

CONTRACEPTION AND FAMILY PLANNING



Contraception and family planning is well protected under international human rights standards.

In the last two decades, the percentage of women accessing contraceptives in both developed and developing countries has increased. The United Nations reports that in 2011, over 63 percent of women ages 15 to 49 were using some form of contraception, compared with 54 percent in 1990.¹ This has increased women's opportunities to choose when and how many children they want to have, which can have a positive impact not only on their right to health, but also on their rights to education, work and an adequate standard of living amongst other human rights.

Despite these advancements, millions of women continue to lack access to modern contraceptives. According to the United Nations Population Fund, recent statistics show that of 867 million women of childbearing age in developing countries who are in need of modern contraceptives, 222 million do not have access to them. Similarly, in developed countries, millions of women are confronted with economic, social and cultural barriers to access contraceptives and family planning services and lack information or education about them.² Any policy or program aimed at increasing access to contraception should ensure that women's decision making needs are at the center of it.

The Convention on the Elimination of All Forms of Discrimination Against Women, guarantees women equal rights in deciding "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."³ Contraception is also a key dimension of the right to the highest attainable standard of physical and mental health.⁴ Women's childbearing role also has an impact on their enjoyment of other rights, such as the rights to education and to work.⁵

At the International Conference on Population and Development in 1994, States recognized the inherent relationship between women's health and their ability to access family planning and other reproductive health services. The document reflects political commitments to provide universal access to a full range of family planning methods by 2015 and to recognize the specific needs of vulnerable groups.⁶ The Beijing Platform for Action affirmed that the 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."*⁷

It also asserts the right of all "women and men to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice."⁸

222 MILLION WOMEN IN DEVELOPING COUNTRIES DO NOT HAVE ACCESS TO MODERN CONTRACEPTIVES



WOMEN USING MODERN METHODS OF CONTRACEPTION ARE MUCH LESS LIKELY TO BECOME PREGNANT THAN THOSE RELYING ON A TRADITIONAL METHOD



ACCESS TO FAMILY PLANNING REDUCES THE NUMBERS OF UNINTENDED AND RISKY PREGNANCIES, WHICH REDUCES THE RISKS OF MATERNAL MORTALITY AND LONG-TERM MORBIDITY



ACCESS TO FAMILY PLANNING SERVICES INCREASES WOMEN'S OPPORTUNITIES TO ENTER THE JOB MARKET

Source: United Nations Population Fund

KEY ISSUES

1 INFORMATION AND EDUCATION ABOUT CONTRACEPTION AND FAMILY PLANNING

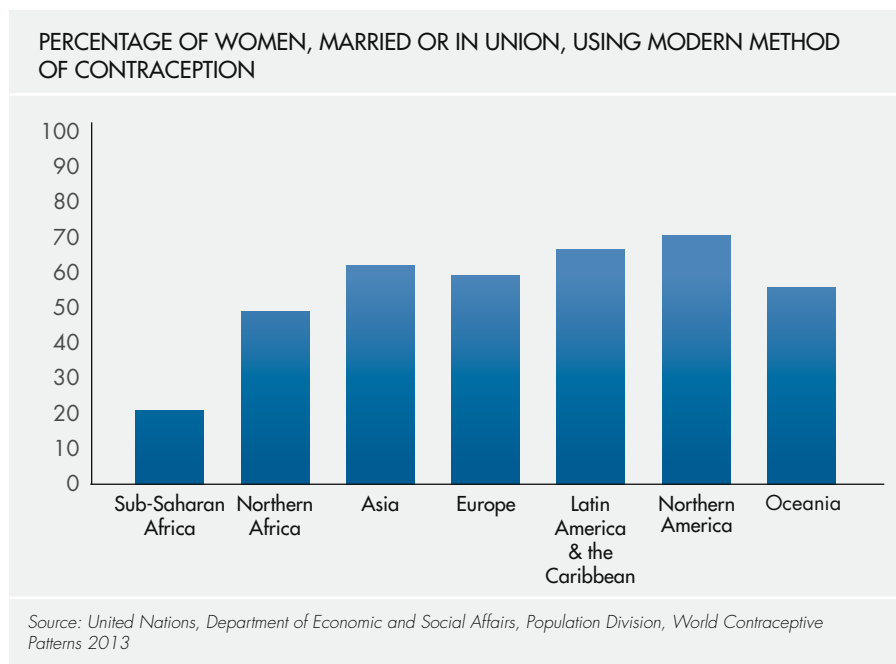
Many women and girls face challenges in accessing information and education on modern methods of contraception.

The Committee on the Elimination of Discrimination Against Women has explained that "in order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning

services, as provided in article 10 (h) of the Convention."⁹ Such information should be scientifically accurate and free from discrimination. The Committee has also recommended that States should prioritize the "prevention of unwanted pregnancy through family planning and sex education."¹⁰

A great majority of adolescents do not have access to education on sexuality or sexual and reproductive health services.

The Committee on the Rights of the Child has clarified that family planning services encompass sexuality education and has highlighted the need to ensure that “adolescents are not deprived of any sexual and reproductive health information or services due to providers’ conscientious objections.”¹¹ In accordance with the evolving capacities of the child, this information should be provided regardless of their marital status and their parents, or guardians, consent.¹²



A RECENT UNITED NATIONS SURVEY INDICATES THAT **ONLY 59.3% OF COUNTRIES WERE COMMITTED TO “INCORPORATING COMPREHENSIVE SEXUALITY EDUCATION INTO FORMAL EDUCATION”** AND ONLY **49.3% WERE COMMITTED TO “REACHING OUT-OF-SCHOOL YOUTH WITH SEXUAL AND REPRODUCTIVE HEALTH INFORMATION AND SERVICES.”**¹³

2 BARRIERS TO ACCESS SERVICES AND CONTRACEPTIVES

*Ensuring women’s sexual and reproductive health rights means that women’s capacity to make decisions regarding their bodies must be respected. Requirements of third-party consent for access to certain services have been consistently criticized by human rights mechanisms as contrary to women’s rights.*¹⁴

For instance, the Human Rights Committee has deemed legal provisions requiring the husband’s consent for a woman to undergo sterilization a violation of the woman’s right to privacy.¹⁵ Similarly, the Committee on the Elimination of Discrimination Against Women has clarified that “States parties

should not restrict women’s access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women.”¹⁶

Notions of religion or personal convictions of health care providers can not interfere with the realization of sexual and reproductive health rights.

While practitioners have a right to conscientious objection, the protection of that right must not infringe on women’s right to accurate and objective information on contraception. The European Court of Human Rights, for

instance, has held that pharmacists may not refuse to sell contraceptives based on their personal religious beliefs.¹⁷



THE COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN has found that a city policy banning modern forms of contraception in City of Manila, Philippines, constituted grave and systematic violations of the

Convention, including violations of women's right to health and their right to decide the number and spacing of their children. The Committee observed in this case that the policy in the City of Manila was "particularly egregious as a result of an official and deliberate

policy which places a certain ideology above the well-being of women and was designed and implemented by the Manila local government to deny access to the full range of modern contraceptive methods, information and services."¹⁸



STATES HAVE OBLIGATIONS TO RESPECT, PROTECT AND FULFIL HUMAN RIGHTS RELATED TO CONTRACEPTION AND FAMILY PLANNING

RESPECT States should refrain from ordering coercive medical treatments, such as compulsory sterilization of women with disabilities or women from minority or indigenous groups. Denying access to contraceptive services based on the lack of authorization of a woman's husband, partner, parent or health authority, or because a woman is unmarried, is also a violation of the obligation to respect.

PROTECT States should ensure that third parties do not limit people's access to contraceptives and family planning information and services. If health care workers refuse to sell or provide contraceptives based on their personal religious beliefs, the State must still ensure that contraception is available and accessible to women and girls.

FULFIL States should adopt legislative, administrative, budgetary, judicial, and other measures to achieve the full realization of rights related to contraception, which includes the obligation to provide information and access to a wide range of contraceptive methods, including essential drugs, such as hormonal and emergency contraception.

CONTRACEPTIVES AND FAMILY PLANNING GOODS AND SERVICES MUST ALSO BE:

Available in sufficient quantities; **accessible** in a physical, economic and non-discriminatory manner; culturally and ethically **acceptable**; and scientifically and medically appropriate and of good **quality**.¹⁹

3 MARGINALIZED GROUPS AND HUMAN RIGHTS RELATED TO CONTRACEPTION AND FAMILY PLANNING

Persons with disabilities face particular risks of being denied their human rights in relation to contraception and family planning.

Article 23 of the Convention on the Rights of Persons with Disabilities protects the right of persons with disabilities to found and maintain a family and to retain their fertility on an equal basis with others. The Committee on the Rights of Persons with Disabilities has expressed concerns about discrimination in the provision of sexual and reproductive health services against persons with disabilities and has asked

States to provide these services.²⁰ Persons with disabilities should be provided with comprehensive information and support to make informed decisions about reliable and safe contraceptive measures.²¹

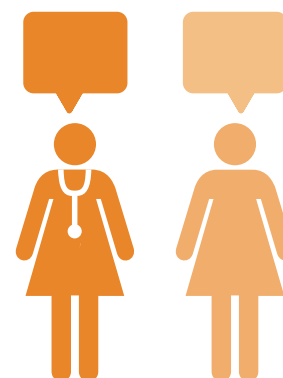
Adolescents face significant obstacles to accessing contraception and family planning services.

The Committee on the Rights of the Child has established that "States should ensure that health systems and services are able to meet the specific sexual and reproductive

health needs of adolescents, including family planning and safe abortion services. States should work to ensure that girls can make autonomous and informed decisions on their reproductive health."²² The Committee recommended that "short-term contraceptive methods such as condoms, hormonal methods and emergency contraception should be made easily and readily available to sexually active adolescents. Long-term and permanent contraceptive methods should also be provided."²³

Certain marginalized groups face an increased risk of being subjected to involuntary sterilization.

Coercive practices such as involuntary sterilization infringe the right of women to decide on the number and spacing of their children and adversely affects women's physical and mental health.²⁴ This particularly impacts women living with HIV, indigenous and ethnic minority women and girls, women and girls with disabilities, transgender and intersex persons,²⁵ as well as women and girls living in poverty. The Committee on the Rights of Persons with Disabilities has requested States to revise "laws and policies in order to prohibit compulsory sterilization and forced abortion on women with disabilities"²⁶ and has recommended "the abolition of surgery and treatment without the full and informed consent of the patient."²⁷ Similarly, the Committee on the Rights of the Child has expressed its deep concern about the practice of forced sterilisation, and has established that this practice seriously violates the right of the child to her or his physical integrity.²⁸



IN A.S. V. HUNGARY, a Hungarian woman of Roma origin was **coercively sterilized** in a public hospital after signing a statement of consent to a caesarean section that contained a barely legible consent note for sterilization. The Committee on the Elimination of Discrimination Against Women found that by failing to provide information and advice on family planning, the State had violated the victim's rights.²⁹ The Committee established that the victim had a right "to specific information on sterilization and alternative procedures for family planning in order to guard against such an intervention being carried out without her having made a fully informed choice."³⁰

IN THE CASE OF MARÍA CHÁVEZ V. PERU, a rural woman was **forced by public health officials to undergo sterilization surgery** which resulted in her death. In 2002, the Peruvian government signed a friendly settlement and "admitted international responsibility for the facts described and pledged to take steps for material and moral reparation of the harm done and to initiate a thorough investigation and trial of the perpetrators and take steps to prevent the recurrence of similar incidents in the future."³¹

NOTES

- 1 United Nations, Department of Economic and Social Affairs, Population Division, *World Contraceptive Patterns 2013*.
- 2 United Nations Population Fund, *State of World's Population (2012), By Choice, Not by Chance: Family Planning, Human Rights and Development*, pp. ii, 1.
- 3 Article 16.
- 4 Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/66/254 (2011), paras. 44, 48. See also International Covenant on Economic, Social and Cultural Rights, Article 12.
- 5 International Covenant on Economic, Social and Cultural Rights, Articles 13, 6.
- 6 International Conference on Population and Development, Programme of Action (1994), para. 7.16.
- 7 Fourth World Conference on Women, Platform for Action (1995), para. 96.
- 8 *Ibid.*, para. 97.
- 9 General Recommendation 21 (1994) on equality in marriage and family relations, para. 22.
- 10 General Recommendation 24 (1999) on women and health, para. 31(c).
- 11 General Comment 15 (2013) on the child's right to the enjoyment of the highest attainable standard of health, para. 69.
- 12 Committee on the Rights of the Child, General Comment 4 (2003) on adolescent health and development, para. 24; Committee on the Elimination of Discrimination Against Women, General Recommendation 24, para. 14.
- 13 Messages and Preliminary Findings From the ICPD Beyond 2014 Global Review, June 24, 2013, page 32, available at: <http://icpdbeyond2014.org/about/view/2-global-survey>.
- 14 Committee on the Elimination of Discrimination Against Women, General Recommendation 24, para. 14; Concluding Observations on Indonesia, CEDAW/C/IDN/CO/5 (2007), para. 16; Turkey, A/52/38/Rev.1 (1997), para. 196; Committee on the Rights of the Child, General Comment 15, para. 31.
- 15 General Comment No. 28 (2000) on the equality of rights between men and women, para. 20.
- 16 General Recommendation 24, para. 14.
- 17 European Court of Human Rights, *Pichon and Sajous v. France*, application No. 49853/99 (2001).
- 18 Committee on the Elimination of Discrimination Against Women, Inquiry report on the Philippines, CEDAW/C/OP.8/PHL/1 (2015), para. 48.
- 19 Committee on Economic, Social and Cultural Rights, General Comment 14 (2000) on the right to the highest attainable standard of health, para. 12.
- 20 Committee on the Rights of Persons with Disabilities, Concluding Observations on Paraguay, CRPD/C/PRY/CO/1 (2013), paras. 59, 60. See also Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement (2014), pp. 5-7.
- 21 Interagency Statement on involuntary sterilization, p. 15.
- 22 General Comment 15, para. 56; General Comment 4, para. 29.
- 23 General Comment 15, para. 70.
- 24 Committee on the Elimination of Discrimination Against Women, General Recommendation 19 (1992), on violence against women, para. 22.
- 25 Interagency Statement on involuntary sterilization.
- 26 Concluding Observations on China, CRPD/C/CHN/CO/1 (2012), para. 34; Peru, CRPD/C/Per/CO/1, para. 35. See also Interagency Statement on involuntary sterilization, pp. 5-7.
- 27 Concluding Observations on Tunisia, CRPD/C/TUN/CO/1, para. 29. See also OHCHR, Thematic study on the issue of violence against women and girls and disability, A/HRC/20/5 (2012).
- 28 General Comment 9 (2006) on the rights of children with disabilities, para. 60.
- 29 *A.S. v. Hungary*, Communication No. 4/2004 (2006), para. 11.2.
- 30 *Ibid.*
- 31 Inter-American Commission on Human Rights, *María Chávez v. Peru*, Case 12.191, Report No. 71/03 (2003), para. 14.