**Call for inputs on the right to access and take part in scientific progress issued by the Special Rapporteur in the field of cultural rights**

**21 November 2023**

**The Center for Reproductive Rights (the Center)—an international non-profit legal advocacy organization headquartered in New York City, with regional offices in Nairobi, Bogotá, Geneva, and Washington, D.C. and a staff of approximately 200 diverse professionals in 14 countries—uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfil. Since its inception 30 years ago, the Center has advocated for the realization of women and girls’ human rights on a broad range of issues and has conducted advocacy to support norm development at the U.N., including with the treaty monitoring bodies in the development of general recommendations and comments.**

The Center is pleased to provide this submission to the Special Rapporteur in the field of cultural rights on the right to access and take part in scientific progress to inform the upcoming report of the Special Rapporteur to the Human Rights Council to be presented in March 2024. This submission focuses on state obligations in protecting and fulfilling the right to enjoy the benefits of scientific progress for all in the area sexual and reproductive health and rights (SRHR). It particularly focuses on 1) Assisted Reproductive Technology and Surrogacy (ART), providing specific cases about a) the discriminatory access in the United States; b) the lack of regulation and restrictive and discriminatory frameworks in India, Nepal and Thailand; and c) the criminalization of surrogates and use of anti-trafficking laws to arrest, detain, and prosecute surrogates in Cambodia and The Philippines. It continues with 2) the right to abortion with a focus on the restricted access to medical abortion and self-managed abortion in the Asia region; and 3) the right to contraception and the lack of access to emergency contraceptives in the Philippines. Section 4) includes information the Participation of indigenous peoples and local communities in a global intercultural dialogue for scientific progress. The document concludes with specific recommendations to be included in the upcoming thematic report.

1. **Introduction**

The right to access and take part in scientific progress is inextricably linked with sexual and reproductive health and rights (SRHR). Medical innovations that prevent diseases or enable more effective treatment are necessary for its realization.[[1]](#footnote-2) However, growing inequalities in accessing medical innovations are increasingly threatening these rights.[[2]](#footnote-3) Such inequalities restrict the enjoyment of the latest scientific innovations to upper-income or more privileged households.[[3]](#footnote-4) Furthermore, there are specific impacts on the rights of women, girls and persons with diverse Sexual Orientation, Gender Identity and Expression, and Sex Characteristics (SOGIESC) that have been acknowledged by the UN Treaty Monitoring bodies (UNTMB).[[4]](#footnote-5)

The CESCR Committee, in its General Comment No. 25 (2020) on science and economic, social, and cultural rights, highlights the particular relevance to SRHR and underlines States’ obligations to ensure access to up-to-date scientific technologies. In particular, the CESCR Committee calls on States to ensure access to modern and safe forms of contraception, including emergency contraception, medication for abortion, assisted reproductive technologies, and other sexual and reproductive goods and services.[[5]](#footnote-6) Discrimination in accessing and taking part in scientific progress must be eliminated both formally and substantively.[[6]](#footnote-7) This might require special measures to remove conditions that perpetuate discrimination.[[7]](#footnote-8)

For instance, treaty monitoring bodies have long recognized the need to use a substantive equality approach to ensure gender equality in the context of SRHR and have repeatedly condemned laws that restrict or prohibit health services primarily or exclusively needed by women on the basis that they violate the rights to equality and non-discrimination.[[8]](#footnote-9) Non-discrimination, in the context of SRHR, encompasses the right of all persons, including LGBTQ persons, to be fully respected for their sexual orientation, gender identity, and intersex status.[[9]](#footnote-10) Furthermore, it requires special attention to groups that have experienced systemic discrimination in the enjoyment of the right to participate in and to enjoy the benefits of scientific progress and its applications.[[10]](#footnote-11)

The submission will explore the areas of sexual and reproductive rights where the right to benefit from scientific progress is expressed, look at barriers preventing its fulfilment, and in some instances interrogate how cultural and traditional practices are considered, or not, as scientific progress.

1. **Areas in focus**
2. **Assisted Reproductive Technology and Surrogacy (ART)**

***Context***

Access to scientific progress is critical for those who need assisted reproduction to build their family. Affecting 1 in 6 people globally, infertility has become a public health concern.[[11]](#footnote-12) Although assisted reproductive technology (ART) can help persons impacted with infertility seeking to build a family,[[12]](#footnote-13) with more than five million children born worldwide from ART interventions,[[13]](#footnote-14) barriers persist in regions across the globe in accessing ART, particularly for people who are low-income, single or unmarried, limited access to health-related education,[[14]](#footnote-15)

Surrogacy is an assisted reproduction practice for which international human rights standards need to be further developed. While surrogacy practices offer new reproductive opportunities, they also implicate the rights and interests of many key stakeholders involved in surrogacy arrangements, frequently in unregulated contexts, and can imply power imbalances between intended parents and women acting as surrogates.

The stigma of infertility and gender stereotyping disproportionately affect women. This is true even though male-factor infertility contributes to 35% of infertility cases globally and is the main cause of infertility in another 8% of cases.[[15]](#footnote-16) Infertility strikes at the core of harmful gender stereotypes that women's natural role in society is primarily as a mother and caregiver, ascribing motherhood as an essential attribute of being a woman.[[16]](#footnote-17) Any deviation from this norm, intentional or not, may not only engender societal stigma or personal shame, but can also lead to societal isolation and result in high levels of anxiety and depression.[[17]](#footnote-18) In some cases, infertility may lead to domestic or intimate partner violence.[[18]](#footnote-19) Similarly, transgender and individuals with diverse SOGIESC who seek fertility treatment can also face extreme stigma, bias, and prejudice.

***Human rights framework***

The Human Rights Committee has called on the elimination of excessive restrictions on the use of ART,[[19]](#footnote-20) while the CEDAW Committee has praised States for passing legislation that regulates ART and guarantees access to all scientific methods of ART.[[20]](#footnote-21) Particular concerns in accessing ART include the criminalization of certain ART practices, gender-based and intersectional discrimination, the right to bodily autonomy, ineffective regulations unable to keep pace with technological developments, and in some states, the lack of any regulations that results in disproportionate impacts on marginalized communities.[[21]](#footnote-22)

States must, at minimum, ensure access to up-to-date scientific technologies like ART “on the basis of non-discrimination and equality, as outlined in CESCR general comment No. 22 (2016) on the right to sexual and reproductive health.”[[22]](#footnote-23) The use of ART must respect the fundamental principle that every person has the right to make decisions about their reproductive life.[[23]](#footnote-24) Equally, every person has the right to comprehensive, unbiased, and evidence-based information and services.[[24]](#footnote-25) Essential to ensuring that ART actually accounts for the needs, realities, and contexts of women— and in particular vulnerable groups— is the inclusion of persons directly impacted in the development, adoption, and implementation of laws and policies on ART’s implementation.[[25]](#footnote-26)

Individuals and couples have the right to decide the number, timing, and spacing of their children. Infertility can negate the realization of these essential human rights. Addressing infertility and ensuring equitable access to fertility care are therefore an important part of realizing the right of individuals and couples to found a family.[[26]](#footnote-27)

***Specific cases***

1. **Discriminatory access to ART in the United States**

In the United States, about 1 in 5 married women aged 15 to 49 with no prior births experience infertility, according to the US Centers for Disease Control and Prevention.[[27]](#footnote-28) However, these estimates only capture infertility rates among heterosexual, cisgendered individuals. Well-documented disparities in access to fertility care in the U.S. reveal that people of color, low-income people, people with disabilities, and the LGBTQ community, access fertility treatment at disproportionately low rates.[[28]](#footnote-29)

**Racial and Ethnic Minorities:** Black women in the United States are nearly twice as likely to experience infertility than non-Hispanic white women yet are 20% less likely than white women to receive care.[[29]](#footnote-30) Higher rates of infertility among Black women may be due in part to racial stereotypes that characterize Black women as “hyper fertile” so that they are more often counseled on contraception than on fertility and suffer longer periods of biomedical causes of infertility, like endometriosis, without diagnosis or treatment.[[30]](#footnote-31) Below-average rates of fertility care use have also been found among Hispanic and American Indian/Alaska Native non-Hispanic women, while Asian/Pacific Islander and Black non-Hispanic women have reported longer periods of infertility and accessing assisted reproduction at later ages compared to their non-Hispanic white counterparts.[[31]](#footnote-32)Even in states that try to mitigate the financial barrier to fertility care by providing insurance coverage for assisted reproduction, racial disparities in access persist.[[32]](#footnote-33) This suggests the presence of social and cultural determinants as barriers to fertility care, including systemic racism, implicit biases, and other forms of discrimination within the reproductive health care system.[[33]](#footnote-34)

**LGBTQ+ Community:** too often in the United States, LGBTQ and people with diverse SOGIESC struggle to access and receive non-judgmental care.[[34]](#footnote-35) Instead, health care insurers and providers operate in and propagate a health care system that is cis-gender and hetero-normative and hostile towards LGBTQ and gender non-conforming people.An additional access barrier is that LGBTQ and gender non-conforming people are more likely to be uninsured than their heterosexual counterparts.[[35]](#footnote-36) This disparity can be attributed, in part, to discriminatory laws and policies. For example, many insurers require patients to prove clinical infertility by demonstrating that they have tried to become pregnant through unprotected sex for a designated period of time before providing coverage for in vitro fertilization (IVF). Such a requirement fails to be inclusive of or sensitive to the experiences of same-sex couples.[[36]](#footnote-37)

**Low Income Individuals:** Having low-income and lacking access to insurance can be major barriers to fertility care. In the U.S., a single round of IVF can cost around $20,000 out of pocket and multiple rounds are often necessary to achieve a live birth. Individuals without insurance are three times more likely than individuals with insurance to discontinue care after a single cycle of treatment.[[37]](#footnote-38) Furthermore, Medicaid, an income-restricted health insurance program and the largest source of public funding for medical and health-related services for low-income people and families, does not cover ART.[[38]](#footnote-39) Currently, only two jurisdictions (New York and Washington DC) provide Medicaid coverage for the diagnosis of infertility and ovulation-enhancing drugs, but the coverage does not extend to other fertility treatments, like IVF.[[39]](#footnote-40) This makes access to most forms of fertility care prohibitively expensive for the 87 million people enrolled in Medicaid.[[40]](#footnote-41)

**People with disabilities:** while people with disabilities are impacted by the same barriers related to fertility care, they also face distinct barriers. Accessibility barriers, including physical access to provider facilities and to usable, adaptable or specialized examination and diagnostic equipment, prevent people with disabilities from accessing fertility care.[[41]](#footnote-42) People with disabilities may be denied access to ART necessary to have a child due to stigma and stereotypes regarding people with disabilities and their ability or appropriateness to parent, lack of medical professionals who are not adequately experienced or trained to care for people with disabilities, and the fact that many people with disabilities are on Medicaid, which does not provide coverage for assisted reproductive technology.[[42]](#footnote-43)

1. **Lack of regulation, and restrictive and discriminatory frameworks in India, Nepal and Thailand**

**India**

In 2022, two new laws regulating surrogacy and ART came into force. The ART (Regulation) Act and the Surrogacy (Regulation) Act restrict who can access ART and surrogacy as well as who can be a donor and a surrogate.[[43]](#footnote-44) For instance, the laws prohibit single men, unmarried couples, and those in same-sex relationships from accessing these services, thus excluding and discriminating against key marginalized populations. Likewise, compensated surrogacy is completely prohibited, and the altruistic surrogacy framework that has been introduced under the law has been critiqued for its failure to address the root causes of poverty and lack of economic/livelihood opportunities for surrogates and those providing gametes.

Petitions pending before the Supreme Court of India and several High Courts have challenged the inequitable and discriminatory provisions of the law for leaving out key populations from accessing assisted reproduction.[[44]](#footnote-45) These petitions have challenged the various provisions of the laws as arbitrary and discriminatory on various grounds, including on i) an upper-age eligibility criteria for receiving ART services, ii) the prohibition on the use of donor gametes in surrogacy by a couple, iii) a blanket ban on compensated surrogacy. The grounds used contribute to further exploitation of women within the family and push these services into unregulated markets; that leaving those in same-sex and live-in relationships outside the scope of the laws discriminates against their right to reproductive autonomy and privacy as upheld by the Supreme Court of India in its earlier decisions; and that bringing medical practitioners within the purview of the Indian Penal Code will have a chilling effect on practitioners across the country.[[45]](#footnote-46)

In May 2023, the Center and its national partner, the SAMA Resource Group for Women and Health, organized a national consultation to understand the impact of the Surrogacy and ART laws. The discussions during the consultation highlighted the fact that the laws do not adopt a rights-based approach to regulate ART and surrogacy and its heteronormative and exclusionary framing contributes to the creation of a legal framework that is prohibitive in nature. This has led to the voice of surrogates and donors who are most marginalized and vulnerable being suppressed, and that it is increasingly difficult to access surrogates who were earlier involved in compensated surrogacy, even for research and documentation of their experiences. The participants called for greater evidence-building on the impact of the laws on marginalized persons.[[46]](#footnote-47)

**Nepal**

A 2014 decision of the Cabinet[[47]](#footnote-48) allowed surrogacy services for foreign couples intending to be parents through surrogacy.[[48]](#footnote-49) A writ was filed at the Supreme Court seeking to declare such decision void and to ban the practice of surrogacy altogether. Through a subsequent decision, the Cabinet declared its 2014 decision allowing surrogacy void.[[49]](#footnote-50) The Court gave a directive order for the government to enact a law regulating surrogacy, stipulating that commercial or compensated surrogacy cannot be allowed. Surrogacy without compensation to the surrogate may be permitted only when a sufficient medical condition exists for the intending parents as certified by a medical board and limited only to married Nepali couples.[[50]](#footnote-51)

**Thailand**

In 2015, Thailand enacted the Protection of Children Born Through Assisted Reproductive Technologies Act, (ART Act) to regulate any form of ART, including surrogacy.[[51]](#footnote-52) The ART Act prescribes that only Thai citizens are permitted to adopt surrogacy arrangements.[[52]](#footnote-53) A Thai citizen whose partner is a non-Thai is also allowed, but they will have to be legally married for three years or more. The surrogate must be a blood relative of either one of the intended parents. An exception to this is when the intended parents can prove that they do not have a blood relative. In such cases, the surrogate will still have to share the same nationality with at least one of the intended parents.[[53]](#footnote-54) The ART Act only extends to surrogacy arrangements that are approved by the Committee of the Protection of a Child Born by Medically Assisted Reproductive Technology and involve the surrogate giving birth in Thailand.[[54]](#footnote-55)

The Department of Health Services Support (DHSS) of the Ministry of Public Health aims to modify the ART Act to allow commercial surrogacy in Thailand to “address illicit baby trading”[[55]](#footnote-56) and promote the country as a medical hub for surrogacy.[[56]](#footnote-57) The proposed amendment would legalize hiring women as surrogates and allow foreigners to access surrogacy services in Thailand. Additionally, the amendment would enable the export of eggs and sperm for surrogacy overseas.

1. **Criminalization of surrogates and use of anti-trafficking laws to arrest, detain, and prosecute surrogates in Cambodia and The Philippines**

**Cambodia**

Surrogacy practices became popular in Cambodia around 2015 following increasing restrictions in neighboring countries. Surrogacy agencies found Cambodia attractive because, at the time, it lacked regulations on surrogacy or any other form of ART.[[57]](#footnote-58)

As Cambodia continued to be a hub for transnational surrogacy, though, it decided to curb the practice and prohibit all forms of surrogacy in 2016 via government edict sent to all fertility clinics.[[58]](#footnote-59) The ban prohibits compensated surrogacy, and in other cases it criminalizes surrogates, intended parent(s), and clinics operating without proper approvals.[[59]](#footnote-60)

In November 2016, 23 women were arrested for acting as surrogates, and in June 2018, 32 women acting as surrogates were arrested for violating the ministerial order to ban surrogacy. The women were given two options: (1) to raise the child as their own, or (2) to face a 20-year imprisonment according to the State party’s criminal laws. The 32 women were eventually released on bail after they signed documents declaring they would take care of the children until the age of 15 or 18.[[60]](#footnote-61) However, because most of the women acting as surrogates were from very poor families and desperately needed money, there was a substantial risk that they would not be able to adequately provide for the children. In the absence of formal regulations, it is unclear what mechanisms are in place to provide support to the women to ensure that they and the children are provided the care that they need.

In November 2018, an additional 18 persons, including 11 pregnant women acting as surrogates were arrested. The 11 women and four other people were charged with surrogacy and human trafficking.[[61]](#footnote-62) The pregnant women were all sent directly to prison but were released in May 2019 on similar terms, i.e., that they agree to raise the children.[[62]](#footnote-63) In July 2019, three Cambodian women who acted as surrogates for Chinese nationals and who delivered in Vietnam were questioned and then detained by Cambodian authorities when they returned to Cambodia. They have been charged with violations of anti-trafficking laws and of the provision under the Cambodia’s Criminal Code which prohibits a person from acting as an intermediary between an adoptive parent and a pregnant woman.[[63]](#footnote-64) In early 2018, the first draft of a surrogacy law was completed by the Ministry of Justice and Ministry of Women’s Affairs. The proposed law prohibits compensated surrogacy, and in other cases it criminalizes surrogates, intended parent(s), and clinics operating without proper approvals. Any ART services provided without approval are subject to fines and criminal prosecution. If an embryo is created for purposes other than surrogacy, such as for scientific studies, or not disposed of properly, those responsible shall be subject to up to five years’ imprisonment and a fine of approximately USD 2,446. Municipal and provincial instant courts are tasked with the review of any complaints concerning parentage of the child.[[64]](#footnote-65)

The current regulations and proposed law do not recognize or uphold women’s rights to bodily autonomy[[65]](#footnote-66) and impose an “additional financial and emotional burden on women who are in precarious situations, which led them to act as surrogates in the first place, and that they face discrimination and stigmatization by their families and communities for having acted as surrogates.”[[66]](#footnote-67) Upon these concerns, the CEDAW Committee has recommended Cambodia to (a) end the practice of detaining women who act as surrogates and of making their release conditional upon the obligation to carry the pregnancy to term and raise the children as their own; (b) address the root causes of women deciding to act as surrogates, (c) ensure that any laws, regulations and policies on surrogacy take into account the unequal power relations between the parties to a surrogacy arrangement, particularly the weak position of women acting as surrogates, (d) ensure that the draft law on surrogacy does not impose criminal liability or administrative sanctions on women who act as surrogates.[[67]](#footnote-68) Similarly, the CRC Committee recommended that the State party ensure that it protects the rights of children born through surrogacy, including their protection from discrimination and right to access to information about their origins and expeditiously adopt the draft law on surrogacy.[[68]](#footnote-69) To date, the government has failed to implement these recommendations despite earlier reports of public consultations and creation of a task force to reconsider the provisions of the 2018 draft law.[[69]](#footnote-70)

**Philippines**

There is no specific law governing surrogacy in the Philippines. This lack of regulation allows the application of anti-trafficking laws that do not adequately protect women acting as surrogates and do not take into account the unequal power relations between the parties in a surrogate agreement. Under the expanded law on anti-trafficking, “recruiting a woman to bear a child for the purpose of selling the child” and “simulating a birth for the purpose of selling the child” are deemed as attempted trafficking in persons.[[70]](#footnote-71) Offenders can be imprisoned for up to 15 years and pay a fine of up to a million pesos. Surrogates are considered as victims of trafficking in need of rescuing. As victims of trafficking, they are to be immediately placed in the temporary custody of the local social welfare and development office, or any accredited or licensed shelter institution devoted to protecting trafficked persons after the rescue.

The House Bill 8301 was filed on May 23, 2023 in Philippines’ Congress.[[71]](#footnote-72) The bill aims to protect the rights of all parties involved, especially children born through ART procedures. It acknowledges the significant problem of infertility in the Philippines and the increasing popularity of ART and surrogacy as options for couples struggling to conceive. The bill highlights the need for regulation due to reported cases of issues and concerns surrounding these procedures. It mentions cases of unpaid medical expenses for surrogate mothers and instances of exploitation and mistreatment of children and vulnerable women involved in surrogacy. The bill proposes the establishment of a regulatory body to oversee ART and surrogacy practices in the country. This proposed law mandates that all parties involved are informed of their rights and responsibilities and that appropriate safeguards are in place. The bill also emphasizes the registration of all ART and surrogacy procedures with the regulatory body to gather accurate data on the number and outcomes of these procedures.

Regarding parentage, the bill states that a child born through a surrogacy procedure would be considered the biological child of the intending couple. The child would be entitled to all the rights and privileges available to a natural child under existing laws, reflecting the principle of prioritizing the best interests of the child in surrogacy and ART matters. The bill concludes by emphasizing the necessity of enacting an ART and Surrogacy Regulation Law to ensure the ethical and safe implementation of these procedures in the Philippines.

The bill, however, includes numerous discriminatory and restrictive provisions, such as confining services to intending couples, by age, and to medical reasons, i.e., infertility. The definition of infertility in the bill also excludes social or situational infertility, as it is limited to the inability to conceive after one year of unprotected coitus or other proven medical condition preventing a couple from conception. The surrogate must also be married, have a child of her own, and be between the age of 25 to 35 years on the day of implantation and shall only perform her obligations voluntarily without any compensation or remuneration. The bill also imposes penalties for offenses such as conducting commercial surrogacy, exploiting children born through ART or surrogacy, and conducting sex selection for surrogacy.

1. **The right to abortion**

***Context***

The WHO has recognized that scientific progress on medical abortion has revolutionized access to quality abortion care globally, recommending that medical abortion be “provided at the primary-care level and on an outpatient basis, or from a pharmacy.”[[72]](#footnote-73) Abortion can be effectively managed using medication via pill or a surgical procedure, both of which can be provided at the primary care level.[[73]](#footnote-74) Recognizing the central role of autonomy in abortion care, WHO highlights that medicines for abortion can be safely and effectively self-administered outside a facility (e.g., at home).[[74]](#footnote-75)

Telemedicine has proved valuable in helping facilitate access to safe abortions and expanding SRH services to more remote areas and underserved communities.[[75]](#footnote-76) WHO, specifically, recommends “the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part.”[[76]](#footnote-77) While increasing access to medication abortion and other SRH services through telemedicine has significantly expanded the availability of safe, high-quality abortion care in countries that have embraced it,[[77]](#footnote-78) many states in the United States and other countries continue to prohibit the use of telemedicine for medication abortion.[[78]](#footnote-79) Likewise, there is a call for greater commitments and investments in self-care interventions for SRHR, which aim to help people gain autonomy over their health while improving access to vital healthcare.[[79]](#footnote-80)

Barriers such as a lack of providers and facilities that can safely provide services, limited available methods of abortion, costs, stigma, and legal restrictions make it difficult or impossible for many women to access abortion care, which may lead them to use unsafe method. In countries that prohibit abortion or allow it only to save the life of the woman or protect her physical health, estimates suggest that nearly three-quarters of the procedures are unsafe.[[80]](#footnote-81) By contrast, in countries that allow abortion for any reason, nine in every ten abortions are safe.[[81]](#footnote-82)

***Human Rights Framework***

Unnecessary restrictions on access to abortion, including via medication may result in a violation of the right to enjoy the benefits of scientific progress and the right to health.[[82]](#footnote-83) Treaty monitoring bodies have long recognized the connection between restrictive abortion laws, high rates of unsafe abortion, and maternal mortality, finding that restrictive abortion laws violate a range of human rights, including the rights to health, life, privacy, freedom from gender discrimination or gender stereotyping, and freedom from ill-treatment.[[83]](#footnote-84) Criminalization of abortion, denial or delay of safe abortion and post-abortion care, and forced continuation of pregnancy are forms of gender discrimination and gender-based violence.[[84]](#footnote-85)

In its most recent abortion guidelines, the WHO uses public health evidence to recommend that States decriminalize and repeal any laws or regulations restricting abortion.[[85]](#footnote-86) The WHO recommends that abortion be available on the request of the woman, girl, or any other pregnant person,[[86]](#footnote-87)  against gestational limits,[[87]](#footnote-88) mandatory waiting periods for abortion,[[88]](#footnote-89) and third-party authorization.[[89]](#footnote-90) The WHO Guideline further reiterates the safety and efficacy of medication abortion – it is on the WHO’s essential medicines list – and human rights bodies have long recognized states’ obligation to ensure its availability and accessibility.[[90]](#footnote-91) Noting its safety, it recognizes that medication abortion can be self-administered at home and should not be considered “a last resort option,” but rather should be employed to meet the circumstances and preferences of the pregnant person.[[91]](#footnote-92) It further recommends “the option of telemedicine as an alternative to in-person interactions” with health care providers for the provision of counseling, instructions for the administration of medicines, and follow-up post-abortion care.[[92]](#footnote-93)

WHO remarks that self-managed abortion should be available as an option and that restrictions on prescribing and dispensing abortion medicines “may need to be modified or other mechanisms put in place for self-management within the regulatory framework of the health system.”[[93]](#footnote-94) Furthermore, all individuals who self-manage medical abortion must be able to access accurate information, quality medications (including for pain management), the support of health workers, and a health facility and referral services if needed or desired. Further, WHO notes that self-management should not be criminalized and should not be restricted for non-clinical reasons, such as age.[[94]](#footnote-95)

The WHO, along with partner organizations, has included in recent recommendations on self-managed care the need for particular attention devoted to marginalized or criminalized communities that considers broader determinants of health and well-being.[[95]](#footnote-96) Ensuring public confidence in the local health system is one such broader determinant that the WHO focuses on in its recommendations. Achieving that confidence requires a health system rooted in an effective legal and policy framework informed by international standards of scientific and medical knowledge, monitors the implementation of those standards in the medical system and is transparent in doing so, and combines epidemiological and public health principles with human rights, gender equality, ethics and law.[[96]](#footnote-97)

***Specific cases***

1. **Access to medical abortion and self-managed abortion is restricted in most countries in the Asia region**

Access to abortion varies in the Asia region as legal frameworks on abortion range from liberal to highly restrictive. Abortion is allowed regardless of reason in Nepal up to 12 weeks of pregnancy and up to 28 weeks on certain grounds. Abortion is also expressly permitted to save the life of the pregnant person in all the focus countries except the Philippines. Abortion to protect the health of the pregnant person is expressly permitted only in India, Nepal, and Pakistan. For pregnancies involving fetal impairment and those resulting from rape and incest, only Nepal and India expressly allow abortion in these cases. [[97]](#footnote-98)

Examining the current laws and policies of the focus countries, most of their legal frameworks limit access to essential medicines for abortion. For example, only India and Nepal expressly allow medical abortion and only when the pregnancy is below 7-10 weeks. Bangladesh, on the other hand, allows the use of abortion medicines for menstrual regulation only. Further, despite the safety and privacy that telemedicine and self-managed abortion provide, self-managed abortion is criminalized and the use of telemedicine for abortion is not expressly permitted by law for pregnant persons in all six countries.[[98]](#footnote-99)

Reviewing the compliance of the six states to major international human rights treaties, human rights bodies have expressed concerns on the limited abortion access in these countries and recommended for governments to address the discriminatory structures and barriers which prevent pregnant persons from fully accessing abortion care.[[99]](#footnote-100) The impact on maternal morbidity and mortality rates because of unsafe abortions and restrictive laws have been raised in the state party reviews of Nepal, Philippines, and Sri Lanka.[[100]](#footnote-101) Human rights bodies have called on the governments of Bangladesh, Nepal, Pakistan, Philippines, India, and Sri Lanka to reform their abortion laws.[[101]](#footnote-102)

1. **Right to contraception**

**Context**

While progress has been made in ensuring the accessibility of contraceptive goods and services, there are still 164 million women globally who have an unmet need for family planning.[[102]](#footnote-103) According to UNFPA, based on data from 57 countries, only 55 percent of married or in-union women aged 15 to 49 make their own decisions regarding sexual and reproductive health and rights.[[103]](#footnote-104) There are many aspects of the rights to bodily autonomy and integrity that are compromised for women and girls living in poverty. Furthermore, the privatization of reproductive health services and commodities very often renders them unaffordable for low-income women and girls, which perpetuates intergenerational poverty. [[104]](#footnote-105) In addition, as noted above, the criminalization of women and girls seeking contraceptive goods and services or abortion care disproportionately affects those without the means to travel to other jurisdictions to access those services.[[105]](#footnote-106) The CEDAW Committee has also found that a systematic denial of access to modern contraceptive methods particularly harms disadvantaged groups of women, including poor women, adolescent girls, and women in abusive relationships. [[106]](#footnote-107)

***Human Rights Framework***

States must ensure that a full range of good quality, modern, and effective contraceptives, including emergency contraception, are available and accessible to everyone.[[107]](#footnote-108) Ensuring particular contraception-related health outcomes for women has been viewed as a means of ensuring substantive equality.[[108]](#footnote-109) The CEDAW Committee remarks that a lack of access to contraceptives disproportionately affects women, violating women’s right to access health services and information, including family planning, without discrimination.[[109]](#footnote-110)

Modern methods of contraception should be affordable, with treaty monitoring bodies recognizing that contraceptives should be subsidized, covered by public health insurance schemes, or provided free of charge to women and girls.[[110]](#footnote-111) Treaty monitoring bodies emphasize the obligation of States to ensure that the use of contraceptives is voluntary, fully informed, and without coercion or discrimination, and particular attention should be paid to groups who have historically been subject to coercive family planning practices.[[111]](#footnote-112) Effective remedies should be available when violations of informed consent and other abuses around contraceptive access and use have occurred.[[112]](#footnote-113) States also have an obligation to gather disaggregated data on contraceptive use and barriers to contraceptive access,[[113]](#footnote-114) and to formulate laws, policies, and programs that reflect the needs of society, including marginalized groups.[[114]](#footnote-115)

Treaty monitoring bodies have paid particular attention to the issue of access to emergency contraception, which prevents pregnancy following unprotected sexual intercourse. Emergency contraception should be available without a prescription,[[115]](#footnote-116) be free for victims of violence, including adolescents,[[116]](#footnote-117) and special measures should be taken to ensure that it is available to women in conflict and post-conflict zones.[[117]](#footnote-118) Failure to ensure legal and accessible emergency contraception for women who are victims of rape or sexual abuse can result in physical and mental suffering that may amount to ill-treatment.[[118]](#footnote-119)

**Specific cases**

1. **Lack of access to dedicated emergency contraceptives in the Philippines**

The continuing lack of access to dedicated emergency contraceptives[[119]](#footnote-120) in the Philippines poses a threat to women’s and girls’ lives. It also discriminates against thousands of women and girls in the country, including victims of sexual violence who are exposed to serious traumatic stress. This is especially worrying given the incidence of sexual violence in the Philippines.[[120]](#footnote-121)

In 2014, the Department of Health recommended the use of the levonorgestrel-only pill to prevent pregnancies in instances of unprotected sex.[[121]](#footnote-122) Despite this recommendation, the Philippines has not taken any steps to ensure access to dedicated emergency contraceptives and even worse, enacted a provision expressly prohibiting national hospitals from purchasing or acquiring them. While a levonorgestrel-only pill was previously approved in 1999 by the state party for victims of sexual violence, it was de-listed from the Philippine registry of drugs in 2001 based on the claim that it has an “abortifacient effect.”[[122]](#footnote-123) This is contrary not only to the recommendation by the now Philippines Food and Drugs Administration, but also to WHO and medical experts who explain emergency contraception pills do not induce abortion, but simply prevents pregnancy by preventing or delaying ovulation and recognized levonorgestrel-only pills as essential drugs. [[123]](#footnote-124)

1. **Participation of indigenous peoples and local communities in a global intercultural dialogue for scientific progress**

***Context***

Indigenous women and girls have limited access to SRHR and face racial and gender-based discrimination in health systems where their right to free, prior and informed consent is repeatedly not respected. Health professionals are often race- and gender-biased, insensitive to the realities, culture and views of Indigenous women, do not speak Indigenous languages, and they rarely offer services respecting the dignity, privacy, informed consent and reproductive autonomy of Indigenous women. Furthermore, indigenous midwives and birth attendants are often criminalized, and technical knowledge is undervalued by non-Indigenous health systems.[[124]](#footnote-125) This relies on the historical discrimination against Indigenous women and girls perpetuated not only by gender stereotypes but also by forms of racism, colonialism and militarization. These underlying causes of discrimination are reflected directly and indirectly in laws and policies that impede the access of Indigenous women and girls to their rights.[[125]](#footnote-126)

***The Committee on the Elimination of Racial Discrimination and Human Rights Committee recommendations to the United States of America***

The Committee on the Elimination of Racial Discrimination (CERD) and the Human Rights Committee, have recently reviewed the United States and have issued recommendations to protect the traditional practices of indigenous and afro-descendant midwives, recognizing their contribution to the protection of SRHR.[[126]](#footnote-127)

In the recent reviews, both Committees highlighted that racial and ethnic minorities have the highest rates of maternal mortality, in particular women of African descent and Indigenous women. They also noted with concern the limited availability of culturally sensitive and respectful maternal health care, including midwifery care for those with low incomes, those living in rural areas, people of African descent, and indigenous communities.[[127]](#footnote-128)

Upon these concerns, both Committees recommended that the State party take further steps to eliminate racial and ethnic disparities in the field of SRHR, while integrating an intersectional and culturally respectful approach in, for instance, policies and programmes aimed at removing barriers to access to comprehensive sexual and reproductive health services, and those aimed at reducing the high rates of maternal mortality and morbidity affecting racial and ethnic minorities, including through midwifery care.[[128]](#footnote-129) The Human Rights Committee specifically refers to the restrictions and criminalization of midwifery in several states in the US, limiting the availability of culturally sensitive and respectful maternal health care for those with low income, those living in rural areas, people of African descent and indigenous communities. [[129]](#footnote-130) Upon this, the Committee urged the US to take steps to remove restrictive and discriminatory legal and practical barriers to midwifery care, including those affecting midwifes in communities of people of African descent and Indigenous peoples.[[130]](#footnote-131)

**Human Rights Framework**

Indigenous peoples and local communities all over the globe should participate in a global intercultural dialogue for scientific progress, as their inputs are precious, and science should not be used as an instrument of cultural imposition. States parties must provide indigenous peoples, with due respect for their self-determination, to both the educational and technological means to participate in this dialogue. They must also take all measures to respect and protect the rights of indigenous peoples, particularly their land, their identity and the protection of the moral and material interests resulting from their knowledge, of which they are authors, individually or collectively. Genuine consultation in order to obtain free, prior and informed consent is necessary whenever the State party or non-State actors conduct research, take decisions or create policies relating to science that have an impact on indigenous peoples or when using their knowledge.[[131]](#footnote-132) Local, traditional and indigenous knowledge are precious and have an important role to play in the global scientific dialogue. States must take measures to protect such knowledge through different means, including special intellectual property regimes, and to secure the ownership and control of this traditional knowledge by local and traditional communities and indigenous peoples.[[132]](#footnote-133)

The CEDAW Committee specifically recommends that States parties ensure the recognition of Indigenous health systems, ancestral knowledge, practices, sciences and technologies, and prevent and sanction the criminalization thereof.[[133]](#footnote-134) Likewise, the Committee calls on States parties to ensure that quality health services and facilities are available, accessible, affordable, culturally appropriate and acceptable for Indigenous women and girls, including those with disabilities, older women, and lesbian, bisexual, transgender and intersex women and girls, and ensure that free, prior and informed consent, confidentiality and privacy are respected in the provision of health services.[[134]](#footnote-135) Furthermore, in regard to the right to culture, the Committee urges the States party to ensure the individual and collective rights of Indigenous women and girls to maintain their culture, identity and traditions and to choose their own path and life plans; [[135]](#footnote-136) as well as to recognize and protect Indigenous women’s intellectual property, cultural heritage, scientific and medical knowledge.[[136]](#footnote-137)

1. **Conclusions and recommendations**

The international human rights framework must keep pace with the proliferation of health technologies and other medical advancements to ensure that the rights of women and girls and persons with diverse SOGIESC enjoy the benefits of scientific progress and their right to health, and SRHR is fully realized. In doing this, it is paramount to observe an intersectional perspective that guarantees the participation of local, traditional, and indigenous without discrimination and that recognizes their knowledge and their role in the realization of SRHR without discrimination.

As the regional examples have highlighted, many States continue to exclude historically marginalized groups from the benefits of scientific innovations in ART, access to abortion, and contraception. Likewise, many States across the globe keep using scientific knowledge as an instrument of cultural imposition, restricting the participation of indigenous women and traditional local practices in an intercultural dialogue.

Perpetuating and entrenching harmful gender and racist stereotypes, many states remain unwilling or neglect their obligations to ensure regulations and laws are updated to comply with the right to enjoy the benefits of scientific progress for all. This requires rules and regulations developed with the meaningful participation of women, girls, and persons with diverse SOGIESC, with a strong intersectional perspective that ensures their rights are respected, protected, and fulfilled without discrimination. To this end, States parties should identify appropriate indicators and benchmarks, including disaggregated statistics and time frames, which allow them to monitor effectively the implementation of the right to participate in and to enjoy the benefits of scientific progress and its applications.[[137]](#footnote-138) Furthermore, like all other rights, the right to participate in and to enjoy the benefits of scientific progress and its applications is enforceable and is therefore also justiciable.[[138]](#footnote-139)

In line with the central issues raised above, the Center recommends that the report of the Special Rapporteur highlights the following key issues:

* **Reiterate States’ obligation to eliminate gender stereotypes and to address social barriers that enhance and perpetuate exclusion from the benefits of scientific progress and restrict access to SRHR. Highlight that these practices disproportionately impact women and persons with diverse SOGIESC facing intersecting forms of discrimination and guide States in operationalizing an intersectional perspective and taking the necessary steps to achieve substantive equality.**
* **Recognize the links between scientific progress and SRHR and reiterate that every person is entitled to dignified, safe, respectful, affordable, and accessible reproductive healthcare including fertility treatment, contraception, and abortion without discrimination.**
* **Recognize that access to scientific progress is critical for those who need assisted reproduction to build their family and call on States to take the necessary measures to address the barriers that persist across regions to guarantee access to ART, based on non-discrimination and equality, as outlined in General Comment No. 22 (2016) on the right to sexual and reproductive health.**
* **Call on States to eliminate unnecessary restrictions, lack of rights-based regulations, and criminalization of certain practices on the use of ART, including on surrogacy and highlight the disproportionate impact on impoverished and historically marginalized women, girls, and persons with diverse SOGIESC. Specifically, urge States to ensure that laws on surrogacy do not impose criminal liability or administrative sanctions on women who act as surrogates, and that laws, regulations, and policies on surrogacy prevent deprivation of liberty and exploitation, as well as coercion, discrimination, and violence against them.**
* **Urge States to ensure the availability and accessibility of medication for abortion, reiterating its safety for self-administration and recognizing the benefits of self-managed abortion and of telemedicine in abortion and post-abortion care. In doing this, highlight that restrictive abortion laws are discriminatory and violate a range of human rights, including the rights to health, life, privacy, freedom from gender discrimination or freedom from ill-treatment; and recommend states to guarantee access to abortion be available on the request of the woman, girl, or other pregnant person, and remove unnecessary restrictions such as on gestational age limits, mandatory waiting periods for abortion, and third-party authorization.**
* **Call on States to ensure that States take the necessary measures to ensure that a full range of good quality, modern, and effective contraceptives, including emergency contraception, are available and accessible to everyone, including impoverished and marginalized sectors of the population. In doing this, indicate the affirmative measures States must take to eradicate social barriers such as norms, beliefs and practices that based on harmful stereotypes prevent women, girls, and persons with diverse SOGIESC from autonomously exercise their right to sexual and reproductive health.**
* **Urge States to ensure the recognition of Indigenous health systems, ancestral knowledge, practices, sciences and technologies, and prevent and sanction the criminalization thereof. This while, State parties take the necessary measures to ensure that quality health services and facilities are available, accessible, affordable, culturally appropriate and acceptable for Indigenous women and girls, including those with disabilities, older women, and lesbian, bisexual, transgender and intersex women and girls, and ensure that free, prior and informed consent, confidentiality and privacy are respected in the provision of health services.**

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2. *Id.*, para. 36. [↑](#footnote-ref-3)
3. *Id.* [↑](#footnote-ref-4)
4. For instance, CESCR has specifically recognized that a gender-sensitive approach is critical toward states’ fulfillment on the right of all to enjoy the benefits of scientific progress. *Id*., para. 32. [↑](#footnote-ref-5)
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11. Infertility prevalence estimates, 1990–2021. Geneva: World Health Organization; 2023. License: CC BY-NC-SA 3.0 IGO. <https://www.who.int/publications/i/item/978920068315> [↑](#footnote-ref-12)
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117. Committee on the Elimination of Discrimination against Women, General Recommendation No. 30: Women in conflict prevention, conflict, and post-conflict situations, in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 52(c), U.N. Doc. CEDAW/C/GC/30 (2013) [hereinafter CEDAW Committee, Gen. Recommendation No. 30].; CEDAW Committee, Concluding Observations: Central African Republic, paras. 39-40, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014) in in BG 20 [↑](#footnote-ref-118)
118. CEDAW Committee, Gen. Recommendation No. 35, supra note 22, paras. 18, 40(c).; CAT Committee, Concluding Observations: Greece, paras. 24, 25, U.N. Doc. CAT/C/GRC/7 (2018) in BG 2020 [↑](#footnote-ref-119)
119. This refers to contraceptives specifically formulated to be an emergency contraceptive i.e., levonorgestrel only pill, and distinguish it from the use of combined oral contraceptives which can have the same effect. [↑](#footnote-ref-120)
120. The number of rapes reported to the Philippine National Police (PNP) increased 30.6% between 2018-2019, although the imposition of lockdowns and quarantine measures decreased the number in 2020. While a downward trend is reflected, these figures may be attributed, in part, to the difficulty that victims faced when trying to report such crimes during the restrictions imposed by quarantine. Reports on the prevalence of reported sexual abuse incidents in various schools in the Philippines have sparked investigations by the Department of Education and the Commission on Human Rights. In August 2023, Senate Resolution 168 was introduced urging an investigation into alleged sexual harassment cases in schools. [↑](#footnote-ref-121)
121. Republic of the Philippines, Department of Health, *The Philippine Clinical Standards Manual on Family Planning 2014*

     *Edition*, 232 (2014), https://bit.ly/2LHBZdp. [↑](#footnote-ref-122)
122. Domini M. Torrevillas, Women In, *Postinor Still Out, the Philippine Star*, Mar. 15, 2015, https://www.philstar.com/opinion/2005/03/15/270435/women-in-postinor-still-out [↑](#footnote-ref-123)
123. *See* World Health Organization, *Emergency Contraception* (9 November 2021) <https://www.who.int/news-room/fact-sheets/detail/emergency-contraception>; WHO, Model List of Essential Medicines (2015); Shadow Report submitted to the CEDAW Committee by EnGendeRights, Center for Reproductive Rights, et al (2006) (On December 1, 2003, five members out of the seven-member Special Committee created by BFAD recommended the re-listing of Postinor on the basis that it is not an abortifacient. The DOH Secretary refused to re-list Postinor and instead took advantage of Schwarz Pharma Philippines’ withdrawal to distribute Postinor by issuing an order stating, “[the] re-listing or delisting [of Postinor] has become moot and academic.). [↑](#footnote-ref-124)
124. CEDAW, General recommendation No. 39 (2022) on the rights of Indigenous women and girls U.N. Doc CEDAW/C/GC/39, para 51 [hereinafter CEDAW Gen. Rec. 39]. [↑](#footnote-ref-125)
125. CEDAW Gen. Rec. 39, para 20 [↑](#footnote-ref-126)
126. Committee on the Elimination of Racial Discrimination (CERD), Concluding observations on the combined tenth to twelfth reports of the United States of America (2022) CERD/C/USA/CO/10-12 para 35; Human Rights Committee, Concluding observations on the fifth periodic report of the United States of America, UN Doc. CCPR/C/USA/CO/5, (2023), para 26-27 [↑](#footnote-ref-127)
127. Committee on the Elimination of Racial Discrimination (CERD), Concluding observations on the combined tenth to twelfth reports of the United States of America (2022) CERD/C/USA/CO/10-12 para 35; Human Rights Committee, Concluding observations on the fifth periodic report of the United States of America, UN Doc. CCPR/C/USA/CO/5, (2023), para 26 [↑](#footnote-ref-128)
128. CESCR GC 25 para 36 [↑](#footnote-ref-129)
129. arts. 2, 3, 6, 7, 17 and 26 Human Rights Committee, Concluding observations on the fifth periodic report of the United

     States of America, UN Doc. CCPR/C/USA/CO/5, (2023), para 26 [↑](#footnote-ref-130)
130. Ibid, para 27 [↑](#footnote-ref-131)
131. CESCR GC 25 para 40 [↑](#footnote-ref-132)
132. CESCR GC 25 para 39 [↑](#footnote-ref-133)
133. CEDAW Gen. Rec. 39, para 52 (d) [↑](#footnote-ref-134)
134. CEDAW Gen. Rec. 39, para 52 (a) [↑](#footnote-ref-135)
135. arts. 3, 5, 13 and 14 in CEDAW Gen. Rec. 39, para 5 [↑](#footnote-ref-136)
136. CEDAW Gen. Rec 39, para 55 (f) [↑](#footnote-ref-137)
137. CESCR, GC 25, paras 88 [↑](#footnote-ref-138)
138. See Committee on Economic, Social and Cultural Rights, general comment No. 9 (1998) on the domestic application of the Covenant in CESCR, GC 25, paras 89 [↑](#footnote-ref-139)