



ESCR-Net



# Women and ESCR Working Group briefing paper: the intersection between health and women's economic, social and cultural rights<sup>1</sup>

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## The Women and ESCR Working Group briefing paper series

ESCR-Net's Women and ESCR Working Group briefing paper series focuses on the intersection between women and specific economic, social and cultural rights (ESCR) issues. The papers present specific and systemic challenges to the realisation of women's ESCR in practice and explore progressive approaches to the application of a substantive equality perspective. The papers draw primarily upon ESCR-Net members' work in different areas, and are further informed by and enhanced through dialogue with other experts in this field. This paper was prepared for, and informed by, the Working Group's consultation with members of the CEDAW Committee and CESCR on 'Women and economic, social and cultural rights: current challenges and opportunities for advancement', held in Geneva on 7 November 2015. For more information and the meeting report, see: <https://www.escr-net.org/node/368261>.

## Taking a substantive equality perspective

In foregrounding a substantive equality analysis in its collective projects and activities, the Women and ESCR Working Group encourages a shift from a gender-neutral approach limited to ensuring similarity of treatment, to one that considers the effects of particular (in)action. To start, substantive equality requires consideration of indirect discrimination against women, where an apparently neutral law, policy or practice affects women adversely in a disproportionate way, because of biological difference and/or the ways in which women are situated or perceived in the world through socially and culturally constructed gender differences. More broadly, the achievement of substantive equality in practice requires a multifaceted approach which: **redresses disadvantage** (based on historical and current social structures and power relations that define and influence women's abilities to enjoy their human rights); **addresses stereotypes, stigma, prejudice, and violence** (with underlying change in the ways in which women are regarded and regard themselves, and are treated by others); **transforms institutional structures and practices** (which are often male-oriented and ignorant or dismissive of women's experiences); and **facilitates social inclusion and political participation** (in all formal and informal decision-making processes).<sup>2</sup>

<sup>1</sup> We would like to acknowledge with appreciation the members of ESCR-Net's Women and ESCR Working Group who took a lead role in drafting and reviewing this paper, including: Center for Reproductive Rights (international); Hakijamii (Kenya); Nazdeek (India); François-Xavier Bagnoud Center for Health and Human Rights, Harvard University (USA); Asia Pacific Forum on Women, Law and Development (Asia region), as well as other members who provided valuable input.

<sup>2</sup> For more information on this framework, see Sandra Fredman and Beth Goldblatt *Gender Equality and Human Rights* (2015) UN Women Discussion Paper No. 4, <http://www.unwomen.org/en/digital-library/publications/2015/7/dps-gender-equality-and-human-rights>.

## Introduction

Women face a number of unique barriers that prevent or frustrate the full realization and enjoyment of their right to the highest attainable standard of physical and mental health.<sup>3</sup> Some of these barriers include States' differential treatment of women's health needs, legal or other obstacles preventing women from accessing quality healthcare services, and a variety of formal and informal impediments faced by women in making autonomous decisions about their health. Interpreting women's rights to health through a substantive equality lens is critical for addressing these barriers.

The health needs of women differ from those of men. This is as a result of biological differences, such as women's reproductive capacities, as well as social factors, such as deeply rooted gender roles and stereotypes that negatively impact women's enjoyment of the right to health.<sup>4</sup> With regard to reproductive capacities, women are often forced to contend with discriminatory laws that deny or otherwise inhibit access to essential reproductive health services<sup>5</sup> including restrictive abortion laws, bans on certain forms of contraception, and targeted funding restrictions for specific health services.<sup>6</sup> Various procedural barriers, such as mandatory waiting periods and biased counselling, also frequently inhibit women's access to reproductive health services. Furthermore, pervasive stigma around women's sexuality also acts as a barrier to their access to sexual and reproductive health information and services.

<sup>3</sup> The right to the highest attainable standard on mental and physical health is recognized in a number of international law instruments, including Art 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR); the preamble of the Constitution of the World Health Organization (WHO); Art 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); and Art 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (CERD); and Art 24 of the International Convention on the Rights of the Child (CRC).

<sup>4</sup> See UN *Beijing Declaration and Platform for Action* (1995), para 90. See also UN Women 'Women and Health' in UN Women *Beijing at Ten* (2005), p. 7, available at: <http://www.un.org/womenwatch/daw/beijing/beijingat10/>.

<sup>5</sup> In 2005, reproductive health problems were the leading cause of women's ill health and death worldwide. See UN Women 'Women and Health' in UN Women *Beijing at Ten* (2005), p. 5.

<sup>6</sup> *Ibid.*, p. 5.

Despite the right to health being enshrined in international human rights law, and in many national legal frameworks, legal and cultural norms about women's ability to make autonomous decisions also undermine their right to health. For example, women may be required to receive authorization from a male family member or spouse before accessing any health services.<sup>7</sup> Patriarchal attitudes, discriminatory gender roles and stereotypes also negatively impact on the realization and enjoyment of women's right to health. Women may, for example, have less control over household expenditure and, as result, may be unable to allocate financial resources for their health needs. This phenomenon is exacerbated by prevailing gender norms and stereotypes that place men's and boys' needs above those of women and girls.<sup>8</sup> For single mothers or families living in poverty, women's socialized role as the primary caregiver may make them unwilling to sacrifice spending money on their children's needs in order to attend to their own healthcare.

Where health systems are functioning inadequately – either throughout a State or in a certain region or area – women are often disproportionately impacted both as a result of their particular health needs and their lower social status. For example, where health resources are scarce, hospitals and clinics may prioritize what they view as “general” health needs while neglecting the unique risks women face to their health, such as the need to stock essential medicines and equipment related to pregnancy and childbirth. Further, in developing countries, poor health outcomes such as maternal mortality and morbidity are often seen as fatalistic outcomes rather than conditions that are preventable. Women from marginalized groups are doubly impacted by this, for example, women from *dalit* or indigenous backgrounds, as they both must contend with the neglect of their health needs and often face other forms of discrimination in healthcare settings that undermine their right to quality care. In many countries, women often face serious human rights abuses when seeking reproductive health services in public and private healthcare facilities. These abuses include neglect and mistreatment during and after delivery, physical and verbal abuse, detention in health

<sup>7</sup> *Ibid.*, p. 7.

<sup>8</sup> *Ibid.*, p. 7.

## Case study: Women and health in the context of devolution and resource allocation in Kenya

With the introduction of the 2010 Constitution, health was recognized as a right for the first time in Kenya. This development was meant to address the disparities in access to proper healthcare nationally, with a focus on marginalized areas like the northern part of Kenya (where only 8.2 per cent of women give birth in a health facility, with only 11.3 per cent of those attended to by qualified medical personnel), and areas of low socio-economic development such as informal settlements.

However, following the new Constitution and associated devolution, Kenya in fact reduced its spending on health from 6 to 3.5 per cent of the national budget, well below the 15 per cent committed to by Kenya in the Abuja declaration. The government blames devolution for this decrease, stating that it is too expensive to pay workers at both county and national level. In June 2013, Kenya rolled out free maternity care to all women in public health facilities and by July had recorded a 10 per cent increase in maternal deliveries in hospitals countrywide. Unfortunately, with the project promised as part of an election campaign manifesto, as opposed to enacted within the legal framework, implementation suffered. For example, a number of women were detained in hospital due to unpaid bills despite the billions of shillings allocated for their health care. By 2014 the project was no longer sustainable in practice, leading to a nationwide strike by all health professionals. Kenya failed to achieve its Millennium Development Goals' targets and continues to lag behind other countries at 448 deaths per 1000 births.

Post-devolution, the budgets in Kenya lack transparency, corruption has increased significantly, and ordinary citizens do not feel the benefit of the health budget in practice. For example, a woman died recently in an ambulance after an 18-hour wait for a hospital bed at the country's largest referral hospital; similarly, another woman died after a 14-hour labour due to the lack of relevant medical personnel, despite the monetary resources channelled to the hospital in question.

The Committee on Economic, Social and Cultural Rights' (CESCR) review of Kenya's compliance with the International Covenant on Economic, Social and Cultural Rights (ICESCR) in February 2016 presented an opportunity for Kenya to be questioned about budget transparency, resource allocation in the health sector, and the enactment of the health bill 2014 which requires prioritization of women's health generally and specifically states that a person shall not be denied emergency medical treatment.

facilities for inability to pay for services, and female genital mutilation.

Moreover, gender is a critical social determinant of health. The World Health Organization (WHO) defines social determinants of health as “conditions in which people are born, grow, work, live, and age, and [which are] in turn shaped by a wider set of forces and systems shaping the conditions of daily life.”<sup>9</sup> Gender should therefore be viewed as a determinant, as it affects access to information and education, the way individuals experience poverty, and the quality of and access to nutrition, housing, water, and sanitation, among a range of other factors that affect an individual’s health. Addressing the social determinants of health, and also recognizing and addressing potential intersectional discrimination, is essential for improving health outcomes and realizing the right to health. Due to intersectional discrimination, women with disability, indigenous women, migrant women workers, refugee women, older women, LGBTI women, and girls can face specific health rights issues.

Finally, power dynamics, both within and outside of healthcare settings, strongly influence women’s right to health. Where women are not empowered to assert their rights, they are unable to seek remedies for human rights violations perpetrated against them, such as maltreatment or abuse in healthcare settings or violations of their right to informed consent. Furthermore, where women fear experiencing abuse in healthcare settings, it deters them from accessing healthcare services. The way these power dynamics permeate societies also influences patterns of gender-based violence which, in addition to directly undermining women’s health, requires that healthcare services be equipped to respond appropriately and effectively.

## Positive developments

The Committee on the Elimination of Discrimination against Women (CEDAW Committee) and CESCR have each articulated strong comments and

issued significant guidance to States regarding women and the right to health.

The CEDAW Committee has issued a number of General Recommendations that are linked to women’s right to health, with the most comprehensive of these being General Recommendation 24.<sup>10</sup> Other recommendations deal with various aspects of women’s rights to health, including General Recommendation 18,<sup>11</sup> General Recommendation 14,<sup>12</sup> and General Recommendation 15.<sup>13</sup> CESCR has also been a leader in advancing the human rights standards on health and gender equality. CESCR’s General Comment 14 on the right to health affirms the principle of equality and non-discrimination and expresses a serious commitment to eradicating substantive inequalities especially in relation to women’s unequal enjoyment of the right to health.<sup>14</sup> Both the CEDAW Committee and CESCR have issued additional guidance to States through the Concluding Observations on State party reports, making reference to the intersection of women and the right to health, as well as the right to health more generally. Key commentary from both committees is set out in the Annex to this paper.

Over the past several years, the CEDAW Committee has integrated a strong intersectional approach into its consideration of women’s right to health. For example, in the case of *Alyne da Silva Pimentel v Brazil*<sup>15</sup> regarding the preventable maternal death of a poor, Afro-Brazilian woman, the CEDAW Committee recognized that the State discriminated against her both on the basis of her sex and her

10 CEDAW Committee *General Recommendation No 24: Article 12 of the Convention (Women and Health)* (1999).

11 CEDAW Committee *General Recommendation No 18: Disabled Women* (1991).

12 CEDAW Committee *General Recommendation No 14: Female Circumcision* (1990).

13 CEDAW Committee *General Recommendation No 15: Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)* (1990).

14 CESCR *General Comment 14: The Right to the Highest Attainable Standard of Health* (2000), paras 18-22.

15 *Alyne da Silva Pimentel Teixeira v Brazil*, CEDAW Committee Communication No 17/2008 (2011) UN Doc CEDAW/C/49/D/17/2008, para 3.4. For further information on the case and its impacts, see ESCR-Net’s summary, available at: <https://www.escr-net.org/docs/lj/1623066>.

9 For further information on social determinants of health, see WHO ‘Key Concepts’ (2008), available at [http://www.who.int/social\\_determinants/thecommission/finalreport/key\\_concepts/en/](http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/).

socio-economic status.<sup>16</sup> This recognition that States are not in compliance with their human rights obligations where health measures neglect or fail to reach all sectors of society, including the most marginalized, is an essential component of substantive equality. The CEDAW Committee further utilized this approach in its Philippines inquiry, released in 2015, wherein it recognized that Manila City's effective ban on modern contraceptives violated the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and had a disproportionate effect on women from disadvantaged groups, including poor women, adolescents and women in abusive relationships.<sup>17</sup>

The ground-breaking precedent in *Alyne v. Brazil* was recently built upon in a domestic case in Kenya surrounding the detention of poor women in hospitals after delivery for failing to pay their medical bills. Relying on the standards set forth by CESCR in its General Comment 14, and by the CEDAW Committee's jurisprudence, the judge found that the State violated the rights to health and non-discrimination, among other rights, by failing to provide affordable reproductive health care and discriminated against women on the basis of their sex and economic status.<sup>18</sup> Similarly, a domestic case in India explored how socio-economic status and gender adversely affected access to the right to health in practice, with the judge finding that the denial of maternal health and nutritional benefits and services violated the constitutional and international human rights of poor pregnant women.<sup>19</sup>

The 2012 decision by the Inter-American Court of Human Rights in the case of *Artavia Murillo et al v Costa Rica*,<sup>20</sup> which overturned Costa Rica's

ban on *in vitro fertilization* (IVF), also adopted a substantive equality approach in examining the disproportionate impact the ban had on the basis of gender, disability and economic status. The Court ordered Costa Rica to make IVF available within its health care system as a treatment for infertility, in accordance with the principle of non-discrimination.

The Office of the High Commissioner for Human Rights' Technical Guidance on the application of a humanrights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity provides States with concrete measures for realizing human rights on the ground.<sup>21</sup> Although targeted towards maternal issues, the document's utility spans the health sector generally as it provides critical guidance on ensuring accountability, including through monitoring, reviews and oversight and remedies. Furthermore, it provides guidance on a gendered and human rights-based approach to planning and budgeting in the health sector.

More recently, the adoption of an optional protocol providing an individual complaints mechanism related to ICESCR is a significant development for women's rights to health, as CESCR has been a leader in advancing the human rights standards on health and gender equality. The mechanism represents a significant opportunity for greater access to justice for violations of women's rights in the health sector and further elaboration on gender and the right to health.

## The 2030 agenda

The Sustainable Development Goals (SDGs) adopted in September 2015,<sup>22</sup> explicitly support gender equality and the realization of the human rights of women and girls, including the right to

<sup>16</sup> Ibid, para 7.7.

<sup>17</sup> Inquiry Procedure CEDAW/C/OP8/PHL/1 (Advanced unedited version, April 22, 2015). For further information on the case and its impacts see ESCR-Net's summary available at: <https://www.escr-net.org/node/365940>.

<sup>18</sup> *Awuor and Olieli v The Attorney-General and others*, No. 562 of 2012 (2015) High Court of Kenya. For further information, see: <http://www.reproductiverights.org/press-room/kenyan-high-court-maternity-hospital-illegally-imprisoned-women-violated-human-rights>

<sup>19</sup> *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors*, W.P. (C) Nos. 8853/2008 High Court of Delhi. For further information on the case and its impacts, see: <https://www.escr-net.org/docs/i/1370523>.

<sup>20</sup> *Artavia Murillo et al v Costa Rica*, Judgment of the Inter-American Court of Human Rights, November 28, 2012, available

at: [http://www.corteidh.or.cr/docs/casos/articulos/seriec\\_257\\_ing.pdf](http://www.corteidh.or.cr/docs/casos/articulos/seriec_257_ing.pdf).

<sup>21</sup> Office of the High Commissioner on Human Rights (OHCHR) *Technical Guidance on the Application of a Human Rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality* (2012) UN Doc A/HRC/21/22, available at: [http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22\\_en.pdf](http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf).

<sup>22</sup> See UN *Transforming Our World: The 2030 Agenda for Sustainable Development* (2015). For more information about the SDGs, see: <https://sustainabledevelopment.un.org/post2015/transformingourworld>.

health for all.<sup>23</sup> However, these agendas also promote trade and investment liberalization in the context of international private finance and public-private partnerships (PPPs) as key strategies for financing the goals. PPPs, broadly descriptive of collaboration between the public and private sectors to achieve a public policy goal, and include private companies financing, building or operating a public service or facility,<sup>24</sup> have been frequently used to provide social services, particularly health and education. It has been noted that the promotion of private sector engagement in service delivery of key social areas has aimed to create “very profitable and flourishing enterprises that are disrespectful of human rights obligations”.<sup>25</sup> This has often led to an exacerbation of inequality in access to services and deepened social inequalities.

In particular, the privatization of healthcare services has increased inequity in the accessibility of healthcare, including greater out-of-pocket expenditure.<sup>26</sup> For instance, in the Philippines, the privatization of various public hospitals (in line with policy prescriptions of the Asian Development Bank and World Bank over decades) has been linked by the Government of the Philippines to the increasing maternal mortality rate.<sup>27</sup> Access to medicines and prioritization of investments are frequently decided following financing principles which has led to reductions in, or dismantling of, key services for women’s health which have proven to be expensive and not profitable.<sup>28</sup>

Cuts in public spending and the outsourcing of essential public services have a direct impact on women’s rights in various ways: first, women

rely more than men on public services and social security guarantees; and second, women are left to fill the gaps in provision that occur when services are reduced.

## Key issues to consider

Women are not a homogenous group within a specific context, and have different health needs both as a result of their biological differences, such as women’s reproductive capacities, and as a result of gender roles and stereotypes that impact the risks to their health with which women must contend. This paper does not seek to address every situation, but instead focuses on a number of key issues and recommendations based upon the Working Group members’ expertise and recent experience.

- Many States have put in place strong laws or policies around women’s health but have failed to allocate adequate financial resources to fully implement them. To comply with their human rights obligations, these programs must be fully funded and be implemented equitably, which requires disaggregated monitoring of their outcomes on the basis of, at least, sex, race, indigenous status, age, geography, sexuality and gender orientation, and disability. There is also a need for increased transparency in accessing budgets to determine allocations, utilisations and expenditures, including robust right to information laws to empower communities and civil society to access budgetary information. Further, accountability safeguards must be put in place to address possible negative impacts of devolution and privatization of public health services.
- As several regional and international human rights cases have recognized, States must put in place mechanisms for women to challenge denials of their right to access health services, especially reproductive health services, whether in public or private settings, in a timely manner. Such mechanisms must enable the woman’s opinion to be heard, issue a decision within a timeframe that would still enable her to access the services, and be subject to appeal if she is denied services. States should also be responsive to community-based monitoring programs, especially as they feed into citizen grievance forums and other mechanisms.

23 See, specifically, SDGs 3, 5, 6 and 16.

24 Asia Pacific Forum on Women, Law and Development *Delivering Development Justice? Financing the 2030 Agenda for Sustainable Development* (2015), a background paper for the Expert Group Meeting on ‘Women’s empowerment and the link to sustainable development’ held in New York on 2-4 November 2015.

25 UN General Assembly *Report of the Special Rapporteur on the Right to Education: Protecting the right to education against commercialization* (2015) UN Doc A/HRC/29/30.

26 UN General Assembly *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* (2012) UN Doc A/HRC/20/15/Add.2. See also UN *Beijing Declaration and Platform for Action* (1995), para 91.

27 See specifically SDGs 3, 5, 6 and 16.

28 UN *Beijing Declaration and Platform for Action* (1995), para 91.

- Laws and policies criminalizing women on the basis of their immigration status, area of work, HIV status, or sexual orientation or gender identity, among other factors, undermine their right to health by deterring or preventing them from accessing essential care. Furthermore, despite the recognition that laws preventing or limiting access to health services that only women need is a form of discrimination, restrictive laws and policies continue to undermine women's access to health services and perpetuate stigma and gender-based stereotypes, and must be overturned.
- To enable women to make meaningful decisions about their health, it is essential that States take positive measures to elevate the status of women, including eradicating harmful gender norms and stereotypes and guaranteeing women access to the information and resources to act on these decisions, and facilitating sex education for adolescents.
- Inadequately functioning health systems disproportionately impact women, particularly women from marginalized groups. It is critical that States ensure *all* individuals have access to health facilities with the properly trained staff and adequate resources to provide quality care.
- Within a context of growing private investment and private economic operators, mechanisms are required to allow all stakeholders to have a voice and to protect against the influence of vested interests which may disproportionately impact women's rights to health and other human rights.

## Conclusion

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While some advances have been and continue to be made at the intersection of health and women's economic, social and cultural rights, the issues outlined above reflect continued direct and indirect discrimination experienced by women in relation to the availability, accessibility, and quality of health care. Taking a substantive equality approach to women's enjoyment of their rights in relation to health requires more careful consideration of the manifestations of, and strategies for dealing with, such interrelated issues.

## Selected additional resources

- CEDAW Committee, *General Recommendations* No. 24 (women and health), No. 27 (older women), and No. 26 (women migrant workers)
- CEDAW Committee and Committee on the Rights of the Child, *Joint general recommendation/comment on harmful practices* (2014)
- Center for Reproductive Rights, *Accountability for Discrimination Against Women in the Philippines: Key Findings and Recommendations from the CEDAW Committee's Special Inquiry on Reproductive Rights* (2015).
- Center for Reproductive Rights, *Breaking Ground 2015: Treaty Monitoring Bodies on Reproductive Rights* (2015).
- Center for Reproductive Rights, *Mandatory Waiting Periods and Biased Counseling Requirements in Central and Eastern Europe* (2015).
- Center for Reproductive Rights, *Substantive Equality and Reproductive Rights: A Briefing Paper on Aligning Development Goals with Human Rights Obligations* (2014).
- Audrey Chapman, *The Impact of Reliance on Private Health Services on the Right to Health* (2014) 16(1) *Health and Human Rights Journal* 122.
- Audrey R. Chapman, 'The social determinants of health, health equity, and human rights' (2010) 12(2) *Health and Human Rights Journal* 17.
- Human Rights Council, *Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, Report of the Office of the UN High Commissioner for Human Rights (2012).
- Paul Hunt, et al, *Making the Case: What is the Evidence of Impact of Applying Human Rights-Based Approaches to Health?* (2015) 17(2) *Health and Human Rights Journal* 1.
- Tessa Khan, APWLD, *Delivering Development Justice? Financing the 2030 Agenda for Sustainable Development* Background paper for UN Women's expert group meeting, in preparation for the 60th session of the CSW, on 'Women's empowerment and the link to sustainable development' New York, 2-4 November 2015 (2015).
- Gillian MacNaughton, *Untangling equality and non-discrimination to promote the right to health care for all* (2009) 11(2) *Health and Human Rights Journal* 47.
- Jyoti Sanghera, et al, *Human Rights in the New Global Strategy* (2015) *BMJ* 351.
- UNFPA, *Lessons from the First Cycle of the Universal Periodic Review: From Commitment to Action on Sexual and Reproductive Health and Rights* (2014).
- UN General Assembly, *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (on criminalization of sexual and reproductive health) (2011).
- UN General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (on criminalization of HIV transmission) (2010).
- World Health Organization, *Closing the Gap in a Generation: Health equity through action on the social determinants of health*, Final Report of the Commission on Social Determinants of Health, (Chapter 13: Gender Equity) (2008).
- Alicia Ely Yamin, *Shades of dignity: Exploring the demands of equality in applying human rights frameworks to health* (2009) 11(2) *Health and Human Rights Journal* 1.



## Annex: CEDAW/CESCR references to women and health in concluding observations:<sup>29</sup>

CEDAW	CESCR
<b>Ensuring women's access to health care services</b>	
<p>Expressed concern about the range of structural obstacles hindering access of women and girls to adequate health care services, including lack of adequate physical infrastructure and human and financial capacity constraints<sup>30</sup></p> <p><b>Called upon States to:</b></p> <ul style="list-style-type: none"> <li>• Take concrete measures to improve women's access to a wide range of quality health care facilities and services, including sexual and reproductive health care<sup>31</sup></li> <li>• Take steps to improve health infrastructure in order to ensure women's access to health care services<sup>32</sup></li> <li>• Increase budgetary allocations to the health care sector<sup>33</sup></li> </ul>	<p>Expressed concern about the range of structural obstacles hindering access of women and girls to adequate health care services, including lack of adequate physical infrastructure, human and financial capacity constraints, and inadequate budget allocation for the health sector.<sup>34</sup></p> <p><b>Called on States to:</b></p> <ul style="list-style-type: none"> <li>• Take concrete measures to improve women's access to a wide range of quality health care facilities and services, including basic health care services and sexual and reproductive health care services<sup>35</sup></li> <li>• Intensify measures to increase budgetary allocations to the health sector<sup>36</sup></li> </ul>
<b>Ensuring women's access to reproductive health care services</b>	
<p>Expressed concern about women's lack of access to sexual and reproductive health care services, including family planning and access to a wide range of contraceptive services.<sup>37</sup> Expressed concern that women require the consent of their husbands in order to undergo certain medical procedures or gain access to certain medical services.<sup>38</sup> Expressed concern that some States prohibit or heavily restrict abortions, which lead women to seek unsafe or clandestine abortions.<sup>39</sup> Expressed concern about instances of forced sterilization and the increased use of sterilization or abortion forms of contraception in some States due to unavailability and/or inaccessibility of other forms of contraception.<sup>40</sup></p>	<p>Expressed concern about women's lack of access to sexual and reproductive health care services.<sup>41</sup> Expressed concern about reports of forced sterilizations.<sup>42</sup> Expressed concerns about distorted sex ratios at birth and the possible linkage to sex-selective abortions due to discrimination against women, including in inheritance, and son preference.<sup>43</sup></p>

<sup>29</sup> This is a non-exhaustive list of references to women and health. The following concluding observations of the CEDAW Committee were analysed for this table: Congo, Eritrea, Malawi, Mexico (2006); Belize, Hungary, Indonesia, Mozambique (2007); Bahrain, Uruguay (2008); Guinea-Bissau (2009); Bangladesh, Kenya, Lesotho, Paraguay (2011); Afghanistan, Cambodia, Colombia, Moldova, Serbia, Seychelles, Tajikistan (2013); Sri Lanka (2014); Spain, Uzbekistan (2015). The following concluding observations of the CESCR Committee were analysed for this table: Albania, Kuwait (2013); China, Indonesia, Ukraine, Uzbekistan (2014); Gambia, Paraguay, Tajikistan (2015).

<sup>30</sup> Malawi, Mexico (2006); Mozambique (2007); Guinea-Bissau (2009); Paraguay (2011); Afghanistan, Tajikistan (2013).

<sup>31</sup> Congo, Eritrea, Malawi, Mexico (2006); Hungary, Indonesia, Mozambique (2007); Belize (2008); Bangladesh, Lesotho (2011); Afghanistan, Serbia, Tajikistan (2013).

<sup>32</sup> Guinea-Bissau (2009).

<sup>33</sup> Afghanistan (2013).

<sup>34</sup> Albania (2013); China (2014); Gambia, Tajikistan (2015).

<sup>35</sup> Indonesia, Ukraine (2014); Gambia (2015).

<sup>36</sup> Albania (2013); China, Ukraine (2014); Gambia, Tajikistan (2015).

<sup>37</sup> Eritrea, Mexico (2006); Belize (2008); Guinea-Bissau (2009); Kenya, Lesotho, Paraguay (2011); Cambodia (2013); Sri Lanka (2014).

<sup>38</sup> Bahrain (2008); Afghanistan (2013).

<sup>39</sup> Lesotho (2011); Afghanistan, Seychelles (2013); Sri Lanka (2014).

<sup>40</sup> Colombia, Moldova, Serbia (2013); Uzbekistan (2015).

<sup>41</sup> Paraguay (2015).

<sup>42</sup> China (2014).

<sup>43</sup> Albania (2013).

CEDAW	CESCR
<b>Ensuring women's access to reproductive health care services</b>	
<p><b>Called on States to:</b></p> <ul style="list-style-type: none"> <li>• Improve the availability of, and access to, sexual and reproductive health services to women, including family planning, with the aim of preventing early pregnancies and clandestine abortions<sup>44</sup></li> <li>• Strengthen and expand efforts to increase access to a comprehensive range of safe and affordable contraceptive services,<sup>45</sup> and take measures to prevent the use of sterilization or abortion as a form of contraception.<sup>46</sup></li> <li>• Adopt and implement effective measures to prevent unsafe abortions<sup>47</sup> and enhance access to effective, safe abortions<sup>48</sup> and post-abortion health care services<sup>49</sup></li> <li>• Strengthen sexual education programmes, awareness-raising campaigns, and sexual and reproductive health services to ensuring that women and men can make informed choices on the number and spacing of children<sup>50</sup></li> <li>• Take appropriate measures to ensure that women can give their free, prior and informed consent to procedures and medical treatment without the consent and/or authorization of any other person, including that of their husbands<sup>51</sup></li> <li>• To repeal laws that prohibit abortion<sup>52</sup> and review laws relating to abortion to remove punitive provisions imposed on women who undergo abortion imposed by these laws.<sup>53</sup></li> </ul>	<p><b>Called on States to:</b></p> <ul style="list-style-type: none"> <li>• Improve the availability of, and access to, sexual and reproductive health services to women, including family planning<sup>54</sup></li> <li>• Strengthen and expand efforts to increase access to a comprehensive range of safe and affordable contraceptive services, and take measures to prevent the use of abortion as a form of contraception<sup>55</sup></li> <li>• Adopt and implement effective measures to prevent unsafe abortions and enhance access to effective, safe abortions and post-abortion health care services<sup>56</sup></li> <li>• Strengthen sexual education programmes, awareness-raising campaigns, and information about sexual and reproductive health services<sup>57</sup></li> <li>• Amend legislation on the prohibition of abortion to render it compatible with other fundamental rights, such as women's right to health, life and dignity<sup>58</sup></li> <li>• Take action to prevent and criminalize the use of forced sterilizations or abortions, hold those responsible for these actions accountable and compensate victims who have experienced these actions<sup>59</sup></li> </ul>
<b>Addressing the impact of armed conflict</b>	
<p>Expressed concern about the negative impact of armed conflict on maternal and infant mortality and morbidity, and women's access to health care services (including access to emergency obstetric care and health related services).<sup>60</sup></p>	

44 Eritrea, Malawi, Mexico (2006); Indonesia (2007); Belize (2008); Guinea-Bissau (2009); Kenya, Paraguay (2011); Colombia (2013); Sri Lanka (2014).

45 Malawi, Mexico (2006); Hungary (2007); Belize (2008); Bangladesh, Kenya, Lesotho, Paraguay (2011); Moldova, Seychelles (2013); Uzbekistan (2015).

46 Colombia, Serbia (2013); Uzbekistan (2015).

47 Mexico (2006). Belize, Uruguay (2008); Bangladesh, Kenya, Paraguay (2011), Sri Lanka (2014).

48 Mexico (2006); Paraguay (2011); Colombia, Moldova (2013).

49 Colombia (2013).

50 Mexico (2006); Hungary, Mozambique (2007); Belize, Uruguay (2008); Kenya, Lesotho, Paraguay (2011); Moldova (2013).

51 Bahrain (2008); Colombia, Moldova (2013); Uzbekistan (2015).

52 Lesotho (2011).

53 Afghanistan, Seychelles (2013); Sri Lanka (2014).

54 China, Indonesia (2014); Gambia, Paraguay (2015).

55 Albania (2013); China (2014); Paraguay (2015).

56 Albania (2013).

57 Paraguay (2015).

58 Paraguay (2015).

59 China (2014).

60 Congo (2006); Afghanistan (2013); Sri Lanka (2014).

CEDAW	CESCR
<b>Ensuring access to health care services for vulnerable groups of women</b>	
<p>Expressed concern about the lack of access to health care services and continued inequalities in the availability, quality and accessibility of health care services experienced by vulnerable groups of women and girls, including migrant women,<sup>61</sup> poor women,<sup>62</sup> women with disabilities,<sup>63</sup> elderly women,<sup>64</sup> indigenous women<sup>65</sup> and rural women.<sup>66</sup> Expressed concern about reports of forced sterilizations, in particular of women with disabilities,<sup>67</sup> rural women and Roma women.<sup>68</sup></p> <p><b>Called upon States to:</b></p> <ul style="list-style-type: none"> <li>• Enhance access to health care services for rural women,<sup>69</sup> and ensure that rural women do not face barriers in accessing family planning information and services<sup>70</sup></li> <li>• Enhance access to affordable health care to older women,<sup>71</sup> poor women and women with disabilities.<sup>72</sup></li> </ul>	<p>Expressed concern about the lack of access to health care services and continued inequalities in the availability, quality and accessibility of health care services experienced by disadvantaged and marginalized individuals and groups, including persons with disabilities, refugees, asylum seekers,<sup>73</sup> ethnic minorities and people in rural areas.<sup>74</sup></p> <p><b>Called upon States to:</b></p> <ul style="list-style-type: none"> <li>• Enhance access to health care services for disadvantaged and marginalized individuals and groups.<sup>75</sup></li> <li>• Enhance access to health care services for rural women, including access to sexual and reproductive health care services<sup>76</sup> and access to health care facilities.<sup>77</sup></li> <li>• Take the necessary measures to guarantee that asylum seekers have full access to free emergency medical care<sup>78</sup></li> </ul>
<b>Addressing negative stereotypes and harmful traditional practices</b>	
<p>Expressed concern about the persistence of unequal power relations between women and men and gender-specific norms,<sup>79</sup> which may hamper the ability of women to negotiate safe sexual practices and increase their vulnerability to infection of a range of STIs or HIV/AIDS.<sup>80</sup> Expressed concern about the high incidence of female genital mutilation in some States and the lack of legislation aimed at eradicating this practice.<sup>81</sup></p> <p><b>Called upon States to:</b></p> <ul style="list-style-type: none"> <li>• Study the behavioural patterns of communities, and specifically women, to identify what inhibits women's use of existing health care services and to take appropriate action<sup>82</sup></li> </ul>	<p>Expressed concern about the continued practice of female genital mutilation<sup>83</sup> and lack of legislation prohibiting the practice of female genital mutilation in some States.<sup>84</sup></p> <p><b>Called upon States to:</b></p> <ul style="list-style-type: none"> <li>• Enact legislation explicitly prohibiting female genital mutilation, and ensure its strict implementation and implement awareness-raising efforts to change the cultural perceptions connected with female genital mutilation<sup>85</sup></li> <li>• Intensify efforts to prevent and combat all practices that are harmful to women and girls<sup>86</sup></li> </ul>

61 Colombia (2013); Spain (2015).

62 Colombia (2013).

63 Colombia, Serbia (2013).

64 Moldova (2013).

65 Mexico (2006).

66 Congo, Eritrea, Malawi (2006); Guinea-Bissau (2009); Bangladesh, Kenya, Lesotho (2011); Tajikistan (2013); Cambodia, Tajikistan (2013).

67 Tajikistan (2013).

68 Moldova (2013).

69 Congo, Eritrea (2006); Hungary; Indonesia (2007); Afghanistan, Colombia (2013).

70 Eritrea (2006); Bangladesh, Lesotho (2011).

71 Colombia, Moldova (2013).

72 Colombia, Serbia (2013).

73 Ukraine (2014).

74 China, Indonesia (2014); Tajikistan (2015).

75 China (2014); Tajikistan (2015).

76 Ukraine (2014); Gambia, Paraguay (2015).

77 Uzbekistan (2014).

78 Ukraine (2014).

79 Afghanistan (2013).

80 Kenya, Lesotho (2011).

81 Eritrea (2006); Indonesia (2007); Guinea-Bissau (2009); Kenya (2011).

82 Congo (2006).

83 Indonesia, Ukraine (2014); Gambia (2015).

84 Gambia (2015).

85 Gambia (2015).

86 Gambia (2015).

CEDAW	CESCR
<b>Addressing negative stereotypes and harmful traditional practices</b>	
<ul style="list-style-type: none"> <li>• Conduct awareness raising campaigns to eliminate patriarchal attitudes and cultural beliefs which impede women's free access to health services and contraceptive methods<sup>87</sup></li> <li>• Enact legislation explicitly prohibiting female genital mutilation, ensure that offenders are prosecuted and adequately punished, and implement awareness-raising efforts to change the cultural perceptions connected with female genital mutilation<sup>88</sup></li> <li>• Establish support services to meet the health and psychosocial needs of women and girls who are victims of female genital mutilation.<sup>89</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Take steps to prevent all forms of discrimination against women, including address customary practices as well as patriarchal and stereotyped attitudes<sup>90</sup></li> </ul>
<b>Addressing the prevalence of HIV/AIDS</b>	
<p>Expressed concern at prevalence of HIV/AIDS pandemic among women,<sup>91</sup> the high incidence of death as a result of AIDS-related illnesses,<sup>91</sup> and the stigmatization and discrimination of women living with HIV/AIDS.<sup>93</sup> Expressed concern about the lack of access to anti-retroviral treatment for women living with HIV/AIDS.<sup>94</sup> Expressed concern about the direct linkage between harmful traditional practices and the spread of HIV/AIDS.<sup>95</sup></p> <p><b>Called on States to:</b></p> <ul style="list-style-type: none"> <li>• Take comprehensive measures to combat the HIV/AIDS pandemic, take strong preventative measures and ensure that women and girls infected with HIV/AIDS are not discriminated against and are given appropriate assistance.<sup>96</sup> States should also include a gender perspective in their policies and programmes on HIV/AIDS.<sup>97</sup></li> <li>• Ensure effective implementation of their HIV/AIDS strategies, if these strategies have already been developed<sup>98</sup></li> <li>• Improve the dissemination of information about the risks and ways of transmission of HIV/AIDS<sup>99</sup></li> </ul>	<p>Expressed concern at prevalence of HIV/AIDS<sup>100</sup> and the high incidence of death as a result of AIDS-related illnesses, including tuberculosis,<sup>101</sup> and the stigmatization and discrimination of women living with HIV/AIDS.<sup>102</sup></p> <p><b>Called on States to:</b></p> <ul style="list-style-type: none"> <li>• Take comprehensive measures to combat the HIV/AIDS pandemic and improve the dissemination of information about the risks and ways of transmission of HIV/AIDS<sup>103</sup></li> <li>• Take measures to repeal or amend laws or policies to ensure that persons living with HIV/AIDS are not discriminated against and are able to access health care services<sup>104</sup></li> <li>• Improve the dissemination of information about the risks and ways of transmission of HIV/AIDS<sup>105</sup></li> <li>• Ensure effective implementation of their HIV/AIDS strategies, if these strategies have already been developed<sup>106</sup></li> <li>• To provide increased access to antiretroviral treatment for women and men living with HIV/AIDS, including pregnant women<sup>107</sup></li> </ul>

87 Malawi (2006); Afghanistan (2013).

88 Eritrea (2006); Indonesia (2007); Guinea-Bissau (2009); Kenya (2011).

89 Kenya (2011).

90 Albania (2013).

91 Malawi (2006); Belize, Uruguay (2008); Kenya, Lesotho (2011); Cambodia, Tajikistan (2013); Sri Lanka (2014).

92 Belize (2008).

93 Cambodia, Tajikistan (2013).

94 Serbia (2013).

95 Malawi (2006).

96 Mozambique (2007); Uruguay (2008); Guinea-Bissau (2009); Colombia, Tajikistan (2013).

97 Belize (2008); Kenya (2011); Tajikistan (2013).

98 Congo, Malawi (2006); Kenya, Lesotho (2011).

99 Malawi (2006); Belize (2008); Kenya, Lesotho (2011).

100 Ukraine, Uzbekistan (2014).

101 China (2014); Paraguay, Tajikistan (2015).

102 China (2014).

103 China, Ukraine, Uzbekistan (2014); Tajikistan (2015).

104 China (2014).

105 China (2014).

106 Congo, Malawi (2006); Kenya, Lesotho (2011).

107 Ukraine (2014).

CEDAW	CESCR
<b>Addressing the prevalence of HIV/AIDS</b>	
<ul style="list-style-type: none"> <li>• To provide increased access to antiretroviral treatment for women and men living with HIV/AIDS, including pregnant women<sup>108</sup></li> <li>• Provide detailed statistical and analytical information about women and HIV/AIDS in its next periodic report<sup>109</sup></li> </ul>	
<b>Addressing maternal mortality</b>	
<p>Expressed concern at the high maternal mortality rate, which is primarily caused by the practice of unsafe or clandestine abortions.<sup>110</sup> Expressed concern that States did not develop strategies for the reduction of maternal mortality and that maternal health policies do not include attention to complications arising from unsafe abortion.<sup>111</sup></p> <p><b>Called upon States to:</b> take necessary measures to identify the causes of, and reduce maternal mortality by developing comprehensive interventions plans that includes adequate pre- and postnatal care, access to trained birth attendants, access to emergency obstetric care, as well as education and awareness-raising programmes<sup>112</sup></p>	<p>Expressed concern about high maternal and infant mortality rates.<sup>113</sup></p> <p><b>Called on States to:</b></p> <ul style="list-style-type: none"> <li>• Take the necessary legislative and administrative measures to prevent maternal mortality and morbidity<sup>114</sup></li> <li>• Take steps to reduce the rates of maternal and infant mortality by improving the quality, availability and accessibility of health care services<sup>115</sup></li> <li>• Address disparities in the availability and quality of maternal health care services, including by putting into place pre-service training, in-service training, supervision and accreditation of facilities<sup>116</sup></li> </ul>
<b>Addressing specific diseases and conditions</b>	
	<p>Expressed concern about the prevalence of tuberculosis, the insufficiency of anti-tuberculosis drugs, deficient infection control activities, the low impact of detection efforts and the inadequate service delivery at the primary health-care level.<sup>117</sup></p> <p><b>Called on States to:</b> step up efforts to improving policies and strategies for disease prevention and detection, and ensure that there is sufficient, accessible specialized tuberculosis treatment and medication<sup>118</sup></p>

108 Colombia, Moldova, Serbia (2013)

109 Congo (2006).

110 Eritrea, Malawi, Mexico (2006); Indonesia, Mozambique (2007); Beziile, Uruguay (2008); Guinea-Bissau (2009); Bangladesh, Kenya, Lesotho, Paraguay (2011); Afghanistan, Cambodia, Tajikistan (2013); Sri Lanka (2014).

111 Uruguay (2008); Kenya (2011).

112 Eritrea (2006); Mozambique (2007); Guinea-Bissau (2009);

Bangladesh, Kenya, Lesotho, Paraguay (2011); Afghanistan, Tajikistan (2013); Sri Lanka (2014).

113 Indonesia, Ukraine, Uzbekistan (2014); Gambia, Tajikistan (2015).

114 Paraguay (2015).

115 Albania (2013); Ukraine, Uzbekistan (2014); Gambia, Paraguay, Tajikistan (2015).

116 Indonesia (2014).

117 Ukraine (2014).

118 Ukraine, Uzbekistan (2014).

CEDAW	CESCR
<b>Addressing mental health problems</b>	
	<p>Expressed concern about the rate of mental health problems, including high suicide rates, affective disorders, schizophrenia and alcohol-related psychosis,<sup>119</sup> and the lack of availability and accessibility of mental health care services.<sup>120</sup></p> <p><b>Called on States to:</b> address the root causes of the prevalence of, and increase in, mental health problems and increasing the availability, accessibility and quality of professional mental health-care services and skilled personnel<sup>121</sup></p>
<b>Collection of disaggregated data</b>	
<p>Expressed concern over the lack of comprehensive data on women's access to health care services and the health status of women, and encouraged States to collect and provide such data.<sup>122</sup></p> <p><b>Called upon States to:</b></p> <ul style="list-style-type: none"> <li>• Collect and analyze disaggregated data on the on women's health needs, access to health care services and the measurable indicators to tackle progress in the realization of women's health rights<sup>123</sup></li> <li>• Provide detailed statistical and analytical information on the measures taken to improve women's access to health care services and information, including sexual, reproductive health and family planning, and the impact of these measures<sup>124</sup></li> </ul>	

<sup>119</sup>Paraguay (2015).

<sup>120</sup>Indonesia (2014).

<sup>121</sup>Paraguay (2015).

<sup>122</sup>Bangladesh (2011).

<sup>123</sup>Moldova (2013); Sri Lanka (2014).

<sup>124</sup>Congo (2006); Hungary, Mozambique (2007).



## ESCR-Net and its Working Group on Women and ESCR

The International Network for Economic, Social and Cultural Rights (ESCR-Net) unites over 270 NGOs, grassroots groups, and advocates across 70 countries, facilitating strategic exchange, building solidarity, and coordinating collective advocacy to secure social and economic justice through human rights. ESCR-Net members define common strategies and advance joint action foremost through international working groups, including the Working Group on Women and ESCR which is made up of about 40 members – NGOs, social movements, and individual advocates – working across regions to advance women’s ESC rights and substantive equality. Through engagement with UN bodies, capacity building, and advocacy at multiple levels, the Working Group works collectively to ensure women’s experiences and analyses are at the center of domestic and international policy-making and legal developments.

To comment on this briefing paper or to find out more about the Women and ESCR Working Group, please contact [wescr@escr-net.org](mailto:wescr@escr-net.org) or visit <https://www.escr-net.org/women>



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