



**Submission for the CEDAW Committee's  
Half Day of General Discussion on Rural Women**

I. Introduction and Background

The Center for Reproductive Rights (“CRR”), an international human rights organization dedicated to the advancement of reproductive freedom worldwide, submits this paper to the Committee on the Elimination of Discrimination against Women (“CEDAW Committee”), calling attention to the barriers that rural women face in exercising their reproductive rights, for its upcoming half-day of general discussion on rural women.

The exercise of reproductive rights, including the rights to life, to health, to decide freely on the number and spacing of one’s children, to privacy and confidentiality, to access information and exercise informed consent, and to be free from violence against women and torture or ill- treatment, is essential to ensuring that rural women can achieve substantive equality and overcome discrimination. Too often, however, women, particularly marginalized women, face restrictions, in law and in practice, on the exercise of their reproductive rights. State failure to take positive measures to ensure access to reproductive health services and to prevent and punish human rights violations contributes to the barriers women face in exercising their reproductive rights. Because reproductive health services are services that are essential to women’s health, life, autonomy, dignity and equality, and are also services that primarily women need, it is incumbent on states to ensure access to the full range of these services in order to respect, protect, and fulfill women’s human rights.

Rural women make up a substantial part of the world’s population but are disproportionately affected by a lack of realization of human rights.<sup>1</sup> For instance, according to the UN Secretary General in the lead-up to the 56th session of the Commission on the Status of Women, there are “serious urban/rural discrepancies as a result of poor service delivery in rural areas and rural underdevelopment,” which include higher rates of poverty.<sup>2</sup> Rural women also report more physical abuse than urban women, with more difficulty accessing police or other services because of their geographic location.<sup>3</sup> Rural girls in particular face more significant pressure to submit to harmful traditional practices, such as early and forced marriage and early pregnancy, which put their rights at risk.<sup>4</sup>

The barriers that all women face in exercising their reproductive rights are compounded for rural women who may experience multiple layers of discrimination that result in additional obstacles and marginalization. Studies have found that only 35 percent of rural women in Africa and developing parts of Asia have physical access to needed reproductive health services.<sup>5</sup> The additional barriers that account for this disparity include lack of nearby health facilities, lack of affordability of services, discrimination within traditional families and societies, and the disproportionate impact of legal restrictions on accessing reproductive health services. Rural women are also a very diverse group and include women with disabilities, women with HIV, women from minority and indigenous groups, women living in poverty, as well as adolescent girls, all of whom have unique experiences of discrimination which are compounded by their rural status.

As this submission illustrates, although women across the world face barriers or encounter abuse when accessing reproductive health services, rural women often experience violations of reproductive rights more

acutely than other women. This submission first outlines the scope of states' legal obligations to respect, protect, and fulfill rural women's reproductive rights, based on the rights to non-discrimination and substantive equality. Second, the submission examines specific areas of concern for the reproductive health and rights of rural women, including access to contraception and abortion. Finally, the submission provides a short list of recommendations to states as they seek to ensure rural women's reproductive rights under the Convention on the Elimination of Discrimination against Women ("CEDAW Convention").

## II. Nature and Scope of Key State Obligations Regarding the Reproductive Rights of Rural Women

### A. Non-Discrimination and Substantive Equality

Reproductive rights lie at the heart of human rights for women, as they are essential to ensuring women's self-determination and to achieving substantive as well as formal equality. Under Article 1 of the CEDAW Convention, states are obligated to ensure that, when combating gender discrimination, they tackle laws or policies that have either the purpose of negating a woman's rights or the effect of doing so.<sup>6</sup> According to Article 2 of the CEDAW Convention, states parties must "condemn discrimination against women in all of its forms."<sup>7</sup> As part of the requirement to end discrimination, the CEDAW Convention also calls on states to ensure the "equality of men and women" in all realms of life, including in legislation, education, employment, health care, social life, and marriage and family life.<sup>8</sup>

As the CEDAW Committee has noted, discrimination against women includes both direct discrimination, which encompasses laws and policies that make unjustified distinctions based on gender that disadvantage women in the exercise of their rights, and indirect discrimination, which encompasses laws, policies, and practices (or the lack thereof) that are ostensibly gender neutral but result in a disparate impact on women, or particular groups of women.<sup>9</sup> The CEDAW Committee has recognized that equality in fact, or substantive equality, is required to adequately address historic and systemic discrimination against women.<sup>10</sup> Formal models of equality regard women and men as the same and require laws to be formulated in a gender-blind manner.<sup>11</sup> Substantive equality on the other hand is less concerned with equal treatment and focuses on equal access and equal benefits.<sup>12</sup> Substantive equality requires that states are accountable not only for the measures they have taken, but also for the effectiveness of those measures in improving women's equality in fact.<sup>13</sup> It also requires states to take positive measures, including allocation of resources, which eliminate conditions that perpetuate discrimination,<sup>14</sup> to take proactive measures which seek to transform the context that gave rise to the violation in the first place, and to provide access to effective remedies to realize women's human rights.<sup>15</sup>

### B. Right to Health

The CEDAW Convention obligates states to ensure that women are free from discrimination and can achieve substantive equality in exercising the right to health. The right to health is broadly defined in the International Covenant on Economic, Social, and Cultural Rights ("ICESCR"), which recognizes the right "of everyone to the highest attainable standard of physical and mental health."<sup>16</sup> As the CEDAW Convention outlines, this includes reproductive health care, in which states are obligated to "ensure, on the basis of equality of men and women, access to health care services, including those related to family planning."<sup>17</sup> As the CEDAW Committee noted in its General Recommendation No. 24, women have reproductive health needs that men do not, due to their different reproductive capacities,<sup>18</sup> making the provision of these services essential for ensuring comparable outcomes and thus also substantive equality.

The CEDAW Committee has found in its General Recommendation No. 24 that, in order to achieve non-discrimination and substantive equality, states must ensure that their health systems have services "to prevent, detect and treat illnesses specific to women."<sup>19</sup> Further, the CEDAW Committee has stated that "[i]t is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women."<sup>20</sup>

The CEDAW Convention recognizes the particular vulnerability of rural women to discrimination in the right to health, including in the area of reproductive health. Article 14 of the Convention requires that states take into account the particular barriers that rural women face in exercising their rights and calls on states to take proactive measures to ensure that rural women “have access to adequate health care facilities, including information, counseling and services in family planning.”<sup>21</sup>

### C. Reproductive Self-Determination

Self-determination is one of the core principles underscoring women’s rights, particularly realization of reproductive rights. In order to enable self-determination in the exercise of reproductive rights, states must work to ensure that women have the freedom to make informed decisions about all aspects of their lives. As such, achieving self-determination for women requires states to ensure the right to non-discriminatory exercise of legal capacity<sup>22</sup> so that women can make important life decisions, including decisions with legal effect, for themselves. Additionally, the right to decide on the number and spacing of children<sup>23</sup> is particularly important to self-determination in a number of spheres because, as the CEDAW Committee has noted, it affects a woman’s access to education and employment, as well as physical and mental health, and determines whether a woman carries an inequitable burden of uncompensated work.<sup>24</sup> At the same time, the rights to physical integrity and to be free from violence, including torture and ill-treatment,<sup>25</sup> are central to women’s decision-making power. Finally, the right to physical integrity<sup>26</sup> guarantees that women are not forced to undergo pregnancy or childbirth, matters with significant implications for their bodies and personal liberty, and the right to privacy ensures that women can make decisions free from undue influence, including by requiring medical confidentiality.<sup>27</sup>

Substantive equality is a necessary precondition to women’s ability to exercise self-determination, particularly in relation to sexual and reproductive healthcare decisions. As the CEDAW Committee has noted in its General Recommendation No. 28, “[i]nherent to the principle of equality between men and women, or gender equality, is the concept that all human beings, regardless of sex, are free to develop their personal abilities, pursue their professional careers and *make choices without the limitations set by stereotypes, rigid gender roles and prejudices.*”<sup>28</sup>

### III. Specific Areas of Concern in Access to Reproductive Health Information and Services for Rural Women

Access to reproductive health information and services is essential for ensuring women’s substantive equality, including in areas that affect their reproductive rights. Rural women, however, face particular barriers to accessing reproductive health services that put their health and lives at risk. Because of these barriers to accessing services, rural women experience higher rates of maternal mortality and morbidity, are less likely to access needed contraception, and face a greater risk of unsafe abortion.<sup>29</sup> Further, rural women are disproportionately impacted by laws that restrict access to reproductive health services for all women, including third-party authorization requirements, waiting periods, and criminalization of abortion.<sup>30</sup>

This section describes some of the general barriers that rural women face in accessing reproductive health services, as well as particular issues in accessing contraception and abortion, and provides examples of where countries have fallen short on ensuring the full range of reproductive rights for rural women. This section also describes some legal restrictions that are commonly placed on reproductive health services and how those restrictions disproportionately affect rural women.

#### A. General Barriers to Accessing Reproductive Health Information and Services

As noted above, rural women are more likely to experience poverty and less likely to have formal education or paid employment, while many also face language barriers, which can result in multiple impediments to

accessing reproductive health services. These barriers include the distance of health providers from their communities, which may require women to travel long distances, as well as access to transportation to get to services.<sup>31</sup> Costs associated with traveling long distances to services, such as loss of income, transportation, or accommodation costs, can also disproportionately limit rural women's access to reproductive health services, as rural women are more likely to live in poverty.<sup>32</sup> Further, the disparate geographical access to health services means that women may not have another provider or health facility that they can turn to for reproductive health services if their closest provider does not have access to the proper or appropriate medicines or tools or if the provider refuses to administer certain reproductive health services such as in instances of conscientious objection.<sup>33</sup>

Physical accessibility can be a particular issue for rural women. Rural women in Uganda report at two times the rate of their urban counterparts that their unmet need for contraceptives results from lack of access to family planning services and information.<sup>34</sup> Official statistics from rural, post-conflict northern Uganda indicate that, in one district, only one-fourth of the population lives within five kilometers of a health center, while only 40 to 60 percent of women in the other two main districts were able to access health services.<sup>35</sup> In rural Mali, more than 80 percent of women and girls live more than 30 kilometers from the nearest health center.<sup>36</sup>

Rural women from minority groups may face additional barriers to accessing reproductive health services, due to discrimination and social exclusion. For example, Romani women face discrimination in accessing social services such as social registration. In many states, social registration in the state or city where one lives is a pre-requisite to accessing other social services, including state-provided health information and services. This places Romani women who need to access reproductive health services at a particular disadvantage.<sup>37</sup>

Barriers to accessing reproductive health services have a negative impact on rural women's health, leading to persistent problems that to date states have failed to address, such as high rates of maternal mortality. States pledged through the Millennium Development Goals ("MDGs"), specifically MDG5, to lower maternal mortality by 75 percent by 2015 but have mostly failed to do so.<sup>38</sup> The failure to achieve MDG5 is largely due to inequalities, including disparities between rural and urban women. For instance, rural women are less likely to have access to skilled birth attendants<sup>39</sup> or to be able to reach hospitals in cases of complications, due to poor road infrastructure and transportation to often distant medical facilities.<sup>40</sup> This can be a particular problem for rural adolescent girls and young women. For instance, in India, rural women are twice as likely as urban women to have had their first child before age 18,<sup>41</sup> a situation that places them at greater risk of pregnancy complications.<sup>42</sup> Moreover, access to antenatal care in India is significantly worse in rural areas, with less than half of women aged 15-24 receiving proper care,<sup>43</sup> thus putting their health and lives at risk.

Access to reproductive health information can be especially difficult for rural women but is essential to ensuring their reproductive self-determination, and thus also their substantive equality. The CEDAW Committee in its General Recommendation No. 21 has recognized the importance of adequate access to information and sexuality education to support women's reproductive decision-making.<sup>44</sup> For adolescents, international human rights bodies have found that reproductive health information is essential and that, in order to realize their right to health, adolescents have the right to confidential, universal access to sexual and reproductive health services that enable them to make free and responsible decisions in accordance with their evolving capacities.<sup>45</sup> The Special Rapporteur on Torture has outlined the importance of access to information, stating that "[a]ccess to information about reproductive health is imperative to a woman's ability to exercise reproductive autonomy, and the rights to health and to physical integrity."<sup>46</sup>

In many countries, rural women, particularly from other marginalized groups, lack the information they need to make reproductive health decisions. Girls who are subjected to early marriage, which in many countries is more common in rural areas,<sup>47</sup> may be more at risk for HIV infection but are less likely to have access to information about how to avoid HIV.<sup>48</sup> According to a UN Inter-Agency Report on Rural Women and the

MDGs, young women in rural areas are almost always less likely to know about methods to prevent transmission of sexually-transmitted diseases or to use condoms.<sup>49</sup> In India, only 6.8 percent of women in rural areas know about the uses for emergency contraception (compared with 11.3 percent in urban areas).<sup>50</sup>

## B. Access to Contraceptive Information and Services

International human rights standards require that, as part of their core obligations to fulfill the right to health and eradicate discrimination against women, states must provide access to essential medicines, as defined on the WHO Model List of Essential Medicines.<sup>51</sup> This list contains many forms of modern contraception, including emergency contraception.<sup>52</sup> The CEDAW Committee has also acknowledged that states have an obligation to provide access to affordable family planning services in order to promote a woman's reproductive self-determination and equality.<sup>53</sup> However, women in rural areas worldwide, as well as women who are poor or who have low levels of education, have a higher unmet need for contraceptives than women in urban areas.<sup>54</sup> A survey of 22 countries in sub-Saharan Africa revealed that rural women, poor women, and women with limited schooling were up to four times less likely than other women to use contraceptives to avoid or delay pregnancy.<sup>55</sup>

Rural women have some of the highest unmet need for contraceptives because they face the greatest barriers to accessing and effectively using modern contraceptives.<sup>56</sup> As described above, one of the most significant barriers for rural women in accessing contraceptives is the lack of physical accessibility of health facilities near their homes. This lack of physical accessibility may combine with other barriers to further limit rural women's access to effective contraception.

For instance, rural women who live far from health facilities may prefer longer-term methods of contraception in order to reduce the amount they need to travel, but because of shortages or ill-equipped facilities those methods are not always available. In rural areas of Nigeria, where women have to travel long distances to the nearest health care facility, rural women report that they prefer to receive contraceptive injections, which will last for several months, but clinics often face shortages of these injections.<sup>57</sup> In Nepal, where more than 80 percent of the population lives in rural areas, rural women have limited contraceptive choices,<sup>58</sup> particularly for long term methods,<sup>59</sup> while transportation issues during the rainy season lead to shortages in supplies.<sup>60</sup>

Discrimination against women in their families and stigma associated with reproductive health services have also created barriers that lead to an unmet need for contraceptives in rural areas. A women's health advocate in Uganda reported to CRR that many rural women in Uganda cannot access family planning services because of fear that their husbands will subject them to abuse.<sup>61</sup> Stigma surrounding contraceptive services for rural women in some countries stems from the strong influence of the Catholic Church hierarchy, which condemns the use of contraceptives. CRR found that some doctors in Slovakia, who in rural areas may be the only providers in the area, invoke conscientious objection when asked to provide a contraceptive prescription based on Catholic beliefs, giving women little recourse to other providers because there are no others available in their communities.<sup>62</sup> Rural women may also feel more uncomfortable going to providers for contraceptives because of fears that, in a small community, confidentiality may be breached.<sup>63</sup> An advocate for women's health issues in rural Slovakia reported to CRR that girls in rural areas have a harder time admitting that they use or would like to use contraceptives, because the strong influence of religion means that sexual activity before marriage is stigmatized.<sup>64</sup>

As noted above, rural women are also more likely to be subjected to physical abuse, including sexual violence, a situation that makes access to emergency contraception particularly imperative. The CEDAW Committee has stated that States should ensure women and girls affordable and timely access to emergency contraception.<sup>65</sup> The Committee against Torture has also found that denying victims of rape access to emergency contraception could amount to torture or cruel, inhuman or degrading treatment.<sup>66</sup>

In some countries, rural women have been offered sterilization without adequate information about or access to other forms of contraception. In India, the most widely used form of contraception is female sterilization,<sup>67</sup> a situation compounded by poverty and caste. There have been reports of mass sterilizations in rural areas of impoverished states in India, such as Bihar.<sup>68</sup> Members of the Romani minority, many of whom live in rural areas and often in informal settlements, have been sterilized without free and informed consent in at least three countries in Europe: the Czech Republic, Hungary, and Slovakia.<sup>69</sup> For many Romani women, sterilization occurred during cesarean sections without prior discussion, or consent to sterilization was sought during labor without fully explaining the procedure or offering any alternatives.<sup>70</sup> The CEDAW Committee has found that forced or coerced sterilization, where a woman is denied informed consent to a procedure that may permanently deprive her of reproductive capacity, “adversely affects women’s physical and mental health, and infringes the right of women to decide on the number and spacing of their children.”<sup>71</sup>

The CEDAW Committee has specified in its General Recommendation No. 24 that, in order for a state to meet its obligation to ensure acceptable health services for women, those services must be “delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.”<sup>72</sup> The CEDAW Committee has in particular highlighted the importance of health confidentiality and how breaches of confidentiality disproportionately affect women:

While lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases where they have suffered sexual or physical violence.<sup>73</sup>

Both the CEDAW Committee and the ESCR Committee have identified many of the barriers that rural women face in accessing reproductive health services and called on states to address those barriers. The ESCR Committee has commented on the barriers that place the largest burden on rural women’s access to contraceptives by calling on states to remove fees for services, fund free access to contraceptives, ensure information accessibility by raising public awareness, and provide sexuality education.<sup>74</sup> The CEDAW Committee has further called on states to remove sociocultural barriers to rural women’s access to reproductive health services.<sup>75</sup>

As these provisions indicate, in order for states to meet their obligations to facilitate rural women’s access to contraception, they must take positive measures, including through increased allocation of resources, to address the particular concerns that rural women face, including physical and financial barriers to access, barriers to providing free and informed consent, breaches of confidentiality, and stigma associated with reproductive health services.

### C. Access to Abortion Information and Services

Rural women in many countries face unique barriers that make them disproportionately unable to access safe abortion services.<sup>76</sup> In addition to the many general barriers to accessing reproductive health services outlined above, rural women may be unable to access abortion services at their primary health center due to providers’ lack of accurate information about legal abortion, lack of necessary equipment to safely induce abortion, or providers’ refusal to provide abortion services, based on conscientious objection or fear of stigma and harassment.<sup>77</sup> When rural women cannot access abortion care at their local health facility, they are forced to travel farther than their urban counterparts to access another facility.<sup>78</sup> Further, because health care services in rural communities are frequently provided by community members, women may be deterred from seeking such abortion services from local providers due to concerns about confidentiality, particularly in light of stigma surrounding abortion, a problem the CEDAW Committee has recognized in its General Recommendation No. 24.<sup>79</sup>

As the World Health Organization (“WHO”) has made clear, when women cannot access abortion services, they may seek out clandestine, unsafe abortions that can result in elevated levels of maternal mortality and morbidity.<sup>80</sup> In many countries, due to lack of access to trained providers and the fact that they live in poverty, rural women are more likely to either seek abortion services from untrained providers, such as traditional healers, lay practitioners, or pharmacists, or induce abortion themselves.<sup>81</sup> As hormonal drugs that can induce abortion may be less accessible in rural areas, providers may instead use herbs or sharp objects to induce abortion, which can be far more dangerous.<sup>82</sup>

Treaty monitoring bodies have repeatedly addressed rural women’s lack of access to abortion services, linking it to elevated rates of unsafe, clandestine abortion and maternal mortality.<sup>83</sup> The CEDAW Committee has urged states to guarantee rural women effective access to sexual and reproductive health services to prevent women from resorting to unsafe abortion.<sup>84</sup> As noted above, rural women and girls face a heightened risk of physical abuse, including sexual violence, a situation in which it is critical that, where pregnancy results, they have access to safe, legal abortion services. Treaty monitoring bodies, including the CEDAW Committee, ESCR Committee, Committee against Torture, and Human Rights Committee, agree that abortion should be legal where pregnancy results from sexual violence.<sup>85</sup>

Further, regional and international human rights bodies have made clear that where abortion is legal, states have an obligation to ensure that it is accessible.<sup>86</sup> In the case of *LC v. Peru*, the CEDAW Committee determined that the state’s failure to ensure an adolescent access to legal abortion services, even though abortion was legal in cases in which a pregnancy placed a woman’s health at risk and L.C.’s pregnancy posed serious risks to her health, violated the right to health, the right to be free from sex roles and stereotyping,<sup>87</sup> the right to be free from discrimination,<sup>88</sup> and the right to a remedy.<sup>89</sup> In *KL v. Peru*, the Human Rights Committee found that compelling a pregnant adolescent to carry a fetus with a fatal fetal anomaly to term, in spite of the risk that it posed to her health, amounted to cruel, inhuman and degrading treatment.<sup>90</sup>

Domestic courts have also taken measures to realize the right to access legal abortion services for rural women. For example, in the case of *Lakshmi Dhikta v. Nepal*, Nepal’s Supreme Court addressed the state’s failure to ensure a poor, rural woman access to legal abortion services, finding that the right to equality requires the state to ensure that abortion services are affordable and accessible for all women.<sup>91</sup> The court further noted that individuals must have information about their rights in order to exercise them.<sup>92</sup> In particular, the Supreme Court called on the government to introduce a comprehensive abortion law, expand and decentralize abortion services, establish a government fund to cover abortions, and launch an awareness program to educate the public about abortion rights, all with the aim of increasing accessibility and availability of this essential reproductive health service.<sup>93</sup>

#### D. Disproportionate Impact on Rural Women of Legal Restrictions on Reproductive Health Services

Despite international human rights norms recognizing women’s right to comprehensive sexual and reproductive health services and states’ affirmative duties to ensure that such services are accessible in practice, including in the CEDAW Committee’s General Recommendation No. 24,<sup>94</sup> a number of states nonetheless impose discriminatory restrictions on women’s access to these services. Such restrictions include third-party authorization requirements, such as judicial, parental, spousal or medical commission authorizations; waiting periods; and restrictive abortion laws. These legal restrictions have a further disproportionate effect on rural women, as they compound the already substantial time and other resources that rural women must expend to access reproductive health services.<sup>95</sup>

## 1. Third Party Authorization

A number of states across the globe require third-party authorizations – such as spousal, parental, judicial or medical authorizations – for women to access particular sexual and reproductive health services.<sup>96</sup> In addition to being inherently discriminatory, as they deprive women and adolescents of their right to autonomous decision-making, they also disproportionately affect rural women for a variety of reasons.

Spousal and parental authorization requirements may prevent or deter women and adolescents from accessing reproductive health services, as they may not want to disclose that they are seeking such services to their parent or spouse due to the stigma surrounding sexual and reproductive health services or fear of abuse.<sup>97</sup> The distance that rural women must travel to access sexual and reproductive health services can make complying with parental or spousal authorization requirements particularly cumbersome, as these requirements can compel both the woman seeking services and her spouse or her parent to expend significant time and resources traveling to the requisite health center for such services. Furthermore, recognizing that early and forced marriage is more common in rural areas,<sup>98</sup> spousal authorizations are particularly detrimental to married adolescents, who are frequently under intense pressure to prove their fertility and bear children.<sup>99</sup> As a result, married adolescents who decide to terminate a pregnancy may not want to disclose this to their husbands, out of fear of being compelled to carry the pregnancy to term.

Judicial authorization requirements can appear either as an alternative to parental authorization, wherein the adolescent obtains permission from a judge in lieu of permission from a parent or guardian,<sup>100</sup> or under restrictive abortion laws that permit abortion in instances of rape. In the latter case, the woman may be required to demonstrate within particular evidentiary parameters that she was the victim of sexual violence.<sup>101</sup> Rural women's disparate geographical access to courts can hinder their ability to seek judicial authorization, due to both the time and money required to travel to where the judiciary is located.<sup>102</sup> Further, many rural women have never interacted with formal judicial mechanisms,<sup>103</sup> and the prospect of doing so may be insurmountably daunting under such circumstances, particularly in light of the stigma surrounding both abortion and rape.

Medical authorizations require women to receive approval from either multiple doctors or a formal hospital commission prior to accessing legal abortion services under particular circumstances.<sup>104</sup> Women in rural areas may face particular difficulty obtaining authorization from multiple health service providers as health clinics may be smaller and therefore not employ multiple staff members with the authority to make such a determination. Traveling to a different facility or a larger health clinic in order to obtain permission delays women's access to critical healthcare and may not be a possibility due to the costs and time required.

The CEDAW Committee, the WHO, and other treaty monitoring bodies have made clear that women should not be required to obtain permission or authorization from third parties – including from parents, spouses, judicial figures, or medical authorities – in order to obtain sexual and reproductive health services.<sup>105</sup> As the CEDAW Committee noted in its General Recommendation No. 24, “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.”<sup>106</sup> Such requirements can deter women from seeking care and delay women from accessing care, thereby posing a serious threat to their lives and health.<sup>107</sup>

## 2. Waiting Periods

The CEDAW Committee has reinforced that, in order for states to guarantee accessibility of health services for women, they should not force women to comply with medically-unnecessary waiting periods.<sup>108</sup> The WHO has further noted that mandatory waiting periods demean women's decision-making capacity, delay care, and jeopardize women's access to abortion services.<sup>109</sup> However, a number of states require women seeking abortion services to wait a certain number of days between their initial consultations and when they



can terminate their pregnancies. For example, in Russia, depending on the pregnancy's gestation, women must wait a minimum of either two or seven days between the time they request the termination and when it can be performed.<sup>110</sup> These waiting periods require women to make two visits to the health center, which may be particularly burdensome for rural women traveling to health facilities. One study on mandatory waiting periods found that women in U.S. states with 24-hour waiting periods were also more likely to travel greater distances to access abortion services as compared to women in other states.<sup>111</sup> This demonstrates that in some places where waiting periods are in place, states may also be unwilling to ensure that health facilities providing abortion services are geographically accessible, thereby compounding the effects of the waiting period.

### 3. Laws restricting legal abortion services

As the WHO recognizes, laws restricting the circumstances under which women can access legal abortion services do not reduce the incidence of abortion.<sup>112</sup> In some instances, laws that restrict access to abortion compel women to seek unsafe, clandestine procedures, while other women may seek abortion services abroad in a state with a less restrictive abortion law. Traveling abroad to terminate a pregnancy requires significant amounts of time and money and this requirement is amplified for rural women. The CEDAW Committee has outlined that, as part of a state's obligation to ensure that health services are accessible to women, measures to end discrimination against women in health must work to "prevent, detect, and treat illnesses specific to women" and that "[i]t is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."<sup>113</sup> Further, treaty monitoring bodies have expressed concern about women being forced to travel abroad to access abortion services,<sup>114</sup> and the CEDAW Committee has noted that this creates hardship for marginalized groups.<sup>115</sup>

## IV. Conclusions and Recommendations

The realization of reproductive rights is essential to ensuring the equality and well-being of rural women, including their rights to life, to health, to decide freely on the number and spacing of one's children, to privacy and confidentiality, to access information and exercise informed consent, and to be free from violence against women and torture or ill-treatment. Although all women face barriers to accessing reproductive health services, rural women's access is further hindered by their remote geographic location, higher levels of poverty, and stereotypes related to women's traditional reproductive and caretaking roles. In order to achieve substantive equality for rural women in the context of reproductive health, states must take positive measures to address these disparities, ensuring rural women's access to health services and information as well as their autonomy and privacy in obtaining those services.

To ensure the full realization of reproductive rights for rural women, CRR suggests the following recommendations to the CEDAW Committee to include in its guidelines for states:

- States should uphold rural women's right to health and support women's reproductive self-determination by ensuring that reproductive health services are *physically accessible*, including by providing a sufficient number of medical facilities or mobile clinics that are trained to provide reproductive health services near rural communities, as well as transportation options for women.
- States should also refrain from imposing burdensome requirements on access to these services, including waiting periods or third-party authorization requirements.
- States should take proactive measures to ensure that reproductive health services are *affordable*, including by eliminating user fees and covering reproductive health services under national health insurance schemes.
- States should guarantee an *adequate supply* of reproductive health services in rural areas, including by taking all reasonable measures to avoid shortages of medication and trained health personnel. In particular, states should ensure that a range of modern contraception is available to rural women, so that they can exercise full reproductive self-determination.

- States should take special measures in line with their obligations to ensure substantive equality for women to provide reproductive health services to rural women with ***cultural sensitivity and guarantees of confidentiality***, including information and services in forums to which rural women have access and in ways they can understand, with particular regard to marginalized groups of rural women.
- States should support the self-determination of rural women by ensuring that all forms of reproductive health care, including abortion, are ***legal and accessible*** for rural women. This includes removing third-party authorization requirements, such as spousal, parental, judicial, and medical authorizations, which undermine women's decision-making autonomy and pose particular barriers to accessing services for rural women. It also includes eliminating mandatory waiting periods for individuals seeking abortion services, in order to ensure that rural women are not disproportionately burdened by unnecessary restrictions on their access to reproductive health services.
- States should guarantee rural women's right to non-discrimination and substantive equality by ***actively combating negative stereotypes of women and harmful cultural practices***, such as early and forced marriage, that may be prevalent in rural communities and which place further barriers in the way of rural women's access to reproductive health services.

<sup>1</sup> U.N. Secretary-General, *Improvement of the situation of women in rural areas, Rep. of the Secretary General*, paras. 2-4, U.N. Doc. A/62/202 (2007).

<sup>2</sup> U.N. Secretary-General, *The empowerment of rural women and their role in poverty and hunger eradication, development and current challenge: Rep. of the Secretary-General*, paras. 5-7, U.N. Doc. E/CN.6/2012/3 (2011) [hereinafter U.N. Secretary-General, *The empowerment of rural women* (2011)].

<sup>3</sup> INTER-AGENCY TASK FORCE ON RURAL WOMEN, RURAL WOMEN AND MILLENNIUM DEVELOPMENT GOALS REPORT 5 (2010) [hereinafter INTER-AGENCY TASK FORCE ON RURAL WOMEN REPORT (2010)].

<sup>4</sup> U.N. Secretary-General, *The empowerment of rural women* (2011), *supra* note 2, para. 12.

<sup>5</sup> WORLD HEALTH ORGANIZATION (WHO), UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2008, at 7 (6<sup>th</sup> ed. 2011), available at [http://whqlibdoc.who.int/publications/2011/9789241501118\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf).

<sup>6</sup> Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 1, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

<sup>7</sup> *Id.* Art. 2.

<sup>8</sup> *Id.* Arts. 1, 2, 10-14 & 16.

<sup>9</sup> *Id.* Art. 1; CEDAW Committee, *General Recommendation No. 28: The core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, (47<sup>th</sup> Sess., 2010), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 16, U.N. Doc. CEDAW/C/GC/28 (2010) [hereinafter CEDAW Committee, *Gen. Recommendation No. 28*].

<sup>10</sup> CEDAW Committee, *General Recommendation No. 25: Article 4, paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures*, (30<sup>th</sup> Sess., 2004), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, paras. 5 & 8, U.N. Doc. HRI/GEN/1/Rev.7 (2004) [hereinafter CEDAW Committee, *Gen. Recommendation No. 25*].

<sup>11</sup> *Id.* paras. 6-8.

<sup>12</sup> *Id.* para. 8.

<sup>13</sup> *Id.* para. 9.

<sup>14</sup> CEDAW, *supra* note 6, Art. 4; CEDAW Committee, *Gen. Recommendation No. 25*, *supra* note 10, para. 15; CEDAW Committee, *Gen. Recommendation No. 28*, *supra* note 9, para. 37(d).

<sup>15</sup> CEDAW Committee, *Gen. Recommendation No. 25*, *supra* note 10, paras. 10 & 14.

<sup>16</sup> International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 12, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976).

<sup>17</sup> CEDAW, *supra* note 6, Art. 12 (1).

<sup>18</sup> CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20<sup>th</sup> Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 12(a) U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

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<sup>19</sup> *Id.* para. 11.

<sup>20</sup> *Id.*

<sup>21</sup> CEDAW, *supra* note 6, Arts. 14(1) & 14(2)(b).

<sup>22</sup> *Id.* Art. 15.

<sup>23</sup> *Id.* Art. 16.

<sup>24</sup> CEDAW Committee, *General Recommendation No. 21: Equality in marriage and family relations*, (13th Sess., 1994), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 21 U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 21*].

<sup>25</sup> International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, Art. 7, G.A. Res. 2200A (XXI), U.N. GAOR, 21<sup>st</sup> Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *adopted* Dec. 10, 1984, Arts. 1 & 16, G.A. Res. 39/46, U.N. GAOR, 39<sup>th</sup> Sess., Supp. No. 51, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (*entered into force* June 26, 1987); CEDAW Committee, *General Recommendation No. 19: Violence against women*, (11th Sess., 1992), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 19*].

<sup>26</sup> The right to physical integrity is given formal recognition in treaty provisions protecting the right to respect for human dignity and the rights to liberty and security of the person. The right to physical integrity is also explicitly protected in article 4 of the African Charter of Human and Peoples' Rights (Banjul Charter) and article 5(1) of the American Convention on Human Rights.

<sup>27</sup> See CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 18, para.12(d).

<sup>28</sup> CEDAW Committee, *Gen. Recommendation No. 28*, *supra* note 9, para. 22 (emphasis added).

<sup>29</sup> See Sections B and C below.

<sup>30</sup> See Section D below.

<sup>31</sup> See, *i.e.*, U.N. Secretary-General, *The empowerment of rural women* (2011), *supra* note 2, para. 9.

<sup>32</sup> See EUROPEAN MONITORING CENTRE ON RACISM AND XENOPHOBIA, COUNCIL OF EUROPE, *BREAKING THE BARRIERS- ROMANI WOMEN AND ACCESS TO PUBLIC HEALTH CARE 17* (2003) (describing that Roma women throughout Europe face barriers to accessing gynecological services because of transportation issues from their rural communities) [hereinafter COUNCIL OF EUROPE, *BREAKING THE BARRIERS- ROMANI WOMEN AND ACCESS TO PUBLIC HEALTH CARE* (2003)].

<sup>33</sup> See CENTER FOR REPRODUCTIVE RIGHTS ET AL., *CALCULATED INJUSTICE: THE SLOVAK REPUBLIC'S FAILURE TO ENSURE ACCESS TO CONTRACEPTIVES 33* (2011) [hereinafter *CALCULATED INJUSTICE*].

<sup>34</sup> *Contraception and Unintended Pregnancy in Uganda*, GUTTMACHER INSTITUTE, Jan, 2013, available at <http://www.guttmacher.org/pubs/FB-Contraception-and-unintended-pregnancy-in-Uganda.html> (last visited Sept. 13, 2013).

<sup>35</sup> UNOCHA, *Acholi Sub-Region, Health Accessibility within 5 Km Radius*, June 2010, available at <http://reliefweb.int/sites/reliefweb.int/files/resources/91C4315CDED062EEC125774C00364CA8-map.pdf>.

<sup>36</sup> GORDON BROWN, *EDUCATION FOR ALL CAMPAIGN, OUT OF WEDLOCK, INTO SCHOOL: COMBATING CHILD MARRIAGE THROUGH EDUCATION 17* (2012), available at <http://educationenvoy.org/Child-Marriage.pdf>.

<sup>37</sup> COUNCIL OF EUROPE, *BREAKING THE BARRIERS- ROMANI WOMEN AND ACCESS TO PUBLIC HEALTH CARE* (2003), *supra* note 35, at 7.

<sup>38</sup> U.N. Secretary-General, *A life of dignity for all: accelerating progress towards the Millennium Development Goals and advancing the United Nations development agenda beyond 2015*, para. 27, U.N. Doc. A/68/202 (2013).

<sup>39</sup> INTER-AGENCY TASK FORCE ON RURAL WOMEN REPORT (2010), *supra* note 3, at 6; UNFPA, *Messages and Preliminary Findings from the ICPD Beyond 2014 Global Review*, 26 (June 24, 2013), available at [http://icpdbeyond2014.org/uploads/browser/files/initial\\_findings\\_of\\_icpd\\_beyond\\_global\\_survey.pdf](http://icpdbeyond2014.org/uploads/browser/files/initial_findings_of_icpd_beyond_global_survey.pdf)

<sup>40</sup> AFRICA PROGRESS PANEL, *POLICY BRIEF, MATERNAL HEALTH: INVESTING IN THE LIFELINE OF HEALTHY SOCIETIES AND ECONOMIES 9* (2010), available at [http://www.africaprogresspanel.org/files/1412/8523/5171/APP\\_Maternal\\_Health\\_English%20FINAL.pdf](http://www.africaprogresspanel.org/files/1412/8523/5171/APP_Maternal_Health_English%20FINAL.pdf).

<sup>41</sup> GOVERNMENT OF INDIA, *MINISTRY OF HEALTH AND FAMILY WELFARE, INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES, A PROFILE OF YOUTH IN INDIA: NATIONAL FAMILY HEALTH SURVEY (NFHS-3) 2005-06, VOLUME I, 55-58* (2009), available at <http://www.measuredhs.com/pubs/pdf/OD59/OD59.pdf> [hereinafter *NFHS-3*].

<sup>42</sup> World Health Organization (WHO), *Factsheet: Adolescent Pregnancy*, May 2012, available at <http://www.who.int/mediacentre/factsheets/fs364/en/>.

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<sup>43</sup> NFHS-3, *supra* note 42, at 72.

<sup>44</sup> CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 24, para. 22.

<sup>45</sup> See Committee on the Rights of the Child, *General Comment No. 15: The right of the child to the enjoyment of the highest attainable standard of health*, (62<sup>nd</sup> Sess., 2013), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, paras. 31, 69 & 70, U.N. Doc. CRC/C/GC/15 (2013); Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, (33<sup>rd</sup> Sess., 2003), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 1, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).

<sup>46</sup> Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, para. 47, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) (by Juan E. Méndez).

<sup>47</sup> U.N. Secretary-General, *The empowerment of rural women* (2011), *supra* note 2, para. 12.

<sup>48</sup> Chi-Chi Undie, Population Council, *Addressing Sexual Violence and HIV Risk Among Married Adolescent Girls in Rural Nyanza, Kenya*, 19 PROMOTING HEALTH, SAFE, AND PRODUCTIVE TRANSITIONS TO ADULTHOOD 2 (2011), available at [http://www.popcouncil.org/pdfs/TABriefs/19\\_KenyaMarriedAdol.pdf](http://www.popcouncil.org/pdfs/TABriefs/19_KenyaMarriedAdol.pdf).

<sup>49</sup> INTER-AGENCY TASK FORCE ON RURAL WOMEN REPORT (2010), *supra* note 3, at 7-8.

<sup>50</sup> NFHS-3, *supra* note 42, tbl. 3.1 at 29.

<sup>51</sup> Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22<sup>nd</sup> Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 43(d), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*].

<sup>52</sup> WORLD HEALTH ORGANIZATION (WHO), MODEL LIST OF ESSENTIAL MEDICINES (17<sup>th</sup> ed., Mar. 2011), available at [http://www.who.int/selection\\_medicines/committees/expert/17/sixteenth\\_adult\\_list\\_en.pdf](http://www.who.int/selection_medicines/committees/expert/17/sixteenth_adult_list_en.pdf).

<sup>53</sup> CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 24, para. 22; CEDAW Committee, *Concluding Observations: Niger*, paras. 33-34, U.N. Doc. CEDAW/C/NER/CO/2 (2007) (“[The CEDAW Committee] also recommends that programmes and policies be adopted to increase knowledge of and access to affordable contraceptive methods, so that women and men can make informed choices about the number and spacing of children.”).

<sup>54</sup> SUSHEELA SINGH & JACQUELINE E. DARROCH, GUTTMACHER INSTITUTE & UNITED NATIONS POPULATION FUND (UNFPA), ADDING IT UP: COSTS AND BENEFITS OF CONTRACEPTIVE SERVICES, ESTIMATES FOR 2012 17 (2012) [hereinafter SINGH & DARROCH].

<sup>55</sup> UNITED NATIONS SECRETARIAT ET AL., THE MILLENNIUM DEVELOPMENT GOALS REPORT 37 (2010), available at <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20.pdf>.

<sup>56</sup> SINGH & DARROCH, *supra* note 55, at 17.

<sup>57</sup> Jane Dreaper, *Contraception: Rural Nigeria's family-planning challenge*, BBC, July 11, 2012, available at <http://www.bbc.co.uk/news/health-18763614> (last visited Sept. 17, 2013).

<sup>58</sup> Many rural health facilities have shortages of supplies as well as trained personnel. World Health Organization (WHO), *Accelerating Universal Access to Reproductive Health: Nepal 2* (2011), available at [http://www.who.int/reproductivehealth/publications/monitoring/Nepal\\_access\\_rh.pdf](http://www.who.int/reproductivehealth/publications/monitoring/Nepal_access_rh.pdf) [hereinafter WHO, *Accelerating Universal Access to Reproductive Health: Nepal*].

<sup>59</sup> USAID, NEPAL FAMILY PLANNING PROGRAM, UNFPA, REPOSITIONING FAMILY PLANNING: STRATEGIC REVIEW OF THE NEPAL NATIONAL FAMILY PLANNING PROGRAM 47 (2006).

<sup>60</sup> WHO, *Accelerating Universal Access to Reproductive Health: Nepal*, *supra* note 59, at 2.

<sup>61</sup> CENTER FOR REPRODUCTIVE RIGHTS ET AL., THE STAKES ARE HIGH: THE TRAGIC IMPACT OF UNSAFE ABORTION AND INADEQUATE ACCESS TO CONTRACEPTION IN UGANDA 28 (2013).

<sup>62</sup> CALCULATED INJUSTICE, *supra* note 34.

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> CEDAW Committee, *Concluding Observations: Hungary*, para. 31(b), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); Committee on the Rights of the Child, *Concluding Observations: Costa Rica*, para. 64(e), U.N. Doc. CRC/C/CRI/CO/4 (2011).

<sup>66</sup> Committee Against Torture (CAT Committee), *Concluding Observations: Peru*, para.15, U.N. Doc. Doc. CAT/C/PER/CO/5-6 (2013).

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<sup>67</sup> GOVERNMENT OF INDIA, MINISTRY OF HEALTH AND FAMILY WELFARE, INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES, MINISTRY OF HEALTH AND FAMILY WELFARE, DISTRICT LEVEL HOUSEHOLD AND FACILITY SURVEY (DLHS-3) 2007-2008, 116 (2010), available at [http://www.rchiips.org/pdf/INDIA\\_REPORT\\_DLHS-3.pdf](http://www.rchiips.org/pdf/INDIA_REPORT_DLHS-3.pdf).

<sup>68</sup> Dhananjay Mahapatra, *53 Sterilized in Bihar in Two Hours*, TIMES OF INDIA, Apr. 3, 2012, available at [http://articles.timesofindia.indiatimes.com/2012-04-03/india/31280459\\_1\\_sterilization-rural-women-three-women](http://articles.timesofindia.indiatimes.com/2012-04-03/india/31280459_1_sterilization-rural-women-three-women) (last visited Sept. 17, 2013); Manjari Mishra, *Bring 500 for Sterilization, Take Home a Nano*, TIMES OF INDIA, March 17, 2013, available at [http://articles.timesofindia.indiatimes.com/2013-03-17/bhopal/37786782\\_1\\_sterilization-gold-coin-health-department](http://articles.timesofindia.indiatimes.com/2013-03-17/bhopal/37786782_1_sterilization-gold-coin-health-department) (last visited Sept. 17, 2013).

<sup>69</sup> OPEN SOCIETY FOUNDATIONS, AGAINST HER WILL: FORCED AND COERCED STERILIZATION OF WOMEN WORLDWIDE 3 (2011).

<sup>70</sup> *Id.*

<sup>71</sup> CEDAW Committee, *Gen. Recommendation No. 19*, *supra* note 26, para. 21.

<sup>72</sup> CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 18, para. 22.

<sup>73</sup> *Id.* para. 12(d).

<sup>74</sup> CESCR Committee, *Concluding Observations: Kenya*, para. 33, U.N. Doc. E/C.12/KEN/CO/1 (2008).

<sup>75</sup> CEDAW Committee, *Concluding Observations: Togo*, para. 35(b), U.N. Doc. CEDAW/C/TGO/CO/6-7 (2012).

<sup>76</sup> See WOMEN'S HEALTH ASSOCIATION OF VICTORIA, VICTORIAN RURAL WOMEN'S ACCESS TO FAMILY PLANNING SERVICES, SURVEY REPORT 30-31, 56-57, & 65 (2012), available at

[http://www.whg.org.au/uploads/files/147\\_Victorian%20Rural%20Womens%20Access%20to%20Family%20Planning%20Services%20Survey%20Report%20August%202012.pdf](http://www.whg.org.au/uploads/files/147_Victorian%20Rural%20Womens%20Access%20to%20Family%20Planning%20Services%20Survey%20Report%20August%202012.pdf); see also Jennifer Dressler, Nanamma Maughn Judith A. Soon, & Wendy V. Norman, *The Perspective of Rural Physicians Providing Abortion in Canada: Qualitative Findings of the BC Abortion Providers Survey (BCAPS)*, 8 PLOS ONE, 2-3 (2013) (noting that rural abortion providers indicated that lack of facilities were a barrier to the provision of services); see Teddy D. Walker, John Battaglia, Christine Brems, Mark E. Johnson & Laura Weiss Roberts, *Ethical Considerations in Rural Health Care: A Pilot Study of Clinicians in Alaska and New Mexico*, 41 NHI (2005) [hereinafter WALKER ET AL.].

<sup>77</sup> See Wendy V. Norman, Judith A. Soon, Nanamma Maughn, & Jennifer Dressler, *Barriers to Rural Induced Abortion Services in Canada: Findings of the British Columbia Abortion Providers Survey (BCAPS)* 8 PLOS ONE (2013) (noting that rural health facilities reported refusals and resignations by providers to provide abortion services based on stigma and harassment, while no health facilities in urban areas reported such refusals/resignations); see also PARLIAMENTARY ASSEMBLY OF EUROPE, WOMEN'S ACCESS TO LAWFUL MEDICAL CARE: THE PROBLEM OF UNREGULATED USE OF CONSCIENTIOUS OBJECTION (July 20, 2010) (expressing concern that the unregulated use of conscientious objection disproportionately affects certain groups of women, including rural women).

<sup>78</sup> See ELENA PRADA, FLORENCE MIREMBE, FATIMA H. AHMED, ROSE NALWADDA & CHARLES KIGGUNDU, ABORTION AND POSTABORTION CARE IN UGANDA: A REPORT FROM HEALTH CARE PROFESSIONALS AND HEALTH FACILITIES, GUTTMACHER INSTITUTE 28 (2005), available at <http://www.guttmacher.org/pubs/2005/05/28/or17.pdf> ("For instance, the estimated median distance from a woman's home to the nearest health facility offering family planning services is 12 miles, too great a distance for women whose primary mode of transportation is walking. In rural areas, only 39% of the population lives within three miles of a health facility offering family planning services, compared with 99% in urban areas") [hereinafter PRADA ET AL.].

<sup>79</sup> See CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 18, para.12(d) (recognizing that lack of confidentiality in health services may deter women from accessing such services); WALKER ET AL., *supra* note 78, at 1 (Rural clinicians also reported their patients expressed more concern about knowing them in both personal and professional roles, had more concerns over confidentiality, and experienced more embarrassment concerning stigmatizing illnesses").

<sup>80</sup> WORLD HEALTH ORGANIZATION (WHO), SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 17 & 23 (2<sup>nd</sup> ed. 2012), available at [http://www.who.int/reproductivehealth/publications/unsafe\\_abortion/9789241548434/en/index.html](http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/index.html) [hereinafter WHO, SAFE ABORTION (2012)].

<sup>81</sup> See PRADA ET AL., *supra* note 79, at 5 (noting that "Poor women have less access to doctors, especially in rural areas, and are more likely to rely on less safe providers—traditional healers, other lay practitioners and pharmacists—or to induce an abortion themselves"); ELIZABETH WESTLEY, FAMILY CARE INTERNATIONAL, THE SAFE MOTHERHOOD INTER-AGENCY GROUP (IAG), SAVING WOMEN'S LIVES, THE HEALTH IMPACT OF UNSAFE ABORTION 7 (2005) available at [http://www.familycareintl.org/UserFiles/File/pdfs/pub\\_pdfs/gsm20.pdf](http://www.familycareintl.org/UserFiles/File/pdfs/pub_pdfs/gsm20.pdf) (noting that "poor rural women are more likely to use untrained or unskilled providers, and thus to suffer abortion complications").

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<sup>82</sup> See PRADA ET AL., *supra* note 79, at 5, 6 & 26 (“Most nonphysicians in urban areas are thought to use hormonal drugs or rubber catheters, and many in rural areas turn to herbs and sharp objects (such as sticks and hangers)”); (“Hormonal drugs were also mentioned as commonly used by women in urban areas (over one-fifth of respondents); however, no one mentioned them as a favored method by women in rural areas. This is probably due to the lack of access to hormonal drugs in rural areas.”).

<sup>83</sup> See CESCR Committee, *Concluding Observations: Kenya*, para. 33, U.N. Doc. E/C.12/KEN/CO/1 (2008) (“The Committee is concerned about the limited access to sexual and reproductive health services and contraceptives, especially in rural and deprived urban areas, as well as about the high number of unsafe clandestine abortions in the State party. (art. 12) The Committee recommends that the State party ensure affordable access for everyone, including adolescents, to comprehensive family planning services, contraceptives and safe abortion services, especially in rural and deprived urban areas, by eliminating formal and informal user fees for public and private family planning services, adequately funding the free distribution of contraceptives, raising public awareness and strengthening school education on sexual and reproductive health, and decriminalizing abortion in certain situations, including rape and incest”); CEDAW Committee, *Concluding Observations: Brazil*, paras. 126-127, U.N. Doc. A/58/38 (2003) (“The Committee is concerned at the high maternal mortality rate, particularly in the more remote regions where access to health facilities is very limited. The Committee is also concerned at the health condition of women from disadvantaged groups and at the high rate of clandestine abortion and its causes, linked to, among others, poverty, exclusion and a lack of access to information... The Committee recommends that further measures be taken to guarantee effective access of women to health-care information and services, particularly regarding sexual and reproductive health, including young women, women from disadvantaged groups and rural women. Those measures are essential to reduce maternal mortality and to prevent recourse to abortion and protect women from its negative health effects”); *Concluding Observations: Dominican Republic*, para. 309, U.N. Doc. A/59/38 part II (2004) (“The Committee recommends the adoption of measures to ensure that women, especially young women, the disabled and women living in rural areas, have access to information and health services, particularly those relating to sexual and reproductive health and cancer prevention. Such measures are essential in order to reduce the rate of maternal mortality, prevent women from resorting to unsafe abortion and protect women against the negative effects on their health. In this regard, the Committee recommends that the State health services should provide an abortion when the pregnancy is a result of rape or when the mother’s health is in danger.”); *Concluding Observations: Lebanon*, para. 112, U.N. Doc. A/60/38 (2005) (“The Committee urges the Government to strengthen, especially in rural areas, implementation of programmes and policies aimed at providing effective access for women to health-care information and services, in particular regarding reproductive health and affordable contraceptive methods, with aim also of preventing clandestine abortions”); *Concluding Observations: Ethiopia*, para. 35, U.N. Doc. CEDAW/C/ETH/CO/6-7 (2011) (“In line with its previous concluding observations (CEDAW/C/ETH/CO/4-5, para. 258) and its general recommendation No. 24 (1999), the Committee calls on the State party to: (a) Continue training health extension workers on referring women to maternal health-care facilities, including safe abortion services, and further increase the number of health-care facilities providing safe abortion services in rural areas”); see CESCR Committee, *Concluding Observations: Serbia*, para. 33, U.N. Doc. E/C.12/UNK/CO/1 (2008) (The Committee recommends “that adolescents and adults have access to comprehensive sexual and reproductive health services and information, as well as to contraceptives and safe abortion services, including in rural areas.”).

<sup>84</sup> CEDAW Committee, *Concluding Observations: Dominican Republic*, para. 309, U.N. Doc. A/59/38 part II (2004) (“The Committee recommends the adoption of measures to ensure that women, especially young women, the disabled and women living in rural areas, have access to information and health services, particularly those relating to sexual and reproductive health and cancer prevention. Such measures are essential in order to reduce the rate of maternal mortality, prevent women from resorting to unsafe abortion and protect women against the negative effects on their health. In this regard, the Committee recommends that the State health services should provide an abortion when the pregnancy is a result of rape or when the mother’s health is in danger.”); see also CEDAW Committee, *Concluding Observations: Brazil*, paras. 126-127, U.N. Doc. A/58/38 (2003) (“The Committee is concerned at the high maternal mortality rate, particularly in the more remote regions where access to health facilities is very limited. The Committee is also concerned at the health condition of women from disadvantaged groups and at the high rate of clandestine abortion and its causes, linked to, among others, poverty, exclusion and a lack of access to information... The Committee recommends that further measures be taken to guarantee effective access of women to health-care information and services, particularly regarding sexual and reproductive health, including young women, women from disadvantaged groups and rural women. Those measures are essential to reduce maternal mortality and to prevent recourse to abortion and protect women from its negative health effects”).

<sup>85</sup> See *L.C. v. Peru*, CEDAW Committee, Commc’n No. 22/2009, para. 12(b)(iii), U.N. Doc. CEDAW/C/50/D/22/2009 (2011); Human Rights Committee, *Concluding Observations: Dominican Republic*, para. 15, U.N. Doc.

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CCPR/C/DOM/CO/5 (2012); CAT Committee, *Concluding Observations: Peru*, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013); CESCR Committee, *Concluding Observations: Kenya*, para. 33, U.N. Doc. E/C.12/KEN/CO/1 (2008).

<sup>86</sup> L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011); K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); P and S v. Poland, No. 57375/08 Eur. Ct. H.R. (2008); R.R. v. Poland, No. 27617/04 Eur. Ct. H. R. (2011); Tysiąc v. Poland, No. 5410/03 Eur. Ct. H.R., (2007); L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011).

<sup>87</sup> L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15 U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

<sup>88</sup> *Id.* para. 8.17.

<sup>89</sup> *Id.*

<sup>90</sup> K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).

<sup>91</sup> Lakshmi & Others v. Government of Nepal, Writ No. 0757, Jestha, 2066 9-11 (2011) *available at* <http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Lakshmi%20Dhikta%20-%20English%20translation.pdf>.

<sup>92</sup> *Id.* at 10.

<sup>93</sup> *Id.* at 9-11.

<sup>94</sup> *See, e.g.*, CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 18, paras. 1, 13, 17 & 29; ESCR Committee, *Gen. Comment No. 14*, *supra* note 52, para. 14; L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.17 U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

<sup>95</sup> *See* Section IIIA above.

<sup>96</sup> *See, e.g.*, Penal Code, Chapter V, Art. 339(2) (1969) (Cameroon) (requiring the woman to receive a “certificate by the prosecution of a good case” to access abortion services in instances of rape); The Medical Termination of Pregnancy Act 1971 (Act No. 34 of 1971), Art. 3(4) (India) (requiring women under age 18 to obtain parental consent for abortion services); Act LXXIX of 1992 on the protection of fetal life, Art. 12(1) (Hungary) (requiring medical specialists to authorize abortion where pregnancy poses a risk to the woman’s health); *see also State Policies in Brief, An Overview of Minors’ Consent Law*, GUTTMACHER INSTITUTE, Sept. 1, 2013, *available at* [http://www.guttmacher.org/statecenter/spibs/spib\\_OMCL.pdf](http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf) (last visited Sept. 18, 2013); CALCULATED INJUSTICE, *supra* note 34, at 34.

<sup>97</sup> *See, e.g.*, Melanie Zuch, Amanda J. Mason-Jones, Catherine Mathews, & Lesley Henley, *Changes to the law on consent in South Africa: implications for school-based adolescent sexual and reproductive health research*, BMC INTERNATIONAL HEALTH & HUMAN RIGHTS (April 10, 2012) *available at* <http://www.jstor.org/discover/10.2307/25593915?uid=3739832&uid=2129&uid=2&uid=70&uid=4&uid=3739256&sid=21102632486033> (noting that “discussions surrounding sexuality are often shrouded in stigma and parent-child communication with regards to sex and sexuality is often limited. An adolescent therefore may not feel comfortable confronting a parent or guardian about participation in a sexual and reproductive health research study or may face disapproval if he or she chooses to do so”); Derek A. Kreager and Jeremy Staff, *The Sexual Double Standard and Adolescent Peer Acceptance*, SOCIAL PSYCHOLOGY QUARTERLY 143 (2009), *available at* <http://spq.sagepub.com/content/72/2/143.abstract> (exploring the “sexual double standard” wherein boys are praised while girls are stigmatized for engaging in sexual activity); Parental Notification and Consent Laws for Teen Abortions: Overview and 2006 Ballot Measures, MEDSCAPE (Feb. 12, 2007), *available at* <http://www.medscape.com/viewarticle/549316> (noting that a significant portion of minors not revealing their abortion to a parent had experienced or feared violence or feared being forced to leave home).

<sup>98</sup> UNFPA, MARRYING TOO YOUNG, END CHILD MARRIAGE 26 (2012), *available at*

<http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf>.

<sup>99</sup> UNFPA, *From Childhood to Womanhood: Meeting The Sexual and Reproductive Health needs of Adolescent Girls*, 2 (Dec. 2012), *available at* <https://www.unfpa.org/webdav/site/global/shared/factsheets/srh/EN-SRH%20fact%20sheet-Adolescent.pdf>; Nawal M. Nour, *Health Consequences of Child Marriage in Africa*, 12 EMERGING INFECTIOUS DISEASES 1644, 1645 (Nov. 2006) *available at* <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3372345/pdf/06-0510.pdf>.

<sup>100</sup> *See State Policies in Brief, Parental Involvement in Minors’ Abortions*, GUTTMACHER INSTITUTE, Sept. 1, 2013, *available at* [http://www.guttmacher.org/statecenter/spibs/spib\\_PIMA.pdf](http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf) (last visited Sept. 18, 2013).

<sup>101</sup> *See, e.g.*, The Family Planning, Human Embryo Protection and Conditions of Permissibility of Abortion Act of Jan. 7, 1993, as amended as of Dec. 23, Art. 149a§3(4) (Pol.) (requiring women seeking abortion services in instances of

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rape to receive a certificate of authorization from a public prosecutor); Penal Code, Chapter V, Art. 339(2) (1969) (Cameroon) (requiring women woman to receive a “certificate by the prosecution of a good case”).

<sup>102</sup> FOOD AND AGRICULTURE ORGANIZATION (FAO), GENDER AND LAW

WOMEN’S RIGHTS IN AGRICULTURE (2001), *available at* <http://www.fao.org/docrep/005/y4311e/y4311e07.htm> (“rural women’s access to courts may be constrained by geographical inaccessibility, as courts are mainly located in towns and transport costs may be high.”).

<sup>103</sup> WORLD BANK, EMPOWERING WOMEN 126, *available at*

[http://siteresources.worldbank.org/EXTGENDER/Resources/9780821395332\\_ch4.pdf](http://siteresources.worldbank.org/EXTGENDER/Resources/9780821395332_ch4.pdf)

<sup>104</sup> *See, e.g.*, Protection of Life during Pregnancy Act of 2013 (Act No. 35/2013), Art. 9 (Ir.) (requiring confirmation from three medical practitioners to authorize abortion on the grounds of risk of suicide).

<sup>105</sup> CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 18, para. 14; CEDAW Committee, *Concluding Observations: Burkina Faso*, para. 38, U.N. Doc. CEDAW/C/BFA/CO/6 (2010) (“The Committee urges the State party to address the obstacles to women’s access to health care including sociocultural norms...including discriminatory practices whereby a woman has to request permission from her husband to use contraceptive methods.”); L.M.R. v. Argentina, Human Rights Committee, Comm’n No. 1608/2007, para. XX, U.N. Doc. CCPR/C/101/D/1608/2007 (2011) (finding that the petitioner’s right to privacy was violated when she was compelled to seek judicial authorization to terminate a pregnancy when such an authorization was not required by law); WHO, SAFE ABORTION (2012), *supra* note 81, at 94-95 (Examples of barriers include... requiring third-party authorization from one or more medical professionals or a hospital committee, court or police, parent or guardian or a woman’s partner or spouse... requiring third-party authorization from one or more medical professionals or a hospital committee, court or police, parent or guardian or a woman’s partner or spouse).

<sup>106</sup> CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 18, para. 14.

<sup>107</sup> WHO, SAFE ABORTION (2012), *supra* note 81, at 96.

<sup>108</sup> CEDAW Committee, *Concluding Observations: Hungary*, para. 31(c), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013) (“Ensure access to safe abortion without subjecting women to mandatory counselling and a medically unnecessary waiting period as recommended by the World Health Organization”).

<sup>109</sup> *Id.* (“Mandatory waiting periods can have the effect of delaying care, which can jeopardize women’s ability to access safe, legal abortion services and demeans women as competent decision-makers”).

<sup>110</sup> Federal Law of 21 November 2011, No. 323-FZ, “On the Foundations of the Protections of Citizen’s Health in the Russian Federation”, Articles 56 & 70(3), Art. 3 (Russia) (Please note that the waiting period requirement may be waived in emergency situations).

<sup>111</sup> Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, JOURNAL OF WOMEN’S HEALTH 706 (Aug. 2013) (finding that “women who lived in a state with a 24-hour waiting period, women obtaining second trimester abortions, those who crossed state lines, and, in particular, rural women were more likely to travel greater distances relative to their counterparts”).

<sup>112</sup> WHO, SAFE ABORTION (2012), *supra* note 81, p. 17.

<sup>113</sup> CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 18, para. 11.

<sup>114</sup> CESCR Committee, *Concluding Observations: Nicaragua*, para. 26, U.N. Doc. E/C.12/NIC/CO/4 (2008) (; Human Rights Committee, *Concluding Observation, Ireland*, para. 13, U.N. Doc. CCPR/C/IRL/CO/3; *Nicaragua*, para. 13, U.N. Doc. CCPR/C/NIC/CO/3.

<sup>115</sup> CEDAW Committee, *Concluding Observations: Ireland*, para. 185, U.N. Doc. A/54/38/Rev.1 (1999).