of rights -- into which existing human rights norms, drawn from the different treaties and applicable to women’s health, can be grouped:

- Autonomy or the capacity to make decisions;
- Maximization of health status, services and healthful conditions;
- Elimination of all forms of adverse discrimination and protection of diversity; and
- Full and equal participation of women in all spheres of life or citizenship.

The rights contained in the "autonomy bundle" involve the capacity and means to make decisions about one’s body and life, recognizing that this involves not isolated individualism but rather the interconnectedness of women’s lives with others as well as their dependence upon economic, social, cultural and political conditions. Autonomy rights range from the freedom
from slavery, torture and inhuman treatment to liberty, security of person, privacy and respect for family life, freedom of thought, conscience, religion and expression and the right to seek, receive and impart information. At the core of autonomy rights is the integrity of the body. For women, sexuality and reproduction are the central concerns of bodily integrity. Autonomy rights engage the responsibility of the State in both negative and positive ways. Governments must not only refrain from obstructing the exercise of these rights but also take affirmative steps both to protect their exercise from private interference and to ensure that the conditions necessary for their exercise are in place.

The right to health encompasses the attainment of the highest possible state of health. The elements of women's sexual and reproductive health are defined in the conference documents. There are three components:

- The right to health starts with healthy conditions -- including other social and economic rights such as adequate housing, food, safe drinking water, sanitation, information, the ability to obtain education and earn a livelihood under healthy occupational conditions, and the elimination of environmental hazards;
- The right to health entails access to information and health services which are safe, of high quality, affordable, voluntary and gender-sensitive. As such, rights related to health are inseparable from the autonomy rights discussed above;
- The right to health specifically includes the right to enjoy the benefits of scientific progress.

With respect to the right to health, as with other social and economic rights, the responsibility of the State is to provide a core minimum of protection, eliminate discrimination and take measures progressively to maximize the enjoyment of health. Cutbacks on resources allocated to health thus raise a prima facie issue of violation of the right to health and will likely produce violations of the other bundles as well. It is especially important, therefore, that the treaty bodies consider the impact of structural adjustment policies, internal budget cuts and other privatization policies on the progressive maximization of health.

The third "bundle" -- elimination of discrimination -- requires consideration of all recognized categories of impermissible discrimination (race, colour, sex, language, religion, political or other opinion, national or social origin, property and birth) and "other statuses" such as age, rural v. urban location, sexual orientation, marital status, health status such as HIV/AIDS, and number of children. Discrimination, as defined in the Women's Convention, applies to discriminatory treatment of and disproportionate impact on women in diverse contexts. The State is responsible for eliminating its own discriminatory practices, as well as ensuring the elimination of private discrimination in all spheres. With respect to sexual and reproductive health rights, the responsibility of States to eliminate discrimination requires attention to sex-specific differences and to positive measures to enable women to realize equality.

The final "bundle" of rights -- involving rights to full and equal participation in all spheres of life -- focuses attention on the processes as well as the substance of protection of health rights and women's citizenship. It encompasses women's equal rights to education; respect for
decision-making in intimate life -- to choose sexual and life partners, and child-bearing; and equal sharing with men of the responsibilities of child-rearing and the household. It also encompasses rights to political and democratic participation, including rights to expression and association, to resist violations and build gender-sensitive programmes, and to participate equally in the selection of representatives and as public office-holders. As underscored by the ICPD and Beijing documents, these rights include participation in the planning, implementation and evaluation of programmes related to reproductive and sexual health. Finally, the participation bundle includes the development and use of mechanisms of redress, which should involve special mechanisms designed to provide access to those with complaints about programmatic activity.

2. Discussion

The discussion focused on the value of the "bundles" approach to an analysis of the human rights dimensions of health. Some treaty body members appreciated this approach, as did a number of the agency and NGO participants. This approach provides an overview particularly for those seeking to embed a holistic or indivisible human rights framework into their programmatic work. Other participants preferred a treaty-by-treaty approach reflective of their own concerns in the respective treaty bodies. It was recognized that a treaty-based approach is essential when engaging with particular treaty bodies on aspects of the problem within their legal competence.

Ms. Virginia Bonoan Dandan, Rapporteur, Committee on Economic, Social and Cultural Rights (CESCR), commented on the interconnections between economic, social and cultural rights and an indivisible concept of women's right to health, in particular, sexual and reproductive health. She emphasized that the right to health lies at the core of all human rights. A holistic view of health, in accordance with the Beijing PFA, is not limited to health care but requires the consideration of other determinants of health, including adequate housing, education, sanitation and protection against discrimination.

Ms. Dandan noted that the ICESCR protects a broad range of rights essential to the protection of women's health. She emphasized that the fundamental right of the ICESCR, which requires immediate and not simply progressive implementation by the States parties, is the broad right to non-discrimination articulated in article 2(2). The right to non-discrimination requires examination of the health status, conditions and policies through different lenses and is of special relevance to women from migrant communities, indigenous peoples or any disadvantaged or vulnerable group.

Ms. Shanthi Dairiam discussed means to further the application of human rights to women's health, elaborating on the challenges of applying a gender perspective and overcoming gender discrimination in regard to women's sexual and reproductive health rights. To promote the acceptance of human rights, it is important to bear in mind the principles of equality, universality and indivisibility. The principle of universality confronts competing claims for identity, particularly with respect to reproductive and sexual health rights. The principle of
interdependence of rights confronts the public/private dichotomy. There is considerable difficulty in applying these principles to the situation of women, given that the biological and social differences between women are often used to justify discrimination. Moreover, the law fails to ensure autonomy for women; thus, the principle of equality is especially significant (see Box 4).

**Box 4. Structural and other underpinnings of inequality**

A human rights approach to women’s health needs to take account of the specificity of issues which relate to women’s health, to address the systemic and systematic nature of discrimination, and to distinguish the linkages between gender discrimination and the structural basis of inequality. Institutions such as the household, community, market and State do not function as isolated units of society. All are based on underlying norms, on particular rules and assumptions, which perpetuate and mask the construction and reproduction of gender differences. For example, the assumption underlying the national legislation of many States that fail to recognize a concept of marital rape is that men are legally entitled to sexual access to their spouses within marriage. A similar assumption underpins the application of laws which provide for the restitution of conjugal rights.

Securing women’s human rights will require the identification of the specific context for the interplay of the principles of equality, universality and indivisibility of rights and an examination of the role of the State and the extent to which it reinforces norms reproducing discrimination though both its action and its inaction. It will also require the formulation and articulation of demands to be addressed to the State to eliminate such gender-based discrimination.
PART III. APPLICATION OF A HUMAN RIGHTS APPROACH TO WOMEN’S HEALTH: TREATY BODIES, UNITED NATIONS AGENCIES AND OTHER UNITED NATIONS BODIES

A. Treaty Bodies

Each of the treaty bodies reviewed the steps taken to develop a gender perspective on human rights, the scope for developing a human rights approach to women’s health and the possibilities for contributions to their work by other United Nations bodies. The general comments and recommendations referred to are contained in the Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies.17

1. Human Rights Committee

Ms. Evatt’s paper summarized the work of the HRC in implementing the ICCPR as it relates to women’s health. She commented that although the Committee had not conducted a specific study of issues relating to women’s reproductive and sexual health rights, it was taking steps to provide a framework for considering how the rights protected by the ICCPR relate to health, including women’s health.

In the context of women’s right to health, article 3 and article 26 of the ICCPR are especially relevant. These provide, respectively, for gender equality in the enjoyment of rights under the Covenant, and the prohibition on adverse discrimination on many grounds, including sex. The Committee does not consider differentiation per se to constitute discrimination, if the criteria for differentiation are “reasonable and objective” and are aimed at achieving a purpose which is legitimate under the Covenant. Further, the Committee recognizes that affirmative action is a legitimate and necessary measure to ensure equality in the enjoyment of human rights and fundamental freedoms, even if this requires preferential treatment on a temporary basis (General Comment No. 4, adopted in 1981).

In a series of cases relating to the social security legislation of the Netherlands, the Committee determined that the prohibition on discrimination extends to all legislation and to any area regulated by public authorities, including health services, and is not limited only to the human rights protected by the ICCPR. Thus, although the State is not obligated under the ICCPR to provide health services or access to family planning information, if it does so, it must ensure that there is no discrimination in its application. (S.W.M. Broeks v Netherlands 172/1984, views adopted 9 April 1987; F.H. Zwaan-de Vries v The Netherlands, 182/1984, views adopted 9 April, 1987.)

Following the Vienna Conference, the Committee considered the steps it could take to give greater prominence to factors affecting the equality of status and human rights of women. At its 53d session in 1995, the Committee amended its guidelines regarding initial reports of States parties. It required that States refer, in the section on factors or difficulties affecting the enjoyment of each substantive right protected by the Covenant, to “factors affecting the equal enjoyment of women of that right.” This amendment reflects the Committee’s recognition that
the application of human rights standards to women may be gender-differentiated, acknowledging that human rights have been defined mostly in terms of their application to men. To ensure equality in women’s enjoyment of rights, gender-specific aspects of rights cannot be overlooked.

The Committee also decided to revise its General Comment on article 3, concerning the meaning of the equal right of men and women to enjoyment of human rights. This revision provides an opportunity for a comprehensive gender analysis of each provision of the ICCPR and the identification of issues of special relevance to women. For example:

- The right to life (article 6, ICCPR) has already been applied to infant mortality. The Committee has emphasized the obligation of States parties to take affirmative measures to ensure protection. It could be extended to the issue of life expectancy, including distinctions between women and men, particularly in respect of issues of women’s reproductive and sexual health which adversely affect women’s life expectancy, such as maternal mortality, strict abortion laws which lead women to seek unsafe abortions, FGM and the risk of HIV/AIDS, including factors which increase the risk for women;

- The right to freedom from torture and cruel, inhuman or degrading treatment (article 7, ICCPR) clearly encompasses sexual abuse, rape and violence against women committed as an act of war or in armed conflict. In General Comment No. 16, adopted in 1988, the Committee recommended that persons subjected to body searches by state officials or medical personnel at the request of the State should be examined only by persons of the same sex. As this right also extends to “treatment” by private persons, it is relevant to consider whether the State has introduced measures of protection and, therefore, whether the State’s condoning of, or failure to take action to prevent, FGM could be considered. The right specifically prohibits medical or scientific experimentation on any individual without his or her consent (General Comment No. 7, adopted in 1982, and No. 20, in 1992) and could, therefore, include consideration of drug testing on poor, uneducated or illiterate women who have little understanding of the issues or risks involved;

- The prohibition on slavery and servitude, forced or compulsory labour (article 8, ICCPR), concerns both private and public action and could include consideration of trafficking and forced prostitution, as States have a duty to take effective measures to prevent this kind of exploitation;

- The right to equality before the courts and before the law (articles 14 and 26, ICCPR) could encompass laws which imprison women for certain offences while men go free, as in the case of abortion and prostitution, or which restrict women’s access to health and family planning services by the operation of spousal consent requirements;

- The right to freedom of movement (article 12, ICCPR) could extend to the consideration of laws which prohibit women from travelling abroad to seek an abortion, as this could rarely be justified as a restriction necessary to protect
public health or morals;

- The right to procedural guarantees in respect of the expulsion of aliens (article 13, ICCPR) could include the right of women asylum seekers to have circumstances of domestic and sexual abuse, sexual harassment and genital mutilation taken into consideration in a claim for refugee status based on a fear of persecution;

- The right to protection of privacy and the home (article 17, ICCPR) could include consideration of women's right to make their own decisions about pregnancy and abortion, which are violated by compulsory tests for virginity or pregnancy by employers and officials, or discrimination or sanctions based on sexual orientation. The latter has already been addressed by the Committee (Toonen v. Tasmania);

- In General Comment No. 19, adopted in 1990, the Committee reaffirmed that the age of marriage should be such as to enable each spouse to give his or her free and full personal consent in a form and under conditions prescribed by law. In relation to the right to found a family, which implies the right to procreate and live together, the Committee stated that family planning policies, where adopted by States, should be compatible with provisions of the Covenant and should not be discriminatory or compulsory;

- The right to freedom of expression and to seek, receive and impart information (article 19, ICCPR) protects the freedom of women of all ages to receive and impart information about health services, including contraception and abortion, and to have access to personal medical records;

- The right to equality in the family and in marriage (article 23, ICCPR) includes the right to found a family, which implies freedom from compulsory and child marriage, and to access to information and education about health and reproduction. It requires that family planning policies be compatible with the ICCPR, that they be non-discriminatory and non-compulsory, and that spouses have equal rights and responsibilities in all matters arising from the relationship, recognizing that equality requires that each person must be able to decide independently on matters that involve bodily integrity; and

- The protection of children (article 24, ICCPR) could extend to consideration of the prevention of early pregnancy and child marriages, by raising the age of marriage for girls; protecting children from sexual abuse, including genital mutilation and forced prostitution; reducing infant mortality and eradicating malnutrition; and ensuring adolescent access to sex education and decision-making in respect to reproductive and sexual health services. Son preference, which may have an adverse effect on the health and education of girls, could also be addressed.

With reference to the Committee's General Comment on article 27, which provides for the right to enjoy culture, language and religion, these rights should not be used or relied upon
to undermine women's equality or other rights protected by the ICCPR.

The Committee faces a number of obstacles in developing a human rights approach to issues of women's health, as these require positive measures of protection by States parties, including a framework of laws and policies for ensuring rights. There is a difficulty in identifying when such broader rights have been violated with respect to individuals. Although this difficulty may diminish in relation to a reporting process, it is a special problem in respect of the complaints procedure. This distinction, reflected in the separation of the ICCPR and ICESCR (and, to some extent, redressed by the draft optional protocol to CEDAW), obscures the close interrelationship between political and civil and social, economic and cultural rights. For example, the right to life implies that a person has the means of survival, and that States have an obligation to create a framework of laws and policies to this end.

A fundamental challenge is to ensure the acceptance by States of a human rights approach to women's health, which is a prerequisite for compliance. The Committee is hampered by the lack of gender-specific information relating to particular countries and would benefit from specific data, including statistics, for use in its dialogue with States. When such information has been available, the Committee has used it to advantage. For example, when considering Peru's report, the Committee expressed its concern that abortion in Peru is subject to criminal sanctions, even when pregnancy results from rape, and that unlawful abortion is a major cause of maternal mortality. It concluded that this aspect of Peruvian law subjected women to inhuman treatment and was incompatible with articles 3, 6 and 7 of the Covenant (Concluding Observations on Peru, November 1996).

2. Committee on Economic, Social and Cultural Rights

Mr. Juan Alvarez Vita, Vice-Chairperson, CESCR, the monitoring body of the ICESCR, highlighted the need to place scientific and technological advances at the service of all persons and to ensure that medical experiments, including genetic experiments, respect human dignity and do not result in violations of human rights.

The CESCR, in its General Comment No. 5 adopted in 1994, recognized that women with disabilities often face double discrimination. It requested States parties to address the situation of women with disabilities. In particular, it reaffirmed that persons with disabilities should have the right to marry and found families, and that they should have access to necessary counselling services to fulfil their rights and duties within the family. Further, the CESCR commented that women with disabilities have the right to protection and support in relation to motherhood and pregnancy. It specifically condemned the sterilization of women with disabilities and compulsory abortion of their unborn children without their informed consent as a serious violation of article 10 of the ICESCR. With respect to the right to health, the Committee reaffirmed that persons with disabilities have the same rights to medical care as other members of society. This includes the right to have access to, and benefit from, medical and social services, including orthopaedic and rehabilitation services to enable them to become independent and participate in society.

In General Comment No. 6, adopted in 1995, the Committee recognized the equal rights of older women under the Covenant and specifically requested that States parties pay particular attention to Recommendations 1 to 17 of the Vienna International Plan of Action on Ageing.
providing guidelines on health policy to preserve the health of the elderly.

The CESCR is currently engaged in the development of a General Comment on article 12 of the Convention, which protects the right to health. This provides an important opportunity to mainstream gender perspectives.

The right to health of indigenous peoples and minorities should be given special attention, although protection of their traditions should not hamper access to other health services. Discrimination, in particular, discrimination against women, children and persons with HIV/AIDS, restricts the enjoyment of the right to health and access to health services.

3. Committee on the Elimination of All Forms of Racial Discrimination

Mr. Michael Banton, Chairperson, CERD, the treaty body which monitors the Convention on the Elimination of All Forms of Racial Discrimination (Race Convention), suggested that the Race Convention, unlike the Women's Convention, does not extend protection against discrimination beyond “public life.” Further, the Committee’s mandate was limited to discrimination on grounds of race; it did not encompass discrimination on the grounds of gender. To ensure the effective functioning of the treaty system, treaty bodies should respect the limits of their competence.

The CERD had concluded that its guidelines for reporting by States parties did not require revision to incorporate gender perspectives as its existing guidelines enabled it to address the issue of racial discrimination wherever it seemed particularly relevant to women. Thus, the CERD’s questions to States parties included reference, for example, to the ethnic dimensions of discouraging FGM, foetal alcoholism syndrome among disadvantaged indigenous populations, and the protection of female migrant domestic workers.

The CERD has rarely referred to gender-specific violations of human rights in its General Recommendations, an exception being General Recommendation No. XVIII, adopted in 1994, which calls for the establishment of an international tribunal to prosecute crimes against humanity, including rape.

Several Round-table participants suggested that the Committee could not fulfill its mandate to protect all members of minority groups from racial and ethnic discrimination without considering the differential status of minority women and men and identifying the differential impact of discrimination on women and men, particularly in the area of reproductive and sexual health rights.

Constraints on the possible improvement of the reporting process to incorporate a gender perspective were identified, including the lack of material or human resources, severe time constraints resulting from an increasing workload (preparing initial reports, periodic reports, early warning and urgent action procedures and individual petitions) and the lack of access to information. Despite improvements in the quality of dialogue between the Committee and States parties, and the provision by the International Training Centre of the International Labour Organization (ILO) and the Office of the High Commissioner for Human Rights (OHCHR) of valuable assistance in the preparation of reports, the reporting process has placed a significant burden on States parties. In view of these factors, Mr. Banton suggested the need to consider
a reassessment of the entire reporting system.

In relation to women’s health, Mr. Banton suggested that it would be preferable to focus on social processes of disadvantage and their physical consequences and to identify points of intervention. Treaty bodies should be wary of exceeding their mandates or of overlapping their functions.

4. Committee on the Elimination of All Forms of Discrimination against Women

Ms. Carmel Shalev, Member, CEDAW, outlined the Committee’s approach to women’s health by reviewing provisions of the Women’s Convention, CEDAW’s general recommendations and suggestions, and other initiatives related to women’s health concerns:

- Article 1 of CEDAW adopts an “effects” approach to discrimination, which condemns discrimination even though it may have been unintended. Discrimination in respect of women’s health may impair women’s enjoyment of rights protected under other human rights treaties, including the right to life, liberty and security of the person, and equality before the law and privacy. Because of the significance of inequality in the private sphere of life where women are concerned, articles 1 and 3 make clear that the obligation of States to eliminate discrimination extends to all spheres, including the private sphere;

- Article 12 of CEDAW relates to States parties’ obligations to ensure gender equality in health care, including access to health care — in particular, to family planning. It also obliges States parties to provide appropriate services for women in relation to pregnancy, confinement and the postnatal period, including free services where necessary as well as adequate nutrition during pregnancy and lactation; and

- Other articles directly relevant to women’s health include article 10(h), on the right of access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning; article 11(f) on the right to protection of health and safety in working conditions, including the safeguarding of the function of reproduction; and article 16(1)(e) on the equal rights of women and men to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

Articles of the Convention which are indirectly relevant to women’s health include article 2(f), on the modification or abolition of discriminatory customs or practices; article 5(b), which provides for education for a proper understanding of maternity as a social function; article 10(f), on the reduction of female drop-out rates in education; article 14(h), on the right of rural women to adequate living conditions, including sanitation; and article 16(2), on the minimum age for marriage.

Based on the authority conferred by article 21 of the Convention, CEDAW has issued a number of general recommendations on matters related to women’s health. These include General Recommendation No. 14 (1990), which recommends that States parties undertake
research, education and training to ensure that health personnel and women are informed about the harmful effects of FGM and about other harmful traditional practices as a means of eradicating them.

On the subject of gender violence, General Recommendation No. 12 (1989) requests States parties to include information in their reports relating to legislation protecting women against violence and to available support services and statistical data on the incidence of violence. In General Recommendation No. 19 (1992), the Committee provided a comprehensive treatment of the issue of violence against women and referred to particular health aspects of physical, mental and sexual violence against women. It noted that States may be responsible for private acts if they fail to act with due diligence to prevent violations of rights or provide compensation to women victims of violence. It further identified traditional practices perpetuated by culture and tradition harmful to women’s health, such as dietary restrictions for pregnant women, son preference and FGM. It identified the treatment of women as sexual objects as contributing to violence against women, and trafficking and prostitution as making women especially vulnerable to abuse. It referred to the increase in sexual assaults on women during armed conflict; it also identified the adverse effects of compulsory sterilization or abortion on women’s health. The Committee recommended that States take measures to overcome traditional practices, ensure that measures are taken to prevent coercion in regard to fertility and reproduction, and ensure that the lack of appropriate services does not force women to seek unsafe medical procedures such as illegal abortion. The Committee’s Recommendation also directs States to ensure that services for victims of violence are accessible to women in rural areas and in isolated communities, and to include in their reports information on all available data on each form of violence and its effects on women.

In General Recommendation No. 15 (1990), the Committee addressed the problem of discrimination against women in national strategies for the prevention and control of AIDS. It recommended that AIDS-related programmes should pay special attention to the rights of women and children, and to factors relating to women’s reproductive role and subordinate position which make them particularly vulnerable to HIV infection. It recommended that States parties intensify efforts to disseminate information to raise public awareness of the risk of HIV infection -- in particular, AIDS -- in women and children, and ensure women’s active participation in health care and enhance their role as care providers, health workers and educators in the prevention of infection with HIV. It called upon States parties to include in their reports information on the effects of AIDS on women’s situation and on action taken to meet the needs of HIV/AIDS-infected women and to prevent specific discrimination against women with AIDS.

In General Recommendation No. 18 (1991), the Committee expressed concern about women with disabilities as a vulnerable group and recommended that States provide information in their reports about disabled women, including measures to deal with their situation and special measures to ensure their equal access to health services.

In General Recommendation No. 21 (1992), the Committee addressed issues relating to women’s reproductive health in the context of the protection of equality in marriage and family relations (article 16). The General Recommendation refers to the minimum age of marriage and notes the effects of women’s physical and mental health on their power to control the number and spacing of their children. It further refers to women’s right to make decisions about their
reproductive health, to have the information to make such decisions in an informed manner and to have access to appropriate services. The Committee emphasized that gender equality requires that women, who alone bear the child and still, usually, bear at least disproportionate responsibility for the nurture of children, be able to make reproductive decisions free of interference by spouses or others claiming an interest.

CEDAW has made a number of suggestions specifically related to women’s reproductive and sexual health. In 1994, it adopted Suggestion No. 6, directed to the ICPD, urging it to adopt a non-discrimination framework for the Programme of Action. In 1995, the Committee adopted Suggestion No. 8, expressing its intention to follow the implementation of the ICPD Programme of Action with respect to women’s human rights and to develop a jurisprudence of international legal standards with respect to women’s health through the reporting mechanism under the Convention. The Committee also requested its Chairperson to consult with the Executive Director of UNFPA to ensure more effective exchange of information among the treaty bodies and coordination with other United Nations organs on human rights issues.

In 1996, the Committee revised its guidelines regarding the form and content of States parties’ reports in the light of the Beijing Declaration and the PFA. Under the new guidelines, the Committee invited States parties to take into account critical areas of concern identified in the PFA, including health, to enable it to monitor women’s enjoyment of rights under the Convention. In November 1996, the Committee met jointly with the CRC and recommended that gender-sensitive data should be included in the States’ reports. At the time of the Round Table, CEDAW was developing a General Recommendation on women’s health.

5. Committee against Torture

M. Alexis Dipanda Mouelle, President, Committee against Torture (CAT), suggested that the CAT did not concern itself directly with issues relating to health or women’s health. The Committee had, however, considered the issue of women tortured in armed conflict. He emphasized the need for providing medical and psychiatric services to women in this context and, where possible, state pensions and compensation.

Participants noted that the Committee could take account of the reports of the Special Rapporteur on Torture, recognizing rape in detention as a form of torture as well as developments in relationship to the recognition and prosecution of sexual violence as a form of torture in the context of war crimes against women in the former Yugoslavia and violations of the American Convention on Human Rights in respect of Haitian women. It was also suggested that consideration be given to private activities, such as domestic battering and sexual violence, where the State acquiesces in such behaviour by failing to punish or provide effective redress, and that this be recognized as within the definition of torture.

6. Committee on the Rights of the Child

Ms. Akila Belembaogo, Chairperson of the CRC, the treaty body monitoring the Convention on the Rights of the Child (Children’s Convention), discussed the steps taken by the CRC to address issues of reproductive and sexual health.

In relation to mainstreaming gender, the CRC participated in the sixth and seventh
annual meetings of chairpersons of the treaty bodies, which discussed the mainstreaming of a gender perspective into all aspects of the work of the treaty bodies. It also participated in meetings on elaborating guidelines for mainstreaming a gender perspective into all human rights programmes, organized by the OHCHR and UNFPA; on planning for the integration of women's rights into system-wide United Nations activities, organized by the OHCHR and the International Centre for Human Rights and Democratic Development; and on commitment to action for girls, organized by the United Nations Children's Fund (UNICEF).

At its eighth session, in January 1995, the CRC spent a day of general debate on the topic of the girl child, identifying persistent practices and traditions which discriminate against girl children. The CRC has considered the situation of girls during the preparatory stages of the consideration of States parties' reports, in its questions to States and during the dialogue with the States' representatives.

Greater collaboration between the CRC and CEDAW would further more effective implementation of the rights elaborated in each Convention, particularly in relation to the right to health. Special consideration could be given to the impact on women's and girls' reproductive and sexual health resulting from the sale of and traffic in women and children, forced prostitution, sexual assault and other violence and harmful practices affecting the health of women and girls. Other concerns noted include early or forced marriage, clandestine abortion and dietary restrictions on women.

B. United Nations Agencies and Other United Nations Bodies

The participating United Nations organizations and agencies reviewed the steps taken to develop a gender perspective and integrate human rights in their approaches to women's health and their possible contributions to the work of the treaty bodies.

1. United Nations Development Programme

Operationally, UNDP facilitates and promotes enabling policy and legal environments for women's human rights through its country-specific and regional programming initiatives. It examines issues of social equity and gender equality through UNDP-supported National Poverty Strategies at the country level. It prioritizes poverty eradication and recognizes the disproportionate impact of poverty on women's human rights to have control over and decide freely on matters relating to their sexuality.

The UNDP Human Development Report series, which provides an increasing number of human development indicators, now includes an empowerment indicator for women in decision-making positions in public and private sectors. This indicator can be used for monitoring compliance by States parties with human rights standards. UNDP is examining means to develop new indicators addressing social issues of empowerment, participation, dependency, discrimination and exclusion, which will have relevance to women's sexual and reproductive health.

UNDP has collaborated with other United Nations bodies to provide legal and practical protection to women against violence, including sexual assault, in situations of armed conflict;
to promote the health and well-being of women through the provision of maternal/child health service programmes; to demonstrate the value of preventive care and counselling; and to encourage the need to consider empowerment and economic issues as well as health issues in connection with the Joint United Nations Programme on HIV/AIDS (UNAIDS).

2. United Nations Development Fund for Women

Ms. Ilana Landsberg-Lewis, UNIFEM, outlined the work of the UNIFEM Women's Human Rights Programme, which focuses on building the capacity of women's human rights organizations in the developing world, increasing women's access to and use of international human rights mechanisms and enhancing the accountability of States and communities for protecting the human rights of women. To date, this Programme has concentrated on three main activities: mainstreaming women's human rights; eliminating violence against women; and strengthening women's knowledge and use of human rights, focusing on the use of CEDAW and other treaties.

To mainstream women's human rights, UNIFEM, UNFPA and the OHCHR co-sponsored an expert group meeting to develop guidelines for the integration of gender perspectives into human rights activities and programmes. UNIFEM has also organized, at the invitation of the OHCHR, a briefing on gender integration and documentation of gender-based violations for the annual meeting of thematic and country rapporteurs appointed by the Commission on Human Rights. The rapporteurs expressed their interest in receiving from UNIFEM short background papers on methods for identifying the gender dimensions of their mandates. They also requested UNIFEM's assistance in identifying NGOs working on women's human rights at the country level.

In the furtherance of its work on violence against women, UNIFEM has established a Trust Fund on Violence to undertake initiatives to eliminate violence against women. The Fund is focused on raising the issue of violence against women; ensuring women's awareness of their rights and how to exercise them; training both government and non-government personnel on developing and implementing policies to eliminate violence against women; producing action-related research on the causes, consequences and remedies for such violence; and developing innovative approaches for preventing and deterring violence against women.

In connection with its work on CEDAW, UNIFEM supports efforts to ensure universal ratification of the Women's Convention. It encourages communication between national women's human rights NGOs and CEDAW as well as NGO use of the Women's Convention in their advocacy. UNIFEM initiatives regarding the Women's Convention include sponsoring 10 members of CEDAW to participate in the NGO Forum at Beijing; collaborating with UNICEF to produce an information kit on CEDAW and exploring CEDAW's complementarity with the CRC; focusing on CEDAW's use as a women's human rights instrument and assisting NGOs in providing greater support to CEDAW; disseminating information about CEDAW's work; and supporting the development of an optional protocol to the Women's Convention.

In the context of reproductive health and rights, UNIFEM believes that the application of a women's human rights approach strengthens women's empowerment. To expand and broaden traditional perspectives on reproductive rights, UNIFEM is collaborating with UNFPA to ensure that policies and programmes on reproductive and sexual health are devised and
implemented with critical input from women themselves. This process involves bringing together specialists on reproductive health and women’s human rights to discuss strategies for operationalizing programmes which integrate reproductive rights within a human rights framework.


UNAIDS recognizes the need to protect and promote women’s human rights for the success of national and international responses to the HIV/AIDS epidemic, to slow the spread of HIV infection and to alleviate the socio-economic impact of HIV/AIDS-related morbidity and mortality. Women are increasingly affected by the pandemic, with 9.2 million living with HIV/AIDS by the end of 1996, and nearly 50 per cent of new infections occurring in women. Women are usually infected during their child-bearing and reproductive years and are seriously disadvantaged not only by their own infection and morbidity but also by the impact of the infection on their partners or spouses, and the risk of transmitting the virus to their children.

UNAIDS seeks to lead and support, in collaboration with other United Nations agencies, human rights bodies and NGOs, an expanded response to the HIV/AIDS pandemic which aims at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS and alleviating the impact of the epidemic.

UNAIDS also calls for addressing gender-related issues through a comprehensive, multisectoral response to HIV/AIDS. The UNAIDS gender objectives include providing access to HIV-prevention and care information, education and skills, such as sex education curricula; including basic and accurate information on reproduction, sex and sexual health; ensuring that such information reaches women and adolescent boys and girls; advocating policies and programmes to increase women’s access to formal education and information about new technologies for HIV prevention; advocating changes in national legal and economic policies to improve women’s access to economic resources, including employment, land, credit and property; providing gender-sensitive health services, including STD diagnosis, treatment and community outreach; advocating and facilitating the availability and affordability of female-controlled prevention technologies; providing access to social support for the integration of HIV/AIDS services into other development programmes; strengthening networks of women infected with or affected by HIV/AIDS; and creating guidelines and gender-sensitive messages within HIV/AIDS programming.

Discriminatory HIV/AIDS policies are often justified on the grounds of public health. As a result, persons with, or suspected of having, HIV/AIDS may be expelled from, or denied access to, educational institutions. Many workers are required to undergo mandatory HIV testing, and, if there is a breach of confidentiality, those who test positive for HIV/AIDS may experience discrimination and denial of their social security or employment benefits. Social and economic opportunities may be denied to women with or affected by HIV/AIDS, enhancing HIV/AIDS-related morbidity and destitution. The rights to protection of the family and equality in marital relations are violated by required pre-marital or prenatal HIV testing: those who refuse may be denied a marriage license while those who test positive may be coerced into abortion or involuntary sterilization. Women with HIV/AIDS, or those who lose husbands or partners to HIV/AIDS, may lose their only means of support for themselves and their children, following their abandonment, or may lose custody of their children.
UNAIDS could collaborate with NGOs to provide HIV-related information, including information on the status of women, to the treaty bodies. Further it could support the systematic monitoring of HIV-related human rights issues at the national level, by encouraging NGOs to contribute to the reports of States parties to treaty bodies, submitting independent reports, or contributing to the development by treaty bodies of human rights standards pertaining to HIV/AIDS.

4. International Labour Organization

The ILO prepares a report for every session of each treaty body, drawing attention to the relevant ILO conventions and recommendations and comments by ILO supervisory bodies, including ILO Committees of Experts on the Application of the Conventions and Recommendations.

The ILO takes an active part in discussions of the treaty bodies in plenary or pre­sessional working groups. The ILO’s contributions are used to varying degrees by the treaty bodies, perhaps most productively by the CESCR and the CRC.

With regard to women’s human rights, and reproductive and sexual health rights in particular, treaty bodies could find the data gathered from each of the ILO’s member States useful in relation to ILO standards on gender inequality and on reproductive and sexual health. The ILO governing body may call for reports regarding a State’s compliance with standards enunciated in any ILO convention, even if the State has not ratified that convention.

The ILO has addressed reproductive health issues in its training on the rights of women workers, which focuses on the standards applicable under both the ILO conventions and human rights instruments. There is further scope for the ILO to raise issues relating to women’s reproductive and sexual health during the pre-sessional and plenary meetings of treaty bodies in which it participates, and through the incorporation of such issues in its published analyses of the reports of States parties to the treaty bodies.

5. United Nations High Commissioner for Refugees

Ms. Tsegereda Assebe, Office of the United Nations High Commissioner for Refugees (UNHCR), described the steps taken by UNHCR to address the reproductive health needs of refugees, the majority of whom have no access to health services, primarily due to economic, social and cultural constraints. UNHCR aims at providing a comprehensive package of services and at making these more accessible to adolescents and young people, both women and men.

UNHCR is currently completing a manual on the awareness of women’s human rights for use in training staff and its partners in the implementation of its programmes: the manual addresses, inter alia, the issues of violence against women, marriage and health, and includes an overview on women’s human rights.
6. United Nations Population Fund

Dr. Charlotte Gardiner, UNFPA, stated that UNFPA needs to find mechanisms for working more closely with each of the treaty bodies, in the absence of an established relationship with a particular treaty body, as exists in the case of the CRC and UNICEF.

As part of the process of mainstreaming gender, UNFPA has developed a series of indicators which are in the process of being field-tested. It has held a meeting with African NGOs to develop a framework to address harmful traditional practices and their impact on women’s reproductive and sexual health. UNFPA sponsored this meeting as part of its commitment to find mechanisms for working more closely with each of the treaty bodies as well as for encouraging broader collaboration among the treaty bodies, agencies and NGOs, as called for in the ICPD and Beijing documents.

7. World Health Organization

Dr. Claudia Garcia-Moreno, Chief, Women’s Health Unit, Family and Reproductive Health, World Health Organization (WHO), outlined the work of WHO in the field of women’s health and human rights. WHO has recognized the centrality of reproductive health to health and human development and has been actively involved in seeking to build dialogue and working relations between those working in the fields of women’s health and human rights. WHO presented to the Vienna Conference on Human Rights and later published *Women’s Health and Human Rights: The Promotion and Protection of Women’s Health Through International Human Rights Law* by Professor Rebecca Cook.

WHO recognizes that a substantial proportion of the global burden of disease is related to sexual and reproductive health and that reproductive health is a crucial part of general health throughout the life cycle and intergenerationally. Among the significant indicators of reproductive health problems is the unmet need for contraceptive services (about 120 million couples want to limit family size but do not use modern contraception). Twenty million pregnancies are terminated by unsafe abortions, resulting in hundreds of thousands of deaths and disabilities. Maternal mortality is one of the best indicators of women’s health. In 1990, UNICEF and WHO estimated the total number of maternal deaths at 585,000, and it is estimated that there are 20 million cases of severe or chronic morbidity as a result of pregnancy. The incidence of RTIs, especially STDs, including HIV/AIDS, continues to rise in much of the developing world.

WHO emphasizes the need to develop a participatory and community-based approach rather than vertical models of medical intervention focused on maternal and child health and family planning. Reproductive and sexual health strategies must take a life-cycle approach to women’s health, giving special attention to adolescents and the need to develop relations of mutual respect and to provide needed information and services. Such strategies should involve women and other users in planning and evaluation and be designed to empower women based on respect for their human right to respect for their autonomy to make informed and appropriate decisions as well as their equality with men. Reproductive and sexual health programmes must eliminate discrimination on the grounds of age or marital status and be linked effectively with services that take into account the relation between reproductive health and the broader context of people’s lives, including economic circumstances, education,
employment and the social, legal and cultural determinants of women’s control over their lives, sexuality and fertility.

WHO has published a set of important health indicators, including those directly related to sexual and reproductive health, which include: maternal mortality ratio; prenatal care coverage (at least one visit with trained personnel); anaemia; case fatality rate for direct obstetric complications; births attended by trained health personnel; availability of essential obstetrical care; current use of contraception by women; HIV prevalence in pregnancy; and prevalence of STDs in women.

WHO is giving priority to introducing gender analysis and women’s perspectives into health research, policies and programmes and has established a Gender Advisory Panel to ensure the involvement of women in research-related activities. WHO is engaged in a number of projects including close cooperation with UNFPA. WHO notes the lack of sex-disaggregated data which results in widespread neglect of women’s health concerns. It also stresses that financial, cultural, legal and regulatory barriers, along with time constraints and poor quality of care, impede women’s access to health care. In family planning, major challenges include reaching adolescents and marginalized populations, improving services and developing safer contraceptive technologies. There is also a need for effective risk assessment methods and referrals in pregnancy and the development of well-functioning primary health-care systems at all levels.

8. United Nations Children’s Fund

In January 1996, UNICEF adopted a Mission Statement, indicating that, guided by the Children’s Convention, it strives to establish children’s rights as enduring ethical principles and international standards of behaviour towards children. The Mission Statement stresses the importance of UNICEF’s work to promote the equal rights of women and girls and their participation in the political, social and economic development of their communities. Today, UNICEF plays an active role in development, emergency and human rights activities.

Article 45 of the Children’s Convention recognizes UNICEF by name and entitles the Organization to be represented when the implementation provisions of the treaty are considered by the CRC. UNICEF may be invited to provide expert advice and to submit reports on the implementation of the treaty in areas relevant to its mandate. Following the examination of States Parties reports, UNICEF also provides technical advice or assistance in areas identified by the CRC as requiring international cooperation.

UNICEF supports the reporting process through activities to enhance national capacity. The following are examples of UNICEF’s human-rights-related work:

- Organizing information and training activities for government officials, NGOs and other relevant actors on child rights and the process of State reporting to the CRC;
- Organizing briefings and consultations between governmental departments, national institutions on human rights and children’s rights, as well as NGOs, on the implementation process;
• Facilitating national debates through the media and within Parliament, often as a follow-up to the examination of the report by the CRC in order to encourage the adoption of appropriate measures;

• Assisting in the translation and dissemination of Convention, States party reports and Concluding Observations of the Committee to the general public; and

• Participating, in general, in the follow-up process to the examination of States party reports at national and local levels.

In November 1996, UNICEF, in collaboration with the Centre for Human Rights, organized the first consultation between the CRC and CEDAW so that members of both treaty bodies could address the links between the two treaties, discuss areas of common concern and make recommendations for future collaboration. The meeting was held in Cairo under the auspices of UNICEF Egypt.
PART IV. COLLABORATIVE APPROACHES FOR TREATY BODIES, UNITED NATIONS AGENCIES AND NGOS IN PROMOTING THE SEXUAL AND REPRODUCTIVE HEALTH RIGHTS OF WOMEN

Professor Rebecca Cook, University of Toronto, set out a framework for collaboration among treaty bodies, United Nations agencies and other United Nations bodies, and NGOs on adopting a human rights approach to women’s health.

The existing approaches adopted by these bodies are polarized in three ways: first, between a human rights and a development-oriented approach; second, between a normative and an empirical approach, and third, between an approach focused on the work of treaty bodies and another on the specialized agencies. It is vital to begin the process of developing cross-sectoral and interdisciplinary collaboration, and to communicate across these polarities, focusing on training and capacity-building for treaty bodies, agencies and NGOs on the issue of women’s reproductive and sexual health.

Different bodies have brought different strengths to the process of developing a human rights approach to women’s health. The United Nations agencies and other bodies have been effective in data gathering and preparation. Their activities have focused on eight areas: contraceptive information and services; antenatal and post-partum care; screening for diagnosis of maternal morbidity; screening for STDs; services for abortion; services relating to infertility; referral services; counselling and information services. NGOs have been successful in developing analyses of women’s experiences, for example, through the international tribunals on women’s human rights held at the United Nations conferences.

The United Nations conferences were critical in developing an understanding of women’s health issues and the interlinkages between such issues and women’s human rights. The ICPD marked a watershed in moving away from a demographic approach to population policies to a reproductive-health approach, and in its application of the expanded definition of health developed by WHO in the context of reproductive and sexual health.

The United Nations conference consensus provides a framework for the enforcement of legal obligations of women’s right to health. This consensus identifies the policy goals to be followed by specialized agencies and actions by States. It remains to identify how human rights provide a tool for achieving such goals and making a real change in the situation of women’s health.

In adopting a human rights approach to women’s health, the treaty bodies could consider the issue of maternal mortality, and the means to reduce the incidence of maternal mortality by the application of specific rights provided for in the respective treaties. Thus, for example, the Human Rights Committee could apply the right to life (article 6, ICCPR); the CESCR could apply the right to health care (article 12, ICESCR); CEDAW could apply the right to non-discrimination on the ground of gender, in relation to the criminalization of medical
procedures which are only needed by women, such as abortion (article 1 and article 12, Women's Convention); the CRC could apply the right to non-discrimination, in respect of early marriage or coercive marriage of young women (article 1 and article 24, Children's Convention); CERD could apply the right to non-discrimination on the ground of race or ethnicity in respect of the denial of anaesthesia to women of particular ethnic groups (article 1 and article 5(e) Race Convention); and CAT could apply the right to be free from torture, in respect of women being raped in custodial-type situations (article 1 and article 4, Torture Convention).

The United Nations agencies could contribute to the work of the treaty bodies by providing them with relevant data in order to ascertain compliance with or violation of such rights. Such data could be events-based, for example, the incidence of rape of women; standards-based, for example, rates of maternal mortality; or norms-based data, for example, the absence of a law on the minimum age of marriage, or the lack of implementation of such a law, or the lack of an ethical code on confidentiality.

A considerable amount of data is available on issues relating to women’s reproductive and sexual health. Therefore, the priority task should be not to generate more data but to develop means for their effective use and application. Such data could be made available in relation to the reporting process (in such stages as the drafting of the report, the development of guidelines for reporting, the pre-sessional working group of the treaty body, the dialogue of the treaty body with a particular State party, the search for alternative information from NGOs and agencies, and the development of concluding comments); the standard-setting process; and the compliance process (for example, in the development by agencies of indicators to monitor compliance). The data could be channelled by agencies or NGOs to the media, to note the success or failure of a particular State in complying with human rights standards. They could also be used as a basis for initiating complaints and for calling for particular remedies, for reparations, or for the amendment of laws or practices.

Ms. Jane Connors, Chief, Women’s Rights Unit, DAW, commented on the need to ensure that the treaty bodies develop an approach to addressing women’s human rights which focuses on collaboration rather than on duplication of efforts.

The treaty monitoring system is key to the promotion and implementation of human rights standards and provides a process for self-monitoring by individual States through the mechanism of their constructive dialogue with the treaty bodies. The development of concluding comments or general recommendations is a part of this self-monitoring process and provides an action plan for States parties. The general comments and recommendations also open up possibilities for further interpretation of the rights recognized under each of the human rights treaties. Only three of the treaty bodies -- namely, the HRC, CERD and CAT -- currently have complaints mechanisms.

To date, despite significant changes following the United Nations conferences, few of the treaty bodies, with the exception of CEDAW, appear to have developed their approaches to incorporate a consideration of the gender dimensions of human rights. The constructive dialogue between treaty bodies and States needs to be more reflective of the interests of women and to reflect the values contained in the declarations emanating from Cairo and Beijing.

Although significant information is provided by the agencies to the treaty bodies, it
tends to be general. There is a need to develop practical strategies for such information to meet the needs of the treaty bodies in the constructive dialogue. Treaty bodies could develop guidelines for ways and means in which both agencies and NGOs could contribute to their work.

Ms. Sofia Gruskin, Assistant Director, François-Xavier Bagnoud Center for Health and Human Rights, proposed a framework for promoting, monitoring and implementing women’s right to health with a focus on the implications for governmental accountability and responsibility. This entails concrete application of relevant provisions of the ICPD and Beijing conference documents to particular women’s reproductive and sexual health issues. The proposal draws upon the conference documents as a source of problems, human rights considerations and, very importantly, as a broader set of potential indicators for implementation of a human rights perspective in relation to health. In this regard, the programmatic steps in the conference documents can supplement more traditional epidemiological indicators as measures of human rights implementation. Ms. Gruskin emphasized the usefulness of the ICPD Programme of Action and the Beijing PFA in providing indicators and guideposts for the role of treaty bodies in monitoring States’ reports, but noted that these indicators and their relation to human rights can also be used to examine programmatic initiatives within the agencies as well.

The application of the framework requires a multi-step process: first, identification of the issue, with attention to basic facts such as the sectors of the population most affected (reflecting socio-economic status, age etc.); second, identification of the internationally promoted objectives and action steps relevant to the issue, as set out in the Cairo and Beijing documents; and, third, identification of the human rights implications of the actions which the State under consideration is or is not taking towards the objectives, and of the actions relevant to the particular health issue under consideration.

The fourth step involves consideration of the indicators and elements of information pertinent to monitoring State action under the relevant rights affecting reproductive or sexual health. The treaty bodies will focus on the pertinent rights contained in their respective treaties, while the agencies could use the four-part "bundles" approach presented by Professor Copelon (see Part II, C, above) to identify the rights dimensions of the programmatic work and the policies, action and information that would indicate progress or identify obstacles to progress. Specific attention could be focused on: the current status of relevant laws, policies and programmes adopted by the Government; and any obstacles towards implementation including such factors as lack of human and financial resources and cultural constraints.

Of particular significance in this respect is an examination the implementation of the relevant Strategic Objectives and Actions to Be Taken, laid out in the Cairo and Beijing documents. Given that these reflect a consensus of nations, they can function as valuable indicators for both the treaty bodies and the agencies concerning progress in the protection of rights. Finally, upon completion of the analysis, priorities for future work could be established. Efforts should be made to disaggregate relevant information by sex and age to the fullest extent possible.

HIV/AIDS among women was used as the case example of the application of the proposed method. The outcome of this analysis as applied to HIV/AIDS highlighted governmental responsibility both for lowering women’s specific vulnerability to acquiring HIV.
infection and for responding to its impact. The model was applied to different issues in group discussion among the participants.

Ms. Claudia Garcia-Moreno, WHO, commented that the framework could be useful to the work of United Nations agencies. Although the agencies are already engaged in the collection of information, they have not considered its potential use for the work of the treaty bodies. For example, WHO has developed a database on violence against women, focusing on domestic violence, and has also begun to collect data on its health consequences. The general recommendations issued by the treaty bodies could guide the agencies in making better use of the information available to them.

Mr. Daniel Whelan, UNAIDS, commented that the framework provided a method for collaboration between treaty bodies, agencies and NGOs working on HIV/AIDS. It identified the issues of concern to treaty bodies as well as the information which agencies and NGOs will need to provide to them. Application of this framework would help to identify critical gaps in the available information, or guidelines on the nature of data that was needed.

Ms. Charlotte Abaka, Member, CEDAW, welcomed the framework, commenting that it provided a method for the treaty bodies to monitor States’ compliance with the conference documents and to operationalize, within the human rights framework, the policies developed by States at the conferences.

Dr. Pramilla Senanayake, International Planned Parenthood Federation (IPPF), noted that IPPF, the largest NGO working in the field of reproductive and sexual health, has produced a Charter on reproductive and sexual health. IPPF has drawn on international human rights standards and the conference documents, deliberately adapting the language of human rights to issues of reproductive and sexual health in order to demonstrate the key interrelationship of reproductive and sexual health with human rights. The Charter provides an ethical framework for the activities of IPPF affiliates worldwide.


5 Vienna Declaration and Programme of Action, supra note 3, at I, para. 18; II, paras. 36-37, 40-42.

6 International Conference on Population and Development, Programme of Action, supra note 4; see Chap. IV: Gender Equality, Equity and Empowerment of Women; Chap. VII: Reproductive Rights and Reproductive Health.

7 Ibid., para 92.

8 Ibid., para 96.

9 Ibid., para 222.

10 IESCR, supra note 1, art. 12; see also, Children’s Convention, art. 24; Race Convention, art. 5(e)(4).

11 IESCR, art.15 (1)(b).

12 Prohibited bases of discrimination are identified in UDHR art. 2; ICESCR and ICCPR, art. 2; CRC, art. 2(1). See also Race Convention, Preamble; Women’s Convention, Preamble; Torture Convention, art. 1.

13 Women’s Convention, art 4.

14 ICCPR, art. 25; Women’s Convention, art. 7.

15 UN Doc. HRI/GEN/Rev.2 (29 March 1996).


17 UN Doc. CERD/C/SR.1166, para. 54 per Mr. Wolfrum.
### ANNEX I. LIST OF PARTICIPANTS

#### Round Table of Human Rights Treaty Bodies on 
"Human Rights Approaches to Women’s Health with a focus on Reproductive and Sexual Health and Rights"

**9-11 December 1996**  
**Harrison Conference Center, Glen Cove, New York**

<table>
<thead>
<tr>
<th>COMMITTEE/ORGANIZATION</th>
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<tbody>
<tr>
<td><strong>Treaty Bodies</strong></td>
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</table>
| Committee on the Rights of the Child | Mrs. Akila Belembaogo  
Presidente - 01 B.P. 2216  
Ouagadougou 01  
(Fax: 226-310-654) | Burkina Faso |
|                         | Ms. Hoda Badran, Member  
Helwan University  
39 Dokki St., Cairo  
(Fax: 202-39-36-820) | Egypt |
| Human Rights Committee | Sr. Francisco Jose Aguilar Urbina  
Presidente  
Apartado Postal 844  
4050 Alajuela  
(Fax: 506-289-4303 -H) | Costa Rica |
|                         | Ms. Elizabeth Evatt, Member  
67 Brown Street, Paddington,  
Sydney NSW 2021  
(Fax: 331-6734) | Australia |
| Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) | Ms. Ivanka Corti  
Chairperson  
(Fax: 011-39-6-320-1913) | Rome |
|                         | Ms. Carmel Shalev, Member and Director of Policy Development for Civil Rights in Israel (ACRI)  
P.O. Box 35401  
(Fax: 011-972-2-652-1219) | Jerusalem |
<table>
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<th>COMMITTEE/ORGANIZATION</th>
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<tr>
<td>CEDAW (continued)</td>
<td>Ms. Charlotte Abaka, Member and National Council on Women and Development</td>
<td>Ghana</td>
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<tr>
<td></td>
<td>P.O. Box M 53, Accra, Ghana</td>
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<tr>
<td></td>
<td>(Fax: 011-233-21-669-707)</td>
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<tr>
<td>Committee against Torture</td>
<td>Mr. &amp; Mrs. Alexis Dipanda Mouelle, President &amp;</td>
<td>Cameroon</td>
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<td></td>
<td>Pres. Supreme Court of Cameroon</td>
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<td></td>
<td>(Fax: 011-237-220-576)</td>
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<tr>
<td></td>
<td>Mr. &amp; Mrs. Atangana Clément</td>
<td>Cameroon</td>
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<td>Supreme Court of Cameroon</td>
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<td>Ms. Marie Noëlle Ndemo</td>
<td>Cameroon</td>
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<td>Supreme Court of Cameroon</td>
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<td>Ms. Julia Iliopoulos-Strangas, Member</td>
<td>Greece</td>
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<td>106-81 Athens</td>
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<td></td>
<td>(Fax: 011-301-380-5413)</td>
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<tr>
<td>Committee on the Elimination of All Forms of Racial</td>
<td>Mr. Michael Banton</td>
<td>United</td>
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<tr>
<td>Discrimination</td>
<td>Gwent, Great Britain</td>
<td>Kingdom</td>
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<td></td>
<td>H. E. Mr. Ion Diaconu</td>
<td>Romania</td>
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<td></td>
<td>Ambassador of Romania</td>
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<td></td>
<td>Copenhagen, Strandagervej, 27</td>
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<tr>
<td></td>
<td>2900 Hellerup/Denmark</td>
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<td></td>
<td>Tel: 011-4539-407177</td>
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<td></td>
<td>(Fax: 011-4539-627899)</td>
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<tr>
<td>Committee on Economic, Social and Cultural Rights</td>
<td>Mrs. Virginia Bonoan Dandan</td>
<td>Philippines</td>
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<tr>
<td></td>
<td>Rapporteur</td>
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<td></td>
<td>College of Fine Arts</td>
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<td>University of the Philippines</td>
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<td>(Fax: 011-632-928-2863 - 924-3495)</td>
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**Round Table of Human Rights Treaty Bodies on**

"Human Rights Approaches to Women’s Health with a focus on Reproductive and Sexual Health and Rights"

**9-11 December 1996**

Harrison Conference Center, Glen Cove, New York

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</table>
| Committee on Economic, Social and Cultural Rights (continued) | Mr. Juan Alvarez Vita  
Vice-Chairperson  
Avenue 15 de Enero 651 Miraflores  
(Fax: 011-511-241-5492) | Peru |

**United Nations Organizations and Agencies**

**United Nations Population Fund**

<table>
<thead>
<tr>
<th>Executive Director</th>
<th>Dr. Nafis Sadik</th>
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<tbody>
<tr>
<td>Office of the Executive Director</td>
<td>Mari Simenon</td>
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<tr>
<td>Information and External Relations Division</td>
<td>Mr. Stan Bernstein</td>
</tr>
<tr>
<td>Technical and Policy Division, Reproductive Health Branch</td>
<td>Dr. Charlotte Gardiner</td>
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<tr>
<td>Technical and Policy Division, Education, Communication and Youth Branch</td>
<td>Ms. Sylvie I. Cohen</td>
</tr>
</tbody>
</table>
| Technical and Policy Division, Gender, Population and Development Branch | Ms. Virginia Ofosu-Amaah  
Ms. Ana Angarita  
Ms. Victoria Rector  
Ms. Janice Bristol  
Ms. Diane Langston |
<p>| Africa Division | Ms. Francine Godin |
| Asia and the Pacific Division | Mr. Asger Ryhl |
| Latin America and Caribbean Division | Ms. Maria Jose Alcala |
| Division for Arab States and Europe | Dr. Hedia Belhadj-El Ghouayel |</p>
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<tr>
<td>UNFPA Task Force on ICPD Implementation</td>
<td>Ms. Ranjana Dikhit</td>
<td>New York</td>
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</table>
| Division for the Advancement of Women (DAW)    | Ms. Angela King  
Director                                                   | New York         |
|                                                | Ms. Jane Connors, Chief, Women’s Human Rights Unit                           |                  |
|                                                |                                                                               |                  |
| Centre for Human Rights                        | Ms. Helga Klein, Chief, a.i. Support Services Branch                         | Geneva           |
|                                                | Ms. Purificacion Quisumbing  
Head, New York Office*                  | New York         |
|                                                | *Now Office of the High Commissioner for Human Rights (New York)             |                  |
|                                                |                                                                               |                  |
| United Nations Development Programme (UNDP)    | Mr. Benjamin Gurman                                                         | New York         |
|                                                |                                                                               |                  |
| United Nations Development Fund for Women (UNIFEM) | Ms. Ilana Landsberg-Lewis  
Tel: 906-6458                      | New York         |
|                                                |                                                                               |                  |
|                                                | Ms. Rebeca Rios-Kohn                                                         |                  |
|                                                | Ms. Guillemette Meunier                                                      |                  |
|                                                | Ms. Misrak Elias                                                            |                  |
|                                                | Ms. Sherrill Whittington                                                     |                  |
|                                                |                                                                               |                  |
| International Labour Organization (ILO)         | Ms. Eugenia Date-Bah  
TSS GPD Specialist                             | Geneva           |
|                                                |                                                                               |                  |
| World Health Organization (WHO)                | Dr. Claudia Garcia-Moreno, Chief Women, Health and Development;  
Family and Reproductive Health  
(Fax: 011-41-22-791-0746)               | Geneva           |
**Round Table of Human Rights Treaty Bodies on Human Rights Approaches to Women’s Health with a focus on Reproductive and Sexual Health and Rights**

9-11 December 1996
Harrison Conference Center, Glen Cove, New York

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<tr>
<td>United Nations High Commissioner for Refugees (UNHCR)</td>
<td>Ms. Tsegereda Assebe</td>
<td>Geneva</td>
</tr>
<tr>
<td>United Nations Educational, Scientific and Cultural Organization (UNESCO)</td>
<td>Ms. Sofia Olszowska Tel: 963-2007 (Fax: 963-8014)</td>
<td>Paris</td>
</tr>
</tbody>
</table>

**Non-governmental Organizations and Consultants**

| Fundación para el Estudio y Investigación de la Mujer (FEIM) | Ms. Mabel Bianco | Argentina |
| International Reproductive Rights Research Action Group (IRRAG) | Prof. Rosalind Petchesky | |
| International Women’s Rights Action Watch (IWRA)--Asia Pacific | Ms. Shanti Dairiam | Bangladesh |
| International Human Rights Legal Group (IHRLG) | Ms. Alice Miller Director, Women in Law Project | |
| Research and Action Information Network for Bodily Integrity of Women (RAINBOW) | Dr. Nahid Toubia Director | United States of America |
| Consultant | Ms. Rhonda Copelon, Esq. Professor of Law & Director Intn’l Wmn’s Human Rights Law Clinic City Univ of New York School of Law (Fax: 1-718-575-4478) | United States of America |
| Consultant | Ms. Maria Isabel Plata Executive Director PROFAMILIA | Colombia |
### Round Table of Human Rights Treaty Bodies on
**"Human Rights Approaches to Women's Health with a focus on Reproductive and Sexual Health and Rights"**

**9-11 December 1996**

**Harrison Conference Center, Glen Cove, New York**

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<tr>
<td>Consultant</td>
<td>Ms. Charon Asetoyer, Director Native American Women’s Health Education Resource Center P.O. Box 572, 809 High Street Lake Andes, South Dakota 57356 Tel. 605-487-7072 (Fax - 1-605-487-7964)</td>
<td>United States of America</td>
</tr>
<tr>
<td>Consultant</td>
<td>Ms. Yvette Delph Washington, D. C.</td>
<td>United States of America</td>
</tr>
<tr>
<td>Consultant</td>
<td>Ms. Sophia Gruskin, Esq. François-Xavier Bagnoud Ctr Hlth/HR Harvard University Tel: 617-432-0656 (Fax: 617-432-4310)</td>
<td>United States of America</td>
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<tr>
<td>Consultant</td>
<td>Ms. Rebecca Cook, Prof. of Law Univ. Of Toronto - Faculty of Law Tel: 416-978-4-16 (Fax: 416-978-7899)</td>
<td>Canada</td>
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<tr>
<td>Consultant</td>
<td>Ms. Sara Hossain, Esq. (Rapporteur) Tel: 011-88-02-405051 (Fax: 011-88-02-956-4953)</td>
<td>Bangladesh</td>
</tr>
<tr>
<td>Consultant</td>
<td>Dr. Colette Dehlot c/o UNFPA Congo (Fax: 011-242-837866)</td>
<td>Brazzaville</td>
</tr>
<tr>
<td>Technicians/Translators</td>
<td>Mr. Manual Sanchez, Technician Mr. Jose Perea Ms. Rosalie Plasencia Mr. Daniel Scherr Ms. Marisia Llaure Ms. Marianne Ayvaz Ms. Deniece Visier</td>
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UNDAW/UNFPA/UNHCHR

Round Table of Human Rights Treaty Bodies on "Human Rights Approaches to Women’s Health, with a focus on Reproductive and Sexual Health and Rights", Harrison Conference Center, Glen Cove, Long Island, New York, 9-11 December 1996

AGENDA

Monday, 9 December

9:30 - 11:15 Chair: Ms. Ivanka Corti, Chairperson, Committee on the Elimination of Discrimination Against Women (CEDAW)

Opening

Opening Statement by Dr. Nafis Sadik, Executive Director, UNFPA
Statement by Ms. Angela E. V. King, Director, Division for the Advancement of Women
Message of High Commissioner on Human Rights by Ms. Helga Klein, Centre for Human Rights

11:15 - 11:30 Break

11:30 - 1:00 Chair: Ms. Ivanka Corti, Chairperson, Committee on the Elimination of Discrimination Against Women (CEDAW)

Bringing a Gender Perspective to the Right to Health, including Reproductive and Sexual Rights

Presenter: Ms. Maria Isabel Plata, Executive Director, PROFAMILIA

Discussant/Rapporteur: Ms. Elizabeth Evatt, Human Rights Committee

Discussion
1:00 - 2:15
Lunch

2:15 - 4:00
Chair: Ms. Akila Belembojgo, Chairperson, Committee on the Rights of the Child

Sexual and Reproductive Rights as Human Rights: Interpreting the Treaty Norms
Presenter: Professor Rhonda Copelon, City University of New York Faculty of Law

Indigenous Women
Presenter: Ms. Charon Asetoyer, Director, Native American Women’s Health Education Resource Center

Refugee, Migrant and Displaced Women
Presenter: Dr. Colette Dehlot
Discussant/Rapporteur: Ms. Virginia Bonoan Dandan, Rapporteur, Committee on Economic, Social and Cultural Rights

Discussion

4:00 - 6:00
Presentation and Discussion of Human Rights Treaty Bodies on Perspectives of the Participants on Human Rights Approaches to Women’s Health, including Reproductive and Sexual Rights

6:15
Reception and Dinner
Tuesday, December 10

9:30 - 10:45

Chair: Sr. Francisco José Aguilar Urbina, President, Human Rights Committee

Implementing Women's Health as Human Rights: Collaborative Approaches for Treaty Bodies, Agencies and NGOs

Presenter: Professor Rebecca Cook, University of Toronto Faculty of Law

Discussant/Rapporteur: Ms. Jane Connors, Chief, Women's Rights Unit, DAW

Discussion

10:45 - 11:00
Break

11:00 - 1:00

Chair: Ms. Helga Klein, Chief, a.i., Support Services Branch, Centre for Human Rights, Geneva

Proposing a Framework and Indicators for Promotion, Implementation and Monitoring of Women's Right to Health, including Reproductive and Sexual Rights

Presenters: Ms. Sofia Gruskin, Harvard University, and Prof. Rhonda Copelon, City University of New York

Discussants/Rapporteurs: Dr. Claudia Garcia-Moreno, World Health Organization; Mr. Daniel Whelan, UNAIDS; and Ms. Charlotte Abaka, Member, Committee on the Elimination of Discrimination Against Women

Discussion

1:00 - 2:00
Lunch
**UNDAW/UNFPA/UNHCHR**

2:00 - 6:00  
*Working Groups*

6:30  
Dinner

8:00 - 9:30  
Presentation of Rapporteurs' Reports and Discussion

**Wednesday, December 11**

10:00 - 10:30  
Chair: Ms. Ivanka Corti, Chairperson, Committee on the Elimination of Discrimination Against Women (CEDAW)

**Summary of Meeting by General Rapporteur -- Ms. Sara Hossain**

10:30 - 11:30  
*Discussion*

11:30 - 11:45  
*Closing of Meeting*

Ms. Virginia Ofosu-Amaah, Chief, Gender, Population and Development Branch, UNFPA

12:00 - 1:00  
Lunch and Departures

**General Rapporteur: Ms. Sara Hossain**