



Women Enabled International

account**ABILITY** toolkit

**U.N. Standards on Sexual and Reproductive Health
and Rights of Women and Girls with Disabilities**

accountABILITY:

**U.N. Standards on Sexual and Reproductive
Health and Rights of Women and Girls
with Disabilities**



**Women Enabled
International**

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Cover image depicts three women in silhouette—one using a forearm crutch, one using a wheelchair, and one without any mobility aids—approaching a United Nations building in Geneva through a corridor of flags from countries around the world.

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The *accountABILITY Toolkit* is dedicated to the millions of disabled women and girls around the world who routinely encounter multiple and intersecting forms of discrimination. This *Toolkit* is a call to action, urging and empowering us to collectively raise our voices to demand that international human rights standards protect the rights of all women and girls, regardless of ability.

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Using this Briefing Paper

As discussed in [accountABILITY: Using U.N. Human Rights Mechanisms to Advance the Rights of Women and Girls with Disabilities](#) (“accountABILITY Advocacy Guide”), the U.N. treaty bodies are independent human rights experts whose job it is to (1) monitor whether governments are meeting their international legal obligations under the relevant treaty, and (2) interpret the meaning and content of the corresponding human rights treaty through the development of **General Comments/Recommendations, Concluding Observations**, and, in some instances, **Individual Complaints**. Together, these three types of documents make up the “jurisprudence” of the treaty body. By looking at this jurisprudence, we can better understand what types of actions violate international human rights law and what governments must do to meet their international legal obligations.

When we engage in international human rights advocacy—for instance, when we submit written information like shadow reports—our advocacy is strengthened with an analysis of the existing human rights standards on an issue. When we can demonstrate that treaty bodies have previously interpreted international human rights obligations in a way that supports what we are saying, we are more persuasive, treaty bodies may be more likely to take up our issues, and they may provide better guidance to governments on how they can remedy the issues that we raise.

This briefing paper provides an in-depth summary of what U.N. treaty bodies have said about sexual and reproductive health and rights generally and, in some instances, the sexual and reproductive health and rights of women and girls with disabilities specifically. This paper identifies what the U.N. treaty bodies have said in their concluding observations and individual complaints through the end of 2016 and what they have said in their general comments/general recommendations through 2017. The briefing paper uses the treaty bodies’ language as much as possible. Advocates can use this briefing paper to identify what one or more treaty bodies have said on an issue in the past to help explain why specific situations or actions violate protected rights and what governments must do to instead protect those rights. For each standard or recommendation outlined here, the briefing paper also footnotes the original source(s) for the issues discussed. Advocates can cite to these original sources to help support their interpretation of a particular human rights obligation. Although the majority of citations in this briefing paper include all identified instances where a treaty body addresses a specific issue, there are a few instances where the volume of similar concluding observations on a given topic is too large to cite to each instance; in these cases, the footnotes instead include a set of representative citations from different years and regions. When engaging in country-specific advocacy, we also recommend that advocates always review prior concluding observations for that particular country. Prior concluding observations can be found on the country’s homepage through the website of the [Office of the High Commissioner for Human Rights](#) (OHCHR).*

In addition to summarizing what U.N. treaty bodies have said on sexual and reproductive health and rights, this briefing paper also identifies some gaps in the standards, particularly as related to women and girls with disabilities. Identification of such gaps provides opportunities for treaty bodies to strengthen their jurisprudence, ensure that their interpretations of the legal standards respond to the specific human rights issues that women and girls with disabilities face, and promote greater complementarity of international standards across all U.N. treaty bodies. We encourage advocates to consider this discussion of the gaps in the legal standards as an invitation to raise these issues in written submissions to U.N. human rights mechanisms and to give the treaty bodies more information on these specific issues to help build stronger and more responsive standards.

Several of the U.N. Special Procedure mandate holders have also taken up issues around sexual and reproductive health and rights, including those of women and girls with disabilities, in their thematic reports. Referring to these reports can also strengthen our advocacy. Accordingly, we provide a brief overview of some of the most relevant Special Procedure reports issued through 2017 at the end of this briefing paper.

* Links to the country homepages for all U.N. member States can be found on the website of the Office of the High Commissioner of Human Rights (OHCHR) here: <http://www.ohchr.org/EN/Countries/Pages/HumanRightsintheWorld.aspx>.

Sexual and Reproductive Health and Rights of Women and Girls with Disabilities: An Overview

Women and girls[†] with disabilities worldwide face a wide range of unique human rights abuses in sexual and reproductive health care settings, due to both their gender and disability. Stereotypes about women with disabilities—including that they cannot make decisions for themselves, are asexual, will not be good parents, or cannot become pregnant—may lead health care workers and others to discount their needs or subject them to abuse.¹ At the same time, when sexual and reproductive health services and information are not designed with disability-related accessibility in mind, women with disabilities may be effectively denied access to essential services as well as the opportunity to make decisions about their sexual and reproductive health and about the timing and spacing of their children.

Forms and Manifestations of Sexual and Reproductive Health and Rights Violations against Women and Girls with Disabilities

Women with disabilities face many of the same barriers to exercising their sexual and reproductive rights as women without disabilities; they also face unique obstacles and human rights abuses due to the intersection of their gender and disability. Both legal and practical barriers limit access to essential sexual and reproductive health information, goods, and services for all women. Barriers include laws that restrict access to reproductive health goods (e.g., contraceptives) and services (e.g., abortion) without parental or spousal notice or authorization; formal and informal user fees that make sexual and reproductive health information, goods, and services prohibitively expensive; lack of access to skilled attendance during birth or emergency obstetric care; criminal bans on abortion; lack of clarity on the legal status of abortion; provider refusal to provide abortion or contraceptive services (often referred to as “conscientious objection”), and the stigma associated with such goods and services.

Women with disabilities face additional significant physical and informational barriers to accessing sexual and reproductive health services. For instance, in many parts of the world, children and adolescents with disabilities are often excluded entirely from attending school and are otherwise isolated from their communities, so they have no access to sexuality education.² Children and adolescents with disabilities are often excluded from—or not given access to—sexuality education programs due to assumptions that they do not need this information.³ Information about sexual and reproductive health is also frequently not provided in accessible formats.⁴ As a result, women and girls with disabilities are denied the essential knowledge required to protect themselves from sexual abuse, unwanted pregnancy, and sexually transmitted infections (STIs), and to make autonomous, informed decisions about their own health. Furthermore, equipment and facilities in sexual and reproductive health care settings also may not be physically accessible nor be designed with women with disabilities in mind.⁵

All of this means that women with disabilities may have less access to essential sexual and reproductive health services, such as contraception, abortion, maternal health services, or screening for STIs, and may also be less likely to be screened for reproductive cancers.⁶

Women with disabilities are also disproportionately subjected to practices such as forced or coerced sterilization, contraception, and abortion.⁷ According to the U.N. Special Rapporteur on Violence against Women, these practices are frequently based on false and discriminatory assumptions about the sexuality and ability of women with disabilities to parent or are based on the desire to control their menstrual cycles.⁸ Frequently, these forced reproductive health procedures performed on women with disabilities—particularly for women deprived of legal capacity whose parents, guardians, or doctors might make the decision on their behalf—are not only allowed to occur in practice but are also specifically permitted by law.⁹ Female sterilization is considered a permanent form of contraception, meaning that women who undergo sterilization will not be able to have children.¹⁰ While

[†] Throughout this paper, the term “women” should be interpreted to include women and girls of all ages, unless otherwise noted.

many women around the world voluntarily use sterilization as an effective contraceptive method, forced or coerced sterilization (sterilization that is carried out without the free and informed consent of the woman) causes mental and physical harms so severe that it amounts to cruel, inhuman, and degrading treatment, and arguably torture.¹¹

Furthermore, women with disabilities are at least two to three times more likely than women without disabilities to experience violence and abuse,¹² increasing their need for sexual and reproductive health information and services to protect themselves and address health concerns arising from this violence. However, sexual and reproductive healthcare providers may fail to screen women with disabilities for violence, including sexual and domestic violence, because of the misconception that persons with disabilities are not sexually active.¹³ As a result, women with disabilities have less access to prophylactic services in the wake of sexual violence to prevent pregnancy or STIs, including HIV.

Ensuring Rights Protections for Women and Girls with Disabilities in Sexual and Reproductive Health Care Settings

The right to sexual and reproductive health refers to the “state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes[,] therefore impl[ying] that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so.”¹⁴ This right is underpinned by a number of interdependent and indivisible human rights, including the rights to life, to health, to equal recognition before the law, to the exercise of legal capacity on an equal basis with others, to decide on the number and spacing of children, to found a family, to physical and mental integrity and freedom from torture or ill-treatment, to privacy, to equality and non-discrimination, to freedom from harmful stereotyping, and to accessibility, including access to information and health care services.¹⁵ As an essential component of the right to health, sexual and reproductive health information, goods, and services must be **available, accessible** (including physical, economic, and information accessibility), **acceptable**, and of good **quality**.¹⁶ These well established elements of the right to health are collectively referred to as the AAAQ framework and provide a helpful lens for assessing the degree to which a State is meeting its international legal obligations to respect, protect, and fulfil the right to sexual and reproductive health.

In order to ensure equality and non-discrimination in the context of sexual and reproductive health care, women and girls with disabilities must be able to make decisions for themselves about their sexuality and reproduction, with support when needed.¹⁷ As such, they should be given the opportunity to provide informed consent for any medical procedure, on an equal basis with others. If a reproductive health procedure is performed on a woman or girl without her informed consent—regardless of whether a parent, spouse, guardian, health care worker, judge, or other individual provides consent—it should be considered a forced or coerced procedure in violation of the woman’s fundamental rights.¹⁸

Ensuring autonomous decision-making with respect to sexual and reproductive health requires that sexual and reproductive health information and services are accessible to persons with disabilities, are sensitive to the needs of persons with disabilities, and are provided on the basis of non-discrimination, including by providing reasonable accommodations when needed.¹⁹ Comprehensive sexuality education courses and materials, as well as information on sexual and reproductive health and rights generally, must be available in alternative formats, including, e.g., sign language interpretation, Braille, audio, simplified formats, pictorial guides, and through other technologies to ensure that women with disabilities have the information they need to make decisions.²⁰ Physical spaces where health care services are provided and medical equipment (including, e.g., exam tables, labor and delivery beds, and mammogram equipment) must be accessible to women with disabilities, and there must be available and accessible transportation to and from those facilities. Supported decision-making models can help empower people with disabilities who require assistance to make decisions independently and retain legal authority to make decisions. Finally, States must train health care workers to work with persons with disabilities and provide services that are based on dignity and that respect the autonomy of persons with disabilities.

Questions to Consider

The following questions, while not exhaustive, may help advocates identify key issues to raise in a country-specific submission addressing the sexual and reproductive health and rights of women and girls with disabilities:

- ▶ What are the relevant laws, policies, programs, and national plans around sexual and reproductive health and rights for women? Do these laws address the sexual and reproductive health rights of women with disabilities specifically? Are there any laws and policies that explicitly address parental rights and/or custody for parents with disabilities?
- ▶ What are the relevant laws, policies, programs, and national plans aimed at addressing the rights of persons with disabilities? Do these laws or policies make any provisions for the sexual and reproductive health rights of women with disabilities specifically? To what extent do these laws use substituted decision-making systems, such as guardianship, instead of supported decision-making systems for people with disabilities who may need assistance to exercise their right to legal capacity?
- ▶ Do any laws explicitly outlaw or explicitly permit forced or coerced reproductive health procedures to be performed on women and girls with disabilities? Are there policies on ensuring informed consent for these procedures and specific training for health care providers? Do laws or policies contain procedures for holding accountable those who perform forced or coerced reproductive health procedures on women with disabilities, with provisions for compensation and other forms of redress for victims?
- ▶ Does the State collect data on access to sexual and reproductive health care for women and girls with disabilities? Does the State collect data regarding the number of women and girls with disabilities who are forced to take contraception or undergo abortion or sterilization procedures? Does the State include a disability module in its census?
- ▶ Are there any small-scale or regional studies on sexual and reproductive health for women and girls with disabilities that could shed light on the situation for women and girls with disabilities nationwide?
- ▶ To what extent, if at all, is information on the sexual and reproductive rights of women and girls and the rights of persons with disabilities available in accessible formats?
- ▶ To what extent are existing health care facilities and available equipment accessible to women and girls with disabilities? Does the State make any express provisions to ensure such accessibility? How well are facilities that are equipped to provide services for women with disabilities distributed geographically across the country?
- ▶ Does the State collect data on the number of health care facilities that are equipped to provide services to women and girls with disabilities? Does the State provide any funding for health care services, and if so, does that funding provide for disability-inclusive medical equipment or other accessibility measures?
- ▶ Are health care professionals, including doctors, nurses, midwives, and other medical personnel, given any training on treating women with disabilities? Are they trained on the human rights of women and persons with disabilities? Are they trained on how to meet the accessibility needs of persons with disabilities?
- ▶ Are women and girls with disabilities offered screenings for breast cancer, HIV and other STIs, and other preventative health care screenings on an equal basis with nondisabled women and girls?

- ▶ Are women and girls with disabilities offered counseling on a wide range of contraceptive methods? Is information on such methods available in accessible formats? Do women and girls with disabilities have access to a range of contraceptive goods and services on the basis of free and informed consent?
- ▶ To what extent has the State implemented comprehensive sexuality education programs, either in school settings or through mass media campaigns? Are materials for these sexuality education programs available in accessible formats? Are these programs available to and inclusive of women and girls with disabilities? Do these programs provide women and girls with disabilities any information on their sexual and reproductive rights?
- ▶ Has the State undertaken any awareness-raising campaigns about the rights of persons with disabilities in the context of parenting or sexual and reproductive health and rights, with the aim of overcoming stigma about disability and tackling discrimination?
- ▶ Are there facilities and programs in place to provide shelter, health care, and other services to pregnant women with disabilities? To what extent are prenatal services available and accessible to women with disabilities?
- ▶ To what extent are measures being implemented to provide greater access to sexual and reproductive health for women and girls with disabilities?
- ▶ To what extent are measures being implemented to protect women and girls with disabilities from forced medical interventions?

As discussed in Chapter 3 of [*accountABILITY: Using U.N. Human Rights Mechanisms to Advance the Rights of Women and Girls with Disabilities*](#), it is important that the factual information provided in a written submission include detailed information and be well-substantiated, including with citations or annexed documentation. The most effective submissions will include information of the type addressed in the above questions to establish that a problem is of a systemic or generalized nature, as well as a few detailed case studies to illustrate the impact of the problem on individuals.

Human Rights Committee

The Human Rights Committee is the expert body that monitors State implementation of the International Covenant on Civil and Political Rights (ICCPR). Through its General Comments, Concluding Observations, and Individual Complaints, the Human Rights Committee has demonstrated that States have an obligation to ensure access to the full range of sexual and reproductive health information, goods, and services, and that both the denial and the non-consensual imposition of sexual and reproductive health services can amount to a violation of rights protected by the ICCPR. In particular, the Human Rights Committee has found that violations in the context of sexual and reproductive health contravene rights under articles 2 (right to non-discrimination and effective remedies), 3 (equality of men and women), 6 (right to life), 7 (right to be free from torture or ill-treatment), 9 (right to liberty and security of the person), 10 (rights of detained persons), 14 (rights concerning courts and tribunals), 17 (right to privacy), 19 (right to freedom of expression), 23 (rights in the family), 24 (protection of children), and 26 (equal protection of the laws).

General Comments

■ **General Comment No. 19: Protection of the Family, the Right to Marriage and Equality of the Spouses (Article 23) (1994)**

In its General Comment No. 19, the Human Rights Committee makes an indirect reference to sexual and reproductive rights, discrimination, and forced or coerced practices in the context of family planning policies, recommending that “[w]hen States parties adopt family planning policies, they should be compatible with the provisions of the Covenant and should, in particular, not be discriminatory or compulsory.”²¹

■ **General Comment No. 20: Article 7, Prohibition of torture, or other cruel, inhuman or degrading treatment or punishment (1992)**

In its General Comment No. 20, the Human Rights Committee emphasizes that torture and cruel, inhuman, and degrading treatment can result not only from physical pain but also mental suffering.²² In particular, the Committee recognizes the need to ensure that patients in teaching and medical institutions are protected from torture or ill-treatment,²³ and in that regard also recommends that States ban medical experimentation without free and informed consent.²⁴

■ **General Comment No. 28: Article 3, The equality of rights between men and women (2000)**

In its General Comment No. 28, the Human Rights Committee comments on inequalities between men and women, including in the context of sexual and reproductive rights. Invoking the rights to privacy and to be free from torture or ill-treatment, the Committee calls on States to collect data on maternal mortality, to prevent unwanted pregnancies,²⁵ to report on whether they provide access to safe abortion for women whose pregnancies are the result of rape and on measures to prevent forced abortion and forced sterilization,²⁶ and to provide health services for and respect the inherent dignity of pregnant women who are deprived of liberty.²⁷ The Committee further calls on States to allow women to make decisions for themselves, without third-party authorization, about their reproduction, including about sterilization.²⁸

Concluding Observations

ACCESS TO REPRODUCTIVE HEALTH SERVICES

The Human Rights Committee has explained on numerous occasions that States have an obligation to ensure that reproductive health services are accessible for all women and adolescents,²⁹ and has indicated that such services must be available in all parts of the country, including in rural areas.³⁰ In at least one instance, the

Committee has emphasized the need to ensure the accessibility of reproductive health facilities.³¹ The Committee has also emphasized in at least one instance that States must ensure access to information on sexual and reproductive health services.³² The Committee has further called on at least two States to ensure better training for health care personnel.³³

The Human Rights Committee has expressed concern in at least one instance that many women are denied access to essential reproductive health services, including contraceptive counseling, prenatal testing, and legal abortions.³⁴

Discrimination in Health Care Access

In at least one instance, the Human Rights Committee has expressed concern about discrimination that individuals with disabilities face in accessing health services,³⁵ and called on the State to strengthen measures to protect persons with disabilities from discrimination in health care access.³⁶

ABORTION

Criminalization of Abortion and Restrictive Abortion Laws

The Human Rights Committee has routinely expressed concern about restrictive abortion laws,³⁷ noting on numerous occasions that restrictive laws force women to seek clandestine and/or unsafe abortions that endanger women's lives and health³⁸ or force women to travel to obtain a safe abortion.³⁹ The Committee has noted particular concern about the use of criminal laws and sanctions to restrict access.⁴⁰ In a number of instances, the Committee has expressed concern about existing or pending laws that fail to decriminalize abortion in cases of risk to the pregnant woman's life or health,⁴¹ incest⁴² or rape.⁴³ On at least two occasions, the Committee has expressed concerns about the lack of legal or procedural clarity over when abortion was legally permitted,⁴⁴ which can lead to inconsistent application of the law.⁴⁵ The Committee expressed concern over one State's action to eliminate an exception to a general ban on abortion for therapeutic purposes, noting that the change in law has been directly linked to several deaths of pregnant women who were denied timely and life-saving medical interventions.⁴⁶ The Committee emphasized in at least one other instance that the criminalization of abortion where pregnancy was a result of rape or incest or in situations of fatal fetal abnormality or serious health risks for the pregnant woman causes severe mental suffering.⁴⁷ In at least one instance, the Committee noted with concern that restrictive abortion laws have discriminatory results, leading to higher rates of unsafe abortions by poor and rural women.⁴⁸

The Human Rights Committee has underscored the harmful effects of criminal penalties for illegal abortion,⁴⁹ and has expressed concern in several instances where States have undertaken criminal investigations and punished women suspected of having undergone an illegal abortion,⁵⁰ as well as concern over the risk of criminal investigation and/or prosecution of family members, health care professionals, and reproductive rights advocates.⁵¹ In at least one instance, the Committee noted with concern the chilling effect that criminal sanctions can have, deterring medical professionals from providing abortions even where permitted by law.⁵² The Committee has called on at least two States to take measures to protect confidential medical information and prevent women who were treated in public hospitals from being reported by medical or administrative staff for the offense of abortion.⁵³ The Committee has called on several States to refrain from prosecuting women who have had abortions.⁵⁴ In at least one instance, the Committee further called on a State to release any women currently serving sentences for murder or infanticide as a result of having undergone an abortion.⁵⁵ The Committee has also called on at least one State to avoid penalizing medical professionals in the conduct of their professional duties.⁵⁶

The Human Rights Committee regularly recommends that States amend their abortion laws to explicitly allow for legal abortion in certain circumstances in order to comply with the ICCPR,⁵⁷ including, at a minimum, for "therapeutic" reasons,⁵⁸ in situations where there is a risk to the life or health of the pregnant woman,⁵⁹ in cases of pregnancy resulting from rape or incest,⁶⁰ and in cases of fatal fetal abnormalities.⁶¹ The Committee has

called on at least one State to repeal legal provisions criminalizing abortion in general.⁶² In at least one instance, the Committee has welcomed legislative developments liberalizing a State's abortion law.⁶³

Practical and Procedural Barriers to Abortion

The Human Rights Committee has also expressed concern over procedural and practical barriers to obtaining an abortion where permitted under the law.⁶⁴ In particular, the Committee has expressed concern about laws that require court authorization,⁶⁵ medical authorization laws that impose onerous burdens or cause undue delays,⁶⁶ and health care practitioners' refusals to perform legal abortions.⁶⁷ In at least one instance, the Committee has also expressed concern about the lack of a national protocol to regularize access to legal abortions.⁶⁸ The Committee further expressed concern to at least one State about a legal requirement that abortion for rape victims must be carried out within the first two months of pregnancy.⁶⁹

The Human Rights Committee has called on at least one State to remove all obstacles to obtaining a lawful abortion.⁷⁰ In at least one instance, the Committee has called on a State to lift the requirement for court authorization in order to effectively guarantee access to safe and legal abortions.⁷¹ In several recommendations, the Committee has also called for the adoption of procedural guidance or national protocols to clarify laws surrounding abortion access, including the circumstances under which abortion is lawfully permitted⁷² and to better regulate medical practitioners' refusal to perform legal abortions.⁷³ The Committee has further called on at least one State to reduce the response deadline for a medical commission to issue decisions in abortion-related cases, so as to avoid undue delays.⁷⁴

Post Abortion Care

In at least one instance, the Human Rights Committee has noted that a legal duty imposed on health workers to report cases where women have undergone abortions may deter women from seeking life-saving post-abortion care.⁷⁵ The Committee has expressed concern that at least one other State has failed to provide post-abortion care to women in prison who have undergone abortions and called on the State to provide appropriate health care to women in prison facilities who have undergone abortions.⁷⁶

Access to Information on Abortion

The Human Rights Committee has occasionally expressed concern about lack of access to information on legal abortion, including in one instance a lack of public information on access to legal abortion⁷⁷ and another instance where professionals may face criminal sanctions for providing information on how to access a legal abortion outside of the State.⁷⁸

Training and Guidance

In at least one instance, the Human Rights Committee has called on a State to adopt measures for educating judges and health workers about abortion laws to provide greater clarity on when abortion is lawfully permitted.⁷⁹

Selective Abortion

The Human Rights Committee has expressed concern to at least one State about a rising practice of sex-selective abortion, reflecting a culture of gender inequality, and it called on the State to adopt legislation to prohibit sex selection.⁸⁰ The Committee further called on the State to address the root causes of sex-selective abortion by gathering reliable data on the phenomenon, introducing mandatory gender-sensitive training for family planning officials, and developing awareness-raising campaigns among the general public.⁸¹

Statistics and Data Collection

In at least one instance, the Human Rights Committee lamented the lack of information on the extent of illegal abortions and their consequences for the women concerned.⁸² The Committee has called on at least one State to conduct research into and collect statistics on the use of illegal abortions and the impact of a restrictive abortion law.⁸³

ACCESS TO CONTRACEPTIVE INFORMATION, GOODS, AND SERVICES

The Human Rights Committee has repeatedly emphasized that States must help women avoid unwanted pregnancies,⁸⁴ and has indicated that States must ensure access to contraceptive and other family planning services⁸⁵ in order to do so. At least twice, the Committee has expressed concern about policies and practices that effectively deny access to contraceptive information, goods, and services,⁸⁶ including one that prohibited funding for a range of contraceptive methods, calling on that State to lift the ban on funding for contraceptives.⁸⁷ The Committee called on another State to make access to family planning services and methods free,⁸⁸ recognizing the high cost of contraceptives as a barrier to access. In at least one other set of recommendations, the Committee called for making a comprehensive range of contraceptives widely available at an affordable price and including contraceptives on the list of subsidized medicines.⁸⁹ The Committee expressed concern about the lack of family planning services in some parts of one State,⁹⁰ and called on at least one other State to ensure that contraceptives are available in rural areas.⁹¹

Information on Contraceptives

The Human Rights Committee has repeatedly indicated that States have an obligation to underscore the importance of contraceptive use when developing education and awareness-raising programs on reproductive health.⁹² In at least two instances, the Committee has emphasized that States must ensure access to information on contraception.⁹³

Emergency Contraception

The Human Rights Committee has emphasized in recommendations to at least one State that access to emergency contraceptives is an essential component of adequate sexual and reproductive health services, and that emergency contraceptives must be accessible throughout the country.⁹⁴ The Committee further lamented a decision by one State's Constitutional Court to prohibit free distribution of emergency oral contraceptives.⁹⁵

Abortion as a Method of Contraception

In at least two instances, the Human Rights Committee has expressed concern about the failure to implement laws including contraceptive coverage under a basic medical insurance benefits package,⁹⁶ linking the failure to ensure access to contraception with a reliance on abortion as a method of contraception.⁹⁷ The Committee urged at least one State to eliminate the use of abortion as a method of contraception by ensuring the provision of affordable contraception and introducing sexual and reproductive health education in school curricula and for the broader public.⁹⁸

MATERNAL HEALTH

Maternal Mortality

The Human Rights Committee has regularly expressed concern about high rates of maternal mortality.⁹⁹ The Committee has routinely noted with concern that unsafe abortions due to restrictive abortion laws contribute to high rates of maternal deaths¹⁰⁰ and repeatedly emphasizes that States must help women and girls avoid unwanted pregnancies so that they do not have to resort to illegal abortions that could put their lives at risk.¹⁰¹ In several instances, the Committee has linked high maternal mortality rates with difficulties in accessing appropriate health services,¹⁰² including a lack of health services for high-risk pregnancies,¹⁰³ inaccessible health and family planning services and facilities,¹⁰⁴ and the poor quality of provided health care.¹⁰⁵

The Human Rights Committee has called on States to take steps and strengthen efforts to reduce maternal mortality.¹⁰⁶ To this end, the Committee has urged States to provide adequate and accessible sexual and reproductive health services;¹⁰⁷ amend restrictive abortion laws;¹⁰⁸ ensure access to emergency obstetric care and health services for high-risk pregnancies;¹⁰⁹ provide adequate training for health workers;¹¹⁰ ensure access to contraceptives, including emergency contraceptives;¹¹¹ implement a nationwide network of ambulance services;¹¹² and open clinics in rural areas.¹¹³

In at least one instance, the Human Rights Committee called on a State to undertake a careful assessment of the issue of abortion and maternal mortality, given the lack of information on the extent to which high rates of abortion were a cause of high levels of maternal mortality.¹¹⁴

Early Pregnancy

The Human Rights Committee has also expressed concern on a regular basis about high rates of adolescent pregnancy¹¹⁵ and in at least one instance has lamented the lack of programs aimed at preventing teenage pregnancy.¹¹⁶ The Committee has called on at least two States to address adolescent pregnancy by providing adequate sexual and reproductive health services.¹¹⁷

SEXUALITY EDUCATION AND AWARENESS-RAISING

The Human Rights Committee has repeatedly underscored States' obligations to increase the number and ensure implementation of sexual and reproductive health education and awareness-raising programs¹¹⁸—both formally¹¹⁹ at schools and colleges and informally¹²⁰ through mass media and other communication methods. The Committee has emphasized that such programs should address sexual and reproductive health rights¹²¹ and contraceptive methods and use.¹²² In at least one instance, the Committee has emphasized that such programs should target adolescents in particular.¹²³

In at least one instance, the Committee has expressed concern that insufficient sex education in the school curriculum contributes to high rates of unsafe abortion and the attending loss of life.¹²⁴ The Committee has expressed concern to at least one other State about the nature of sex education, noting that the State should ensure that schools include accurate and objective sexuality education in their curricula.¹²⁵

FORCED STERILIZATION AND FORCED ABORTION

The Human Rights Committee has expressed concern about women being subjected to sterilization without their consent.¹²⁶ The Committee has welcomed the development of laws by several States aimed at requiring prior free and informed consent for surgical sterilization yet noted with concern that legislative developments do not meet the full range of obligations that States have to address forced and coerced sterilizations, including the obligation to make reparations to victims of forced sterilization.¹²⁷ The Committee has called on several States to ensure that women seeking sterilization have given their full and informed consent to the procedure.¹²⁸ In at least two instances, the Committee has called for necessary measures to prevent involuntary or coercive sterilization in the future,¹²⁹ including through written consent forms printed in alternate languages and an explanation of the sterilization procedure by a person competent in the patient's language.¹³⁰

In at least one instance, the Human Rights Committee has also expressed concern about employers requiring sterilization certificates as a component of women's employment and called on the State to impose appropriate sanctions to curb this illegal practice.¹³¹

Legal Capacity and Informed Consent

The Human Rights Committee has expressed concern to at least one State about a lack of legal representation for individuals who have been deprived of their legal capacity in decision-making around medical procedures, as well as the lack of a legally recognized right for individuals who have been declared legally incapacitated to initiate court procedures to review their legal capacity.¹³² The Human Rights Committee emphasized to this State that the lack of appropriate legal representation can carry negative consequences for women with disabilities deprived of their legal capacity, as it can lead to court-authorized abortions and sterilizations.¹³³ The Committee emphasized that the State should ensure free and effective legal representation for individuals in all proceedings regarding their legal capacity, including actions to have their legal capacity reviewed and in all matters impacting their physical and mental health.¹³⁴

Due Diligence Obligations

The Human Rights Committee has expressed concern to at least two States about the lack of criminal proceedings against, and punishment of, perpetrators of involuntary sterilization.¹³⁵ The Committee has underscored that States have an obligation to investigate,¹³⁶ prosecute,¹³⁷ and punish¹³⁸ perpetrators of forced and coerced sterilization, and to provide adequate remedies—including free legal assistance¹³⁹—to victims of involuntary sterilization.¹⁴⁰ In at least one instance, the Committee has also called for a State to publicize the findings of an investigation into forced and coerced sterilizations.¹⁴¹

Training and Guidance

The Human Rights Committee has called on at least two States to introduce special training for health professionals¹⁴² to raise awareness about the harmful effects of forced sterilization¹⁴³ and about patients' human rights.¹⁴⁴

Remedies and Redress

In at least two instances, the Human Rights Committee has expressed concern over a State's failure to compensate victims who were forcibly sterilized.¹⁴⁵ The Committee has called on at least one State to establish a compensation mechanism for victims who experienced forced sterilization in the past, even when those claims may have lapsed.¹⁴⁶ In at least one instance, the Committee has emphasized that a State must make reparations for past sterilizations, including through non-financial means such as a public apology.¹⁴⁷

Individual Complaints

■ Amanda Mellet v. Ireland (2016)

Amanda Jane Mellet was a pregnant woman who wanted to terminate her pregnancy because of a fatal fetal anomaly, which means the fetus would die in utero or shortly after birth.¹⁴⁸ The Irish Constitution provides a right to life for the unborn, and under Irish law, terminating a pregnancy is illegal unless the continuation of the pregnancy constitutes a substantial risk to the woman's life.¹⁴⁹ As a result, Mellet was forced to obtain an abortion in the UK and suffered grave mental consequences from the ordeal. The Human Rights Committee found that Ireland's ban on abortion in cases of fatal fetal impairment and specific treatment of Mellet in this case had violated her rights to be free from torture or ill-treatment,¹⁵⁰ to privacy,¹⁵¹ and to equality and non-discrimination on the basis of sex or gender.¹⁵² In particular, the Committee found that, because her pregnancy was not viable and the options open to her were limited and the source of intense suffering, "the interference in [Mellet's] decision as to how best cope with her non-viable pregnancy was unreasonable and arbitrary."¹⁵³ In order to ensure that Mellet received an effective remedy, the Committee specifically found that, in addition to providing compensation and psychological counseling to Mellet, Ireland must also amend its laws to ensure "effective, timely and accessible procedures for pregnancy termination in Ireland, and take measures to ensure that health-care providers are in a position to [provide] full information on safe abortion services without fearing being subjected to criminal sanction."¹⁵⁴

■ L.M.R. v. Argentina (2011)

L.M.R. was a 20-year-old woman with mental disabilities living with her mother when she became pregnant as a result of rape.¹⁵⁵ Her mother took her to the hospital and requested a legal abortion on her behalf.¹⁵⁶ Under Argentina's laws, an abortion could be legally performed on female rape victims with mental disabilities, without any need for authorization by a judge and with only the need for the consent of the victim's legal representative,¹⁵⁷ but a judge still declared an injunction that halted the abortion.¹⁵⁸ The family ultimately arranged an illegal abortion a few weeks later, when L.M.R. was approximately 23 weeks pregnant.¹⁵⁹ The Human Rights Committee found that Argentina had violated L.M.R.'s right to be free from torture or ill-treatment by denying L.M.R. access to a legal abortion, leading to physical and mental pain and suffering that was exacerbated by her status as a "young girl" with a disability.¹⁶⁰ The Committee also found that Argentina

had violated L.M.R.'s right to privacy by allowing the judiciary to arbitrarily interfere "in an issue that should have been resolved between the patient and her physician."¹⁶¹

■ **K.L. v. Peru (2005)**

K.L. was a 17-year-old girl who was pregnant with a anencephalic fetus, a condition that is fatal in all cases and meant that, if the fetus did not die before birth, the baby would die within a few days of birth.¹⁶² Under Peru's laws at the time, women could access abortion when their lives or health were at risk, but not when there was a fetal impairment;¹⁶³ however, K.L.'s doctor advised her that there was a risk to her life if she continued the pregnancy.¹⁶⁴ The director of the hospital, however, denied her an abortion. K.L. was forced to carry the fetus to term, and the baby died four days after birth.¹⁶⁵ The Human Rights Committee found that Peru had violated K.L.'s rights under the ICCPR by denying her access to a legal abortion, failing to consider her need for special protection as a minor, and failing to provide an adequate remedy.¹⁶⁶ Specifically, the Committee found that Peru had violated K.L.'s rights to be free from torture or ill-treatment, to privacy, and to special protection of the rights of minors.¹⁶⁷ In particular, the Committee noted K.L.'s "special vulnerability ... as a minor girl."¹⁶⁸ It further noted that, because abortion appeared to be legal in Peru in K.L.'s circumstances, "the refusal to act in accordance with [K.L.'s] decision to terminate her pregnancy was not justified."¹⁶⁹

Gaps in the Standards

The Human Rights Committee has covered many of the aspects of sexual and reproductive rights that are within its mandate under the ICCPR. However, there are a few areas where it could more consistently comment on these rights and provide more thorough guidance to States, including as regards the rights of women with disabilities.

In particular, the Human Rights Committee should more consistently address sexual and reproductive rights violations that disproportionately affect diverse groups of women. For instance, to date, the Committee has not fully examined rights violations against persons with disabilities in the context of sexual and reproductive rights. The Committee should better address the rights of women and girls with disabilities by recommending that States prohibit forced medical interventions and require that the women themselves provide informed consent for reproductive health interventions, protecting their right to be free from torture or ill-treatment. The Committee should also reinforce recommendations by other treaty bodies that States ensure supported decision-making and accessible information for persons with disabilities in the context of sexual and reproductive health, as a means of protecting their rights to privacy, information, and bodily integrity. In particular, where the Committee addresses the need for sexual and reproductive health services to be accessible, they could specify particular concerns of access for women with disabilities. Furthermore, the Committee could better speak to the needs of adolescents in the context of sexual and reproductive health in order to ensure their right to privacy, recommending that States ensure that sexual and reproductive health services are provided in confidential, youth-friendly environments, without the need for parental consent.

Finally, in line with comments particularly from the [CEDAW](#), [ESCR](#), and [CRPD](#) Committees, the Human Rights Committee should provide better context for how violations of sexual and reproductive rights are frequently grounded in discrimination against and harmful stereotypes about women and girls, including diverse groups of women such as women with disabilities. The Committee could ground comments on this topic in State obligations under Article 3 of the ICCPR, guaranteeing the equal right of men and women to the enjoyment of all civil and political rights.

Committee on Economic, Social, and Cultural Rights

The Committee on Economic, Social, and Cultural rights (ESCR Committee) monitors State implementation of the International Covenant on Economic, Social, and Cultural Rights (ICESCR). Through its General Comments and Concluding Observations, the ESCR Committee has demonstrated that States have an obligation to ensure access to sexual and reproductive health services, goods, and information, including sexuality education. The ESCR Committee frequently addresses sexual and reproductive rights in the context of Article 12 (right to health). The Committee has also issued recommendations concerning sexual and reproductive rights in the context of Article 13 (right to education) and Article 7 (right to just and favorable conditions of work).

General Comments

■ General Comment No. 5: Persons with disabilities (1994)

In its General Comment No. 5, the ESCR Committee cites the 1993 Standard Rules on the Equalization of Opportunity for Persons with Disabilities to establish that women with disabilities have a right to protection and support in motherhood and pregnancy and should not be denied the opportunity to experience their sexuality and to have sexual relationships.¹⁷⁰ The Committee also finds that sterilization and abortion performed on women with disabilities without their informed consent is a serious violation of the right to special protection for mothers, enshrined in Article 10(2) of the ICESCR.¹⁷¹

■ General Comment No. 14: The right to the highest attainable standard of health (2000)

In its General Comment No. 14, the ESCR Committee finds that the right to the highest attainable standard of physical and mental health is comprised of a set of freedoms and entitlements, including the right to sexual and reproductive freedom and to be free from nonconsensual medical treatments.¹⁷² The right to health also contains a right to participate in decision-making about health at the local, national, and international levels.¹⁷³ The ESCR Committee recognizes that the right to health in the ICESCR contains a specific right to sexual and reproductive health, including family planning services, pre- and post-natal care, emergency obstetric services, access to information, and the means to act on that information.¹⁷⁴ Under the right to health, States must ensure that information, goods, facilities, and services related to health care are available, accessible, acceptable, and of good quality for all persons.¹⁷⁵ Although the right to health is a right of progressive realization, even in times of resource constraint, the ESCR Committee finds that States must still prioritize ensuring non-discrimination in the right to health and ensure a minimum package of health care, including many sexual and reproductive health goods and services.¹⁷⁶

■ General Comment No. 16: The equal right of men and women to enjoyment of all economic, social, and cultural rights (2005)

In its General Comment No. 16, the ESCR Committee finds that, concerning the right to health, the equal enjoyment of rights for men and women requires States to, at a minimum, remove legal obstacles to preventing men and women from accessing health care on an equal basis.¹⁷⁷ As part of this obligation, States must address how gender roles affect social determinants of health and also remove restrictions on access to reproductive health care¹⁷⁸ while eliminating discrimination against women based on their sexual and reproductive health, including their pregnancy status.¹⁷⁹

■ General Comment No. 20: Non-discrimination in economic and social rights (2009)

In its General Comment No. 20, the ESCR Committee finds that age discrimination includes denial of equal access by adolescents to sexual and reproductive health information and services.¹⁸⁰ It also finds that denial of reasonable accommodation to persons with disabilities—including in access to public health facilities—is a form of discrimination in violation of the ICESCR.¹⁸¹

■ General Comment No. 22: The right to sexual and reproductive health (2016)

In its General Comment No. 22, the ESCR Committee explores the many aspects of the right to sexual and reproductive health for all persons as an essential part of the right to health.¹⁸² It explains that the right to sexual and reproductive health contains the freedom to make decisions about health and about the body free from violence, coercion, or discrimination.¹⁸³ The right to sexual and reproductive health also includes the right to unhindered access to the full range of sexual and reproductive health information, services, goods, and facilities.¹⁸⁴

The ESCR Committee recognizes that women and girls face particular barriers to exercising their full right to sexual and reproductive health, as do persons experiencing multiple and intersecting forms of discrimination, including persons with disabilities, who may face further barriers in both in law and in practice.¹⁸⁵ The Committee finds that States should tailor sexual and reproductive health to the specific needs of individual groups, including by ensuring that persons with disabilities have equal access not only to the same range and quality of care as others but also to services, information, and goods to address their particular needs, provided through reasonable accommodations in an accessible and dignified manner that does not further their marginalization.¹⁸⁶ In particular, the Committee recommends that States provide persons with disabilities with physically accessible facilities, information in accessible formats, decision-making support, and services needed specifically because of their disability.¹⁸⁷ The Committee also explains that States have an obligation to dismantle both practical and social barriers, including, e.g., physical barriers and social misconceptions or prejudices, to the enjoyment of the right to sexual and reproductive health.¹⁸⁸

Concluding Observations

ACCESS TO REPRODUCTIVE HEALTH INFORMATION AND SERVICES

The ESCR Committee has expressed concern to States when their population's knowledge about sexual and reproductive health issues is low¹⁸⁹ and where there is inadequate access to sexual and reproductive health information,¹⁹⁰ including due to costs.¹⁹¹ It has in particular expressed concern where access to sexual and reproductive health information and services, particularly in rural areas¹⁹² and deprived urban areas,¹⁹³ is inadequate,¹⁹⁴ and where there is a shortage of health care providers and supplies in areas of the country.¹⁹⁵ The Committee has further expressed concern where States do not have comprehensive sexual and reproductive health programs or policies in place¹⁹⁶ or in at least one State where there is a lack of access to even basic sexual and reproductive health services for the population.¹⁹⁷ In at least one instance, the Committee has noted that uterine prolapse may occur when women do not have sufficient access to sexual and reproductive health information and services.¹⁹⁸

The ESCR Committee has recommended that a number of States take steps to raise awareness about sexual and reproductive health issues¹⁹⁹ and increase access to and availability of sexual and reproductive health information and services,²⁰⁰ including by ensuring their affordability,²⁰¹ by offering them through its primary health care system,²⁰² and by developing sexual and reproductive health programs, laws, or policies.²⁰³ It has further recommended that at least one State ensure access to sexual and reproductive health care as a means of reducing uterine prolapse.²⁰⁴ The Committee has also recommended that at least one State seek the advice and assistance of international organizations to ensure sexual and reproductive health and rights.²⁰⁵

Discrimination in Health Care Access

The ESCR Committee has frequently expressed concern where communities lack access to sexual and reproductive health information and services. These communities include adolescents,²⁰⁶ minority women,²⁰⁷ lower caste women,²⁰⁸ indigenous women,²⁰⁹ refugees,²¹⁰ displaced persons,²¹¹ persons with disabilities,²¹² and LGBT persons.²¹³ The Committee has in particular expressed concern to at least one State where religious institutions or cultural beliefs have impeded access to sexual and reproductive health care.²¹⁴

The Committee has recommended that States take steps to ensure and enhance access to sexual and reproductive health information, education, and services particularly for different groups of women.²¹⁵ It has also called on at least one State to ensure that adequate resources are allocated for this purpose.²¹⁶ The Committee has further recommended that at least one State provide psychological support and undertake information campaigns to address prejudices against unwed mothers.²¹⁷

ABORTION

Criminalization of Abortion and Restrictive Abortion Laws

The ESCR Committee has consistently expressed concern about women's health in the context of laws that criminalize or restrict access to abortion,²¹⁸ including laws that do not allow women to access abortion under any circumstances,²¹⁹ do not have explicit exceptions to bans on abortion,²²⁰ or only have exceptions when women's lives²²¹ or health²²² are at risk. The Committee has expressed concern to at least one State where a restrictive abortion law led health providers to deny a woman necessary medical care, resulting in her death.²²³ It has also expressed concern to at least one State about legislation that only allows abortion in cases of rape when the rape was committed against a person with an intellectual or psychosocial disability, calling on the State to allow abortion on grounds of rape regardless of whether or not the woman in question has a disability.²²⁴ The Committee additionally recommended that the State remove demeaning references to women with intellectual or psychosocial disabilities in the context of this law.²²⁵

The Committee has noted that these restrictive laws may force women to seek out clandestine and unsafe abortions,²²⁶ leading to higher maternal mortality rates,²²⁷ and that restrictive abortion laws impact poor and less educated women in particular.²²⁸ Indeed, the Committee has expressed concern to at least one State where a law permits women to access abortion in cases of a risk to their life, fatal fetal anomaly, or when the pregnancy is a result of a crime committed against them, noting that these grounds may still be too restrictive and lead to clandestine and risky abortions.²²⁹ It has also expressed concern to at least one State where women seeking care for pregnancy complications are reported on suspicion of having had abortions,²³⁰ and to others where severe criminal penalties are imposed on women for abortions or suspected abortions,²³¹ including without adequate due process.²³² Furthermore, the Committee has expressed concern when a law imposes stiff criminal penalties on doctors who perform emergency abortions if it is later determined that the abortion was illegal, creating a possible chilling effect on the provision of even legal abortion.²³³

The ESCR Committee has recommended that States consider decriminalizing abortion or revise legislation to permit abortion when a woman's health or life is at risk and when the pregnancy is a result of rape or incest.²³⁴ It has also recommended that States decriminalize abortion in cases of fetal anomaly,²³⁵ revise laws to reduce the scope and severity of punishments for abortion,²³⁶ and refrain from penalizing health care providers for the exercise of their professional responsibilities in the context of abortion.²³⁷ Further, the Committee has recommended that States facilitate access to professional services with a view towards eliminating the practice of unsafe abortion²³⁸ and that at least one State refrain from adopting laws further limiting access to abortion.²³⁹ It has also recommended to at least one State that it hold a referendum on abortion.²⁴⁰

In recent concluding observations, the ESCR Committee has recommended that States "liberalize" their abortion laws,²⁴¹ including as a means of reducing unsafe abortion and maternal mortality,²⁴² or otherwise amend their laws on abortion to make them more compatible with women's rights to health, life, and dignity, without specific recommendations about when abortion should be decriminalized.²⁴³ In some of these contexts, however, States already allowed abortion in cases of risk to the pregnant woman's life²⁴⁴ or health,²⁴⁵ fetal anomaly,²⁴⁶ and rape or incest,²⁴⁷ indicating that the ESCR Committee wishes for laws to be further liberalized to ensure access to abortion in a wider variety of circumstances.

Practical and Procedural Barriers to Abortion

The ESCR Committee has expressed concern to at least one State where access to legal abortion is not sufficiently regulated²⁴⁸ and to another where there are many obstacles to gaining access to legal abortion,²⁴⁹ including lack of legal and procedural clarity on when and how abortion should be performed.²⁵⁰ It has noted to at least one State that lack of access to legal abortion may force women to resort to illegal and unsafe abortion.²⁵¹ In particular, the Committee has expressed concern to States where doctors are increasingly using conscientious objection, thus hindering access to legal abortion,²⁵² and to at least one State where doctors' use of conscientious objection is not sufficiently regulated, such that doctors are not required to refer women to safe abortion providers.²⁵³ Furthermore, the Committee has expressed concern to at least one State where health providers and public prosecutors direct abusive behavior towards pregnant rape victims, thereby limiting their access to abortion.²⁵⁴

The ESCR Committee has recommended that States establish protocols or guidelines for providing legal abortion²⁵⁵ and ensure that legal abortion information and services are available, accessible, and affordable for all women, including adolescents.²⁵⁶ It has also recommended that States ensure that conscientious objection does not pose an obstacle to accessing legal abortion for women who wish to terminate a pregnancy²⁵⁷ and that at least one State establish an effective referral mechanism for abortions where health providers exercise conscientious objection.²⁵⁸ Further, it has recommended that at least one State ensure and monitor access to legal abortion specifically in cases of rape.²⁵⁹

Post Abortion Care

The ESCR Committee has recommended that States ensure access to health facilities, supplies, and services to reduce pre- and post-abortion risks,²⁶⁰ such as post-abortion care and counseling,²⁶¹ including as a means of combating the prevalence of unsafe and illegal abortions.²⁶² In particular, it has recommended that at least one State focus on providing quality treatment for complications from abortions carried out in unsafe conditions, rather than on prosecutions of illegal abortions.²⁶³

Access to Information on Abortion

The ESCR Committee has expressed concern to at least one State about lack of access to information on abortion within the State, particularly for poor women.²⁶⁴ It has also expressed concern about misinformation regarding abortion in at least one State, obstructing access to legal abortion for victims of rape.²⁶⁵ The Committee recommended that the State publicize information about crisis pregnancy options to women through effective channels of communication.²⁶⁶ The Committee has further determined that mandatory counseling prior to abortion is only acceptable if it is neutral and supports the informed choice of women.²⁶⁷

Training and Guidance

The ESCR Committee has recommended that at least one State raise awareness among health care providers and women about when abortion is legal to avoid unsafe abortions and maternal mortality.²⁶⁸ It has also recommended that one State upgrade training and service delivery to ensure the full implementation of its law on abortion.²⁶⁹

Selective Abortion

The ESCR Committee has frequently criticized States with distorted sex ratios, which the Committee often links to sex-selective abortion,²⁷⁰ and about a high rate of abortion particularly for girl fetuses.²⁷¹ The Committee attributes sex-selective abortion to discrimination against women and to son preferences.²⁷²

The ESCR Committee has recommended that at least one State prevent sex-selective abortion by ensuring access to family planning services and minimizing unsafe abortion.²⁷³ The Committee has also recommended that States examine and tackle the root causes of sex-selective abortion,²⁷⁴ including by conducting studies on the practice,²⁷⁵ taking steps to eliminate discrimination against women, including patriarchal attitudes and stereotypes,²⁷⁶ and raising awareness about gender equality.²⁷⁷

ACCESS TO CONTRACEPTIVE INFORMATION, GOODS AND SERVICES

The ESCR Committee has expressed concern to States when there is a lack of access to modern contraceptive information and services²⁷⁸ or low rates of use of contraception.²⁷⁹ It has also expressed concern to at least one State where contraception is not free of charge.²⁸⁰ The Committee has recommended that States ensure that contraceptive information and services are available, accessible, and affordable for all women, including adolescents²⁸¹ and including in rural areas.²⁸² It has further recommended that States adequately fund the free distribution of contraceptives and remove user fees for public and private family planning services.²⁸³ The Committee has also frequently recommended that States raise awareness about modern and safe contraceptive methods.²⁸⁴

Emergency Contraception

The ESCR Committee has expressed concern to States about restrictions on access to emergency contraception,²⁸⁵ including bans on its use and distribution²⁸⁶ and the removal of emergency contraception as a medication provided through public health programs.²⁸⁷ It has particularly expressed concern to at least one State where emergency contraception is not available to victims of rape.²⁸⁸ The Committee has recommended that at least one State remove barriers to accessing emergency contraception,²⁸⁹ including by removing bans on its use and distribution, ensuring its availability, accessibility, and affordability (including for adolescents and in rural areas), and reinstating the medication as part of the public health program.²⁹⁰ In particular, it has recommended that at least one State remove restrictions on the free distribution of emergency contraception, take steps to overcome prejudices about the use of emergency contraception, and raise awareness about women's right to access emergency contraception.²⁹¹

Abortion as a Method of Contraception

The ESCR Committee has expressed concern about high numbers of abortions in States,²⁹² particularly where abortion appears to be a principle method of contraception.²⁹³ In particular, the ESCR Committee has noted that in at least one State, using abortion as a method of contraception may put women's health at risk.²⁹⁴ It has recommended that at least one State raise awareness about safe contraceptive methods and about the health consequences of using abortion as a method of contraception.²⁹⁵

MATERNAL HEALTH

The ESCR Committee has expressed concern to at least one State where women have poor knowledge about maternal health²⁹⁶ and to another about the low quality of maternal health services.²⁹⁷ It has also expressed concern to at least one State where there are low rates of births attended by skilled birth attendants, particularly in rural areas.²⁹⁸

Maternal Mortality

The ESCR Committee has frequently expressed concern about high rates of maternal mortality,²⁹⁹ including among adolescents and young women.³⁰⁰ It has attributed these high rates in various countries to unsafe abortion.³⁰¹ The Committee also has linked maternal mortality to lack of access to prenatal and/or postnatal care,³⁰² a lack of trained health providers including skilled birth attendants,³⁰³ complications related to pregnancy and childbirth,³⁰⁴ high fees for services,³⁰⁵ lack of access to contraception,³⁰⁶ low quality maternal health services,³⁰⁷ and women's lack of knowledge about maternal health,³⁰⁸ in particular in rural areas.³⁰⁹

To reduce maternal mortality, the ESCR Committee has recommended that States take steps to reduce the incidence of unsafe abortion,³¹⁰ including by reviewing legislation on abortion,³¹¹ ensuring access to legal abortion³¹² and to post-abortion care,³¹³ and ensuring that abortion is performed under sanitary conditions by trained providers.³¹⁴ It has also recommended that States take urgent steps to tackle maternal mortality,³¹⁵ including by promoting greater access to all health services for women, including quality maternal and reproductive health services,³¹⁶ such as skilled birth attendants,³¹⁷ particularly for adolescents³¹⁸ and diverse

groups of women³¹⁹ and particularly in rural areas.³²⁰ In particular, it has recommended that at least one State provide access to waiting homes for women and provide accommodations and living allowances for midwives, to ensure access to maternal health services in remote areas.³²¹ It has also recommended that at least two States provide further assistance and training for midwives.³²²

Early Pregnancy

The ESCR Committee frequently expresses concern about high rates of teenage pregnancy in States,³²³ due to, for instance, inadequate access to sexual and reproductive health services,³²⁴ including contraception.³²⁵ In this context, it has expressed concern about high rates of abortion among adolescents,³²⁶ including illegal and unsafe abortion, which puts their health and lives in danger.³²⁷ The Committee has further expressed concern about early pregnancy in the context of adolescents' right to education and health,³²⁸ particularly where teenage pregnancy leads girls to drop out of school,³²⁹ including due to stigma.³³⁰ The Committee has also expressed concern where teenagers resort to abortion because of the stigma attached with being an unwed mother.³³¹

The ESCR Committee has recommended that States ensure access to sexual and reproductive health information and services for adolescents,³³² including family planning or contraceptive services³³³ and sexuality education,³³⁴ as a means of preventing early pregnancy. In particular, it has recommended that States ensure access to sexual and reproductive health information and services without the need for parental consent.³³⁵ It has also recommended that States provide support to pregnant teenage adolescents, including support to enable them to continue their education.³³⁶

SEXUALITY EDUCATION AND AWARENESS-RAISING

The ESCR Committee frequently recommends that States ensure access to education about sexuality and reproduction³³⁷ for everyone, in particular adolescents,³³⁸ and as part of primary and secondary school curricula³³⁹ and in informal settings.³⁴⁰ It has recommended that this education be comprehensive,³⁴¹ up-to-date,³⁴² and age-appropriate,³⁴³ that it be provided to both sexes,³⁴⁴ and that it contain information about preventing sexually transmitted infections and early pregnancies,³⁴⁵ as well as information about modern contraceptives³⁴⁶ and responsible sexual conduct.³⁴⁷ It has also recommended that States undertake this education as a means of reducing high rates of maternal mortality³⁴⁸ and early pregnancy.³⁴⁹ The Committee has further recommended that sexuality education be mandatory in schools,³⁵⁰ that it be objective and meet medical and educational standards,³⁵¹ and that it be based on a human rights perspective.³⁵²

FORCED STERILIZATION AND FORCED ABORTION

The ESCR Committee has occasionally expressed concern to States about cases of forced sterilization,³⁵³ as well as to at least one State about high rates of forced abortion,³⁵⁴ including the context of population policies.³⁵⁵ It has also expressed concern where laws and policies require informed consent for sterilization, but where in practice these laws and policies have not stopped the non-consensual sterilizations of women.³⁵⁶ The Committee in particular has expressed concern where these forced reproductive health practices are focused primarily on ethnic minority women³⁵⁷ and women with disabilities.³⁵⁸ For instance, the ESCR Committee has expressed concern where the decision to undergo sterilization may be taken by a legal representative, rather than a woman with a disability.³⁵⁹

The ESCR Committee has recommended that at least one State implement safeguards to ensure that the rights of women and girls with disabilities are protected, including by developing a model of supported decision-making in matters related to sexual and reproductive health.³⁶⁰ It has also recommended that at least one State clearly define requirements for free, prior, and informed consent for sterilization and raise awareness among health care providers about these standards.³⁶¹ The Committee has further recommended that at least one State take measures to ensure that abortions are carried out voluntarily and under safe conditions.³⁶² Finally, the

Committee has recommended that a State investigate without delay all cases of forced sterilization and guarantee adequate funding for those investigations,³⁶³ and it has also recommended that a State ensure that victims of forced sterilization receive adequate reparations.³⁶⁴

Individual Complaints

The ESCR Committee's individual complaint mechanism only went into effect in 2013, and, as of June 2017, there are no decisions on individual complaints related to sexual and reproductive health and rights.

Gaps in the Standards

Although the ESCR Committee's General Comments and Concluding Observations have addressed many of the issues women and girls with disabilities face when exercising their sexual and reproductive rights, there are a few areas where its comments could be more comprehensive. For instance, given its General Recommendation No. 22 on the right to sexual and reproductive health—which underscores States' obligations to eradicate practical and social barriers to sexual and reproductive health services—the Committee should more consistently comment on accessibility and attitudinal barriers that women and girls with disabilities face when accessing sexual and reproductive health care. Practical barriers include physical, financial, communication, and informational barriers to access. Social barriers include stereotypes held by health care professionals and communities about women with disabilities' sexuality, decision-making capacity, and ability to parent. It is important for advocates to raise these points with the Committee, so that it has the opportunity to address issues affecting women with disabilities during State reviews.

Taking a cue from other treaty bodies, in particular the [CRPD](#) and [CERD](#) Committees, the ESCR Committee should also more consistently address the issue of forced or coerced reproductive health procedures, including forced or coerced sterilization and abortion. In particular, it would be helpful for the Committee to reinforce agreed ethical guidelines on what constitutes “informed consent,” such as those outlined by the International Federation of Gynecology and Obstetrics,[‡] in the context of the acceptability of health services. It is also important for the Committee to reinforce what steps States should take to meet their obligation to ensure women and girls with disabilities give their voluntary and informed consent for health-related procedures, to investigate allegations of forced or coerced reproductive health procedures performed on women and girls with disabilities, and to provide redress to victims of these human rights violations.

[‡] International Federation of Gynecology and Obstetrics (FIGO), *Ethical Issues in Obstetrics and Gynecology* 122 (October 2012), available at <https://www.figo.org/sites/default/files/uploads/wg-publications/ethics/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf>.

Committee on the Rights of Persons with Disabilities

The Committee on the Rights of Persons with Disabilities (CRPD Committee) monitors State obligations under the Convention on the Rights of Persons with Disabilities (CRPD). Through its General Comments and Concluding Observations, the CRPD Committee has frequently called on States to ensure sexual and reproductive rights, and in particular the right to be free from forced reproductive health interventions. The Committee most often addresses these issues under Articles 1-4 (general principles of the CRPD), 5 (discrimination), 6 (rights of women and girls with disabilities), 17 (right to bodily integrity), 23 (rights in the family), 24 (right to education), and 25 (right to health). The Committee could also address these issues under Articles 8 (awareness raising), 9 (accessibility), 10 (right to life), 12 (recognition before the law and legal capacity), 15 (right to be free from torture), 16 (freedom from exploitation, violence and abuse), and 22 (right to privacy and in the family).

General Comments

■ General Comment No. 1: Article 12: Equal recognition before the law (2014)

In General Comment No. 1, the CRPD Committee examines the issue of legal capacity for persons with disabilities. The CRPD Committee distinguishes legal capacity from mental capacity, noting that “perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity.”³⁶⁵ The Committee finds that denying persons with disabilities legal capacity leads to violations of many of their rights, including their reproductive rights and right to give consent to medical treatment.³⁶⁶ In particular, the Committee notes that the right to health includes the right to health care on the basis of free and informed consent.³⁶⁷ Under the right to legal capacity, States have an obligation to ensure that substitute decision-makers—such as guardians—cannot provide consent to medical treatment for persons with disabilities,³⁶⁸ and States must abolish any substituted decision-making regimes or health laws that permit forced treatment.³⁶⁹ The Committee recommends that only persons with disabilities themselves be permitted to provide informed consent for decisions relating to their physical and mental integrity,³⁷⁰ and States “must provide persons with disabilities access to the support that may be necessary to enable them to make decisions that have legal effect.”³⁷¹ Supported decision-making is a broad concept that includes both informal and formal support arrangements and may include, for instance, the use of “one or more trusted support persons, ... peer support, advocacy (including self-advocacy support), or assistance with communication.”³⁷²

■ General Comment No. 2: Article 9: Accessibility (2014)

In its General Comment No. 2 on accessibility, the CRPD Committee finds that the right to be free from discrimination includes an obligation to ensure that persons with disabilities have equal access to all goods, products, and services that are open to the public, including when provided by private entities.³⁷³ The Committee notes that the exercise of the right to health is not possible without accessible premises where health care services are provided, accessible transportation to access those locations, and accessible information and communication about health, including through sign language, Braille, accessible electronic formats, alternative script, and alternative means of communication.³⁷⁴ In particular, the Committee notes that States should take the “gender dimension” into account when ensuring that reproductive health services are accessible to women and girls with disabilities.³⁷⁵

■ General Comment No. 3: Women and girls with disabilities (2016)

In its General Comment No. 3, the CRPD Committee highlights sexual and reproductive health and rights violations as one of the main issues disproportionately affecting women and girls with disabilities.³⁷⁶ The Committee recognizes that stereotypes about women with disabilities—including that they are asexual or hypersexual incapable, irrational, uncontrollable, or may give birth to persons with disabilities—often lead to violations of their sexual and reproductive rights.³⁷⁷ As a result, women with disabilities may not receive

information about reproductive health, including in accessible formats,³⁷⁸ making them in turn more vulnerable to sexual violence and abuse.³⁷⁹ Women with disabilities may also face physical, economic, and attitudinal barriers to accessing needed sexual and reproductive health services.³⁸⁰ The Committee further finds that women with disabilities must be allowed to exercise their legal capacity concerning sexual and reproductive rights by making their own decisions, based on free and informed consent, related to sexuality, fertility, and reproduction³⁸¹ and recommends that States prohibit forced interventions, including forced sterilization, contraception, and abortion.³⁸²

■ **General Comment No. 4: Article 24: Right to inclusive education (2016)**

In its General Comment No. 4, the CRPD Committee recognizes that education must be directed at ensuring that persons with disabilities can participate fully in a free society,³⁸³ including by ensuring that persons with disabilities build their confidence in exercising legal capacity³⁸⁴ and can exercise their right to health.³⁸⁵ In particular, the Committee notes that States must provide persons with disabilities, on an equal basis with others, with access to comprehensive and inclusive sexuality education that is age-appropriate, based on scientific evidence, including human rights standards, and is provided in accessible formats.³⁸⁶

■ **General Comment No. 5: Article 19: Living independently and being included in the community (2017)**

In its General Comment No. 5, the CRPD Committee notes that personal autonomy and self-determination, including regarding sexual and reproductive rights, are fundamental to living independently.³⁸⁷ The Committee also notes that women with disabilities are more susceptible to violations of their reproductive rights—including forced sterilization—when they are denied the right to live independently, particularly when they are institutionalized and thus further isolated from the community.³⁸⁸ The Committee finds that it is imperative that States monitor this issue as part of monitoring conditions in institutions and that States provide redress for women exposed to gender-based violence, including forced sterilization, in institutions.³⁸⁹

Concluding Observations

ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH INFORMATION AND SERVICES

The CRPD Committee has frequently expressed concern about persons with disabilities lacking access to sexual and reproductive health information and services,³⁹⁰ including physical access³⁹¹ and including in rural areas.³⁹² In particular, it has expressed concern to at least one State where gynecological and obstetric services are not accessible to women with disabilities³⁹³ and where States' policies and laws related to health exclude consideration of persons with disabilities.³⁹⁴ Further, it has expressed concern where health care providers lack training to meet the specific needs of persons with disabilities, including in sexual and reproductive health care.³⁹⁵

The CRPD Committee has recommended that States ensure the accessibility of health facilities, equipment, information (provided in accessible formats), and communications regarding sexual and reproductive health care,³⁹⁶ including by ensuring a gender perspective³⁹⁷ and by collaborating with organizations of women with disabilities.³⁹⁸ It has classified the denial of these accommodations as a form of discrimination.³⁹⁹ The Committee has specifically recommended that States provide accessible information and services to women with disabilities concerning their rights under Article 25 (right to health)⁴⁰⁰ and provide training to health personnel on the rights of persons with disabilities⁴⁰¹ and accessible and inclusive health care to persons with disabilities.⁴⁰² It has also recommended that at least one State recruit and hire professional guides and sign language interpreters to staff health centers.⁴⁰³ Furthermore, the Committee has recommended that at least one State take measures to ensure that health care services are affordable to persons with disabilities.⁴⁰⁴

Discrimination in Health Care Access

The CRPD Committee has expressed concern about discrimination against persons with disabilities, particularly women with disabilities, in access to health information and services, including in sexual and reproductive health care.⁴⁰⁵ In particular, it has noted that women with disabilities may be subjected to harmful stereotypes, such as that they are asexual,⁴⁰⁶ when accessing sexual and reproductive health information and services,⁴⁰⁷ and that some service providers hold prejudices or negative attitudes towards persons with disabilities.⁴⁰⁸ The Committee has recommended that at least one State “strengthen mechanisms” to combat discrimination and stereotyping in the provision of health care,⁴⁰⁹ including by prohibiting discrimination on the grounds of disability in laws and policies related to health care.⁴¹⁰ It has also recommended that at least one State ensure sexual and reproductive rights for persons with disabilities on an equal basis with others, including in matters related to their fertility.⁴¹¹

The CRPD Committee has frequently expressed concern about States performing medical procedures on persons with disabilities—particularly persons with psychosocial or intellectual disabilities⁴¹²—without their full free and informed consent,⁴¹³ including because of specific restrictions on the ability of persons with disabilities to provide informed consent.⁴¹⁴ It has also expressed concern about the lack of training for health care providers on the rights of persons with disabilities, including on the issue of free and informed consent.⁴¹⁵ The Committee has recommended that States abolish laws that allow medical treatment of persons with disabilities without informed consent and adopt legislation that specifically provides the right of persons with disabilities to provide full free and informed consent for medical treatment.⁴¹⁶ The Committee has further called on at least one State to abolish systems of guardianship, specifically so that women with disabilities can exercise their right to sexual and reproductive autonomy on an equal basis with others.⁴¹⁷ It has also recommended that States provide training to health care providers on the issue of informed consent.⁴¹⁸

ABORTION

Selective Abortion

The CRPD Committee has expressed concern about laws on abortion that allow women to legally access abortion for longer periods of time in cases of fetal impairment, sometimes classifying these laws as a form of disability discrimination.⁴¹⁹ Although it has recognized the need to ensure women’s reproductive autonomy,⁴²⁰ it has recommended that States eliminate provisions in their laws on abortion that make distinctions about when women can terminate their pregnancies based on disability.⁴²¹

ACCESS TO CONTRACEPTIVE INFORMATION, GOODS, AND SERVICES

The CRPD Committee has infrequently made comments to States related to contraception, with the exception of sterilization, discussed in more detail below.

MATERNAL HEALTH

Early Pregnancy

In one instance, the CRPD Committee expressed concern to a State about the high rates of early pregnancy for women with disabilities, more than half of whom experience their first pregnancy between the ages of 15 and 19, relating this high rate back to likely sexual abuse.⁴²² It recommended that the State provide a targeted training program on sexual and reproductive rights to women with disabilities, their families, and service providers.⁴²³

SEXUALITY EDUCATION AND AWARENESS-RAISING

The CRPD Committee has expressed concern in several instances where persons with disabilities do not have access to sexual and reproductive health education.⁴²⁴ It has recommended that age-appropriate and accessible information and education on sexual and reproductive health and family planning be made available to all persons with disabilities.⁴²⁵

The CRPD Committee has also called on at least one State to undertake public health campaigns aimed at persons with disabilities, including those addressing their sexual and reproductive health and rights.⁴²⁶ Further, it has called on States to raise awareness among the public, families, and service providers about the rights of persons with disabilities in the context of sexual and reproductive health.⁴²⁷ Specifically, it has called on States to raise awareness among health care professionals about the human rights model of disability,⁴²⁸ including through training on the right to free and informed consent.⁴²⁹

FORCED STERILIZATION, FORCED CONTRACEPTION, AND FORCED ABORTION

The CRPD Committee has expressed concern about sterilization being used as a main form of contraception for persons with disabilities.⁴³⁰ Further, the Committee has expressed concern to at least one State where forced sterilization of women with disabilities still occurs despite legal bans on the practice⁴³¹ and to another where forced sterilization of persons with disabilities is considered a “medical necessity.”⁴³²

Legal Capacity and Informed Consent

The CRPD Committee has repeatedly expressed concern about State laws, policies, and practices that allow for the sterilization of persons with disabilities without their informed consent,⁴³³ and frequently only with the consent of parents or guardians, or with a court order,⁴³⁴ or laws that otherwise do not protect persons with disabilities from forced sterilization.⁴³⁵ In particular, the Committee has expressed concern where laws deprive persons with disabilities of legal capacity or declare them mentally incompetent, thereby denying them free and informed consent for medical procedures.⁴³⁶ It also has expressed concern about situations where children with disabilities in particular are subjected to sterilization without informed consent,⁴³⁷ and where sterilization frequently occurs in institutions, including psychiatric hospitals.⁴³⁸

The CRPD Committee has also expressed concern to States where laws and practices also permit abortion for women and girls with disabilities without their free and informed consent,⁴³⁹ and where legal guardians and others can provide consent for abortion.⁴⁴⁰ It has also expressed concern where health care providers pressure women with disabilities to undergo abortion when they become pregnant.⁴⁴¹ It has further expressed concern about the use of contraceptives on persons with disabilities who have been deprived of legal capacity, without their consent.⁴⁴²

The CRPD Committee has recommended that States abolish or amend laws and directives that allow for forced sterilization or abortion without the informed consent of persons with disabilities, including laws that allow a third party to provide consent for these procedures.⁴⁴³ It has also called on States to abolish laws stripping persons with disabilities of legal capacity⁴⁴⁴ and instead provide them support in making decisions, including decisions about their health and sexuality.⁴⁴⁵ Furthermore, it has recommended that States “protect” persons with disabilities from forced sterilization and forced abortion, including by ensuring that the right to provide full free and informed consent is upheld⁴⁴⁶ and that women are provided with accessible information on their sexual and reproductive rights.⁴⁴⁷ It has also called on at least one State to ensure that prior free and informed consent be required from all individuals, including those deprived of legal capacity, before performing irreversible medical procedures, such as sterilization, on them.⁴⁴⁸ In particular, it has called on a State to unconditionally prohibit the sterilization of girls and boys with disabilities.⁴⁴⁹

Due Diligence Obligations

The CRPD Committee has expressed concern about lack of investigations into instances of forced sterilization of persons with disabilities and others.⁴⁵⁰ It has recommended that States undertake investigations of forced sterilization,⁴⁵¹ including administrative and criminal investigations,⁴⁵² and punish perpetrators.⁴⁵³ It has also recommended that mechanisms providing protection against forced sterilization be effective and accessible,⁴⁵⁴ including through review by an independent authority,⁴⁵⁵ and that States establish mechanisms to monitor health facilities.⁴⁵⁶ Further, the Committee has called on at least one State to investigate instances where women with disabilities have been pressured to undergo abortions and to punish the health providers involved,⁴⁵⁷ and it has called on another State to investigate allegations of forced abortion of women with disabilities following sexual abuse.⁴⁵⁸

Training and Guidance

The CRPD Committee has recommended that at least one State provide training to health care providers on the issue of informed consent for medical treatment, including in the context of sterilization and abortion.⁴⁵⁹ In at least one State where judges or other legal system actors can authorize sterilization, it has called on States to provide training to judges and prosecutors on the rights of persons with disabilities and on informed consent.⁴⁶⁰ The Committee has further called on at least one State to raise awareness among families, communities, and institutions as a means of eradicating the practice of forced sterilization.⁴⁶¹ It has also called on at least one State to provide training to health care providers on alternative communication techniques to work with persons with disabilities.⁴⁶²

Remedies and Redress

The CRPD Committee has expressed concern to at least one State about lack of redress measures for persons subjected to forced sterilization.⁴⁶³ It has called on States to provide redress, including specific remedies and compensation, for victims of forced medical procedures, including sterilization and abortion.⁴⁶⁴

Individual Complaints

As of June 2017, the CRPD Committee has not issued any decisions on individual complaints related to sexual and reproductive health and rights.

Gaps in the Standards

There are several ways the CRPD Committee could more fully address the sexual and reproductive health and rights of women and girls with disabilities.

For instance, the CRPD Committee has not made any comments related to ensuring consensual access to modern contraceptives for persons with disabilities on an equal basis with others. Access to contraceptives is an important part of ensuring that women with disabilities can control their health and fertility, as well as the course of their lives. Given that women with disabilities are frequently denied access to sexual and reproductive health information and services due to physical, informational, and attitudinal barriers and stereotypes about their need for such services, it is likely that there is an unmet need for contraceptives within this population. As such, it would be helpful for the CRPD Committee to ask States to provide data on the unmet need for contraceptives among women and girls with disabilities and for advocates to raise this issue with the Committee.

The Committee also has not made any comments related to emergency contraception for women and girls with disabilities. This is a significant gap, given that women and girls with disabilities are at higher risk of sexual violence than are other women. As several other treaty bodies have noted, access to emergency contraception following sexual violence is an important part of ensuring women's rehabilitation from that violence and also preventing severe pain and suffering that may result from an unwanted pregnancy.

Additionally, concerning abortion, the CRPD Committee's comments have focused almost exclusively on forced abortion or abortion in cases of fetal impairment, without recognizing that women with disabilities may themselves face barriers to accessing needed and consensual abortion services due to stereotypes, the inaccessibility of information and services surrounding abortion, and the attitudes of health providers. These barriers are likely compounded by practices like the unregulated use of conscientious objection, mandatory waiting periods, and biased or misleading counseling, given that barriers to accessing other providers, returning to health facilities on another day to obtain abortions, or accessing accurate information about abortion outside of health facilities are often exacerbated for women with disabilities.

The CRPD Committee's recommendations to date concerning abortion in cases of fetal impairment have also not fully embraced the need to ensure that women in general, including women with disabilities, can access needed abortion services to protect their rights. The CRPD Committee should recommend that States decriminalize abortion in all circumstances, similar to the recent concluding observations from the [CRC](#), [CEDAW](#), and [ESCR](#) Committees, while ensuring that abortion information and services are accessible, affordable, provided on the basis of non-discrimination, and provided through informed consent and with dignity to women and girls with disabilities. The CRPD Committees should emphasize both the need for providers to be trained on the rights of people with disabilities and available services to ensure that they are able to give unbiased, accurate, and evidence-based information and counseling on disability to pregnant women and their families and the obligation of States to provide services and supports to children born with disabilities and their families. The CRPD Committee should also request that States provide data about how procedural barriers to accessing abortion specifically affect women with disabilities.

Committee on the Elimination of Discrimination against Women

The Committee on the Elimination of Discrimination against Women (CEDAW Committee) monitors State implementation of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Through its General Recommendations, Concluding Observations, and Individual Complaints, the CEDAW Committee has a long history addressing sexual and reproductive rights for all women and girls, including women with disabilities. The Committee frequently addresses these rights under Articles 2 (non-discrimination), 5 (stereotyping), 10 (right to education), 12 (right to health), 14 (rights of rural women), and 16(e) (right to decide on the number and spacing of children).

General Recommendations

■ General Recommendation No. 15 (HIV/AIDS) (1990)

In its General Recommendation No. 15, the CEDAW Committee considers the effects on the rights of women surrounding HIV/AIDS and strategies to control it. The Committee recommends that States focus on the vulnerability of women to HIV due to their reproductive role, including in societies where women are in a subordinate position.⁴⁶⁵

■ General Recommendation No. 18: Disabled women (1991)

Noting that women with disabilities suffer from double discrimination, the CEDAW Committee in General Recommendation No. 18 recommends that States take special measures to ensure the rights of women with disabilities, including in the context of health services.⁴⁶⁶

■ General Recommendation No. 19: Violence against women (1992)

In its General Recommendation No. 19 on violence against women, the CEDAW Committee recognizes that forced (compulsory) sterilization and abortion negatively affect women's physical and mental health and are violations of their rights under Article 16 (the right to decide on the number and spacing of children).⁴⁶⁷ It recommends that States take measures to prevent reproductive and fertility-related coercion.⁴⁶⁸ The Committee also recommends that States ensure that women do not have to resort to unsafe medical procedures, such as unsafe abortion, because they lack access to appropriate services for controlling their fertility.⁴⁶⁹

■ General Recommendation No. 21: Equality in marriage and family relations (1994)

In its General Recommendation No. 21, the CEDAW Committee recognizes that women have the right to decide on the number and spacing of their children in part because children impose inequitable responsibilities and burdens of care work on women,⁴⁷⁰ which in turn affects their rights to education, employment, and to access other activities related to personal development.⁴⁷¹ The Committee also recognizes the harm caused by coercive reproductive practices—such as forced abortion, forced sterilization, and forced pregnancies—and notes that a woman's decision to have children, or not, should never be limited by spouses, parents, partners, or the State.⁴⁷²

■ General Recommendation No. 23: Political and public life (1997)

In its General Recommendation No. 23, the CEDAW Committee recognizes that women have traditionally been assigned to the private and domestic sphere, due to their reproductive capacity.⁴⁷³ This means that women have historically been excluded from public life, and men have exercised power to confine women in the private sphere, affecting women's exercise of rights.⁴⁷⁴

■ **General Recommendation No. 24: Women and health (1999)**

In its General Recommendation No. 24, the CEDAW Committee focuses on women's right to health under Article 12, finding that, in order for States to eliminate discrimination against women, they must provide health care services to prevent, detect, and treat illnesses specific to women, including those related to sexuality and reproduction.⁴⁷⁵ The Committee also recognizes that women and girls experience higher rates of violence, harmful practices, and sexual abuse that can impact their health, including their sexual and reproductive health.⁴⁷⁶ In particular, the Committee notes that States should prohibit forced or coerced practices, such as non-consensual sterilization, mandatory pregnancy testing, or mandatory testing for sexually transmitted diseases.⁴⁷⁷ Concerning women with disabilities, it recommends that States ensure that health services are accessible and sensitive to their needs, while respecting their human rights.⁴⁷⁸

■ **General Recommendation No. 26: Women migrant workers (2008)**

In its General Recommendation No. 26, the CEDAW Committee finds that women migrant workers suffer from inequality in access to health care, including reproductive health services, due to their lack of health insurance or access to national health schemes.⁴⁷⁹ The CEDAW Committee recommends that States provide education and raise awareness for women migrant workers about sexual and reproductive health.⁴⁸⁰

■ **General Recommendation No. 27: Older women (2010)**

In its General Recommendation No. 27, the CEDAW Committee recognizes that older women may be viewed as a burden and face neglect due to gender stereotypes, and specifically because they are no longer considered to have a productive or reproductive role,⁴⁸¹ and that information on sexual health and HIV/AIDS may not be provided in appropriate and accessible ways to older women.⁴⁸² The Committee recommends that States adopt a comprehensive health care policy aimed at older women, and design special programs for older women with a focus on women with disabilities.⁴⁸³

■ **General Recommendation No. 30: Women in conflict prevention, conflict and post-conflict situations (2013)**

In its General Recommendation No. 30, the CEDAW Committee notes that access to essential sexual and reproductive health care services is disrupted during times of conflict due to inadequate infrastructure, as well as low numbers of health care workers, medicines, and supplies.⁴⁸⁴ As a result, there is a higher risk for violence, unwanted pregnancy, sexual or reproductive injury, and contracting STIs, including HIV/AIDS, during conflict and post-conflict situations.⁴⁸⁵ The Committee recommends that States ensure access to sexual and reproductive health information and services, including family planning, emergency contraception, maternal health services, safe abortion, post-abortion care, and prevention and treatment for HIV/AIDS and other STIs, during conflict and post-conflict situations.⁴⁸⁶

■ **Joint General Recommendation No. 31: Harmful Practices (2014)**

In this Joint General Recommendation No. 31, the CEDAW Committee and the Committee on the Rights of the Child (CRC Committee) describe how harmful practices—such as female genital mutilation and child, early, and forced marriage—impact sexual and reproductive health and rights,⁴⁸⁷ noting that these practices are connected to and reinforce socially constructed gender roles and often reflect discriminatory beliefs about certain groups of women and girls, including women and girls with disabilities.⁴⁸⁸ Concerning sexual and reproductive rights in particular, the Committees note that women and girls who are at risk of harmful practices likely also encounter barriers to decision-making regarding their sexual and reproductive health and rights.⁴⁸⁹ To reduce harmful practices, the Committees recommend that States ensure that girls complete primary and secondary school⁴⁹⁰ and ensure access to information and education on sexual and reproductive health, including the impact of harmful practices.⁴⁹¹

■ **General Recommendation No. 33: Women’s access to justice (2015)**

In its General Recommendation No. 33, the CEDAW Committee recommends that States decriminalize actions undertaken only women and girls, such as abortion.⁴⁹² It also recommends that States abolish rules and practices requiring third-party authorization—such as parental or spousal consent—for girls to access needed health services, including sexual and reproductive health services, as well as legal services and judicial mechanisms.⁴⁹³

■ **General Recommendation No. 34: The rights of rural women (2016)**

In its General Recommendation No. 34, the CEDAW Committee recognizes that rural women frequently experience disproportionate barriers to exercising their sexual and reproductive rights due to social norms, insufficient budget allocations, lack of trained personnel and health infrastructure, lack of information on modern contraception, and remoteness and lack of transportation.⁴⁹⁴ The CEDAW Committee recommends that States ensure that health care services and facilities providing a comprehensive range of sexual and reproductive health services are physically accessible, affordable, and culturally acceptable for rural women, and that they are staffed by trained personnel.⁴⁹⁵ Furthermore, the Committee recommends that States widely disseminate information in local languages and dialects on health, including sexual and reproductive health education, to rural women.⁴⁹⁶

■ **General Recommendation No. 35: Gender-based violence against women, updating general recommendation No. 19 (2017)**

In its General Comment No. 35, the CEDAW Committee classifies some sexual and reproductive rights violations—including forced sterilizations, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, and abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services—as forms of gender-based violence and potentially forms of torture or ill-treatment.⁴⁹⁷ The Committee then calls on States to repeal all legislation that discriminates against women and justifies, tolerates, encourages, or facilitates violence against women, including legislation that allows for medical procedures to be performed on women with disabilities without their informed consent and legislation that criminalizes abortion.⁴⁹⁸ It further recommends that States provide mandatory, recurrent capacity building, educating, and training on gender-based violence for a range of justice system actors, including health care professionals working in the area of sexual and reproductive health.⁴⁹⁹ Finally, the Committee calls on States to ensure that health services are responsive to trauma and include timely and comprehensive mental, sexual, and reproductive health services, including emergency contraception,⁵⁰⁰ and that these services be provided as part of reparations to victims.⁵⁰¹

Concluding Observations

Because of the large number of concluding observations the CEDAW Committee has issued on sexual and reproductive health and rights, many of the sections below contain citations to only a representative sample of those concluding observations. We recommend that advocates check the Committee’s concluding observations for their particular State, which can be found by selecting the country through the “Human Rights by Country” website of the Office of the High Commissioner on Human Rights.[§]

ACCESS TO REPRODUCTIVE HEALTH SERVICES

The Committee has expressed concern to several States about women’s lack of access to sexual and reproductive health care services and information,⁵⁰² including good quality services,⁵⁰³ particularly in rural areas.⁵⁰⁴ The Committee has noted to States that lack of access to services and poor health outcomes for

§ <http://www.ohchr.org/EN/Countries/Pages/HumanRightsintheWorld.aspx>.

women are frequently the result of persistent discriminatory and patriarchal attitudes,⁵⁰⁵ stereotypes, social taboos about sex before marriage,⁵⁰⁶ the negative influence of some religious beliefs,⁵⁰⁷ sociocultural barriers (including harmful practices),⁵⁰⁸ denials of women's autonomy,⁵⁰⁹ and lack of accessibility, affordability, and availability of sexual and reproductive health information and services, including contraception and abortion.⁵¹⁰ The Committee has in particular expressed concern to at least one State about the fact that access to women's health services is dictated by personal law (in this instance sharia and customary law),⁵¹¹ and called on the State to eliminate references to personal laws in the legislation governing women's health care to ensure access to health care services irrespective of a woman's personal status.⁵¹² It has also expressed concern to at least one State where there is not a specific law on sexual and reproductive health.⁵¹³ It has further expressed concern to at least one State about rising fees for reproductive health services⁵¹⁴ and another about budget cuts to the health sector that will mainly affect women and girls.⁵¹⁵ The Committee has also expressed concern to at least two States about the high cost of or unavailability of assisted reproductive health technologies,⁵¹⁶ and in at least instance, the Committee recommended a State remove its ban on in vitro fertilization.⁵¹⁷

The CEDAW Committee has recommended that States increase the availability of sexual and reproductive health services⁵¹⁸ and monitor actual access to these services.⁵¹⁹ The Committee has also recommended that States improve or increase the training of women's health professionals, including nurses and midwives, in order to ensure greater access to health services for women and girls.⁵²⁰ It has further recommended that States increase budgetary allocations towards sexual and reproductive health⁵²¹ and has recommended that at least one State provide free access to reproductive health services.⁵²² The Committee has further recommended that States address reproductive cancers,⁵²³ including by collecting and providing data on these cancers⁵²⁴ and providing training to medical professionals on early detection of these diseases.⁵²⁵ It has also recommended that at least one State adequately fund and monitor reproductive health services delivered by civil society and non-governmental organizations.⁵²⁶ Additionally, the Committee has recommended that at least one State amend its laws on reproductive health to remove references to personal laws and ensure that women have access to sexual and reproductive health services regardless of their personal status.⁵²⁷ It has further recommended that at least one State prioritize the restoration of sexual and reproductive health services during a conflict situation.⁵²⁸

Discrimination in Health Care Access

Concerning discrimination against women in general, the CEDAW Committee has expressed concern to at least one State about "pronatalist" population policies, which reinforce stereotypes about women and may lead to poverty.⁵²⁹ It recommended that this State ensure that its population policy does not reinforce stereotypes about women, including by adopting poverty reduction measures and ensuring support for women with children.⁵³⁰

The CEDAW Committee has also expressed concern where women from disadvantaged or vulnerable groups experience additional discrimination when accessing sexual and reproductive health services. For instance, the Committee has expressed concern to States where women with disabilities lack of access to quality health services, including sexual and reproductive health information services,⁵³¹ and where their sexual and reproductive rights are not promoted or protected,⁵³² due to prejudices⁵³³ and lack of trained personnel and facilities,⁵³⁴ as well as stigma and discrimination.⁵³⁵ It has also expressed concern about legislation in at least one State that allows courts to restrict the legal capacity of women and girls with intellectual or psychosocial disabilities, including in matters related to family and reproductive rights.⁵³⁶ The Committee has then recommended that States ensure sexual and reproductive health for women with disabilities by eliminating prejudices,⁵³⁷ training health providers,⁵³⁸ providing information on sexual and reproductive health to women with disabilities⁵³⁹ including in accessible formats,⁵⁴⁰ providing free access to contraceptives and other sexual and reproductive health services,⁵⁴¹ and increasing the number of health facilities equipped to address their needs.⁵⁴² It has also recommended that a State amend its laws to allow women with disabilities to marry, exercise parental rights, and adopt children on an equal basis with others.⁵⁴³

The CEDAW Committee has further expressed concern about lack of access to sexual and reproductive health services for adolescents and young women due to cultural stigma,⁵⁴⁴ and about discrimination against lesbian women⁵⁴⁵ and women engaged in prostitution,⁵⁴⁶ which may also limit their access to sexual and reproductive health services. It has additionally expressed concern to States about lack of access for rural, indigenous, poor, and/or minority women,⁵⁴⁷ as well as migrant women,⁵⁴⁸ including physical, cultural, and financial barriers to accessing gynecological services.⁵⁴⁹ It has also expressed concern to at least one State about the segregation of Roma women in maternity hospitals⁵⁵⁰ and discrimination in access to sexual and reproductive health services for women with HIV.⁵⁵¹

The CEDAW Committee has called on States to ensure access to sexual and reproductive health services without discrimination for all women and girls,⁵⁵² including rural women, older women, women with disabilities,⁵⁵³ migrant and refugee women, and lesbian women,⁵⁵⁴ and has recommended to at least one State that this access be free.⁵⁵⁵ In particular, it has recommended that States ensure that sexual and reproductive health services for these groups are safe and respect women's rights to autonomy, privacy, confidentiality, informed consent, and choice.⁵⁵⁶ It has further recommended that at least one State provide training to health personnel, increase the number of obstetric health facilities, and eliminate prejudices to ensure sexual and reproductive health services for adolescents and young women.⁵⁵⁷ The Committee has additionally called on at least one State to monitor and sanction segregation of minority women in hospitals.⁵⁵⁸

ABORTION

The CEDAW Committee has expressed concern about unsafe abortions, particularly for women from disadvantaged groups and in rural areas,⁵⁵⁹ relating the rates of unsafe abortions to women's lack of access to legal abortion services or the criminalization of abortion.⁵⁶⁰ The Committee has recommended that States ensure access to high-quality and safe abortion services where legal.⁵⁶¹ It has also recommended that a State ensure that women do not resort to unsafe abortion due to a lack of appropriate modern contraceptives or the high cost of contraceptives.⁵⁶² It has also recommended that at least one State enhance sex education and the provision of contraceptives as means of reducing unsafe abortion.⁵⁶³

Criminalization of Abortion and Restrictive Abortion Laws

The CEDAW Committee has consistently expressed concern about laws that severely limit access to abortion, such as those that outlaw abortion in seemingly all circumstances⁵⁶⁴ or only allow abortion when a woman's life⁵⁶⁵ or health⁵⁶⁶ is at risk and in situations of sexual violence.⁵⁶⁷ It also has expressed concern to at least one State when abortion is criminalized in other circumstances⁵⁶⁸ and to another where there is not sufficient clarity about the legality of abortion in certain circumstances.⁵⁶⁹ The Committee has in particular expressed concern where abortion following rape is illegal,⁵⁷⁰ and where there are strict and short time limits on accessing abortion.⁵⁷¹ It has linked criminalization of abortion and lack of access to safe abortion to higher rates of unsafe abortion and maternal mortality.⁵⁷² It has also expressed concern to at least one State about restrictions on abortion that require women to travel in order to obtain an abortion, including to travel to other parts of the same State.⁵⁷³ The Committee has further expressed concern that, faced with a declining fertility rate, at least one State was considering reducing the accessibility of abortion.⁵⁷⁴ It has further expressed concern to at least one State about steps it had taken to criminalize abortion, including by imposing severe penalties on women who undergo illegal abortion and on health professionals who assist with complications from unsafe abortion.⁵⁷⁵

The Committee has called on States to legalize or consider legalizing abortion in cases of rape, incest, fetal impairment, and when there is a risk to the health or life of a pregnant woman.⁵⁷⁶ It has also recently called on States to decriminalize abortion in other circumstances,⁵⁷⁷ including by removing punitive measures for women who undergo abortion.⁵⁷⁸ The Committee has further recommended that at least one State extend the time limit for accessing abortion⁵⁷⁹ and that at least one other State expedite the passage of legislation to liberalize abortion laws and otherwise ensure access to safe, affordable, and confidential abortion services.⁵⁸⁰ It has further recommended that at least one State refrain from adopting a law that would limit access to legal and

safe abortion,⁵⁸¹ and that another State adopt a wide interpretation of the right to therapeutic abortion to ensure access for physical, mental, and social health needs.⁵⁸² The Committee has further recommended that at least one State adopt medical standards establishing that rape and incest constitute grounds for abortion⁵⁸³ and has additionally called on at least one State to conduct a public consultation on repealing laws that criminalize abortion.⁵⁸⁴

Practical and Procedural Barriers to Abortion

The CEDAW Committee has consistently expressed concern about barriers to accessing legal abortion, including third-party authorization requirements, under-regulated conscientious objection, and other medically unnecessary requirements placed on accessing abortion. For instance, the Committee has expressed concern to at least one State where legal abortion is not available in a significant portion of that State.⁵⁸⁵ It has also expressed concern to at least one State about burdensome administrative procedures preventing women from accessing legal abortion, recommending that the State simplify these procedures.⁵⁸⁶ The Committee has praised another State for adopting guidelines on abortion, but expressed concern that those guidelines still required approval by a board and the signature of a witness, posing potential barriers to obtaining an abortion.⁵⁸⁷ The Committee has also expressed concern to a State where two doctors are required to sign off on an abortion to save a woman's life and recommended that the State repeal this requirement.⁵⁸⁸ It has expressed concern to another State that requires four consultations before a woman can obtain a legal abortion and recommended that the State remove excessively burdensome procedures to obtaining an abortion "in order to provide women with freedom of informed choice and ensure respect for their autonomy."⁵⁸⁹ The Committee has further expressed concern to a State about a requirement that doctors report each case of a woman seeking abortion, with personal details, to a national database,⁵⁹⁰ and recommended that the State ensure women's confidentiality by repealing this requirement.⁵⁹¹ It has also recommended to at least one State that it ensure the legal and practical availability of abortion, without strict reporting requirements.⁵⁹²

The CEDAW Committee has further expressed concern about the affordability of abortion.⁵⁹³ Indeed, it has classified the lack of inclusion of abortion and contraception in public health insurance as a form of gender discrimination.⁵⁹⁴ The Committee has recommended that at least one State remove high fees for abortion services⁵⁹⁵ and that another State ensure that abortion remains both financially and legally accessible.⁵⁹⁶ It has further recommended that States ensure that abortion services are covered under public health insurance.⁵⁹⁷ Finally, the Committee has recommended that at least one State ensure free access to abortion for victims of rape.⁵⁹⁸

The Committee has also consistently expressed concern about laws and policies that require a third party to authorize access to abortion for women, including spousal consent requirements⁵⁹⁹ and parental consent requirements for girls under the age of 18.⁶⁰⁰ The Committee has recommended that States amend legislation to remove requirements for third-party authorization⁶⁰¹ and ensure that the decision to have a legal abortion is made by the pregnant woman or girl alone.⁶⁰² It has also recommended that a State implement a Constitutional Court ruling abolishing the requirement for judicial authorization for abortion in cases of rape or incest.⁶⁰³

The CEDAW Committee has regularly expressed concern about the excessive or inadequately regulated use of conscientious objection by doctors⁶⁰⁴ and in particular has expressed concern where hospitals are also exercising conscientious objection,⁶⁰⁵ a situation that has led to the unavailability of legal abortion in parts of at least one State.⁶⁰⁶ It has in particular noted that women who are denied abortion due to conscientious objection may resort to unsafe methods or have to resort to expensive private services.⁶⁰⁷ The Committee has recommended that States ensure that the exercise of conscientious objection does not impede access to reproductive health services, including abortion.⁶⁰⁸ It has also recommended that at least one State adopt a regulatory framework surrounding conscientious objection, including that it be considered an individual and not institutional practice and that conscientious objection be accompanied by referrals.⁶⁰⁹ It has recommended that another State monitor hospitals to ensure that women have access to legal abortion and contraception services, without imposing any additional conditions.⁶¹⁰ It has further recommended that a State ensure effective access to legal abortion services by instituting mandatory referrals in cases of institutional conscientious objection and

otherwise respecting individual conscientious objection to performing abortion.⁶¹¹ The Committee has further recommended that a State ensure effective remedies for women who wish to contest refusals of abortion in the context of conscientious objection.⁶¹²

The CEDAW Committee has further expressed concern to States about mandatory waiting periods to access abortion services, as well as requirements for pre-abortion counseling.⁶¹³ In at least one State, the Committee has classified the waiting periods as “medically unnecessary” and the pre-abortion counseling as “biased.”⁶¹⁴ The Committee has noted that, in at least one State, these requirements are aimed at restricting women’s access to abortion.⁶¹⁵ It has recommended that States remove requirements for mandatory waiting periods and pre-abortion counseling.⁶¹⁶ It has also recommended that at least one State ensure that the information health care professionals provide to women seeking abortion is based in evidence and science, to ensure that women are informed and can make an autonomous decision.⁶¹⁷

Post Abortion Care

The CEDAW Committee has expressed concern about difficulties women face in accessing services to treat complications of unsafe abortion,⁶¹⁸ including where provisions of a State’s criminal code result in the prosecution of women seeking emergency obstetric care⁶¹⁹ or where physicians breach confidentiality by reporting women seeking medical care to police after a miscarriage or when they experience complications from abortion.⁶²⁰ It has also expressed concern about criminal penalties imposed on physicians for providing care for complications from illegal abortion.⁶²¹ The Committee has further expressed concern to at least one State about a scarcity of information on post-abortion care services.⁶²²

The Committee has consistently called on States to ensure that post-abortion services are available and accessible,⁶²³ safe,⁶²⁴ confidential,⁶²⁵ affordable,⁶²⁶ and of high quality.⁶²⁷ It has further called on States to develop guidelines on post-abortion care in order to ensure access to these services for women,⁶²⁸ including that at least one State adopt a policy to ensure doctor-patient confidentiality for women seeking post-abortion care.⁶²⁹ The Committee has additionally recommended that at least one State ensure that the exercise of conscientious objection does not impede access to post-abortion care.⁶³⁰

Access to Information on Abortion

The CEDAW Committee has expressed concern to at least one State about State-sponsored campaigns seeking to stigmatize abortion and negatively influence public views on abortion and contraception.⁶³¹ It has also expressed concern to at least one State about lack of access to information about abortion services.⁶³² It has recommended that at least one State undertake an awareness-raising campaign to overcome patriarchal attitudes that limit women’s access to sexual and reproductive health services, including abortion.⁶³³

Training and Guidance

The CEDAW Committee has expressed concern to States where there is a lack of guidelines outlining safe abortion procedures,⁶³⁴ including lack of access to abortion due to the absence of guidelines outlining when women can obtain and medical professionals can perform legal abortions.⁶³⁵ It has recommended that States adopt clear guidelines on legal abortion,⁶³⁶ disseminate them widely among the public, and train health professionals on them.⁶³⁷ It has recommended further to at least one State that it develop guidelines and provide human rights training to medical professionals about their obligation to respect privacy and confidentiality in the context of sexual and reproductive health.⁶³⁸ The Committee has also recommended to at least one State that it develop medical standards that make clear that abortion is legal in cases of rape and incest.⁶³⁹ It has further called on at least one State to implement existing guidelines on access to safe abortion and post-abortion services and to provide training to medical professionals on their obligations in this regard.⁶⁴⁰

Selective Abortion

The CEDAW Committee has expressed concern about high rates of sex-selective abortions occurring in many States,⁶⁴¹ frequently resulting from son preferences.⁶⁴² It has said that these practices devalue women and violate their human rights.⁶⁴³ The Committee has also expressed concern about a State law that criminalizes

women who are pressured into seeking sex-selective abortions.⁶⁴⁴ The Committee has called on at least one State to enforce its ban on sex-selective abortion and female infanticide through fair legal procedures⁶⁴⁵ and for another to address the causes of son preferences, particularly in rural areas.⁶⁴⁶ It has also called on at least one State to take measures to prevent the practice of sex-selective abortion resulting from prenatal sex determination.⁶⁴⁷ It has further called on at least one State to enforce its ban on sex-selective abortion but establish safeguards to ensure that women who are pressured into sex-selective abortions are not criminalized.⁶⁴⁸

Statistics and Data Collection

The CEDAW Committee has expressed concern about lack of data on unsafe and illegal abortion,⁶⁴⁹ calling on States to collect disaggregated data on this topic and how it affects women's health, including maternal mortality.⁶⁵⁰ It has also expressed concern to at least two States about lack of disaggregated data on abortion generally, seemingly in the context of abortion being used as a main method of contraception.⁶⁵¹ It has requested that States provide data on numbers of abortions and unsafe abortions, disaggregated by age and rural or urban residency.⁶⁵² It has also requested that States conduct research on unsafe abortion and its impact on women's health.⁶⁵³

ACCESS TO CONTRACEPTIVE INFORMATION, GOODS AND SERVICES

The CEDAW Committee has consistently expressed concern to States where the use of modern contraceptives among women is limited,⁶⁵⁴ particularly for disadvantaged groups of women including women with disabilities,⁶⁵⁵ and about lack of availability, affordability, and access to contraceptives generally,⁶⁵⁶ including in rural and remote areas.⁶⁵⁷ It has also expressed concern to States about the predominant use of one form of contraception—including intrauterine devices⁶⁵⁸ or sterilization⁶⁵⁹—and about the lack of availability of a comprehensive range of contraceptives,⁶⁶⁰ including reversible methods of contraception.⁶⁶¹ The Committee has further expressed concern about spousal consent requirements for accessing contraception⁶⁶² and has additionally expressed concern to at least one State about local bans on accessing modern contraceptives, despite national legislation permitting this access.⁶⁶³ It has increasingly expressed concern to States about the affordability of contraceptives, including lack of free distribution⁶⁶⁴ and lack of coverage of contraception under public health insurance.⁶⁶⁵ It has further expressed concern to at least one State about biases in the medical profession against the use of modern contraceptives and the exercise of conscientious objection by health professionals, thereby preventing women from accessing contraceptives.⁶⁶⁶

The CEDAW Committee has called on States to increase the availability and accessibility of a wide range of modern contraceptive methods to all women and adolescent girls,⁶⁶⁷ particularly in rural areas.⁶⁶⁸ In particular, it has recommended that States ensure affordable⁶⁶⁹ or free⁶⁷⁰ access to contraceptives, including for adolescents,⁶⁷¹ and regardless of their disability status,⁶⁷² migrant or refugee status,⁶⁷³ HIV status,⁶⁷⁴ marital status, geographical location, or minority status.⁶⁷⁵ It has also specifically recommended that States ensure access to affordable and safe modern contraceptives to reduce the reliance on sterilization as a method of contraception.⁶⁷⁶ The Committee has recommended that States ensure access and affordability by subsidizing modern contraceptives,⁶⁷⁷ ensuring the necessary budget allocations for contraception,⁶⁷⁸ covering the costs under public health insurance,⁶⁷⁹ and including contraceptives on the list the State's essential medicines.⁶⁸⁰ It has also recommended to at least one State that it not require spousal consent for sterilization⁶⁸¹ and that another ensure that modern contraceptives are available to women in practice without spousal consent.⁶⁸²

Information on Contraceptives

The CEDAW Committee has expressed concern about lack of access to accurate, evidence-based information on family planning and the types and effects of contraceptives available to the public.⁶⁸³ It has also expressed concern to at least one State about the low quality of family planning counseling⁶⁸⁴ and to another State about a State-supported campaign to negatively influence public views on contraception.⁶⁸⁵ It has in at least one State

also attributed low rates of use of contraceptives to lack of information.⁶⁸⁶ The Committee has recommended that States conduct awareness-raising campaigns and ensure the widespread dissemination of information about modern contraceptives,⁶⁸⁷ cease campaigns to negatively influence views on contraception,⁶⁸⁸ and increase access to evidence-based information on family planning for all, including girls and boys.⁶⁸⁹ The Committee has further called on at least one State to provide information and education on modern contraceptives to overcome stereotypes, misconceptions, and stigma about their use.⁶⁹⁰ It has also recommended that States ensure access to information on contraception and sexual and reproductive health in accessible formats.⁶⁹¹

Emergency Contraception

The CEDAW Committee has expressed concern to several States about the lack of availability and accessibility of emergency contraception.⁶⁹² It has in particular expressed concern where the free distribution of emergency contraception has been banned, including in cases of sexual abuse,⁶⁹³ or where women who are victims of sexual violence do not have access to emergency contraception.⁶⁹⁴ It has also expressed concern to a State about cultural norms that hamper access to contraceptives, including emergency contraceptives, for girls, because of traditional norms that girls should not be sexually active.⁶⁹⁵

The CEDAW Committee consistently calls on States to ensure that women have affordable access to emergency contraception⁶⁹⁶ and to meet the unmet need for emergency contraception.⁶⁹⁷ It also has called on States to ensure that emergency contraception is available as part of a larger package of sexual and reproductive health information, services, and goods⁶⁹⁸ and as a means of reducing unwanted and early pregnancies.⁶⁹⁹ It has further called on at least one State to ensure that emergency contraception is distributed freely within the public health system, particularly for victims of sexual abuse,⁷⁰⁰ and on another State to eliminate the prescription requirement for emergency contraception.⁷⁰¹ The Committee has also called on at least one State to ensure that its Ministry of Health promotes and raises awareness about emergency contraception.⁷⁰²

Abortion as a Method of Contraception

In several instances, the CEDAW Committee has expressed concern to States about high rates of abortion and the apparent use of abortion as a main method of birth control or family planning,⁷⁰³ particularly for young women and adolescents.⁷⁰⁴ It has attributed the use of abortion as a method of birth control to the insufficient availability, awareness, or use of modern contraceptives.⁷⁰⁵

The Committee has called on States to prevent the use of abortion as a method of contraception⁷⁰⁶ and increase access to affordable modern contraceptives,⁷⁰⁷ including emergency contraception,⁷⁰⁸ to prevent unwanted pregnancy and reduce the reliance on abortion as a means of family planning. It has also called on States to ensure access to age-appropriate education, information, and counseling on sexual and reproductive health and rights as a means of preventing early pregnancy,⁷⁰⁹ encouraging the use of contraceptives for family planning,⁷¹⁰ and discouraging the use of abortion as a method of birth control.⁷¹¹

MATERNAL HEALTH

The CEDAW Committee has expressed concern to several States about women's lack of access to maternal health services and poor maternal health outcomes. For example, it has expressed concern about high rates of unwanted pregnancy in several States⁷¹² and lack of access to comprehensive childbirth services,⁷¹³ including obstetric services and pre- and post-natal care.⁷¹⁴ In particular, it has expressed concern to States about the lack of trained personnel working on maternal health.⁷¹⁵ It has also expressed concern to at least one State about inadequate health budgeting for maternal health care⁷¹⁶ and to States about the unavailability of adequate obstetric services, particularly in rural and remote areas.⁷¹⁷ Further, the Committee has expressed concern to at least one State about conditional access to maternal health benefits that exclude some women.⁷¹⁸ It has additionally expressed concern to at least one State about high rates of uterine prolapse.⁷¹⁹

The CEDAW Committee has recommended that States ensure the accessibility, availability, and affordability of sexual and reproductive health services, including family planning services, to reduce rates of unwanted pregnancy.⁷²⁰ It has also recommended that States ensure access to comprehensive obstetric services throughout the State, including in remote and rural areas.⁷²¹ The Committee has further recommended that at least one State increase the budget for maternal health services and the training of health care personnel, particularly midwives, to ensure access to essential obstetric services.⁷²² It has recommended that at least one State amend reproductive health policies with a view to increasing access to maternal health services, removing disparities between rural and urban areas, and removing conditions for accessing maternal health benefits.⁷²³ To reduce rates of uterine prolapse, the Committee has also recommended to at least one State that it ensure access to family planning services, training under safe motherhood program, and corrective surgeries with adequate follow-up care.⁷²⁴

The CEDAW Committee has also expressed concern where women's autonomy is limited in the context of maternal health. For instance, the Committee has expressed concern to at least one State about the high rates of caesarian sections for delivery in public and private hospitals without medical justification.⁷²⁵ The Committee has further expressed concern to States about limitations they place on women's reproductive health choices in the context of maternal health,⁷²⁶ including disproportionate restrictions on home births⁷²⁷ and the overuse of over-medicalized and caesarian births.⁷²⁸ It has also expressed concern to at least one State about unnecessary separation of women and newborns, frequent use of episiotomies, and unnecessary restrictions on the use of midwives.⁷²⁹

To address these concerns, the CEDAW Committee has recommended that at least one State reduce the rate of caesarian sections by training health care personnel on natural birth methods and introducing strict controls on medical indications for caesarian sections.⁷³⁰ It has also recommended that at least one State develop a protocol for normal obstetric care that prevents unnecessary medical treatment, ensures informed consent, and establishes a mechanism to monitor maternal health facilities.⁷³¹ It has further recommended that States take measures to ensure maternal health choices for women, including home births and the use of midwives,⁷³² and to ensure informed consent for women in the context of medical procedures related to birth.⁷³³

Maternal Mortality

The CEDAW Committee has consistently expressed concern to States about high rates of maternal mortality,⁷³⁴ including among disadvantaged groups of women⁷³⁵ and rural women.⁷³⁶ The Committee has linked maternal mortality to unsafe abortion,⁷³⁷ obstetric complications, female genital mutilation,⁷³⁸ early pregnancy,⁷³⁹ inadequate prenatal care,⁷⁴⁰ lack of skilled birth attendants,⁷⁴¹ and lack of nutrition.⁷⁴² In at least one State, it has attributed maternal mortality to lack of access to post-abortion care, including to lack of high-quality services to address complications of unsafe abortion.⁷⁴³ The Committee has further expressed concern to at least one State about a rise in maternal mortality during the Ebola outbreak.⁷⁴⁴ It has expressed concern to at least one State about lack of a mechanism for universal and accurate reporting on maternal deaths⁷⁴⁵ and to another State about discrepancies between official statistics and international estimates on maternal mortality.⁷⁴⁶ The Committee has further expressed concern to States about lack of data on maternal mortality,⁷⁴⁷ including resulting from unsafe abortion⁷⁴⁸ and also expressed concern to at least one State about disparities in maternal mortality rates between urban and rural areas.⁷⁴⁹

The CEDAW Committee has recommended that, in order to reduce maternal mortality, States should improve access to good quality prenatal and postnatal care, emergency obstetric services, and skilled birth attendants,⁷⁵⁰ and ensure access to safe abortion,⁷⁵¹ post-abortion,⁷⁵² and comprehensive contraceptive services.⁷⁵³ It has in particular recommended that States implement the OHCHR technical guidance on maternal mortality and human rights^{**}.⁷⁵⁴ The Committee has further recommended that States develop plans for reducing maternal

^{**} Office of the High Commissioner on Human Rights, *Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, U.N. Doc. A/HRC/21/22 (July 2012), available at <http://undocs.org/A/HRC/21/22>.

mortality⁷⁵⁵ and that at least one State establish an effective mechanism for monitoring maternal deaths that occur in both private and public health facilities, as well as in homes and on the way to health facilities.⁷⁵⁶ It has also recommended that a State tackle maternal mortality by providing accurate information on the prevalence rates, definition, and measurement of maternal mortality.⁷⁵⁷ The Committee has further called on at least one State to undertake a study on illegal and unsafe abortion and its impact on the lives and health of women, particularly maternal mortality, to use as the basis of legislation and policy,⁷⁵⁸ and has called on at least one other State to gather general statistics about maternal morbidity.⁷⁵⁹

Early Pregnancy

The CEDAW Committee has frequently expressed concern about high rates of teenage or early pregnancy,⁷⁶⁰ including in a country's overseas territories⁷⁶¹ and in conflict-affected areas,⁷⁶² sometimes attributing early pregnancy to lack of access to family planning⁷⁶³ or high rates of sexual violence and abuse.⁷⁶⁴ The Committee has expressed concern in particular to one State about high levels of unsafe abortion resulting from early pregnancy⁷⁶⁵ and to other States about maternal mortality resulting from early pregnancy.⁷⁶⁶ It has noted that lack of access to modern contraceptives contributes to early and unwanted pregnancies,⁷⁶⁷ and that obstetric fistula also results from early and frequent pregnancies.⁷⁶⁸

The CEDAW Committee has recommended that States reduce rates of teenage pregnancy by ensuring that adolescents and young women, including disadvantaged groups of women,⁷⁶⁹ have access to affordable sexual and reproductive health services,⁷⁷⁰ including modern contraceptives⁷⁷¹ and safe abortion.⁷⁷² It has also recommended that States reduce rates of early pregnancy by ensuring access to age-appropriate education on sexual and reproductive health and rights.⁷⁷³ It has in particular recommended that at least one State conduct research into the causes of high rates of teenage pregnancy.⁷⁷⁴

The CEDAW Committee has also expressed concern about the implications of early pregnancy on the health and education of girls,⁷⁷⁵ including high school dropout rates for girls who become pregnant,⁷⁷⁶ particularly for girls in rural areas and from ethnic minorities.⁷⁷⁷ To at least one State, the Committee has expressed concern about forced pregnancy testing in schools and the expulsion of pregnant girls from school.⁷⁷⁸ The Committee has recommended that States reduce teenage dropout rates due to pregnancy by implementing effective strategies to tackle teenage pregnancy and facilitating re-entry of young mothers into school,⁷⁷⁹ including by establishing or enforcing a policy on the topic,⁷⁸⁰ creating monitoring mechanisms and raising awareness among girls and their parents about the importance of education,⁷⁸¹ and reducing stigma surrounding teenage pregnancy.⁷⁸² It has also recommended that at least one State cease the practice of forced pregnancy testing in schools and the expulsion of pregnant girls from school.⁷⁸³

SEXUALITY EDUCATION AND AWARENESS-RAISING

The CEDAW Committee consistently calls on States to provide age-appropriate education on sexual and reproductive health and rights as part of school curricula,⁷⁸⁴ including in vocational schools,⁷⁸⁵ primary schools,⁷⁸⁶ and to women and men out of school.⁷⁸⁷ It has found that this education should include not only information on reproduction, contraception, and prevention of sexually transmitted infections and early pregnancy, but also information about gender relations,⁷⁸⁸ responsible sexual behavior,⁷⁸⁹ gender equality, respect, and combating sexual violence.⁷⁹⁰ The Committee has also recommended that this education be based on human rights standards and scientific evidence.⁷⁹¹ Furthermore, the Committee has recommended that States provide operational guidelines and training to teachers on age-appropriate sexuality education⁷⁹² and on providing education on sexual and reproductive health in a gender-sensitive manner.⁷⁹³

The CEDAW Committee has also called on States to undertake awareness raising campaigns that combat the negative influence of customary and traditional attitudes towards women, including those based in religion, that may limit women's autonomy and their exercise of sexual and reproductive rights.⁷⁹⁴ It has also recommended

that at least one State raise awareness about contraceptives, the risks of unsafe abortion, and women's reproductive health rights.⁷⁹⁵

FORCED STERILIZATION AND FORCED ABORTION

The CEDAW Committee has expressed concern to States about forced reproductive health procedures performed on women and girls, particularly girls from disadvantaged or vulnerable groups. For instance, it has occasionally expressed concern to States about the forced sterilization and abortion of women with disabilities.⁷⁹⁶ In particular, the Committee has expressed concern about legislation in at least one State designed to prevent the birth of children with disabilities or diseases, leading to the forced sterilization of women with disabilities without any redress,⁷⁹⁷ and about the high number of sterilizations of women with intellectual or psychosocial disabilities in another State.⁷⁹⁸ The Committee has called on at least two States to adopt legislation that protects women with disabilities from being sterilized without their consent.⁷⁹⁹

The CEDAW Committee has also expressed concern about population policies that may limit women's fertility,⁸⁰⁰ particularly minority women, including policies on the maximum number of children and requirements for birth spacing.⁸⁰¹ It has further expressed concern to at least one State about high numbers of reported forced abortions among women⁸⁰² and to another about general allegations of forced sterilization.⁸⁰³ The Committee has additionally expressed concern to at least two States about requirements that transgender persons prove infertility or undergo sterilization in order to obtain legal recognition of their gender.⁸⁰⁴ Furthermore, it has expressed concern to at least two States about involuntary sterilization of women with HIV.⁸⁰⁵ It has also expressed concern to a State about a lack of a law protecting women from forced sterilization or abortion.⁸⁰⁶

Legal Capacity and Informed Consent

The CEDAW Committee has expressed concern to at least two States where women with intellectual and psychosocial disabilities can be deprived of legal capacity⁸⁰⁷ and sterilized without their consent.⁸⁰⁸ It has also expressed concern about legislation in at least one State that allows courts to restrict the legal capacity of women and girls with intellectual or psychosocial disabilities, including in matters related to family and reproductive rights.⁸⁰⁹ The Committee has further expressed concern about legislation in at least one State that allows a third party to give consent for the sterilization or contraception of a woman with mental disabilities, if she is deemed incapable of giving consent⁸¹⁰ and to another State about legislation that allows forced sterilization and abortion of women with intellectual disabilities without court authorization.⁸¹¹

The CEDAW Committee has stated to at least one State that decisions about sterilization and the use of contraception should be made based on full free and informed consent and the voluntary will of the women or girl concerned.⁸¹² It has called on States to ensure that informed consent is obtained before sterilization,⁸¹³ including by adopting clear requirements for obtaining free, prior, and informed consent for sterilization⁸¹⁴ that include a provision that women be notified of the permanent consequences, risks, and alternatives to sterilization⁸¹⁵ and that women be given a period to reflect on the decision.⁸¹⁶ The Committee has further called on States to repeal legislation that allows women with disabilities, including those who have been deprived of or have limited legal capacity, to be sterilized without their consent⁸¹⁷ and to otherwise ensure that abortion and sterilization of women with disabilities is performed only with free full and informed consent.⁸¹⁸ The Committee has recommended that at least one State ensure that in practice women with disabilities who are deprived of legal capacity are not subjected to non-consensual sterilization and that the State provide support for women to decide whether they want to give informed consent for sterilization.⁸¹⁹ It has also called on a State to ensure that pregnant women give informed consent for abortions in cases of fetal impairment.⁸²⁰ The Committee has further praised at least one State distributing sample informed consent forms in minority languages, in order to ensure informed consent.⁸²¹

Due Diligence Obligations

The CEDAW Committee has expressed concern to at least one State where there was no systematic monitoring of its legislation prohibiting forced sterilization.⁸²² It has also expressed concern to at least one State where there have been no effective investigations into allegations of forced sterilization in the context of implementing a State population policy.⁸²³

The CEDAW Committee has called on States to ensure effective investigations of allegations of forced sterilization⁸²⁴ and forced abortion,⁸²⁵ including in care institutions.⁸²⁶ It has also called on at least one State to ensure effective monitoring of health institutions that perform sterilization procedures to ensure their compliance with national legislation prohibiting forced sterilization.⁸²⁷ The Committee has further recommended that States conduct a study of past incidents of forced sterilization of persons with disabilities⁸²⁸ and of women with HIV⁸²⁹ and that at least one State establish an independent committee to research the harms caused by involuntary sterilization and to support outreach to potential victims.⁸³⁰ It has further called on States to prosecute and punish perpetrators of forced, coerced, or non-consensual sterilization.⁸³¹

Training and Guidance

The CEDAW Committee has recommended that at least one State establish regular training for personnel at public and private health centers on how to ensure informed consent for reproductive health procedures, including sterilization.⁸³² It has also recommended that at least one State train health professionals to raise their awareness about prejudices towards women with disabilities, as means of eliminating the practice of forced sterilization,⁸³³ and that another State provide mandatory training to family planning officials on gender sensitivity.⁸³⁴

Remedies and Redress

The CEDAW Committee has expressed concern to at least one State where courts have dismissed victims' claims of compensation for forced sterilization, due to a restrictive interpretation of the statute of limitations.⁸³⁵ The Committee has further expressed concern about lack of awareness in at least one State among minority women about their rights and ways to seek redress for forced sterilization.⁸³⁶ It has expressed concern to the same State about lengthy court procedures for cases of forced sterilization, indicating the inability of the justice system to provide redress in a timely manner.⁸³⁷ It has further expressed concern to at least one State about the fact that victims of forced sterilization have received no compensation.⁸³⁸

The CEDAW Committee has recommended that at least one State provide victims of forced sterilization with legal assistance.⁸³⁹ It has also recommended that States provide victims of forced sterilization with redress, including compensation and rehabilitative services.⁸⁴⁰ It has also called on at least one State to establish a special compensation mechanism for victims⁸⁴¹ and to extend the statute of limitations for bringing claims of compensation resulting from forced sterilization, to ensure that it accounts for the time of discovery of the real significance and consequences of the sterilization.⁸⁴² It has further recommended that at least one State raise awareness among minority women about ways to seek redress for forced sterilization, including violations that occurred in the past⁸⁴³ and grant prompt, holistic, and appropriate redress to victims of forced sterilization.⁸⁴⁴

Individual Complaints

■ **A.S. v. Hungary (2006)**

A.S., a Hungarian Roma woman, was sterilized by medical staff at a Hungarian hospital during an emergency caesarean section, after her fetus had died in the womb.⁸⁴⁵ A.S. claimed she would never have consented to sterilization, she did not understand the forms that she was asked to sign, and she was in an emergency situation at the time she signed the forms.⁸⁴⁶ The CEDAW Committee found that Hungary had violated several of A.S.'s rights, including her right to information to make an informed choice,⁸⁴⁷ the right to informed consent implied by the right to acceptable health care,⁸⁴⁸ and the right to decide on the number and spacing of her

children.⁸⁴⁹ The Committee recommended that Hungary amend its law and guidelines on informed consent to sterilization to meet international human rights and medical standards and that it monitor health facilities to ensure that sterilizations are not performed without informed consent, with appropriate sanctions when these rights are breached.⁸⁵⁰

■ **L.C. v. Peru (2011)**

L.C. was sexually abused from the age of 11 by a 34 year-old man and became pregnant at the age of 13 as a result of this abuse,⁸⁵¹ causing her mental distress and ultimately leading to a suicide attempt.⁸⁵² L.C. needed emergency spinal surgery following this attempt, but the hospital would not perform the surgery if she remained pregnant and would not perform a legal abortion, leading L.C. to suffer permanent injuries.⁸⁵³ The CEDAW Committee found that Peru had violated L.C.'s rights to health, to be free from discrimination and gender stereotyping, and to an effective remedy when it denied L.C. access to what should have been a legal abortion in Peru under these circumstances.⁸⁵⁴ In particular, the Committee found that when a State has legalized abortion, it must provide a legal framework through which women can exercise their right to access abortion.⁸⁵⁵ It additionally found that L.C.'s status as a minor and a victim of sexual abuse exacerbated the mental and physical health effects of continuing the pregnancy.⁸⁵⁶ Among several recommendations, the Committee recommended that Peru evaluate its laws to establish a mechanism that allows women to access abortion when their physical or mental health is at risk and review legislation to decriminalize abortion in cases of rape and sexual abuse.⁸⁵⁷

■ **Alyne da Silva Pimentel v. Brazil (2011)**

Alyne da Silva Pimentel Teixeira was a pregnant Brazilian national of African descent who suffered pregnancy complications and, due to insufficient care, died following the delivery of a stillborn fetus.⁸⁵⁸ Under these circumstances, the CEDAW Committee found that Brazil had violated Alyne's rights to life and health.⁸⁵⁹ The Committee noted in particular that the denial of needed health services to Alyne stemmed from the lack of an adequately-funded and results-oriented policy on women's health, disproportionately impacting women's maternal health.⁸⁶⁰ The Committee further found that Alyne had been subjected to multiple discrimination in the provision of health care based on her gender, her African descent, and her socio-economic background.⁸⁶¹ As a result, the Committee recommended, among other actions, that Brazil reduce preventable maternal deaths through the implementation of a national policy on the issue and provide adequate professional training for health workers (particularly on women's reproductive health rights), including on emergency care.⁸⁶²

Gaps in the Standards

Because of its previous comments on the rights of women with disabilities, including through its General Recommendation No. 18 on disabled women, the CEDAW Committee is well placed to address barriers that women and girls with disabilities experience in exercising their sexual and reproductive rights. Although it has often expressed concern to States about barriers to accessing sexual and reproductive health information and services for women and girls with disabilities, the Committee should more consistently do so, as these barriers exist in many States across the world. The Committee should more consistently request information on the sexual and reproductive health and rights of women with disabilities through its list of issues to States prior to reviews.

Although the CEDAW Committee has often raised the issue of forced sterilization, contraception, and abortion of women and girls with disabilities through concluding observations, its recommendations to States have rarely gone into the same depth as those it has made concerning the forced sterilization of Roma or other minority women. For instance, the Committee has not yet made specific recommendations to States about ensuring redress, including compensation, for women with disabilities who are victims of forced reproductive health practices. Advocates should consider modeling recommendations to the CEDAW Committee after the concluding observations it has issued to States about the forced sterilization of Roma and other minority women.

Furthermore, the CEDAW Committee should consider more consistently addressing how stereotypes about women and girls with disabilities, based on intersectional discrimination due to both gender and disability, impact their sexual and reproductive rights. In particular, as the [CRPD](#) Committee has found, misperceptions about the sexuality of women with disabilities and about their ability to be good parents influence the sexual and reproductive health information and services they receive and the ways in which health care workers and others treat them in these contexts. The CEDAW Committee should acknowledge that without adequate information and services to ensure their sexual and reproductive autonomy, women with disabilities may be further subjected to forced or coerced reproductive health procedures, be more vulnerable to sexual violence and abuse, and be denied the ability to decide on the number and spacing of their children.

Committee on the Rights of the Child

The Committee on the Rights of the Child (CRC Committee) monitors State obligations under the Convention on the Rights of the Child (CRC). Through its General Comments and Concluding Observations, the CRC Committee frequently raises sexual and reproductive health and rights of both children and mothers with States, including in particular under Articles 6 (right to life) and 24 (right to health). Concerning the rights of children with disabilities, the Committee has also examined sexual and reproductive health and rights under Article 23 (rights of children with disabilities). Although less frequently cited in the context of sexual and reproductive rights, Articles 2 (freedom from discrimination), 3 (best interests of the child), 12 (respect for views of the child), 13 (freedom of expression), 16 (privacy), and 29 (education) are also applicable. Starting in 2016, the CRC Committee began citing not only human rights standards but also relevant provisions of the U.N. Sustainable Development Goals (SDGs)^{††} when making recommendations to States about sexual and reproductive health and rights issues.⁸⁶³

General Comments

■ General Comment No. 3: HIV/AIDS and the rights of the child (2003)

In its General Comment No. 3, the CRC Committee emphasizes the need for States to provide adolescent-friendly health services, as a means of treating and preventing HIV/AIDS.⁸⁶⁴ The Committee encourages States to provide health services that fully respect the child's rights to privacy and non-discrimination, including confidential sexual and reproductive health services and low-cost contraceptives.⁸⁶⁵ It also calls on States to ensure that HIV-related services are provided to the maximum extent possible and are accessible to all children, including children with disabilities.⁸⁶⁶

■ General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child (2003)

In its General Comment No. 4, the CRC Committee notes that States should provide access to sexual and reproductive health information to adolescents—including information on family planning, contraceptives, the dangers of early pregnancies, and the prevention of sexually transmitted diseases—as part of the right to health, regardless of whether adolescents are married and without the need for parental or guardian consent.⁸⁶⁷ The Committee recommends that States work “(a) to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education.”⁸⁶⁸

■ General Comment No. 7: Implementing child rights in early childhood (2005)

In its General Comment No. 7, the CRC Committee recommends that States ensure that pregnant women and new mothers and their babies have access to needed pre- and post-natal care, as a means of ensuring the right to life and other rights for their children.⁸⁶⁹

■ General Comment No. 9: The rights of children with disabilities (2006)

In its General Comment No. 9, the CRC Committee notes that, during adolescence, children with disabilities face challenges relating to establishing relationships with peers and their own reproductive health.⁸⁷⁰ In particular, the Committee raises concerns about the forced sterilization of children with disabilities, particularly girls, which violates their rights to physical integrity and has long-term implications for physical and

^{††} <https://sustainabledevelopment.un.org/sdgs>.

mental health.⁸⁷¹ It recommends that adolescents with disabilities be provided with disability-specific information, guidance, and counseling related to their health, including sexual and reproductive health.⁸⁷² The Committee also recommends that States prohibit forced sterilization of children on the grounds of disability.⁸⁷³

■ **General Comment No. 11: Indigenous children and their rights under the Convention (2009)**

The CRC Committee briefly addresses sexual and reproductive health and rights in its General Comment No. 11, recommending that States consider specific strategies to provide indigenous adolescents with access to sexual and reproductive information and services.⁸⁷⁴

■ **General Comment No. 12: The right of the child to be heard (2009)**

In its General Comment No. 12, the CRC Committee finds that children have the right to participate in making decisions about their individual health care and in promoting health and well-being for children generally, in a manner consistent with their evolving capacities.⁸⁷⁵ This right includes providing them with information about proposed treatments and their effects and outcomes, including in disability-accessible formats.⁸⁷⁶ It also includes access to confidential medical counselling without parental consent and without an age limit where it is needed to protect a child's safety, including safety from violence in the home.⁸⁷⁷ The Committee recommends that States adopt legislation that transfers the right to give medical consent to children at an appropriate age, while encouraging States to ensure that the views of younger children who demonstrate adequate capacity also be given due weight in health care decisions.⁸⁷⁸

■ **General Comment No. 13: The right of the child to freedom from all forms of violence (2011)**

In its General Comment No. 13, the CRC Committee classifies forced sterilization, particularly of girls with disabilities, as a form of physical violence.⁸⁷⁹ The CRC Committee also recognizes the physical health problems stemming from violence against children, including sexually transmitted infections, and notes that such consequences jeopardize "[c]hildren's survival and their 'physical, mental, spiritual, moral and social development.'"⁸⁸⁰

■ **General Comment No. 14: The right of the child to have his or her best interests taken as a primary consideration (2013)**

In its General Comment No. 14, the CRC Committee reiterates that States have an obligation to ensure that all adolescents, both in and out of school, have access to adequate information that is essential for their health and development in order to make appropriate health and behavior choices, including those related to sexual and reproductive health.⁸⁸¹

■ **General Comment No. 15: The right of the child to the enjoyment of the highest attainable standard of health (2013)**

In its General Comment No. 15, the CRC Committee finds that children's right to health includes the sexual and reproductive freedom to make responsible choices as well as an obligation on States to ensure equality of opportunity for all children to enjoy the right to health by providing access to a range of facilities, goods, information, services, and conditions that facilitate this opportunity.⁸⁸² To this end, the Committee recommends, among other actions, that States consider allowing children to consent to receiving certain medical treatments and information, including sexual and reproductive health services and education, contraception, and safe abortion, without the need for consent from a parent, guardian, or caregiver.⁸⁸³

■ **Joint general recommendation/general comment No. 31 of the Committee on the Elimination of Discrimination against Women and No. 18 of the Committee on the Rights of the Child on harmful practices (2014)**

In its Joint General Comment No. 18, the CRC and CEDAW Committees find that women and adolescent girls who have been or are at risk of being subjected to harmful practices face significant risks to their sexual and reproductive health, particularly in a context where they already encounter barriers to decision-making arising from lack of adequate information and services, including adolescent-friendly services.⁸⁸⁴ The Committees find that special attention is therefore needed to ensure that women and adolescents have access to accurate information about sexual and reproductive health and rights and on the impacts of harmful practices, as well as access to adequate and confidential services.⁸⁸⁵ This Joint General Recommendation/General Comment is further summarized above in the CEDAW Committee section.

■ **General Comment No. 20: The implementation of the rights of the child during adolescence (2016)**

In its General Comment No. 20, the CRC Committee finds that adolescents have a right to take increasing responsibility for their lives, and in terms of health services, this means they have a right to confidential medical counseling without the need for parental or guardian consent.⁸⁸⁶ The Committee further finds that the adolescent's consent should be obtained for any medical procedure regardless of whether parental or guardian consent is required; and States should consider ensuring a legal presumption that adolescents can make their own decisions regarding access to sexual and reproductive health services and commodities.⁸⁸⁷ Concerning adolescents with disabilities in particular, the Committee notes that they are frequently denied access to sexual and reproductive health information and services and may be subjected to forced sterilization or contraception,⁸⁸⁸ calling on States to ensure their equal rights, to provide them with opportunities for supported decision-making, and to ensure their access to comprehensive sexuality education.⁸⁸⁹

Concluding Observations

Because of the large number of concluding observations the CRC Committee has issued on sexual and reproductive health and rights, many of the sections below contain citations to only a representative sample of those concluding observations. We recommend that advocates check the Committee's concluding observations for their particular State, which are available on the Committee's website, for further relevant information.

ACCESS TO REPRODUCTIVE HEALTH INFORMATION AND SERVICES

The CRC Committee has frequently expressed concern about lack of access to sexual and reproductive health information and confidential counseling and services for adolescents,⁸⁹⁰ including in rural areas,⁸⁹¹ due to stigma and social constraints on that access,⁸⁹² limits put on the movement of women and girls,⁸⁹³ and parental or guardian consent requirements for unmarried girls to access these services.⁸⁹⁴ It has also expressed concern about lack of knowledge among adolescents on health issues, including sexual and reproductive health issues.⁸⁹⁵

The CRC Committee has consistently called on States to ensure that adolescents have access to confidential counseling and youth-friendly sexual and reproductive health services.⁸⁹⁶ In particular, in recent years, it has called on several States to adopt policies or programs focused specifically on adolescent sexual and reproductive health⁸⁹⁷ and to ensure that adolescents are involved in the development, monitoring, and evaluation of laws, policies, and programs on sexual and reproductive health, so as to ensure that programs address their needs and concerns.⁸⁹⁸ It has also called on at least one State to overcome taboos and stigma related to adolescent sexuality that may hinder access to sexual and reproductive health information and services and to place adolescents' best interests at the center of decisions related to health.⁸⁹⁹

Discrimination in Health Care Access

The CRC Committee has noted to at least two States that health workers hold discriminatory attitudes towards adolescents, particularly in the provision of sexual and reproductive health care, which hinders access to information and services.⁹⁰⁰ It has also expressed concern to at least two States about requirements that parents accompany children or otherwise provide consent for them to access sexual and reproductive health care.⁹⁰¹ In particular, it has noted that in at least two States, discrimination and stigma exists surrounding teenage pregnancy.⁹⁰² The Committee has then called on States to protect girls and adolescent mothers and their children from this discrimination⁹⁰³ and, in at least one case, violence.⁹⁰⁴ It has also noted to at least one State that the views of children are frequently not sought in relation to their sexual and reproductive health⁹⁰⁵ and has noted to another State that children receiving sexual and reproductive health services are not guaranteed a right to privacy.⁹⁰⁶ Furthermore, the Committee has expressed concern to at least one State that adolescent sexual and reproductive health issues had not gained cultural acceptance⁹⁰⁷ and that, in another State, religious values and beliefs prevent the fulfillment of reproductive rights for women and girls.⁹⁰⁸

The CRC Committee has called on States to eliminate parental consent requirements for accessing health services, including sexual and reproductive health services, or to lower the age limits on such requirements,⁹⁰⁹ including when it is in the best interests of the child to do so.⁹¹⁰ It has also called on at least one State to tackle the root causes of poor sexual and reproductive health outcomes for adolescents such as early pregnancy and HIV transmission, including gender inequalities, sexual violence, harmful practices, girls not finishing school, and lack of access to sexuality education.⁹¹¹ It has further called on at least one State to undertake awareness-raising campaigns and educational programs to combat the social marginalization and stigma against women and girls who become pregnant out of wedlock.⁹¹² The Committee has also recommended that a State provide particular support for pregnant girls, including community support and social security benefits⁹¹³ and that a State combat discrimination against pregnant adolescents and adolescent mothers through developing and implementing policies on the topic.⁹¹⁴ It has further called on a State to adopt laws to protect the right to privacy for children, including when receiving sexual and reproductive health services.⁹¹⁵

Further, the CRC Committee has expressed concern about disparities in access to sexual and reproductive health services for poor adolescents, adolescent mothers, orphans, children with disabilities, and other groups of adolescents, calling on States to focus particular attention on these groups.⁹¹⁶ In particular, it has expressed concern to at least one State that children are left out of receiving needed reproductive health services because of the stereotype that they are not sexually active.⁹¹⁷ The Committee has called on at least one State to ensure that its sexual and reproductive health policy pays particular attention to girls with disabilities.⁹¹⁸

ABORTION

The CRC Committee has frequently expressed concern about high rates of unsafe abortion, including among adolescents,⁹¹⁹ and has noted that unsafe abortions are a leading cause of maternal mortality.⁹²⁰ It has expressed concern to at least one State that the stigmatization of pregnancy out of wedlock leads to high rates of unsafe abortion.⁹²¹ The Committee has recommended to at least one State that it reduce instances of unsafe abortion by ensuring access to non-punishable abortion, particularly for girls and victims of rape, without the need for interventions by courts⁹²² and that another State reduce unsafe abortion by reviewing legislation on abortion.⁹²³

Criminalization of Abortion and Restrictive Abortion Laws

The CRC Committee has expressed concern about restrictive abortion laws⁹²⁴ and unsafe and illegal abortions among adolescents,⁹²⁵ including when adolescents have to resort to unsafe abortions because abortion is illegal or inaccessible, putting their health and lives at risk.⁹²⁶ It has particularly expressed concern to individual States about legal abortion being inaccessible to unmarried girls,⁹²⁷ about girls having to travel to another State to access abortion,⁹²⁸ about the criminalization of out-of-wedlock pregnancy, leading many girls to resort to unsafe abortion,⁹²⁹ and about lack of access to safe abortion leading to the abandonment of babies.⁹³⁰ It has also

expressed concern to at least one State where a girl's preferences on abortion do not take precedence over the views of her parents or guardians.⁹³¹ The Committee has expressed concern to at least one State about girls facing criminal sanctions for undergoing illegal abortions.⁹³²

The CRC Committee has consistently called on States to review their abortion laws and make them less restrictive,⁹³³ including by ensuring that abortion is legal when pregnancy poses a risk to the life or health of the pregnant girl, there is a fetal impairment, or in cases of sexual violence.⁹³⁴ Starting in 2015, the CRC Committee also began calling on States to decriminalize abortion in all circumstances.⁹³⁵ Concerning adolescents in particular, it consistently calls on States to ensure access to safe abortion,⁹³⁶ to act in the best interests of pregnant teenagers,⁹³⁷ and to make sure that "the views of the child are always heard and respected in abortion decisions."⁹³⁸ It has also called on at least one State to take urgent action to reduce maternal deaths from unsafe abortion, including by ensuring that abortion and post-abortion care are accessible both in law and in practice.⁹³⁹ Finally, it has called on at least one State to ensure that teenagers wishing to end their pregnancies receive adequate counseling and support in accordance with their age, situation, and needs.⁹⁴⁰

Practical and Procedural Barriers to Abortion

The CRC Committee has generally expressed concern to States where there is a lack of access to legal abortion in practice,⁹⁴¹ including where social stigma reduces access to legal abortion for women and girls.⁹⁴² The Committee has in particular expressed concern where lengthy procedures for authorizing abortion limit girls' access to abortion.⁹⁴³ It has also expressed concern about situations where parental consent,⁹⁴⁴ spousal consent,⁹⁴⁵ or judicial authorization⁹⁴⁶ are required in order to access abortion and has called on States to remove these consent requirements.⁹⁴⁷ Furthermore, it has called on at least one State to ensure that medical professionals know that they do not have to seek judicial authorization before performing abortions on girls and victims of rape.⁹⁴⁸ It has also expressed concern about the high cost of abortion services,⁹⁴⁹ including where abortion is not covered by public health insurance,⁹⁵⁰ and called on at least one State to ensure that abortion is covered by public health insurance schemes.⁹⁵¹ The Committee has additionally expressed concern to at least one State about regional variations in access to legal abortion services and called on the State to review its Penal Code to prevent these disparities.⁹⁵² It has also recommended that a State adopt guidance to clarify when doctors can legally perform abortions, and to ensure that pregnant adolescents and women can appeal a doctor's decision to deny them an abortion.⁹⁵³

The CRC Committee has also expressed concern to at least one State about unnecessary waiting periods and mandatory counseling for adolescents before accessing abortion, "which is intended to dissuade girls, through the provision of medically inaccurate, misleading and stigmatized information, from obtaining abortion services."⁹⁵⁴ The Committee called on this State to repeal mandatory waiting periods and to ensure that health care providers give out accurate and non-stigmatizing information about abortion while guaranteeing girls' confidentiality.⁹⁵⁵

The CRC Committee has further expressed concern to at least two States that inadequately regulate the use of conscientious objection, leading to denial of access to needed reproductive health care for adolescent girls.⁹⁵⁶ In particular, it has expressed concern to at least one State where authorities and medical staff refused to implement a court decision legalizing abortion.⁹⁵⁷ It has called on another State to prohibit institutional conscientious objection, such as that exercised by hospitals, monitor the use of conscientious objection, and collect data on the practice of conscientious objection and on girls' access to legal reproductive health services.⁹⁵⁸ It has also called on at least one State to establish a monitoring mechanism to ensure that authorities and medical staff implement the right to abortion and to provide access to justice for girls denied abortions, including through sanctions against those who deny girls abortions.⁹⁵⁹

Post Abortion Care

The CRC Committee frequently calls on States to ensure access to post-abortion care services to treat complications from abortion for adolescents,⁹⁶⁰ even where abortion is otherwise illegal,⁹⁶¹ and has called on at least one State to expand access to post-abortion care in public hospitals.⁹⁶²

Access to Information on Abortion

The CRC Committee has expressed concern about low rates of awareness of safe abortion practices among the public.⁹⁶³ It has recommended that a State raise awareness about its laws on safe abortion among adolescents, so that they may access safe abortion and receive treatment for complications of unsafe abortion.⁹⁶⁴

Training and Guidance

The CRC Committee has expressed concern to at least two States which lack clear procedures for performing legal abortions, hindering access to abortion for adolescents.⁹⁶⁵ The Committee has recommended that States provide clear guidance to health care providers about when they can legally perform abortions and provide post-abortion care.⁹⁶⁶ It has also recommended that at least one State develop clear procedures for uniform non-restrictive interpretations of abortion laws.⁹⁶⁷ Additionally, the Committee has recommended that at least one State provide clear guidance on confidentiality for those who undergo abortion.⁹⁶⁸

Selective Abortion

The CRC Committee has expressed concern to States where rates of sex-selective abortion appear to be high,⁹⁶⁹ including in rural areas.⁹⁷⁰ The Committee has in particular expressed concern to at least one State where the sex ratio between men and women is imbalanced or has worsened.⁹⁷¹ It has attributed sex-selective abortion to son preferences and the unequal status of girls.⁹⁷²

The CRC Committee has recommended that at least one State enforce legislation on gender discrimination and take steps to prevent and ban sex-selective abortion.⁹⁷³ It has also recommended that States tackle discrimination against women and girls, including social and cultural norms that reinforce discrimination.⁹⁷⁴ It has further recommended that States take immediate legal, policy, and awareness-raising measures to prevent sex-selective abortion.⁹⁷⁵ The Committee has also called on at least one State to ensure the achievement of a more balanced sex ratio and to implement existing legislation on sex-selective abortion.⁹⁷⁶

Statistics and Data Collection

The CRC Committee has expressed concern when States have inadequate data on adolescent sexual and reproductive health,⁹⁷⁷ including abortion and unsafe and illegal abortion.⁹⁷⁸ It has recommended that at least one State conduct in-depth research on unsafe abortion, with the aim of developing appropriate laws and policies to address the practice.⁹⁷⁹ The Committee has also called on at least one State to collect data on the practice of conscientious objection and on girls' access to legal reproductive health services.⁹⁸⁰

ACCESS TO CONTRACEPTIVE INFORMATION, GOODS AND SERVICES

The CRC Committee has frequently expressed concern to States about lack of access to modern contraceptives for adolescents⁹⁸¹ and low rates of use of contraceptives,⁹⁸² including because contraceptives are unaffordable,⁹⁸³ the use of contraceptives by adolescents is stigmatized,⁹⁸⁴ or access requires parental consent.⁹⁸⁵ It has also expressed concern to at least one State where doctors do not adhere to protocols on access to contraception, thereby denying adolescents information and contraceptives.⁹⁸⁶ The Committee has further expressed concern to at least one State about the high cost of contraception and the fact that contraceptives are not subsidized.⁹⁸⁷ In at least one State, the Committee has expressed concern about the widespread use of female sterilization as a method of contraception.⁹⁸⁸

The CRC Committee has called on States to ensure the availability of and access to contraceptive information and services,⁹⁸⁹ including without the need for parental consent,⁹⁹⁰ for unmarried girls⁹⁹¹ and in educational institutions.⁹⁹² It has recommended that States offer access to free and affordable contraceptives to adolescents,⁹⁹³ including through subsidization by public health insurance,⁹⁹⁴ and to consider offering contraceptives in schools.⁹⁹⁵ The Committee has also called on at least one State to provide training and information to public health providers to improve their knowledge on modern contraceptives, as a means of

expanding access.⁹⁹⁶ The Committee has further called on States to conduct studies on adolescent health⁹⁹⁷ and to promote acceptance of contraceptives among men and boys.⁹⁹⁸

Information on Contraceptives

The CRC Committee has expressed concern to several States about information on contraceptives, including about lack of knowledge among adolescents about modern contraceptives,⁹⁹⁹ lack of information available to adolescents on contraceptives,¹⁰⁰⁰ including accurate and objective information,¹⁰⁰¹ and parental consent requirements for receiving information about contraceptives.¹⁰⁰² It has recommended that States make efforts to increase knowledge of and access to contraceptives,¹⁰⁰³ particularly for boys,¹⁰⁰⁴ and that at least one State undertake awareness campaigns about modern contraceptives.¹⁰⁰⁵

Emergency Contraception

The CRC Committee has expressed concern about lack of access to emergency contraception for adolescents,¹⁰⁰⁶ in particular for victims of rape.¹⁰⁰⁷ It has also expressed concern to at least one State where some types of emergency contraception are prohibited.¹⁰⁰⁸ The Committee has recommended that States ensure access to emergency contraception, including free emergency contraception, alongside other modern contraceptives,¹⁰⁰⁹ and has also called on at least one State to raise awareness among women and girls about their right to emergency contraception.¹⁰¹⁰ It has also recommended that at least one State ensure that all emergency contraception is available to adolescents.¹⁰¹¹

Abortion as a Method of Contraception

The CRC Committee has expressed concern about high rates of legal abortion among adolescents in some States,¹⁰¹² and abortion commonly being used as a family planning method.¹⁰¹³ It has recommended that States reduce teenage pregnancies and legal abortions among adolescents by raising awareness and providing information about sexual and reproductive health and increasing access to contraceptive methods and confidential sexual and reproductive health services.¹⁰¹⁴ It has also recommended that at least one State take measures to ensure that abortion is not perceived as a method of contraception.¹⁰¹⁵

MATERNAL HEALTH

Because of its mandate, the CRC Committee addresses maternal health issues not only for adolescent girls but also for other women, as a means of ensuring the health of their children. As such, the CRC Committee has called on States to increase access to and availability of maternal health care services, including emergency obstetric care and skilled birth attendants.¹⁰¹⁶ It has also called on at least one State to ensure maternal health care for the uninsured women and girls living in the most vulnerable situations.¹⁰¹⁷ The Committee has in particular called on at least one State to raise awareness among women about the importance of prenatal and postpartum care, nutritional practices during pregnancy, and optimal birth spacing.¹⁰¹⁸

Maternal Mortality

The CRC Committee addresses maternal mortality in two different contexts. Most frequently, it relates high rates of maternal mortality for all women to high rates of infant and under-5 mortality.¹⁰¹⁹ In some instances, the Committee has also expressed concern about situations where the maternal mortality rate for adolescents is particularly high,¹⁰²⁰ including because they lack access to sexual and reproductive health services,¹⁰²¹ particularly modern contraceptives.¹⁰²² In particular, it has expressed concern about teenage girls who resort to suicide or suffer from depression after becoming pregnant¹⁰²³ and about unsafe abortion as a major cause of maternal mortality for girls.¹⁰²⁴

The CRC Committee has called on States to improve data on maternal deaths,¹⁰²⁵ including those that occur outside health facilities,¹⁰²⁶ and to implement the OHCHR technical guidance on preventable maternal mortality

and human rights¹⁰²⁷. It has also called on States to reduce maternal mortality among adolescents and other women by ensuring that they have access to a range of maternal health services¹⁰²⁸ and a wide range of other sexual and reproductive health services, including emergency contraception, safe abortion, and post-abortion services or contraceptives.¹⁰²⁹ It has further called on at least one State to review legislation on abortion in the context of unsafe abortion with a view of ensuring the best interests of pregnant teenagers.¹⁰³⁰ Furthermore, the Committee has called on States to improve training of midwives and other health care professionals for childbirth,¹⁰³¹ including by increasing the number of maternal health clinics, particularly in rural areas, so as to limit the distance women have to travel.¹⁰³² It has also recommended that at least one State adopt a comprehensive strategy on ensuring safe motherhood, including accountability and monitoring mechanisms.¹⁰³³ The Committee has further called on at least two States to undertake studies on the causes of maternal deaths.¹⁰³⁴ It has also recommended that States seek technical assistance from U.N. agencies to reduce maternal mortality.¹⁰³⁵

Early Pregnancy

The CRC Committee has frequently expressed concern to States about high rates of teenage or other early pregnancy,¹⁰³⁶ including as a result of child marriage,¹⁰³⁷ sexual violence,¹⁰³⁸ low education levels,¹⁰³⁹ lack of access to contraception,¹⁰⁴⁰ and social and cultural barriers to accessing reproductive health information and services.¹⁰⁴¹ The Committee has noted to at least one State that unwanted pregnancy as a result of rape in some cases leads to unsafe abortion and suicide.¹⁰⁴² It has further acknowledged the dangers of early pregnancy, including the higher risks of maternal mortality and morbidity and, in at least one instance, expressed concern about denying adolescents contraception and other sexual and reproductive health services.¹⁰⁴³

The CRC Committee has also expressed concern when teenage pregnancy leads to school dropouts,¹⁰⁴⁴ the segregation of pregnant girls into special schools,¹⁰⁴⁵ the expulsion of girls from school,¹⁰⁴⁶ or where pregnancy otherwise leads to barriers to continuing education.¹⁰⁴⁷ The Committee in particular has expressed concern to at least one State about the lack of a policy on pregnant girls and insufficient reintegration of young mothers back into school.¹⁰⁴⁸ The Committee has also expressed concern about forced pregnancy testing in schools,¹⁰⁴⁹ discrimination and stigma that adolescent girls face when they become pregnant,¹⁰⁵⁰ and about a lack of access to maternal health care services for adolescents due to both discrimination among health care workers and the cost of services.¹⁰⁵¹

The CRC Committee has called on at least one State to reinforce strategies for tackling early pregnancy,¹⁰⁵² on another State to develop legislation on the issue of early marriage and early pregnancy,¹⁰⁵³ and on several States to develop policies and practices to protect the rights of pregnant teenagers and young mothers and their children and ensure they are not subjected to discrimination.¹⁰⁵⁴ It has in particular called on States to ensure free health care for pregnant adolescents up to age 18,¹⁰⁵⁵ covered by public health insurance.¹⁰⁵⁶ Furthermore, it has called on States to raise awareness among families, communities, religious leaders, and judges about the dangers of early pregnancy for adolescent girls, including in the context of child marriage¹⁰⁵⁷ and including by providing sexuality education to children in schools.¹⁰⁵⁸ It has also recommended that States cease the practice of forced pregnancy testing and make efforts to ensure that pregnant adolescents can remain in school and return to school following their pregnancies,¹⁰⁵⁹ including by adopting or implementing policies about pregnant learners.¹⁰⁶⁰

SEXUALITY EDUCATION AND AWARENESS-RAISING

The CRC Committee has consistently called on States to include sexuality education as part of the curriculum in schools¹⁰⁶¹ and to ensure that it is available outside of schools.¹⁰⁶² This sexuality education should include

^{††} OHCHR, *Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, U.N. Doc. A/HRC/21/22 (July 2012), available at <http://undocs.org/A/HRC/21/22>.

information on how to prevent early pregnancy and sexually transmitted infections (STIs), including HIV,¹⁰⁶³ as well as on responsible sexual behavior, particularly among boys,¹⁰⁶⁴ and on contraception,¹⁰⁶⁵ access to and availability of confidential sexual and reproductive health care,¹⁰⁶⁶ unsafe abortion,¹⁰⁶⁷ the prevention of sexual abuse, support services available in cases of sexual abuse, and sexuality, including related to LGBTI persons.¹⁰⁶⁸ The Committee has also recommended that States ensure that sexuality education is age-appropriate, available in accessible formats, and respects the dignity of children with disabilities.¹⁰⁶⁹ In at least one case, it has expressed concern about a State's model of sexuality education that relies on parents to provide information to adolescents, calling on the State to provide information about the effectiveness of this program and to move towards providing sexuality education in schools.¹⁰⁷⁰

The CRC Committee has also expressed concern about low rates of awareness among adolescents about sexual and reproductive health and rights.¹⁰⁷¹ It has called on States to raise awareness throughout the community about sexual and reproductive rights issues,¹⁰⁷² including in poor households and minority communities.¹⁰⁷³ In particular, it has called at least one State to raise awareness among health care providers about the need to ensure that adolescents have access to child-friendly, non-judgmental, and respectful health services.¹⁰⁷⁴ The Committee has also frequently called on States to raise awareness about responsible sexual behavior, particularly among men and boys.¹⁰⁷⁵

FORCED STERILIZATION AND FORCED ABORTION

The CRC Committee has expressed concern to at least one State about the forced sterilization and forced abortion of adolescents, as a result of State population policies.¹⁰⁷⁶ It has in particular expressed concern where States forcibly sterilize girls with disabilities,¹⁰⁷⁷ including despite a ban on the practice.¹⁰⁷⁸ The Committee has recommended that at least one State prohibit the sterilization of children, with and without disabilities, and instead promote measures to prevent unwanted pregnancies.¹⁰⁷⁹ The Committee has further recommended that at least one State take all necessary measures to enforce a prohibition on forced sterilization of girls with disabilities and ensure sexual and reproductive rights for girls with disabilities.¹⁰⁸⁰ The Committee has classified as discrimination the absence of laws prohibiting forced sterilization of persons with disabilities.¹⁰⁸¹

In recent years, the CRC Committee has also frequently expressed concern about unnecessary medical and surgical treatments performed on children, in particular intersex children,¹⁰⁸² before they can provide informed consent.¹⁰⁸³ It has noted in particular that the outcomes of these irreversible surgeries can lead to severe physical and psychological trauma for children.¹⁰⁸⁴ The Committee has called on States to ensure the bodily integrity, autonomy, and self-determination of children by avoiding such practices,¹⁰⁸⁵ classifying these unnecessary medical and surgical interventions as harmful practices.¹⁰⁸⁶ It has also called on States to provide families of intersex children with adequate counseling and support services¹⁰⁸⁷ and to set up procedures for health teams to follow in order to ensure that no one is subjected to unnecessary medical or surgical treatment.¹⁰⁸⁸

Legal Capacity and Informed Consent

The CRC Committee has called on at least one State to ensure that, where therapeutic sterilization is carried out on children, that it is carried out on the basis of full free and informed consent of those children, including children with disabilities.¹⁰⁸⁹ It has also recommended that a State adopt legislation specifically prohibiting the sterilization of children with disabilities without their full free and informed consent,¹⁰⁹⁰ and in this context it has called on a State to “ensure that children with severe disabilities are provided with independent advocacy in decisions affecting them.”¹⁰⁹¹

Due Diligence Obligations

The CRC Committee has recommended that States investigate cases and punish perpetrators of forced sterilization,¹⁰⁹² including sterilization of girls with disabilities,¹⁰⁹³ as well as other unnecessary medical or surgical practices on children.¹⁰⁹⁴ It has also recommended that at least one State monitor institutions where children with disabilities reside to ensure freedom from forced sterilization.¹⁰⁹⁵

Training and Guidance

The CRC Committee has expressed concern in at least one State with a history of forced sterilization which had not adopted adequate guidelines on obtaining informed consent for sterilization.¹⁰⁹⁶ The Committee has called on States to provide training to medical and psychological professionals on biological and physical sexual diversity, as well as the physical and mental health consequences of unnecessary medical and surgical practices on children, particularly in the context of intersex children.¹⁰⁹⁷ It has also called on a State to develop and enforce strict guidelines prohibiting the sterilization of women and girls with disabilities who are “unable to give consent.”¹⁰⁹⁸

Remedies and Redress

The CRC Committee has called on States to ensure effective remedies to victims of unnecessary medical and surgical interventions in childhood or infancy,¹⁰⁹⁹ as well as victims of forced sterilization,¹¹⁰⁰ including financial and other reparations.¹¹⁰¹

Individual Complaints

As of June 2017, the CRC Committee has not issued any decisions on individual complaints related to sexual and reproductive health and rights.

Gaps in the Standards

Because the CRC contains provisions directly addressing the rights of children with disabilities, the CRC Committee is in an especially good position to address the barriers that children with disabilities face in exercising their sexual and reproductive rights. To date, however, it has rarely done so, beyond calling for ensuring general health care access or general access to sexual and reproductive health education and care for children with disabilities. Although the Committee has made strong statements in its general comments condemning the practice of forced sterilization of children with disabilities, the Committee rarely addressed this issue in concluding observations to individual States.

The CRC Committee should more comprehensively address the forced sterilization of children with disabilities by adopting the framing it has used for surgical interventions on intersex children, as outlined above. For instance, the Committee should note that forced sterilization is generally irreversible and can have profound physical and psychological consequences on the children involved. It might also consider classifying forced sterilization of children with disabilities as a harmful practice. Furthermore, the Committee should consider calling on States to implement monitoring mechanisms to prevent the forced sterilization of children with disabilities and also provide counseling and support services to families of children with disabilities to ensure their sexual and reproductive rights.

The CRC Committee should also consistently address the need for States to respect adolescents’ capacity to consent or not to sexual and reproductive health goods and services, including by encouraging States to utilize supported decision-making frameworks to ensure that all adolescents—including adolescents with disabilities—are able to actively participate in their reproductive health choices. The Committee could build on the important developments established in its General Comment 20, including the need for a legal presumption that adolescents are competent to seek and access sexual and reproductive health commodities and services.

Regarding sexual and reproductive health and rights more generally, the Committee should recommend that States undertake awareness-raising campaigns to tackle inaccurate and harmful stereotypes about persons with disabilities, particularly girls, such as that they are asexual and therefore not in need of sexual and reproductive health services or information. The Committee should then also emphasize that the full range of sexual and reproductive health information and services, including abortion, contraception, and maternal health services, should be available and accessible to children with disabilities, be tailored to their specific needs, be culturally sensitive, and be provided on the basis of free and informed consent.

Committee against Torture

The Committee against Torture (CAT Committee) monitors State implementation of the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT). While the torture and ill treatment framework historically has been applied to situations that disproportionately impact men, the CAT Committee has increasingly applied a gendered perspective to recognize that certain practices that disproportionately impact women can constitute torture or ill-treatment where they inflict serious physical or mental pain or suffering and are carried out for a discriminatory purpose. Since 2004, the CAT Committee has addressed sexual and reproductive rights in its General Comments and Concluding Observations, classifying certain violations of these rights as forms of ill-treatment under Article 16 (right to be free from cruel, inhuman, or degrading treatment or punishment) and possibly torture under Articles 1 and 2. The Committee has also addressed sexual and reproductive rights under Article 14 (right to redress).

General Comments

■ General Comment No. 2: Implementation of article 2 by State parties

General Comment No. 2, which focuses on reinforcing the absolute prohibition on torture and the obligation to prevent torture under Article 2 of the CAT Convention, also emphasizes that there is an absolute prohibition on cruel, inhuman, and degrading treatment (CIDT).¹¹⁰² Commenting on women in particular, the CAT Committee finds that gender intersects with other identities to create a greater risk of torture or CIDT¹¹⁰³ and that the contexts in which women experience torture are often distinct from those of men and include “deprivation of liberty, *medical treatment, particularly involving reproductive decisions*, and violence by private actors in communities and homes.”¹¹⁰⁴

■ General Comment No. 3: Implementation of article 14 by States parties

In its General Comment No. 3, the CAT Committee focuses on redress for victims of torture under Article 14.¹¹⁰⁵ As part of the obligation to ensure an effective remedy and reparations for victims of torture or ill-treatment, the CAT Committee finds that States must provide training to relevant actors in this context, including medical personnel,¹¹⁰⁶ which should include “the need to inform victims of gender-based and sexual violence and all other forms of discrimination of the availability of emergency medical procedures, both physical and psychological” as part of the process of redress.¹¹⁰⁷

Concluding Observations

ACCESS TO REPRODUCTIVE HEALTH SERVICES

The CAT Committee has frequently called on States to ensure that women have access to needed medical and psychological care, which includes sexual and reproductive health care such as family planning, following gender-based violence.¹¹⁰⁸ This includes when violence occurs in the context of conflict situations,¹¹⁰⁹ in prisons,¹¹¹⁰ and in schools.¹¹¹¹ As part of the response to violence, it has also recommended to at least one State that it train medical personnel to work with victims of violence.¹¹¹²

Discrimination in Health Care Access

The CAT Committee has called on at least one State to establish a complaints mechanism for harassment for seeking post-abortion, post-pregnancy, or other reproductive health care¹¹¹³ and called on at least one other State to investigate, prevent, and punish ill-treatment of women seeking post-pregnancy services.¹¹¹⁴

ABORTION

Criminalization of Abortion and Restrictive Abortion Laws

The CAT Committee has frequently condemned States where there are absolute bans on abortion.¹¹¹⁵ It has also consistently called on States with restrictive abortion laws to ensure that abortion is legal in cases of rape, incest, when the women's health or life is at risk, and when there is a fetal impairment.¹¹¹⁶ The CAT Committee has found that, in addition to ensuring that abortion is legal in these circumstances, abortion must also be regulated so that it is clear under which circumstances abortion is legal,¹¹¹⁷ and that without this regulation, there may be serious consequences in individual cases, including for minors, migrant women, and women living in poverty.¹¹¹⁸ Additionally, it has called on at least one State to establish procedures for challenging different opinions on when abortion should be provided under the law.¹¹¹⁹

Furthermore, the CAT Committee has expressed concern about laws that allow the prosecution of health care providers for performing therapeutic abortions or women for undergoing abortions.¹¹²⁰ In particular, it has expressed concern to at least one State about a situation where health care providers refuse to provide abortions to preserve a woman's health or life, leading to grave consequences for women and violating standards of medical ethics.¹¹²¹ It has emphasized that, without access to legal and safe abortion, women may resort to unsafe methods of abortion, leading to risks to women's health and lives and to higher rates of maternal mortality.¹¹²²

The CAT Committee has in particular emphasized that abortion should be clearly legal and accessible in cases of rape, due to the continuing mental suffering that may result from being forced to carry a pregnancy resulting from rape to term or from the uncertainty about whether the victim will be able to access abortion.¹¹²³ In particular, it has noted to at least one State that forcing a woman to carry a pregnancy resulting from sexual violence "entails constant exposure to the violation committed against her and causes serious traumatic stress and a risk of long lasting psychological problems such as anxiety and depression."¹¹²⁴ The Committee has also explicitly called on at least one State to ensure that abortion is provided free of charge in cases of rape.¹¹²⁵

Practical and Procedural Barriers to Abortion

The CAT Committee has expressed concern about procedural barriers—such as waiting periods and third-party authorization requirements—for accessing abortion, including therapeutic abortion and abortion in cases of sexual violence.¹¹²⁶ In particular, it has found that survivors of sexual violence must have access to safe abortion both in law and in practice without unnecessary obstacles.¹¹²⁷ To that end, the CAT Committee has recommended in at least one instance that a State amend a restrictive abortion law to ensure that survivors of sexual violence and incest can access abortion independent of a medical professional's discretion,¹¹²⁸ and, in another instance, urged a State to eliminate a requirement of judicial authorization that posed an insurmountable barrier to safe abortion in practice.¹¹²⁹

Furthermore, the CAT Committee has expressed concern to at least one State where the use of conscientious objection by health care providers, institutions, and the judiciary has made abortion inaccessible to women.¹¹³⁰ It has noted that this situation may lead to unsafe abortion, with its attendant risks to a woman's health and life.¹¹³¹

Post Abortion Care

The CAT Committee has consistently expressed concern about denial of access to or abuses when accessing post-abortion care services, including emergency medical care,¹¹³² noting to at least one State that this "could seriously jeopardize their physical and mental health and could constitute cruel and inhuman treatment."¹¹³³ In particular, it has expressed concern about laws and policies that require medical professionals to report to the State when a woman seeks post-abortion care, sometimes leading to criminal prosecution, in violation of medical ethics and confidentiality requirements.¹¹³⁴

As a result, the CAT Committee has recommended that at least one State develop a confidential complaints mechanism for those who have experienced harassment or discrimination in seeking post-abortion care

services.¹¹³⁵ It has also recommended that States follow the World Health Organization's guidelines to guarantee immediate and unconditional access emergency medical care, including following an unsafe abortion.¹¹³⁶ Furthermore, it has recommended that States eliminate the practice of extracting confessions from women seeking emergency care after undergoing an illegal abortion¹¹³⁷ and work to preserve patient confidentiality when medical care is provided following an illegal abortion.¹¹³⁸ In cases where women have been prosecuted for illegal abortion following a confession in the context of post-abortion care, the Committee has called on at least one State to review the conviction to ensure that the confession was not coerced and to nullify convictions that do not conform with the CAT Convention.¹¹³⁹

Access to Information on Abortion

The CAT Committee has called on at least one State to undertake a broad public campaign to raise awareness about when abortion is legal and how to access it, so as to ensure that women know when they can legally access abortion and health care providers know when they can legally provide it.¹¹⁴⁰

Training and Guidance

The CAT Committee has found that abortion must be regulated with sufficient clarity such that women and health care providers are confident that they are accessing and providing legal abortion services,¹¹⁴¹ and that without this regulation, there may be serious consequences in individual cases, including for minors, migrant women, and women living in poverty.¹¹⁴² Further, it has recommended that at least one State ensure that health care providers are “aware of and informed about protocols regarding legal abortion.”¹¹⁴³

ACCESS TO CONTRACEPTIVE INFORMATION, GOODS, AND SERVICES

Information on Contraceptives

The CAT Committee has found that States should provide better information about sexual and reproductive health care, including for adolescents.¹¹⁴⁴ It has also expressed concern to at least one State about misinformation about modern methods of contraception—which has led to “a significant number of maternal deaths, fostered domestic violence and caused damage to women’s mental and physical health”—and has called on that State to ensure “universal access to a full range of the safest and most technologically advanced methods of contraception, [and] ensure rights-based counselling and information on reproductive health services to all women and adolescents.”¹¹⁴⁵

Emergency Contraception

The CAT Committee has recommended that States ensure access to emergency contraception in cases of rape, including by making distribution of emergency contraception legal following rape.¹¹⁴⁶

MATERNAL HEALTH

The CAT Committee has expressed concern to at least one State about abuses against women in maternal health facilities, including the detention of women post-delivery if they cannot afford to pay their medical fees.¹¹⁴⁷ It has recommended that the State strengthen efforts to end this practice, including in private health facilities, and ensure that independent agencies monitor conditions in reproductive health facilities.¹¹⁴⁸

Maternal Mortality

The CAT Committee has consistently expressed concern about high rates of maternal mortality, including as a result of unsafe abortion¹¹⁴⁹ and lack of access to contraception.¹¹⁵⁰ It has also expressed concern about lack of access to legal abortion services—both because of procedural barriers to accessing abortion or because abortion is illegal under those circumstances—when a woman’s health or life is at risk, noting that this situation puts women in danger of experiencing maternal mortality.¹¹⁵¹ In particular, it has noted to at least one State that laws that restrict access to abortion, even in cases of rape, may lead women to access to illegal abortions, resulting in unnecessary maternal deaths.¹¹⁵²

To tackle the issue of maternal mortality, the CAT Committee has recommended that at least two States amend their abortion laws to ensure that therapeutic abortion and abortion in cases of rape or incest is legal.¹¹⁵³ It has further called on States to ensure unconditional access to emergency medical care following unsafe abortion, in line with World Health Organization guidelines.¹¹⁵⁴ It has also recommended that at least one State provide information about sexual and reproductive health to women and adolescents, as a means of preventing unwanted pregnancies,¹¹⁵⁵ and that another State raise awareness about when abortion is legal and how to access it, so as to prevent unsafe abortion.¹¹⁵⁶

SEXUALITY EDUCATION AND AWARENESS-RAISING

The CAT Committee has called for information about sexual and reproductive health to be made available, including to adolescents.¹¹⁵⁷

FORCED STERILIZATION AND FORCED ABORTION

Legal Capacity and Informed Consent

The CAT Committee has expressed concern about involuntary sterilization performed without free and informed consent¹¹⁵⁸ and as part of State population control programs.¹¹⁵⁹ The Committee has in particular commented on circumstances where disadvantaged groups are subjected to forced or coerced medical procedures, including forced or coerced sterilizations. These groups include Roma women,¹¹⁶⁰ HIV-positive women,¹¹⁶¹ women with disabilities,¹¹⁶² and intersex persons.¹¹⁶³ Concerning women with disabilities in particular, the CAT Committee has commended a State for eliminating a technical norm that allowed for the sterilization of persons with “mental incompetence” without free and informed consent and recommended that the State repeal a broader administrative decree that still allowed for the forced sterilization of persons with mental disabilities.¹¹⁶⁴

Concerning intersex persons, the CAT Committee has expressed concern about unnecessary and sometimes irreversible surgical procedures performed on intersex children without having all options explained to them¹¹⁶⁵ and before the age when the children themselves are required to give informed consent,¹¹⁶⁶ noting that these procedures can “cause physical and psychological suffering.”¹¹⁶⁷ It has found that these procedures can violate the physical integrity and autonomy of intersex persons.¹¹⁶⁸ The Committee has recommended that States ensure through legislative, administrative or other measures that children are not subjected to non-urgent medical interventions to establish sex.¹¹⁶⁹ In particular, the Committee has recommended to at least one State that it “[e]nsure that no surgical procedure or medical treatment is carried out without the person’s full, free and informed consent and without the person, their parents or close relatives being informed of the available options, including the possibility of deferring any decision on unnecessary treatment until they can decide for themselves.”¹¹⁷⁰ It has further recommended that the decision about whether to undergo these procedures is delayed until the child is mature enough to participate in the decision and give full free and informed consent.¹¹⁷¹ The Committee has also recommended that States conduct studies into the issue of medical and surgical procedures performed on intersex children without free and informed consent to better understand and deal with the issue.¹¹⁷²

Due Diligence Obligations

The CAT Committee has recommended that all allegations of forced or coerced sterilization and abortion be impartially investigated,¹¹⁷³ with perpetrators being held accountable¹¹⁷⁴—including through criminal prosecution and punishment.¹¹⁷⁵ Further, it has expressed concern to at least one State about a lack of data on involuntary sterilization and has recommended that the State keep track of and report to the Committee about the number of involuntary sterilizations.¹¹⁷⁶

Training and Guidance

The CAT Committee has recommended that medical personnel and public officials be trained on how to obtain free and informed consent for sterilization,¹¹⁷⁷ as well as about their potential criminal liability for conducting

involuntary sterilizations.¹¹⁷⁸ It has also recommended that at least one State issue guidelines on sterilization.¹¹⁷⁹ Further, it has recommended that at least two States provide written materials about sterilization that are translated into relevant languages to ensure that they are accessible.¹¹⁸⁰

Remedies and Redress

The CAT Committee has expressed concern about lack of redress measures for victims of forced or coerced sterilization¹¹⁸¹ and recommended that States ensure victims receive fair and adequate redress,¹¹⁸² including compensation.¹¹⁸³ It has also recommended that at least one State extend the time allotted to file complaints on forced or coerced sterilization and that the destruction of medical records should not take place before a time frame determined by law.¹¹⁸⁴

Individual Complaints

As of June 2017, the CAT Committee has not issued any decisions on individual complaints related to sexual and reproductive health and rights.

Gaps in the Standards

The CAT Committee frequently focuses on sexual and reproductive health services as a means of addressing violence against women and girls, rather than on the physical and mental suffering that women and girls may face in being denied sexual and reproductive autonomy. Outside of gender-based violence, the Committee has recognized only in the context of recent concluding observations on forced medical procedures for intersex persons that violations of physical integrity combined with deprivations of autonomy on their own can cause physical or mental pain and suffering that are violations of the Convention.

Using this framework, the CAT Committee could more consistently speak to the pain and suffering that women and girls with disabilities experience when they are denied sexual and reproductive autonomy, not only in the context of forced reproductive health procedures but also when they are denied reproductive health care due to stereotypes or barriers to accessing services or information. Denial of reproductive health services for women with disabilities—including voluntary contraception, abortion, and maternal health care—can have a profound impact on their bodily integrity, as it may place them at greater risk of unwanted pregnancy or higher risk of maternal mortality. Additionally, because women and girls with disabilities face higher rates of sexual violence, barriers to accessing essential sexual and reproductive health care, including prophylactic care to prevent unwanted pregnancy or STIs, carry additional risks to mental health and bodily integrity.

Committee on the Elimination of Racial Discrimination

The Committee on the Elimination of Racial Discrimination (CERD Committee) monitors State implementation of the Convention on the Elimination of All Forms of Racial Discrimination (CERD). Through its General Recommendations and Concluding Observations, the CERD Committee has found that, under Article 5 (right to non-discrimination based on race, color, or national or ethnic origin, including in medical care), States have an obligation to ensure equal health outcomes for all women and protect them from forced or coerced reproductive health interventions.

General Comments

■ General Recommendation No. 25 on gender-related aspects of racial discrimination (2000)

In its General Recommendation No. 25, the CERD Committee recognizes that some forms of racial discrimination, such as coerced sterilization of indigenous women, may be specifically directed towards women due to their gender.¹¹⁸⁵ It also acknowledges that racial discrimination may have consequences that primarily affect women, in particular highlighting pregnancies that result from racially-motivated rape.¹¹⁸⁶

■ General Recommendation No. 27 on discrimination against Roma (2000)

In its General Recommendation No. 27, although the CERD Committee does not specifically mention forced and coerced sterilization of Roma women, it calls on States to ensure that Roma have “equal access to health care and social security services and to eliminate any discriminatory practices against them in this field.”¹¹⁸⁷

Concluding Observations

ACCESS TO REPRODUCTIVE HEALTH SERVICES

Discrimination in Health Care Access

The CERD Committee frequently comments on inequalities in access to health services, including sexual and reproductive health services, for women from minority groups and for immigrants.¹¹⁸⁸ To address these inequalities, the Committee has called for States to provide minority groups with free or otherwise affordable sexual and reproductive health services, including through State health insurance programs,¹¹⁸⁹ for at least one State to ensure data collection on racial disparities in sexual and reproductive health outcomes, including maternal and infant mortality,¹¹⁹⁰ for at least one State to provide sexuality education,¹¹⁹¹ and for States to otherwise improve sexual and reproductive health and access to health services for women from minority groups.¹¹⁹²

ABORTION

The CERD Committee has in only one circumstance commented on abortion, expressing concern about high rates of abortion for minority groups in a State.¹¹⁹³ To address this problem, it has called on the State to provide greater access to contraceptives and family planning methods, as well as to sexuality education so as to prevent unwanted pregnancies.¹¹⁹⁴

ACCESS TO CONTRACEPTIVE INFORMATION, GOODS AND SERVICES

The CERD Committee has recommended that at least one State address racial disparities in sexual and reproductive health care by facilitating access to adequate contraceptives.¹¹⁹⁵ It has in particular criticized at least one State for using sterilization as one of the primary methods of contraception for Roma women,

recommending that the State ensure free and full access to sexual and reproductive health services, including contraception, for those women.¹¹⁹⁶

Information on Contraceptives

As a means of ensuring access to contraception and to prevent forced or coerced sterilization, the CERD Committee has recommended that at least one State provide information about contraceptives to Roma women in conjunction with free and full access to sexual and reproductive health services.¹¹⁹⁷

MATERNAL HEALTH

Maternal Mortality

The CERD Committee has expressed concern about high rates of maternal mortality among minority and indigenous women.¹¹⁹⁸ In particular, it has expressed concern to at least one State about a lack of access to adequate health services and a lack of information on health indicators and steps a State has taken to improve maternal health services.¹¹⁹⁹

To address the persistent issue of racial disparities in maternal mortality, it has recommended that at least one State improve access to maternal health care, including emergency obstetric care and pre- and post-natal care, by reducing eligibility barriers to accessing State health insurance.¹²⁰⁰ It has also recommended that at least one State improve and standardize data collection across its regions on maternal mortality to identify and address the causes of these disparities and improve accountability mechanisms for preventable maternal mortality, including by ensuring that regional-level review boards have enough funding and capacity.¹²⁰¹ It has also recommended that at least one State step up efforts to improve sexual and reproductive health for indigenous women and women of African descent.¹²⁰²

SEXUALITY EDUCATION AND AWARENESS-RAISING

The CERD Committee has commented on access to sexuality education in only one set of concluding observations, recommending that a State ensure access to sexuality education as a means of reducing racial disparities in sexual and reproductive health access and outcomes.¹²⁰³

FORCED STERILIZATION AND FORCED ABORTION

The CERD Committee has expressed repeated concern to States where minorities and indigenous women have been subjected to forced or coerced reproductive health procedures, particularly forced or coerced sterilization.¹²⁰⁴ In particular, it has condemned the forced sterilization of minorities and indigenous women as the result of State policies, including population policies,¹²⁰⁵ but has also noted its occurrence in at least one State where there was an absence of such policies.¹²⁰⁶ It has also condemned at least one State for using forced sterilization against women human rights defenders.¹²⁰⁷ Furthermore, it has expressed concern when sterilization appears to be one of the primary contraceptive methods used by minority women in a State where there was a history of forced or coerced sterilization of those women.¹²⁰⁸

Legal Capacity and Informed Consent

The CERD Committee has repeatedly called on States to ensure that sterilization is provided only with full free and informed consent.¹²⁰⁹

Due Diligence Obligations

The CERD Committee has frequently recommended that States undertake impartial investigations into allegations of forced sterilization against minority and indigenous women,¹²¹⁰ including by re-opening closed investigations of the issue.¹²¹¹ It has also recommended to at least two States that they monitor health facilities where sterilizations take place to ensure that all patients have given their informed consent.¹²¹² The Committee

has further recommended that these States publicly acknowledge the harm done to victims of forced sterilization, particularly minority women.¹²¹³

Training and Guidance

The CERD Committee has recommended that States provide clear and compulsory criteria for obtaining informed consent for sterilization,¹²¹⁴ that these procedures be well known by the public and by practitioners,¹²¹⁵ and that safeguards be put in place to avoid forced sterilizations in the future.¹²¹⁶ In particular, it has called on at least one State to raise awareness about the International Federation of Gynecology and Obstetrics guidelines on sterilization^{§§}.¹²¹⁷

Remedies and Redress

The CERD Committee has called on States to sanction perpetrators of forced sterilization,¹²¹⁸ including in at least one State by establishing criminal responsibility for forced sterilization.¹²¹⁹ The Committee has also called on States to provide reparations, apologies, and compensation to victims of forced sterilization as a means of redress.¹²²⁰ In particular, it has expressed concern when at least one State has delayed providing reparations to victims or has not established adequate compensation mechanisms¹²²¹ and recommended that a State establish such a compensation mechanism and consider waiving statutes of limitations on all cases related to compensation for forced sterilization.¹²²² It has also recommended that at least one State provide free legal aid and establish a fund to assist victims in bringing their claims for redress.¹²²³

Individual Complaints

As of June 2017, the CERD Committee has not issued decisions on any individual complaints directly relevant to sexual and reproductive health and rights.

Gaps in the Standards

Given the CERD Committee's mandate, it has rarely addressed human rights issues as they affect women and girls with disabilities. However, advocates still have the opportunity to raise issues affecting women with disabilities from indigenous and minority groups. With this in mind, the Committee could improve its concluding observations concerning sexual and reproductive rights by more consistently commenting on how intersectional discrimination disproportionately impacts indigenous women and women from racial minorities with disabilities. For instance, the Committee could more consistently comment on disparities in access to safe abortion services, including how legal restrictions on or procedural barriers to accessing abortion may disproportionately affect women with these intersecting identities, and on access to maternal health services more generally. In particular, it should comment on how barriers to accessing sexual and reproductive health information and services are compounded for women with disabilities from minority or indigenous groups, due to language and communication barriers, often long distances to access health facilities, inaccessible transportation, and multiple discrimination that can further affect how health workers and others view the sexuality and parenting ability of these women.

§§ FIGO, *Ethical Issues in Obstetrics and Gynecology* 122 (October 2012), available at <https://www.figo.org/sites/default/files/uploads/wg-publications/ethics/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf>.

Thematic Reports by U.N. Special Procedures

■ **Report of the Special Rapporteur on the Rights of Persons with Disabilities: Sexual and Reproductive Health and Rights of Girls and Young Women with Disabilities (2017)**

In her 2017 report on the sexual and reproductive health and rights of girls and young women with disabilities, the Special Rapporteur on the Right of Persons with Disabilities, Catalina Devandas-Aguilar, identifies the primary barriers and violations that girls and young women with disabilities encounter in trying to exercise their sexual and reproductive health and rights, and provides guidance to States and examples of good practices for ensuring the full realization of these rights.¹²²⁴

■ **Report of the Working Group on Discrimination against Women in Law and Practice: Eliminating discrimination against women in the area of health and safety, with a focus on the instrumentalization of women's bodies (2016)**

In its 2016 thematic report, the Working Group on Discrimination against Women in Law and Practice (Working Group) examines discrimination in health, and in particular sexual and reproductive rights and the instrumentalization of women's bodies,¹²²⁵ including for women and girls with disabilities.¹²²⁶

■ **Report of the Special Rapporteur on Health: Adolescent Health (2016)**

In his 2016 report on the right to health for adolescents, the U.N. Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health, Dainius Puras, addresses the discrimination that adolescents, including adolescents with disabilities, face that affects access to sexual and reproductive health information, goods, and services, resulting in violations of their right to health.¹²²⁷

■ **Report of the Special Rapporteur on Torture: Torture in Healthcare Settings (2013)**

In his 2013 report on torture in health care settings, the U.N. Special Rapporteur on Torture, Juan Mendez, summarizes the findings of treaty bodies, courts, and other special procedures about the pain and suffering women can experience in reproductive health care settings, inflicted frequently on the basis of gender, and the rights of persons with disabilities to be free from forced medical interventions.¹²²⁸

■ **Report of the Special Rapporteur on Violence against Women: Women with Disabilities (2012)**

In her 2012 report on violence against women and girls with disabilities, the former U.N. Special Rapporteur on Violence against Women, Its Causes and Consequences, Rashida Manjoo, addresses the stereotypes and discrimination that women with disabilities face that limits their access to sexual and reproductive health care and leads to forced reproductive health interventions.¹²²⁹

■ **Report of the Special Rapporteur on Education: Sexual Education (2010)**

In his 2010 annual report, former U.N. Special Rapporteur on the Right to Education, Vernor Munoz, focuses on the right to and content of comprehensive sexuality education.¹²³⁰

■ **Report of the Special Rapporteur on Health: Maternal Mortality and Human Rights (2006)**

In his 2006 report to the General Assembly, the former U.N. Special Rapporteur on Right to the Highest Attainable Standard of Physical and Mental Health, Paul Hunt, explores the human rights issues surrounding maternal mortality, in the context of the U.N. Millennium Development Goals.¹²³¹

Endnotes

- ¹ Committee on the Rights of Persons with Disabilities (CRPD Committee), *General Comment No. 3: Article 6: Women and girls with disabilities*, ¶ 38, U.N. Doc. CRPD/C/GC/3 (2016).
- ² HANDICAP INTERNATIONAL & SAVE THE CHILDREN, *OUT FROM THE SHADOWS: SEXUAL VIOLENCE AGAINST CHILDREN WITH DISABILITIES* 13 (2011) [hereinafter *OUT FROM THE SHADOWS*].
- ³ See, e.g., CRPD Committee, *General Comment No. 3: Article 6: Women and girls with disabilities*, ¶ 40, U.N. Doc. CRPD/C/GC/3 (2016); World Health Organization (WHO) AND WORLD BANK, *WORLD REPORT ON DISABILITY* 61, 205-206 (2011);
- ⁴ CRPD Committee, *General Comment No. 3: Article 6: Women and girls with disabilities*, ¶ 40, U.N. Doc. CRPD/C/GC/3 (2016). See also, WHO AND WORLD BANK, *WORLD REPORT ON DISABILITY* 263 (2011).
- ⁵ See, e.g., CRPD Committee, *Concluding Observations: Paraguay*, ¶ 59, U.N. Doc. CRPD/C/PRY/CO/1 (2013); *El Salvador*, ¶ 51, U.N. Doc. CCPR/C/SLV/CO/6 (2010).
- ⁶ Nancy Mele et al., *Access to Breast Cancer Screening Services for Women with Disabilities*, 34 J. OF OBSTETRIC, GYNECOLOGIC, & NEONATAL NURSING 453-64 (July 2005).
- ⁷ U.N. Special Rapporteur on Violence against Women, *Report of the Special Rapporteur on violence against women, its causes and consequences*, ¶¶ 28 & 36, U.N. Doc. A/67/227 (2012).
- ⁸ U.N. Special Rapporteur on Violence against Women, *Report of the Special Rapporteur on violence against women, its causes and consequences*, ¶¶ 28 & 36, U.N. Doc. A/67/227 (2012).
- ⁹ CRPD Committee, *General Comment No. 3: Article 6: Women and girls with disabilities*, ¶¶ 31 & 32, U.N. Doc. CRPD/C/GC/3 (2016).
- ¹⁰ World Health Organization (WHO), et al, *Eliminating forced, coercive or otherwise involuntary sterilization: An interagency statement* 1 (2014), available at http://apps.who.int/iris/bitstream/10665/112848/1/9789241507325_eng.pdf.
- ¹¹ See, e.g., Juan Méndez, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment: gender perspectives on torture and other cruel, inhuman and degrading treatment or punishment*, ¶ 45, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016); Juan E. Méndez, Special Rapporteur on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, *Special Rapporteur on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, Report to the Human Rights Council*, ¶¶ 45-48, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013); Open Society Foundations, *Against Her Will: Forced and Coerced Sterilization of Women Worldwide* 2 (2011); Center for Reproductive Rights, *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis* 19 (2010).
- ¹² UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID), UNITED STATES STRATEGY TO PREVENT AND RESPOND TO GENDER-BASED VIOLENCE GLOBALLY 7 (Aug. 10, 2012), available at <http://www.state.gov/documents/organization/196468.pdf>. It is worth noting that no global data exists on the incidence of such violence, and studies draw on different sources of data.
- ¹³ Carolyn Frohmader & Stephanie Ortoleva, *Issues Paper: The Sexual and Reproductive Rights of Women and Girls with Disabilities* 7 (2013), available at http://womenenabled.org/pdfs/issues_paper_srr_women_and_girls_with_disabilities_final.pdf.
- ¹⁴ United Nations Population Fund (UNFPA), DANISH INSTITUTE FOR HUMAN RIGHTS, & OHCHR, *REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS: A HANDBOOK FOR NATIONAL HUMAN RIGHTS INSTITUTIONS*, HR/PUB/14/16, 18, (2014), available at <http://www.ohchr.org/Documents/Publications/NHRIHandbook.pdf>.
- ¹⁵ See Convention on the Rights of Persons with Disabilities, adopted Dec. 13, 2006, arts. 5, 8, 9, 12, 15, 16, 23 & 25, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611, (entered into force May, 3 2008); Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, arts. 1, 2, 5, 12 & 16, 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); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted Dec. 10, 1984, arts. 2 & 3, G.A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No. 51, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (entered into force June 26, 1987); International Covenant on Civil and Political Rights, adopted Dec. 16, 1966, arts. 7, 17 & 19, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force Mar. 23, 1976); Committee against Torture (CAT Committee), *General Comment No. 2: Implementation of article 2 by States parties*, ¶¶ 21-22, U.N. Doc. CAT/C/GC/2 (2008).
- ¹⁶ Committee on Economic, Social, and Cultural Rights (ESCR Committee), *General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, ¶¶ 12-21, U.N. Doc. E/C.12/GC/22 (2016).
- ¹⁷ CRPD Committee, *General Comment No. 1: Article 12: Equal recognition before the law*, ¶¶ 17 & 27-28, U.N. Doc. CRPD/C/GC/1 (2014).
- ¹⁸ International Federation of Gynecology and Obstetrics (FIGO), *Female Contraceptive Sterilisation*, ¶ 7, Recommendation 5 (June 2011), available at <http://www.figo.org/sites/default/files/uploads/wg-publications/ethics/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf>.
- ¹⁹ CRPD Committee, *General Comment No. 2: Article 9: Accessibility*, U.N. Doc. CRPD/C/GC/2 (2014).
- ²⁰ CRPD Committee, *General Comment No. 1: Article 12: Equal recognition before the law*, ¶ 17, U.N. Doc. CRPD/C/GC/1 (2014).

- ²¹ Human Rights Committee, *General Comment No. 19: Protection of the Family, the Right to Marriage and Equality of the Spouses (Article 23)*, ¶ 5, U.N. Doc. HRI/GEN/1/Rev.1 at 28 (1994).
- ²² Human Rights Committee, *General Comment No. 20: Prohibition of torture, or other cruel, inhuman or degrading treatment or punishment, Article 7*, ¶ 5 (1992).
- ²³ Human Rights Committee, *General Comment No. 20: Prohibition of torture, or other cruel, inhuman or degrading treatment or punishment, Article 7*, ¶ 5 (1992).
- ²⁴ Human Rights Committee, *General Comment No. 20: Prohibition of torture, or other cruel, inhuman or degrading treatment or punishment, Article 7*, ¶ 7 (1992).
- ²⁵ Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, ¶ 10, U.N. Doc. CCPR/C/GC/28 (2000).
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- ³² Human Rights Committee, *Concluding Observations: Great Britain and Northern Ireland*, ¶ 17, U.N. Doc. CCPR/C/GBR/CO/7 (2015).
- ³³ Human Rights Committee, *Concluding Observations: Democratic Rep. of the Congo*, ¶ 14, U.N. Doc. CCPR/C/COD/CO/3 (2006); *Mali*, ¶ 14, U.N. Doc. CCPR/C/CO/77/MLI (2003).
- ³⁴ Human Rights Committee, *Concluding Observations: Poland*, ¶ 12, U.N. Doc. CCPR/C/POL/CO/6 (2010).
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- ³⁷ Human Rights Committee, *Concluding Observations: Angola*, ¶ 13, U.N. Doc. CCPR/C/AGO/CO/1 (2013); *Argentina*, ¶ 13, U.N. Doc. CCPR/C/ARG/CO/4 (2010); *Cameroon*, ¶ 13, U.N. Doc. CCPR/C/CMR/CO/4 (2010); *Chile*, ¶ 15, U.N. Doc. CCPR/C/CHL/CO/6 (2014); *Cote d'Ivoire*, ¶ 15, U.N. Doc. CCPR/C/CIV/CO/1 (2015); *Djibouti*, ¶ 9, U.N. Doc. CCPR/C/DJI/CO/1 (2013); *El Salvador*, ¶ 14, U.N. Doc. CCPR/C/CO/78/SLV (2003); *Great Britain and Northern Ireland*, ¶ 17, U.N. Doc. CCPR/C/GBR/CO/7 (2015); *Honduras*, ¶ 8, U.N. Doc. CCPR/C/HND/CO/1 (2006); *Ireland*, ¶ 9, U.N. Doc. CCPR/C/IRL/CO/4 (2014); *Jamaica*, ¶ 14, U.N. Doc. CCPR/C/JAM/CO/3 (2011); *Madagascar*, ¶ 8, U.N. Doc. CCPR/C/MDG/CO/3 (2007); *Mali*, ¶ 14, U.N. Doc. CCPR/C/CO/77/MLI (2003); *Malta*, ¶ 13, U.N. Doc. CCPR/C/MLT/CO/2 (2014); *Mauritius*, ¶ 9, U.N. Doc. CCPR/C/83/MUS (2005); *Mexico*, ¶ 10, U.N. Doc. CCPR/C/MEX/CO/5 (2010); *Monaco*, ¶ 10, U.N. Doc. CCPR/C/MCO/CO/2 (2008); *Nicaragua*, ¶ 13, U.N. Doc. CCPR/C/NIC/CO/3 (2008); *Panama*, ¶ 9, U.N. Doc. CCPR/C/PAN/CO/3 (2008); *Philippines*, ¶ 13, U.N. Doc. CCPR/C/PHL/CO/4 (2012); *Poland*, ¶ 12, U.N. Doc. CCPR/C/POL/CO/6 (2010); *San Marino*, ¶ 14, U.N. Doc. CCPR/C/SMR/CO/3 (2015); *Sierra Leone*, ¶ 14, U.N. Doc. CCPR/C/SLE/CO/1 (2014); *Sri Lanka*, ¶ 10, U.N. Doc. CCPR/C/LKA/CO/5 (2014); *Trinidad and Tobago*, ¶ 18, U.N. Doc. CCPR/C/70/TTO (2000).
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- ²¹¹ ESCR Committee, *Concluding Observations: Montenegro*, ¶ 24, U.N. Doc. E/C.12/MNE/CO/1 (2014); *Azerbaijan*, ¶ 16, U.N. Doc. E/C.12/AZE/CO/3 (2013).
- ²¹² ESCR Committee, *Concluding Observations: Montenegro*, ¶ 24, U.N. Doc. E/C.12/MNE/CO/1 (2014); *Bosnia and Herzegovina*, ¶ 32, U.N. Doc. E/C.12/BIH/CO/2 (2013).
- ²¹³ ESCR Committee, *Concluding Observations: Ecuador*, ¶ 30, U.N. Doc. E/C.12/ECU/CO/3 (2012).
- ²¹⁴ ESCR Committee, *Concluding Observations: Honduras*, U.N. Doc. E/C.12/1/Add.57 (2001).
- ²¹⁵ ESCR Committee, *Concluding Observations: Israel*, ¶ 19, U.N. Doc. E/C.12/ISR/CO/3 (2011); *Netherlands*, ¶ 27, U.N. Doc. E/C.12/NDL/CO/4-5 (2010); *Former Yugoslav Republic of Macedonia*, ¶ 46, U.N. Doc. E/C.12/MKD/CO/1 (2008).
- ²¹⁶ ESCR Committee, *Concluding Observations: Mexico*, ¶ 44, U.N. Doc. E/C.12/MEX/CO/4 (2006).
- ²¹⁷ ESCR Committee, *Concluding Observations: Korea*, ¶ 31, U.N. Doc. E/C.12/KOR/CO/3 (2009).
- ²¹⁸ ESCR Committee, *Concluding Observations: Uganda*, ¶ 35, U.N. Doc. E/C.12/UGA/CO/1 (2015); *Rwanda*, ¶ 26, U.N. Doc. E/C.12/RWA/CO/2-4 (2013).
- ²¹⁹ ESCR Committee, *Concluding Observations: Burkina Faso*, ¶ 46, U.N. Doc. E/C.12/BFA/CO/1 (2016); *Honduras*, ¶ 53, U.N. Doc. E/C.12/HND/CO/2 (2016); *Dominican Republic*, ¶ 59, U.N. Doc. E/C.12/DOM/CO/4 (2016); *Philippines*, ¶ 47, U.N. Doc. E/C.12/PHL/CO/5-6 (2016); *Burundi*, ¶ 54, U.N. Doc. E/C.12/BDI/CO/1 (2015); *Costa Rica*, ¶ 25, U.N. Doc. E/C.12/CRI/CO/4 (2008); *Nicaragua*, ¶ 26, U.N. Doc. E/C.12/NIC/CO/4 (2008); *El Salvador*, ¶ 25, U.N. Doc. E/C.12/SLV/CO/2 (2007); *Monaco*, ¶ 15, U.N. Doc. E/C.12/MCO/CO/1 (2006); *Chile*, ¶ 26, U.N. Doc. E/C.12/1/Add.105 (2004); *Malta*, ¶ 23, U.N. Doc. E/C.12/1/Add.101 (2004); *Nepal*, ¶ 33, U.N. Doc. E/C.12/1/Add.66 (2001).
- ²²⁰ ESCR Committee, *Concluding Observations: Kenya*, ¶ 53, U.N. Doc. E/C.12/KEN/CO/2-5 (2016); *Jamaica*, ¶ 29, U.N. Doc. E/C.12/JAM/CO/3-4 (2013); *Netherlands*, ¶ 27, U.N. Doc. E/C.12/NDL/CO/4-5 (2010).
- ²²¹ ESCR Committee, *Concluding Observations: Costa Rica*, ¶ 53, U.N. Doc. E/C.12/CRI/CO/5 (2016); *Ireland*, ¶ 30, U.N. Doc. E/C.12/IRL/CO/3 (2015); *Guatemala*, ¶ 23, U.N. Doc. E/C.12/GTM/CO/3 (2014); *Ecuador*, ¶ 29, U.N. Doc. E/C.12/ECU/CO/3 (2012); *Peru*, ¶ 21, U.N. Doc. E/C.12/PER/CO/2-4 (2012); *Kuwait*, ¶ 23, U.N. Doc. E/C.12/1/Add.98 (2004).
- ²²² ESCR Committee, *Concluding Observations: Costa Rica*, ¶ 53, U.N. Doc. E/C.12/CRI/CO/5 (2016); *Guatemala*, ¶ 23, U.N. Doc. E/C.12/GTM/CO/3 (2014); *Ecuador*, ¶ 29, U.N. Doc. E/C.12/ECU/CO/3 (2012); *Peru*, ¶ 21, U.N. Doc. E/C.12/PER/CO/2-4 (2012);

- ²²³ ESCR Committee, *Concluding Observations: Nicaragua*, ¶ 26, U.N. Doc. E/C.12/NIC/CO/4 (2008).
- ²²⁴ ESCR Committee, *Concluding Observations: Ecuador*, ¶ 29, U.N. Doc. E/C.12/ECU/CO/3 (2012).
- ²²⁵ ESCR Committee, *Concluding Observations: Ecuador*, ¶ 29, U.N. Doc. E/C.12/ECU/CO/3 (2012).
- ²²⁶ ESCR Committee, *Concluding Observations: Burkina Faso*, ¶ 46, U.N. Doc. E/C.12/BFA/CO/1 (2016); *Former Yugoslav Republic of Macedonia*, ¶ 49, U.N. Doc. E/C.12/MKD/CO/2-4 (2016); *Philippines*, ¶ 47, U.N. Doc. E/C.12/PHL/CO/5-6 (2016); *Morocco*, ¶ 45, U.N. Doc. E/C.12/MAR/CO/4 (2015); *Jamaica*, ¶ 29, U.N. Doc. E/C.12/JAM/CO/3-4 (2013); *Sri Lanka*, ¶ 34, U.N. Doc. E/C.12/LKA/CO/2-4 (2010); *United Kingdom of Great Britain and Northern Ireland*, ¶ 25, U.N. Doc. E/C.12/GBR/CO/5 (2009); *Poland*, ¶ 29, U.N. Doc. E/C.12/1/ADD.82 (2002).
- ²²⁷ ESCR Committee, *Concluding Observations: Philippines*, ¶ 47, U.N. Doc. E/C.12/PHL/CO/5-6 (2016).
- ²²⁸ ESCR Committee, *Concluding Observations: Ireland*, ¶ 30, U.N. Doc. E/C.12/IRL/CO/3 (2015); *El Salvador*, ¶ 22, U.N. Doc. E/C.12/SLV/CO/3-5 (2014).
- ²²⁹ ESCR Committee, *Concluding Observations: Monaco*, ¶ 21, U.N. Doc. E/C.12/MCO/CO/2-3 (2014).
- ²³⁰ ESCR Committee, *Concluding Observations: El Salvador*, ¶ 22, U.N. Doc. E/C.12/SLV/CO/3-5 (2014).
- ²³¹ ESCR Committee, *Concluding Observations: Philippines*, ¶ 47, U.N. Doc. E/C.12/PHL/CO/5-6 (2016); *El Salvador*, ¶ 22, U.N. Doc. E/C.12/SLV/CO/3-5 (2014); *Rwanda*, ¶ 26, U.N. Doc. E/C.12/RWA/CO/2-4 (2013); *Nepal*, ¶ 33, U.N. Doc. E/C.12/1/Add.66 (2001).
- ²³² ESCR Committee, *Concluding Observations: El Salvador*, ¶ 22, U.N. Doc. E/C.12/SLV/CO/3-5 (2014).
- ²³³ ESCR Committee, *Concluding Observations: Former Yugoslav Republic of Macedonia*, ¶ 49, U.N. Doc. E/C.12/MKD/CO/2-4 (2016).
- ²³⁴ ESCR Committee, *Concluding Observations: Dominican Republic*, ¶ 59, U.N. Doc. E/C.12/DOM/CO/4 (2016); *Guatemala*, ¶ 23, U.N. Doc. E/C.12/GTM/CO/3 (2014); *Ecuador*, ¶ 29, U.N. Doc. E/C.12/ECU/CO/3 (2012); *Peru*, ¶ 21, U.N. Doc. E/C.12/PER/CO/2-4 (2012); *Dominican Republic*, ¶ 29, U.N. Doc. E/C.12/DOM/CO/3 (2010); *Netherlands*, ¶ 27, U.N. Doc. E/C.12/NDL/CO/4-5 (2010); *Sri Lanka*, ¶ 34, U.N. Doc. E/C.12/LKA/CO/2-4 (2010); *Nicaragua*, ¶ 26, U.N. Doc. E/C.12/NIC/CO/4 (2008); *Costa Rica*, ¶ 25, U.N. Doc. E/C.12/CRI/CO/4 (2008); *Kenya*, ¶ 33, U.N. Doc. E/C.12/KEN/CO/1 (2008); *El Salvador*, ¶ 25, U.N. Doc. E/C.12/SLV/CO/2 (2007); *Monaco*, ¶ 15, U.N. Doc. E/C.12/MCO/CO/1 (2006); *Chile*, ¶ 53, U.N. Doc. E/C.12/1/Add.105 (2004); *Malta*, ¶ 41, U.N. Doc. E/C.12/1/Add.101 (2004); *Nepal*, ¶ 35, U.N. Doc. E/C.12/1/Add.66 (2001).
- ²³⁵ ESCR Committee, *Concluding Observations: Dominican Republic*, ¶ 59, U.N. Doc. E/C.12/DOM/CO/4 (2016); *Ecuador*, ¶ 29, U.N. Doc. E/C.12/ECU/CO/3 (2012); *United Kingdom of Great Britain and Northern Ireland*, ¶ 25, U.N. Doc. E/C.12/GBR/CO/5 (2009).
- ²³⁶ ESCR Committee, *Concluding Observations: Rwanda*, ¶ 26, U.N. Doc. E/C.12/RWA/CO/2-4 (2013).
- ²³⁷ ESCR Committee, *Concluding Observations: Nicaragua*, ¶ 26, U.N. Doc. E/C.12/NIC/CO/4 (2008).
- ²³⁸ ESCR Committee, *Concluding Observations: Jamaica*, ¶ 29, U.N. Doc. E/C.12/JAM/CO/3-4 (2013); *Rwanda*, ¶ 26, U.N. Doc. E/C.12/RWA/CO/2-4 (2013).
- ²³⁹ ESCR Committee, *Concluding Observations: Poland*, ¶ 47, U.N. Doc. E/C.12/POL/CO/6 (2016).
- ²⁴⁰ ESCR Committee, *Concluding Observations: Ireland*, ¶ 30, U.N. Doc. E/C.12/IRL/CO/3 (2015).
- ²⁴¹ ESCR Committee, *Concluding Observations: Monaco*, ¶ 21, U.N. Doc. E/C.12/MCO/CO/2-3 (2014).
- ²⁴² ESCR Committee, *Concluding Observations: Philippines*, ¶ 48, U.N. Doc. E/C.12/PHL/CO/5-6 (2016).
- ²⁴³ ESCR Committee, *Concluding Observations: Kenya*, ¶ 54, U.N. Doc. E/C.12/KEN/CO/2-5 (2016); *Burkina Faso*, ¶ 47, U.N. Doc. E/C.12/BFA/CO/1 (2016); *Honduras*, ¶ 54, U.N. Doc. E/C.12/HND/CO/2 (2016); *United Kingdom of Great Britain and Northern Ireland*, ¶ 61, U.N. Doc. E/C.12/GBR/CO/6 (2016); *Costa Rica*, ¶ 54, U.N. Doc. E/C.12/CRI/CO/5 (2016); *Poland*, ¶ 47, U.N. Doc. E/C.12/POL/CO/6 (2016); *Concluding Observations: Chile*, ¶ 29, U.N. Doc. E/C.12/CHL/CO/4 (2015); *Morocco*, ¶ 46, U.N. Doc. E/C.12/MAR/CO/4 (2015); *El Salvador*, ¶ 22, U.N. Doc. E/C.12/SLV/CO/3-5 (2014).
- ²⁴⁴ ESCR Committee, *Concluding Observations: Costa Rica*, ¶ 53, U.N. Doc. E/C.12/CRI/CO/5 (2016); *Monaco*, ¶ 21, U.N. Doc. E/C.12/MCO/CO/2-3 (2014).
- ²⁴⁵ ESCR Committee, *Concluding Observations: Costa Rica*, ¶ 53, U.N. Doc. E/C.12/CRI/CO/5 (2016).
- ²⁴⁶ ESCR Committee, *Concluding Observations: Monaco*, ¶ 21, U.N. Doc. E/C.12/MCO/CO/2-3 (2014).
- ²⁴⁷ ESCR Committee, *Concluding Observations: Monaco*, ¶ 21, U.N. Doc. E/C.12/MCO/CO/2-3 (2014).
- ²⁴⁸ ESCR Committee, *Concluding Observations: Peru*, ¶ 21, U.N. Doc. E/C.12/PER/CO/2-4 (2012).
- ²⁴⁹ ESCR Committee, *Concluding Observations: Poland*, ¶ 46, U.N. Doc. E/C.12/POL/CO/6 (2016).
- ²⁵⁰ ESCR Committee, *Concluding Observations: Costa Rica*, ¶ 53, U.N. Doc. E/C.12/CRI/CO/5 (2016); *Ireland*, ¶ 30, U.N. Doc. E/C.12/IRL/CO/3 (2015); *Mexico*, ¶ 25, U.N. Doc. E/C.12/MEX/CO/4 (2006).
- ²⁵¹ ESCR Committee, *Concluding Observations: Romania*, ¶ 22, U.N. Doc. E/C.12/ROU/CO/3-5 (2014).
- ²⁵² ESCR Committee, *Concluding Observations: Italy*, ¶ 48, U.N. Doc. E/C.12/ITA/CO/5 (2015); *Romania*, ¶ 22, U.N. Doc. E/C.12/ROU/CO/3-5 (2014).
- ²⁵³ ESCR Committee, *Concluding Observations: Poland*, ¶ 46, U.N. Doc. E/C.12/POL/CO/6 (2016).

- ²⁵⁴ ESCR Committee, *Concluding Observations: Mexico*, ¶ 25, U.N. Doc. E/C.12/MEX/CO/4 (2006).
- ²⁵⁵ ESCR Committee, *Concluding Observations: Costa Rica*, ¶ 53, U.N. Doc. E/C.12/CRI/CO/5 (2016); *Ireland*, ¶ 30, U.N. Doc. E/C.12/IRL/CO/3 (2015); *Peru*, ¶ 21, U.N. Doc. E/C.12/PER/CO/2-4 (2012).
- ²⁵⁶ ESCR Committee, *Concluding Observations: Romania*, ¶ 22, U.N. Doc. E/C.12/ROU/CO/3-5 (2014).
- ²⁵⁷ ESCR Committee, *Concluding Observations: Canada*, ¶ 24, U.N. Doc. E/C.12/CAN/CO/6 (2016); *Italy*, ¶ 49, U.N. Doc. E/C.12/ITA/CO/5 (2015); *Spain*, ¶ 24, U.N. Doc. E/C.12/ESP/CO/5 (2012).
- ²⁵⁸ ESCR Committee, *Concluding Observations: Poland*, ¶ 47, U.N. Doc. E/C.12/POL/CO/6 (2016).
- ²⁵⁹ ESCR Committee, *Concluding Observations: Mexico*, ¶ 25, U.N. Doc. E/C.12/MEX/CO/4 (2006).
- ²⁶⁰ ESCR Committee, *Concluding Observations: Guatemala*, ¶ 23, U.N. Doc. E/C.12/GTM/CO/3 (2014); *Argentina*, ¶ 22, U.N. Doc. E/C.12/ARG/CO/3 (2011).
- ²⁶¹ ESCR Committee, *Concluding Observations: Poland*, ¶ 47, U.N. Doc. E/C.12/POL/CO/6 (2016).
- ²⁶² ESCR Committee, *Concluding Observations: Uganda*, ¶ 35, U.N. Doc. E/C.12/UGA/CO/1 (2015).
- ²⁶³ ESCR Committee, *Concluding Observations: El Salvador*, ¶ 22, U.N. Doc. E/C.12/SLV/CO/3-5 (2014).
- ²⁶⁴ ESCR Committee, *Concluding Observations: Ireland*, ¶ 30, U.N. Doc. E/C.12/IRL/CO/3 (2015).
- ²⁶⁵ ESCR Committee, *Concluding Observations: Mexico*, ¶ 25, U.N. Doc. E/C.12/MEX/CO/4 (2006).
- ²⁶⁶ ESCR Committee, *Concluding Observations: Ireland*, ¶ 30, U.N. Doc. E/C.12/IRL/CO/3 (2015).
- ²⁶⁷ ESCR Committee, *Concluding Observations: Former Yugoslav Republic of Macedonia*, ¶ 49, U.N. Doc. E/C.12/MKD/CO/2-4 (2016).
- ²⁶⁸ ESCR Committee, *Concluding Observations: Uganda*, ¶ 35, U.N. Doc. E/C.12/UGA/CO/1 (2015).
- ²⁶⁹ ESCR Committee, *Concluding Observations: Cambodia*, ¶ 32, U.N. Doc. E/C.12/KHM/CO/1 (2009).
- ²⁷⁰ ESCR Committee, *Concluding Observations: Montenegro*, ¶ 24, U.N. Doc. E/C.12/MNE/CO/1 (2014); *Armenia*, ¶ 22, U.N. Doc. E/C.12/ARM/CO/2-3 (2014); *Albania*, ¶ 33, U.N. Doc. E/C.12/ALB/CO/2-3 (2013); *India*, ¶ 17, U.N. Doc. E/C.12/IND/CO/5 (2008).
- ²⁷¹ ESCR Committee, *Concluding Observations: India*, ¶ 17, U.N. Doc. E/C.12/IND/CO/5 (2008); *China*, ¶ 18, U.N. Doc. E/C.12/1/Add.107 (2005).
- ²⁷² ESCR Committee, *Concluding Observations: Montenegro*, ¶ 24, U.N. Doc. E/C.12/MNE/CO/1 (2014); *Albania*, ¶ 33, U.N. Doc. E/C.12/ALB/CO/2-3 (2013).
- ²⁷³ ESCR Committee, *Concluding Observations: Albania*, ¶ 33, U.N. Doc. E/C.12/ALB/CO/2-3 (2013).
- ²⁷⁴ ESCR Committee, *Concluding Observations: Armenia*, ¶ 22, U.N. Doc. E/C.12/ARM/CO/2-3 (2014).
- ²⁷⁵ ESCR Committee, *Concluding Observations: Montenegro*, ¶ 24, U.N. Doc. E/C.12/MNE/CO/1 (2014).
- ²⁷⁶ ESCR Committee, *Concluding Observations: Montenegro*, ¶ 24, U.N. Doc. E/C.12/MNE/CO/1 (2014); *Albania*, ¶ 33, U.N. Doc. E/C.12/ALB/CO/2-3 (2013).
- ²⁷⁷ ESCR Committee, *Concluding Observations: Albania*, ¶ 33, U.N. Doc. E/C.12/ALB/CO/2-3 (2013).
- ²⁷⁸ ESCR Committee, *Concluding Observations: Romania*, ¶ 22, U.N. Doc. E/C.12/ROU/CO/3-5 (2014); *Philippines*, ¶ 31, U.N. Doc. E/C.12/PHL/CO/4 (2008); *Azerbaijan*, ¶ 30, U.N. Doc. E/C.12/1/Add.104 (2004).
- ²⁷⁹ ESCR Committee, *Concluding Observations: Ecuador*, ¶ 28, U.N. Doc. E/C.12/ECU/CO/3 (2012); *Mauritania*, ¶ 28, U.N. Doc. E/C.12/MRT/CO/1 (2012); *Former Yugoslav Republic of Macedonia*, ¶ 26, U.N. Doc. E/C.12/MKD/CO/1 (2008); *Philippines*, ¶ 31, U.N. Doc. E/C.12/PHL/CO/4 (2008).
- ²⁸⁰ ESCR Committee, *Concluding Observations: Romania*, ¶ 22, U.N. Doc. E/C.12/ROU/CO/3-5 (2014).
- ²⁸¹ ESCR Committee, *Concluding Observations: Romania*, ¶ 22, U.N. Doc. E/C.12/ROU/CO/3-5 (2014); *Armenia*, ¶ 22, U.N. Doc. E/C.12/ARM/CO/2-3 (2014); *Dominican Republic*, ¶ 28, U.N. Doc. E/C.12/DOM/CO/3 (2010); *Kenya*, ¶ 33, U.N. Doc. E/C.12/KEN/CO/1 (2008).
- ²⁸² ESCR Committee, *Concluding Observations: Nepal*, ¶ 46, U.N. Doc. E/C.12/NPL/CO/2 (2008).
- ²⁸³ ESCR Committee, *Concluding Observations: Angola*, ¶ 37, U.N. Doc. E/C.12/AGO/CO/3 (2008); *Kenya*, ¶ 33, U.N. Doc. E/C.12/KEN/CO/1 (2008).
- ²⁸⁴ ESCR Committee, *Concluding Observations: Bosnia and Herzegovina*, ¶ 32, U.N. Doc. E/C.12/BIH/CO/2 (2013); *Kenya*, ¶ 33, U.N. Doc. E/C.12/KEN/CO/1 (2008); *China*, ¶ 88, U.N. Doc. E/C.12/1/Add.107 (2005); *Chile*, ¶ 54, U.N. Doc. E/C.12/1/Add.105 (2004); *Moldova*, ¶ 49, U.N. Doc. E/C.12/1/Add.91 (2003); *Estonia*, ¶ 53, U.N. Doc. E/C.12/1/ADD.85 (2002).
- ²⁸⁵ ESCR Committee, *Concluding Observations: Philippines*, ¶ 51, U.N. Doc. E/C.12/PHL/CO/5-6 (2016); *Honduras*, ¶ 53, U.N. Doc. E/C.12/HND/CO/2 (2016); *Ecuador*, ¶ 28, U.N. Doc. E/C.12/ECU/CO/3 (2012).
- ²⁸⁶ ESCR Committee, *Concluding Observations: Honduras*, ¶ 53, U.N. Doc. E/C.12/HND/CO/2 (2016).
- ²⁸⁷ ESCR Committee, *Concluding Observations: Philippines*, ¶ 51, U.N. Doc. E/C.12/PHL/CO/5-6 (2016).
- ²⁸⁸ ESCR Committee, *Concluding Observations: Burkina Faso*, ¶ 46, U.N. Doc. E/C.12/BFA/CO/1 (2016).
- ²⁸⁹ ESCR Committee, *Concluding Observations: Ecuador*, ¶ 28, U.N. Doc. E/C.12/ECU/CO/3 (2012).

- ²⁹⁰ ESCR Committee, *Concluding Observations: Philippines*, ¶ 52, U.N. Doc. E/C.12/PHL/CO/5-6 (2016); *Honduras*, ¶ 54, U.N. Doc. E/C.12/HND/CO/2 (2016); *Burkina Faso*, ¶ 47, U.N. Doc. E/C.12/BFA/CO/1 (2016); *Angola*, ¶ 52, U.N. Doc. E/C.12/AGO/CO/4-5 (2016); *Chile*, ¶ 29, U.N. Doc. E/C.12/CHL/CO/4 (2015); *Peru*, ¶ 21, U.N. Doc. E/C.12/PER/CO/2-4 (2012).
- ²⁹¹ ESCR Committee, *Concluding Observations: Ecuador*, ¶ 28, U.N. Doc. E/C.12/ECU/CO/3 (2012).
- ²⁹² ESCR Committee, *Concluding Observations: Romania*, ¶ 22, U.N. Doc. E/C.12/ROU/CO/3-5 (2014); *Armenia*, ¶ 22, U.N. Doc. E/C.12/ARM/CO/2-3 (2014).
- ²⁹³ ESCR Committee, *Concluding Observations: Azerbaijan*, ¶ 30, U.N. Doc. E/C.12/1/Add.104 (2004); *Estonia*, ¶ 30, U.N. Doc. E/C.12/1/Add.85 (2002).
- ²⁹⁴ ESCR Committee, *Concluding Observations: Estonia*, ¶ 30, U.N. Doc. E/C.12/1/Add.85 (2002).
- ²⁹⁵ ESCR Committee, *Concluding Observations: Estonia*, ¶ 53, U.N. Doc. E/C.12/1/Add.85 (2002).
- ²⁹⁶ ESCR Committee, *Concluding Observations: Djibouti*, ¶ 32, U.N. Doc. E/C.12/DJI/CO/1-2 (2013).
- ²⁹⁷ ESCR Committee, *Concluding Observations: Dominican Republic*, ¶ 28, U.N. Doc. E/C.12/DOM/CO/3 (2010).
- ²⁹⁸ ESCR Committee, *Concluding Observations: Ethiopia*, ¶ 25, U.N. Doc. E/C.12/ETH/CO/1-3 (2012).
- ²⁹⁹ See, e.g., ESCR Committee, *Concluding Observations: Guatemala*, ¶ 23, U.N. Doc. E/C.12/GTM/CO/3 (2014); *Ethiopia*, ¶ 25, U.N. Doc. E/C.12/ETH/CO/1-3 (2012); *Mauritania*, ¶ 28, U.N. Doc. E/C.12/MRT/CO/1 (2012); *Argentina*, ¶ 22, U.N. Doc. E/C.12/ARG/CO/3 (2011); *Dominican Republic*, ¶ 28, U.N. Doc. E/C.12/DOM/CO/3 (2010); *Cambodia*, ¶ 32, U.N. Doc. E/C.12/KHM/CO/1 (2009); *Benin*, ¶ 25, U.N. Doc. E/C.12/BEN/CO/2 (2008); *Azerbaijan*, ¶ 30, U.N. Doc. E/C.12/1/Add.104 (2004); *Panama*, ¶ 20, U.N. Doc. E/C.12/1/Add.64 (2004); *Guatemala*, ¶ 25, U.N. Doc. E/C.12/1/Add.93 (2003); *Moldova*, ¶ 27, U.N. Doc. E/C.12/1/Add.91 (2003); *Algeria*, ¶ 37, U.N. Doc. E/C.12/1/Add.71 (2001).
- ³⁰⁰ ESCR Committee, *Concluding Observations: Mexico*, ¶ 25, U.N. Doc. E/C.12/MEX/CO/4 (2006).
- ³⁰¹ ESCR Committee, *Concluding Observations: El Salvador*, ¶ 22, U.N. Doc. E/C.12/SLV/CO/3-5 (2014); *Djibouti*, ¶ 32, U.N. Doc. E/C.12/DJI/CO/1-2 (2013); *Argentina*, ¶ 22, U.N. Doc. E/C.12/ARG/CO/3 (2011); *Cambodia*, ¶ 32, U.N. Doc. E/C.12/KHM/CO/1 (2009); *Philippines*, ¶ 31, U.N. Doc. E/C.12/PHL/CO/4 (2008); *Nicaragua*, ¶ 27, U.N. Doc. E/C.12/NIC/CO/4 (2008); *Mexico*, ¶ 25, U.N. Doc. E/C.12/MEX/CO/4 (2006); *Brazil*, ¶ 27, U.N. Doc. E/C.12/1/Add.87 (2003); *Benin*, ¶ 23, U.N. Doc. E/C.12/1/Add.78 (2002); *Bolivia*, ¶ 23, U.N. Doc. E/C.12/1/Add.60 (2001); *Jamaica*, ¶ 18, U.N. Doc. E/C.12/1/Add.75 (2001); *Nepal*, ¶ 32, U.N. Doc. E/C.12/1/Add.66 (2001).
- ³⁰² ESCR Committee, *Concluding Observations: Djibouti*, ¶ 32, U.N. Doc. E/C.12/DJI/CO/1-2 (2013).
- ³⁰³ ESCR Committee, *Concluding Observations: Djibouti*, ¶ 32, U.N. Doc. E/C.12/DJI/CO/1-2 (2013); *Cambodia*, ¶ 32, U.N. Doc. E/C.12/KHM/CO/1 (2009); *Bolivia*, ¶ 23, U.N. Doc. E/C.12/1/Add.60 (2001).
- ³⁰⁴ ESCR Committee, *Concluding Observations: Djibouti*, ¶ 32, U.N. Doc. E/C.12/DJI/CO/1-2 (2013).
- ³⁰⁵ ESCR Committee, *Concluding Observations: Cambodia*, ¶ 32, U.N. Doc. E/C.12/KHM/CO/1 (2009).
- ³⁰⁶ ESCR Committee, *Concluding Observations: Philippines*, ¶ 31, U.N. Doc. E/C.12/PHL/CO/4 (2008).
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- ⁴⁹⁷ CEDAW Committee, *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, ¶ 18, U.N. Doc. CEDAW/C/GC/35 (2017) (advance unedited version).
- ⁴⁹⁸ CEDAW Committee, *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, ¶ 31(a), U.N. Doc. CEDAW/C/GC/35 (2017) (advance unedited version).
- ⁴⁹⁹ CEDAW Committee, *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, ¶ 38, U.N. Doc. CEDAW/C/GC/35 (2017) (advance unedited version).
- ⁵⁰⁰ CEDAW Committee, *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, ¶ 40(c), U.N. Doc. CEDAW/C/GC/35 (2017) (advance unedited version).
- ⁵⁰¹ CEDAW Committee, *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, ¶ 46, U.N. Doc. CEDAW/C/GC/35 (2017) (advance unedited version).
- ⁵⁰² CEDAW Committee, *Concluding Observations: Congo*, ¶ 35, U.N. Doc. CEDAW/C/COG/CO/6 (2012); *Belarus*, ¶ 35, U.N. Doc. CEDAW/C/BLR/CO/7 (2011); *Vietnam*, ¶ 24, U.N. Doc. CEDAW/C/VNM/CO/6 (2007).
- ⁵⁰³ CEDAW Committee, *Concluding Observations: Belarus*, ¶ 35, U.N. Doc. CEDAW/C/BLR/CO/7 (2011); *Kenya*, ¶ 37, U.N. Doc. CEDAW/C/KEN/CO/7 (2011).
- ⁵⁰⁴ See, e.g., CEDAW Committee, *Concluding Observations: Russian Federation*, ¶ 35, U.N. Doc. CEDAW/C/RUS/CO/8 (2015); *Lebanon*, ¶ 41, U.N. Doc. CEDAW/C/LBN/CO/4-5 (2015); *Belarus*, ¶ 35, U.N. Doc. CEDAW/C/BLR/CO/7 (2011); *Montenegro*, ¶ 30, U.N. Doc. CEDAW/C/MNE/CO/1 (2011); *Egypt*, ¶ 39, U.N. Doc. CEDAW/C/EGY/CO/7 (2010); *Uganda*, ¶ 35, U.N. Doc. CEDAW/C/UGA/CO/7 (2010); *Armenia*, ¶ 34, U.N. Doc. CEDAW/C/ARM/CO/4/Rev.1 (2009); *Guatemala*, ¶ 35, U.N. Doc. CEDAW/C/GUA/CO/7 (2009); *Haiti*, ¶ 36, U.N. Doc. CEDAW/C/HTI/CO/7 (2009); *Kazakhstan*, ¶ 25, U.N. Doc. CEDAW/C/KAZ/CO/2 (2007); *Brazil*, ¶ 31, U.N. Doc. CEDAW/C/BRA/CO/6 (2007).
- ⁵⁰⁵ CEDAW Committee, *Concluding Observations: Iraq*, ¶ 42, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); *Paraguay*, ¶ 18, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).
- ⁵⁰⁶ CEDAW Committee, *Concluding Observations: Solomon Islands*, ¶ 36, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014).
- ⁵⁰⁷ CEDAW Committee, *Concluding Observations: Paraguay*, ¶ 18, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).
- ⁵⁰⁸ CEDAW Committee, *Concluding Observations: Mali*, ¶ 33, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016).
- ⁵⁰⁹ CEDAW Committee, *Concluding Observations: Mali*, ¶ 33, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016); *Azerbaijan*, ¶ 32, U.N. Doc. CEDAW/C/AZE/CO/5 (2015).
- ⁵¹⁰ CEDAW Committee, *Concluding Observations: Mali*, ¶ 33, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016).
- ⁵¹¹ CEDAW Committee, *Concluding Observations: Gambia*, ¶¶ 9(a), 36, U.N. Doc. CEDAW/C/GMB/CO/4-5 (2015).
- ⁵¹² CEDAW Committee, *Concluding Observations: Gambia*, ¶ 37(g), U.N. Doc. CEDAW/C/GMB/CO/4-5 (2015).
- ⁵¹³ CEDAW Committee, *Concluding Observations: Azerbaijan*, ¶ 32, U.N. Doc. CEDAW/C/AZE/CO/5 (2015).
- ⁵¹⁴ CEDAW Committee, *Concluding Observations: Cape Verde*, ¶ 28, U.N. Doc. CEDAW/C/CPV/CO/7-8 (2013).
- ⁵¹⁵ CEDAW Committee, *Concluding Observations: Greece*, ¶ 30, U.N. Doc. CEDAW/C/GRC/CO/7 (2013).
- ⁵¹⁶ CEDAW Committee, *Concluding Observations: Lithuania*, ¶ 36, U.N. Doc. CEDAW/C/LTU/CO/5 (2014); *Costa Rica*, ¶ 32, U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011).
- ⁵¹⁷ CEDAW Committee, *Concluding Observations: Costa Rica*, ¶ 33, U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011).
- ⁵¹⁸ CEDAW Committee, *Concluding Observations: Armenia*, ¶ 35, U.N. Doc. CEDAW/C/ARM/CO/4/Rev.1 (2009); *Vietnam*, ¶ 25, U.N. Doc. CEDAW/C/VNM/CO/6 (2007).
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- ⁵²⁰ CEDAW Committee, *Concluding Observations: Myanmar*, ¶ 39, U.N. Doc. CEDAW/C/MMR/CO/4-5 (2016); *Iraq*, ¶ 43, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); *Guatemala*, ¶ 36, U.N. Doc. CEDAW/C/GUA/CO/7 (2009).
- ⁵²¹ CEDAW Committee, *Concluding Observations: Mali*, ¶ 34, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016); *Greece*, ¶ 31, U.N. Doc. CEDAW/C/GRC/CO/7 (2013).
- ⁵²² CEDAW Committee, *Concluding Observations: Cape Verde*, ¶ 29, U.N. Doc. CEDAW/C/CPV/CO/7-8 (2013).
- ⁵²³ CEDAW Committee, *Concluding Observations: Mongolia*, ¶ 29, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016); *Gabon*, ¶ 35, U.N. Doc. CEDAW/C/GAB/CO/6 (2015); *Uganda*, ¶ 36, U.N. Doc. CEDAW/C/UGA/CO/7 (2010).
- ⁵²⁴ CEDAW Committee, *Concluding Observations: Mongolia*, ¶ 29, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016); *Ukraine*, ¶ 39, U.N. Doc. CEDAW/C/UKR/CO/7 (2010); *Guatemala*, ¶ 36, U.N. Doc. CEDAW/C/GUA/CO/7 (2009).
- ⁵²⁵ CEDAW Committee, *Concluding Observations: Mongolia*, ¶ 29, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016).

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- 528 CEDAW Committee, *Concluding Observations: Central African Republic*, ¶ 40, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014).
- 529 CEDAW Committee, *Concluding Observations: Mongolia*, ¶ 28, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016).
- 530 CEDAW Committee, *Concluding Observations: Mongolia*, ¶ 29, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016).
- 531 CEDAW Committee, *Concluding Observations: Sweden*, ¶ 36, U.N. Doc. CEDAW/C/SWE/CO/8-9 (2016); *Mongolia*, ¶ 28, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016); *Hungary*, ¶ 32, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Cape Verde*, ¶ 28, U.N. Doc. CEDAW/C/CPV/CO/7-8 (2013); *Liechtenstein*, ¶ 38, U.N. Doc. CEDAW/C/LIE/CO/4 (2011); *Montenegro*, ¶ 30, U.N. Doc. CEDAW/C/MNE/CO/1 (2011); *Oman*, ¶ 40, U.N. Doc. CEDAW/C/OMN/CO/1 (2011); *Tuvalu*, ¶ 43, U.N. Doc. CEDAW/C/TUV/CO/2 (2009).
- 532 CEDAW Committee, *Concluding Observations: Uganda*, ¶ 45, U.N. Doc. CEDAW/C/UGA/CO/7 (2010).
- 533 CEDAW Committee, *Concluding Observations: Serbia*, ¶ 32, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013).
- 534 CEDAW Committee, *Concluding Observations: Mongolia*, ¶ 28, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016); *Serbia*, ¶ 32, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013).
- 535 CEDAW Committee, *Concluding Observations: Mali*, ¶ 39, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016).
- 536 CEDAW Committee, *Concluding Observations: Czech Republic*, ¶ 40, U.N. Doc. CEDAW/C/CZE/CO/6 (2016);
- 537 CEDAW Committee, *Concluding Observations: Serbia*, ¶ 33, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013).
- 538 CEDAW Committee, *Concluding Observations: Mongolia*, ¶ 29, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016); *Serbia*, ¶ 33, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013).
- 539 CEDAW Committee, *Concluding Observations: Mongolia*, ¶ 29, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016).
- 540 CEDAW Committee, *Concluding Observations: Liechtenstein*, ¶ 38, U.N. Doc. CEDAW/C/LIE/CO/4 (2011); *Montenegro*, ¶ 31, U.N. Doc. CEDAW/C/MNE/CO/1 (2011).
- 541 CEDAW Committee, *Concluding Observations: Liechtenstein*, ¶ 38, U.N. Doc. CEDAW/C/LIE/CO/4 (2011); *Montenegro*, ¶ 31, U.N. Doc. CEDAW/C/MNE/CO/1 (2011).
- 542 CEDAW Committee, *Concluding Observations: Serbia*, ¶ 33, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013).
- 543 CEDAW Committee, *Concluding Observations: Czech Republic*, ¶ 41, U.N. Doc. CEDAW/C/CZE/CO/6 (2016).
- 544 CEDAW Committee, *Concluding Observations: Georgia*, ¶ 30, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014).
- 545 CEDAW Committee, *Concluding Observations: Mongolia*, ¶ 28, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016); *Kyrgyzstan*, ¶ 29, U.N. Doc. CEDAW/C/KGZ/CO/4 (2015); *Dominican Republic*, ¶ 36, U.N. Doc. CEDAW/C/DOM/CO/6-7 (2014).
- 546 CEDAW Committee, *Concluding Observations: Kyrgyzstan*, ¶ 29, U.N. Doc. CEDAW/C/KGZ/CO/4 (2015).
- 547 CEDAW Committee, *Concluding Observations: Hungary*, ¶ 32, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Montenegro*, ¶ 30, U.N. Doc. CEDAW/C/MNE/CO/1 (2011); *Nicaragua*, ¶ 17, U.N. Doc. CEDAW/C/NIC/CO/6 (2007).
- 548 CEDAW Committee, *Concluding Observations: Sweden*, ¶ 36, U.N. Doc. CEDAW/C/SWE/CO/8-9 (2016); *Liechtenstein*, ¶ 38, U.N. Doc. CEDAW/C/LIE/CO/4 (2011).
- 549 CEDAW Committee, *Concluding Observations: Former Yugoslav Republic of Macedonia*, ¶ 33, U.N. Doc. CEDAW/C/MKD/CO/4-5 (2013).
- 550 CEDAW Committee, *Concluding Observations: Czech Republic*, ¶ 30, U.N. Doc. CEDAW/C/CZE/CO/6 (2016).
- 551 CEDAW Committee, *Concluding Observations: Hungary*, ¶ 32, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- 552 CEDAW Committee, *Concluding Observations: France*, ¶ 37, U.N. Doc. CEDAW/C/FRA/CO/7-8 (2016); CEDAW Committee, *Concluding Observations: Turkey*, ¶ 48, U.N. Doc. CEDAW/C/TUR/CO/7 (2016); *Mali*, ¶ 40, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016); *Greece*, ¶ 31, U.N. Doc. CEDAW/C/GRC/CO/7 (2013).
- 553 CEDAW Committee, *Concluding Observations: France*, ¶ 37, U.N. Doc. CEDAW/C/FRA/CO/7-8 (2016); CEDAW Committee, *Concluding Observations: Turkey*, ¶ 48, U.N. Doc. CEDAW/C/TUR/CO/7 (2016); *Mali*, ¶ 40, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016).
- 554 CEDAW Committee, *Concluding Observations: Dominican Republic*, ¶ 37, U.N. Doc. CEDAW/C/DOM/CO/6-7 (2014).
- 555 CEDAW Committee, *Concluding Observations: Sweden*, ¶ 37, U.N. Doc. CEDAW/C/SWE/CO/8-9 (2016).
- 556 CEDAW Committee, *Concluding Observations: Turkey*, ¶ 48, U.N. Doc. CEDAW/C/TUR/CO/7 (2016).
- 557 CEDAW Committee, *Concluding Observations: Georgia*, ¶ 31, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014).
- 558 CEDAW Committee, *Concluding Observations: Slovakia*, ¶ 31, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).
- 559 See, e.g., CEDAW Committee, *Concluding Observations: Nepal*, ¶ 31, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011); *Oman*, ¶ 40, U.N. Doc. CEDAW/C/OMN/CO/1 (2011).
- 560 See, e.g., CEDAW Committee, *Concluding Observations: United Republic of Tanzania*, ¶ 34, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016); *Lebanon*, ¶ 41, U.N. Doc. CEDAW/C/LBN/CO/4-5 (2015); *Liberia*, ¶ 39, U.N. Doc. CEDAW/C/LBR/CO/7-8 (2015); *Tuvalu*, ¶ 30, U.N. Doc. CEDAW/C/TUV/CO/3-4 (2015); *Ecuador*, ¶ 32, U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015); *Solomon Islands*, ¶ 36, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014); *Congo*, ¶ 35, U.N. Doc. CEDAW/C/COG/CO/6 (2012); *Indonesia*, ¶ 41,

- U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012); Kenya, ¶ 37, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); Brazil, ¶ 29, U.N. Doc. CEDAW/C/BRA/CO/6 (2007); Saint Lucia, ¶ 31, U.N. Doc. CEDAW/C/LCA/CO/6 (2006).
- ⁵⁶¹ See, e.g., CEDAW Committee, *Concluding Observations: Liberia*, ¶ 40, U.N. Doc. CEDAW/C/LBR/CO/7-8 (2015); Eritrea, ¶ 34, U.N. Doc. CEDAW/C/ERI/CO/5 (2015); Saint Vincent and the Grenadines, ¶ 39, U.N. Doc. CEDAW/C/VCT/CO/4-8 (2015); India, ¶ 31, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); Nepal, ¶ 32, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011); Saint Lucia, ¶ 32, U.N. Doc. CEDAW/C/LCA/CO/6 (2006).
- ⁵⁶² CEDAW Committee, *Concluding Observations: Sri Lanka*, ¶ 37, U.N. Doc. CEDAW/C/LKA/CO/7 (2011); Nicaragua, ¶ 18, U.N. Doc. CEDAW/C/NIC/CO/6 (2007).
- ⁵⁶³ CEDAW Committee, *Concluding Observations: Saint Lucia*, ¶ 32, U.N. Doc. CEDAW/C/LCA/CO/6 (2006).
- ⁵⁶⁴ CEDAW Committee, *Concluding Observations: Tuvalu*, ¶ 30, U.N. Doc. CEDAW/C/TUV/CO/3-4 (2015); Bahrain, ¶ 41, U.N. Doc. CEDAW/C/BHR/CO/3 (2014); Chile, ¶ 34, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012); Haiti, ¶ 36, U.N. Doc. CEDAW/C/HTI/CO/7 (2009); Honduras, ¶ 24, U.N. Doc. CEDAW/C/HON/CO/6 (2007).
- ⁵⁶⁵ See, e.g., CEDAW Committee, *Concluding Observations: Trinidad and Tobago*, ¶ 32, U.N. Doc. CEDAW/C/TTO/CO/4-7 (2016); Myanmar, ¶ 38, U.N. Doc. CEDAW/C/MMR/CO/4-5 (2016); Gabon, ¶ 34, U.N. Doc. CEDAW/C/GAB/CO/6 (2015); Gambia, ¶ 36, U.N. Doc. CEDAW/C/GMB/CO/4-5 (2015); Malawi, ¶ 34, U.N. Doc. CEDAW/C/MWI/CO/7 (2015); Dominican Republic, ¶ 36, U.N. Doc. CEDAW/C/DOM/CO/6-7 (2014); Syria, ¶ 39, U.N. Doc. CEDAW/C/SYR/CO/2 (2014); United Kingdom of Great Britain and Northern Ireland, ¶ 50, U.N. Doc. CEDAW/C/GBR/CO/7 (2013); Afghanistan, ¶ 36, U.N. Doc. CEDAW/C/AFG/CO/1-2 (2013); Indonesia, ¶ 41, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012); Sri Lanka, ¶ 36, U.N. Doc. CEDAW/C/LKA/CO/7 (2011).
- ⁵⁶⁶ CEDAW Committee, *Concluding Observations: Japan*, ¶ 38, U.N. Doc. CEDAW/C/JPN/CO/7-8 (2016); United Republic of Tanzania, ¶ 34, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016); Ecuador, ¶ 32, U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015); Peru, ¶ 35, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014); Congo, ¶ 35, U.N. Doc. CEDAW/C/COG/CO/6 (2012).
- ⁵⁶⁷ CEDAW Committee, *Concluding Observations: Japan*, ¶ 38, U.N. Doc. CEDAW/C/JPN/CO/7-8 (2016).
- ⁵⁶⁸ CEDAW Committee, *Concluding Observations: Myanmar*, ¶ 38, U.N. Doc. CEDAW/C/MMR/CO/4-5 (2016).
- ⁵⁶⁹ CEDAW Committee, *Concluding Observations: Kuwait*, ¶ 42, U.N. Doc. CEDAW/C/KWT/CO/3-4 (2011).
- ⁵⁷⁰ See, e.g., CEDAW Committee, *Concluding Observations: Ecuador*, ¶ 32, U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015); Djibouti, ¶ 20, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011).
- ⁵⁷¹ CEDAW Committee, *Concluding Observations: Indonesia*, ¶ 41, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012); Lithuania, ¶ 24, U.N. Doc. CEDAW/C/LTU/CO/4 (2008).
- ⁵⁷² CEDAW Committee, *Concluding Observations: Philippines*, ¶ 39, U.N. Doc. CEDAW/C/PHL/CO/7-8 (2016); United Republic of Tanzania, ¶ 34, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016); Gambia, ¶ 36, U.N. Doc. CEDAW/C/GMB/CO/4-5 (2015); Malawi, ¶ 34, U.N. Doc. CEDAW/C/MWI/CO/7 (2015); Peru, ¶ 35, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014); Venezuela, ¶ 30, U.N. Doc. CEDAW/C/VEN/CO/7-8 (2014); Afghanistan, ¶ 36, U.N. Doc. CEDAW/C/AFG/CO/1-2 (2013); Tuvalu, ¶ 43, U.N. Doc. CEDAW/C/TUV/CO/2 (2009); Lithuania, ¶ 24, U.N. Doc. CEDAW/C/LTU/CO/4 (2008).
- ⁵⁷³ CEDAW Committee, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland*, ¶ 50, U.N. Doc. CEDAW/C/GBR/CO/7 (2013).
- ⁵⁷⁴ CEDAW Committee, *Concluding Observations: Serbia*, ¶ 32, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013).
- ⁵⁷⁵ CEDAW Committee, *Concluding Observations: Nicaragua*, ¶ 17, U.N. Doc. CEDAW/C/NIC/CO/6 (2007).
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- ⁵⁷⁸ See, e.g., CEDAW Committee, *Concluding Observations: Gambia*, ¶ 37, U.N. Doc. CEDAW/C/GMB/CO/4-5 (2015); Saint Vincent and the Grenadines, ¶ 39, U.N. Doc. CEDAW/C/VCT/CO/4-8 (2015); Peru, ¶ 36, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014); Bahrain, ¶ 41, U.N. Doc. CEDAW/C/BHR/CO/3 (2014); Venezuela, ¶ 31, U.N. Doc. CEDAW/C/VEN/CO/7-8 (2014); Congo, ¶ 36, U.N. Doc. CEDAW/C/COG/CO/6 (2012); Kenya, ¶ 38, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); Sri Lanka, ¶ 37, U.N. Doc. CEDAW/C/LKA/CO/7 (2011); Liechtenstein, ¶ 38, U.N. Doc. CEDAW/C/LIE/CO/4 (2011); Paraguay, ¶ 31, U.N. Doc. CEDAW/C/PRY/CO/6 (2011); Tuvalu, ¶ 44, U.N. Doc. CEDAW/C/TUV/CO/2 (2009); Honduras, ¶ 25, U.N. Doc. CEDAW/C/HON/CO/6 (2007); Nicaragua, ¶ 18, U.N. Doc. CEDAW/C/NIC/CO/6 (2007); Brazil, ¶ 29, U.N. Doc. CEDAW/C/BRA/CO/6 (2007); Philippines, ¶ 28, U.N. Doc. CEDAW/C/PHI/CO/6 (2006).

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- 580 CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016).
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- 584 CEDAW Committee, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland*, ¶ 50, U.N. Doc. CEDAW/C/GBR/CO/7 (2013).
- 585 CEDAW Committee, *Concluding Observations: Slovakia*, ¶ 30, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).
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- 587 CEDAW Committee, *Concluding Observations: Peru*, ¶ 35, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014).
- 588 CEDAW Committee, *Concluding Observations: United Republic of Tanzania*, ¶¶ 34-35, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016).
- 589 CEDAW Committee, *Concluding Observations: Portugal*, ¶¶ 36-37, U.N. Doc. CEDAW/C/PRT/CO/8-9 (2015).
- 590 CEDAW Committee, *Concluding Observations: Slovakia*, ¶ 30, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).
- 591 CEDAW Committee, *Concluding Observations: Slovakia*, ¶ 31, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).
- 592 CEDAW Committee, *Concluding Observations: Malawi*, ¶ 35, U.N. Doc. CEDAW/C/MWI/CO/7 (2015).
- 593 CEDAW Committee, *Concluding Observations: Croatia*, ¶ 30, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015); *Portugal*, ¶ 36, U.N. Doc. CEDAW/C/PRT/CO/8-9 (2015).
- 594 CEDAW Committee, *Concluding Observations: Croatia*, ¶ 30, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015).
- 595 CEDAW Committee, *Concluding Observations: Portugal*, ¶ 37, U.N. Doc. CEDAW/C/PRT/CO/8-9 (2015).
- 596 CEDAW Committee, *Concluding Observations: Serbia*, ¶ 33, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013).
- 597 CEDAW Committee, *Concluding Observations: Slovakia*, ¶ 31, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); *Croatia*, ¶ 31, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015); *Serbia*, ¶ 33, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013).
- 598 CEDAW Committee, *Concluding Observations: Syria*, ¶ 40, U.N. Doc. CEDAW/C/SYR/CO/2 (2014).
- 599 CEDAW Committee, *Concluding Observations: Turkey*, ¶ 18, U.N. Doc. CEDAW/C/TUR/CO/7 (2016); *Japan*, ¶ 38, U.N. Doc. CEDAW/C/JPN/CO/7-8 (2016); *Indonesia*, ¶ 41, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012); *Indonesia*, ¶ 16, U.N. Doc. CEDAW/C/IDN/CO/5 (2007).
- 600 CEDAW Committee, *Concluding Observations: Slovakia*, ¶ 30, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).
- 601 CEDAW Committee, *Concluding Observations: Japan*, ¶ 39, U.N. Doc. CEDAW/C/JPN/CO/7-8 (2016); *Slovakia*, ¶ 31, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); *Indonesia*, ¶ 42, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012).
- 602 CEDAW Committee, *Concluding Observations: Turkey*, ¶ 19, U.N. Doc. CEDAW/C/TUR/CO/7 (2016).
- 603 CEDAW Committee, *Concluding Observations: Bolivia*, ¶ 29, U.N. Doc. CEDAW/C/BOL/CO/5-6 (2015).
- 604 CEDAW Committee, *Concluding Observations: Uruguay*, ¶ 35, U.N. Doc. CEDAW/C/URY/CO/8-9 (2016); *Poland*, ¶ 36, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014); *Hungary*, ¶ 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- 605 CEDAW Committee, *Concluding Observations: Turkey*, ¶ 47, U.N. Doc. CEDAW/C/TUR/CO/7 (2016); *Croatia*, ¶ 30, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015); *Poland*, ¶ 36, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014).
- 606 CEDAW Committee, *Concluding Observations: Slovakia*, ¶ 30, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).
- 607 CEDAW Committee, *Concluding Observations: Turkey*, ¶ 47, U.N. Doc. CEDAW/C/TUR/CO/7 (2016).
- 608 CEDAW Committee, *Concluding Observations: Uruguay*, ¶ 36, U.N. Doc. CEDAW/C/URY/CO/8-9 (2016); *Portugal*, ¶ 37, U.N. Doc. CEDAW/C/PRT/CO/8-9 (2015); *Croatia*, ¶ 31, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015); *Peru*, ¶ 36, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014).
- 609 CEDAW Committee, *Concluding Observations: Hungary*, ¶ 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- 610 CEDAW Committee, *Concluding Observations: Turkey*, ¶ 48, U.N. Doc. CEDAW/C/TUR/CO/7 (2016).
- 611 CEDAW Committee, *Concluding Observations: Slovakia*, ¶ 31, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).
- 612 CEDAW Committee, *Concluding Observations: Poland*, ¶ 37, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014).
- 613 CEDAW Committee, *Concluding Observations: Russian Federation*, ¶ 35, U.N. Doc. CEDAW/C/RUS/CO/8 (2015); *Slovakia*, ¶ 30, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); *Hungary*, ¶ 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- 614 CEDAW Committee, *Concluding Observations: Hungary*, ¶ 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- 615 CEDAW Committee, *Concluding Observations: Russian Federation*, ¶ 36, U.N. Doc. CEDAW/C/RUS/CO/8 (2015).
- 616 CEDAW Committee, *Concluding Observations: Russian Federation*, ¶ 36, U.N. Doc. CEDAW/C/RUS/CO/8 (2015); *Slovakia*, ¶ 31, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); *Hungary*, ¶ 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013);
- 617 CEDAW Committee, *Concluding Observations: Slovakia*, ¶ 31, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).
- 618 CEDAW Committee, *Concluding Observations: Brazil*, ¶ 29, U.N. Doc. CEDAW/C/BRA/CO/6 (2007).
- 619 CEDAW Committee, *Concluding Observations: Peru*, ¶ 35, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014).

- ⁶²⁰ CEDAW Committee, *Concluding Observations: Ecuador*, ¶ 32, U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015); *Paraguay*, ¶ 31, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).
- ⁶²¹ CEDAW Committee, *Concluding Observations: Nicaragua*, ¶ 17, U.N. Doc. CEDAW/C/NIC/CO/6 (2007).
- ⁶²² CEDAW Committee, *Concluding Observations: Iraq*, ¶ 42, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014).
- ⁶²³ See, e.g., CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *Slovakia*, ¶ 31, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); *Liberia*, ¶ 40, U.N. Doc. CEDAW/C/LBR/CO/7-8 (2015); *Lebanon*, ¶ 42, U.N. Doc. CEDAW/C/LBN/CO/4-5 (2015); *Namibia*, ¶ 35, U.N. Doc. CEDAW/C/NAM/CO/4-5 (2015); *Peru*, ¶ 36, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014); *Afghanistan*, ¶ 37, U.N. Doc. CEDAW/C/AFG/CO/1-2 (2013); *Djibouti*, ¶ 31, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011).
- ⁶²⁴ CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *Eritrea*, ¶ 34, U.N. Doc. CEDAW/C/ERI/CO/5 (2015); *India*, ¶ 31, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Indonesia*, ¶ 42, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012).
- ⁶²⁵ CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *Tuvalu*, ¶ 30, U.N. Doc. CEDAW/C/TUV/CO/3-4 (2015); *Eritrea*, ¶ 34, U.N. Doc. CEDAW/C/ERI/CO/5 (2015); *Saint Vincent and the Grenadines*, ¶ 39, U.N. Doc. CEDAW/C/VCT/CO/4-8 (2015); *Paraguay*, ¶ 32, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).
- ⁶²⁶ CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016).
- ⁶²⁷ CEDAW Committee, *Concluding Observations: India*, ¶ 31, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Peru*, ¶ 36, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014); *Solomon Islands*, ¶ 37, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014); *Solomon Islands*, ¶ 37, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014); *Congo*, ¶ 36, U.N. Doc. CEDAW/C/COG/CO/6 (2012); *Sri Lanka*, ¶ 37, U.N. Doc. CEDAW/C/LKA/CO/7 (2011); *Kenya*, ¶ 38, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); *Tuvalu*, ¶ 44, U.N. Doc. CEDAW/C/TUV/CO/2 (2009); *Honduras*, ¶ 25, U.N. Doc. CEDAW/C/HON/CO/6 (2007); *Nicaragua*, ¶ 18, U.N. Doc. CEDAW/C/NIC/CO/6 (2007); *Brazil*, ¶ 30, U.N. Doc. CEDAW/C/BRA/CO/6 (2007); *Philippines*, ¶ 28, U.N. Doc. CEDAW/C/PHI/CO/6 (2006).
- ⁶²⁸ CEDAW Committee, *Concluding Observations: Syria*, ¶ 40, U.N. Doc. CEDAW/C/SYR/CO/2 (2014); *Afghanistan*, ¶ 37, U.N. Doc. CEDAW/C/AFG/CO/1-2 (2013); *Pakistan*, ¶ 32, U.N. Doc. CEDAW/C/PAK/CO/4 (2013).
- ⁶²⁹ CEDAW Committee, *Concluding Observations: Paraguay*, ¶ 32, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).
- ⁶³⁰ CEDAW Committee, *Concluding Observations: Croatia*, ¶ 31, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015).
- ⁶³¹ CEDAW Committee, *Concluding Observations: Hungary*, ¶ 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- ⁶³² CEDAW Committee, *Concluding Observations: Iraq*, ¶ 42, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014).
- ⁶³³ CEDAW Committee, *Concluding Observations: Afghanistan*, ¶ 37, U.N. Doc. CEDAW/C/AFG/CO/1-2 (2013);
- ⁶³⁴ CEDAW Committee, *Concluding Observations: Eritrea*, ¶ 34, U.N. Doc. CEDAW/C/ERI/CO/5 (2015); *Poland*, ¶ 37, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014); *Costa Rica*, ¶ 32, U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011).
- ⁶³⁵ CEDAW Committee, *Concluding Observations: Poland*, ¶ 37, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014); *Costa Rica*, ¶ 32, U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011).
- ⁶³⁶ CEDAW Committee, *Concluding Observations: Eritrea*, ¶ 34, U.N. Doc. CEDAW/C/ERI/CO/5 (2015); *Costa Rica*, ¶ 33, U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011).
- ⁶³⁷ CEDAW Committee, *Concluding Observations: Ecuador*, ¶ 33, U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015); *Peru*, ¶ 36, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014); *Costa Rica*, ¶ 33, U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011).
- ⁶³⁸ CEDAW Committee, *Concluding Observations: Ecuador*, ¶ 33, U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015).
- ⁶³⁹ CEDAW Committee, *Concluding Observations: Algeria*, ¶ 41, U.N. Doc. CEDAW/C/DZA/CO/3-4 (2012).
- ⁶⁴⁰ CEDAW Committee, *Concluding Observations: Colombia*, ¶ 23, U.N. Doc. CEDAW/C/COL/CO/6 (2007).
- ⁶⁴¹ CEDAW Committee, *Concluding Observations: Albania*, ¶ 32, U.N. Doc. CEDAW/C/ALB/CO/4 (2016); *Azerbaijan*, ¶ 32, U.N. Doc. CEDAW/C/AZE/CO/5 (2015); *Vietnam*, ¶ 32, U.N. Doc. CEDAW/C/VNM/CO/7-8 (2015); *China*, ¶ 31, U.N. Doc. CEDAW/C/CHN/CO/6 (2006).
- ⁶⁴² CEDAW Committee, *Concluding Observations: Vietnam*, ¶ 32, U.N. Doc. CEDAW/C/VNM/CO/7-8 (2015); *China*, ¶ 17, U.N. Doc. CEDAW/C/CHN/CO/6 (2006).
- ⁶⁴³ CEDAW Committee, *Concluding Observations: China*, ¶ 17, U.N. Doc. CEDAW/C/CHN/CO/6 (2006).
- ⁶⁴⁴ CEDAW Committee, *Concluding Observations: India*, ¶ 38, U.N. Doc. CEDAW/C/IND/CO/3 (2007).
- ⁶⁴⁵ CEDAW Committee, *Concluding Observations: China*, ¶ 32, U.N. Doc. CEDAW/C/CHN/CO/6 (2006).
- ⁶⁴⁶ CEDAW Committee, *Concluding Observations: China*, ¶ 32, U.N. Doc. CEDAW/C/CHN/CO/6 (2006).
- ⁶⁴⁷ CEDAW Committee, *Concluding Observations: Georgia*, ¶ 31, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014).
- ⁶⁴⁸ CEDAW Committee, *Concluding Observations: India*, ¶ 39, U.N. Doc. CEDAW/C/IND/CO/3 (2007).
- ⁶⁴⁹ See, e.g., CEDAW Committee, *Concluding Observations: Trinidad and Tobago*, ¶¶ 32-33, U.N. Doc. CEDAW/C/TTO/CO/4-7 (2016); *Georgia*, ¶ 30, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014); *Poland*, ¶ 36, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014); *Cyprus*, ¶ 29, U.N. Doc. CEDAW/C/CYP/CO/6-7 (2013); *Indonesia*, ¶ 41, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012); *Djibouti*, ¶ 30, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011); *Armenia*, ¶ 34, U.N. Doc. CEDAW/C/ARM/CO/4/Rev.1 (2009); *Guatemala*, ¶ 35, U.N. Doc. CEDAW/C/GUA/CO/7 (2009).

- ⁶⁵⁰ CEDAW Committee, *Concluding Observations: Trinidad and Tobago*, ¶¶ 32-33, U.N. Doc. CEDAW/C/TTO/CO/4-7 (2016); *Georgia*, ¶ 30, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014).
- ⁶⁵¹ CEDAW Committee, *Concluding Observations: Greece*, ¶ 27, U.N. Doc. CEDAW/C/GRC/CO/6 (2007); *Cuba*, ¶ 27, U.N. Doc. CEDAW/C/CUB/CO/6 (2006).
- ⁶⁵² CEDAW Committee, *Concluding Observations: Indonesia*, ¶ 42, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012); *Cuba*, ¶ 28, U.N. Doc. CEDAW/C/CUB/CO/6 (2006).
- ⁶⁵³ CEDAW Committee, *Concluding Observations: Poland*, ¶ 37, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014); *Cyprus*, ¶ 30, U.N. Doc. CEDAW/C/CYP/CO/6-7 (2013).
- ⁶⁵⁴ See, e.g., CEDAW Committee, *Concluding Observations: Haiti*, ¶ 33, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *Mongolia*, ¶ 28, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016); *Azerbaijan*, ¶ 32, U.N. Doc. CEDAW/C/AZE/CO/5 (2015); *Gabon*, ¶ 34, U.N. Doc. CEDAW/C/GAB/CO/6 (2015); *Tuvalu*, ¶ 30, U.N. Doc. CEDAW/C/TUV/CO/3-4 (2015); *Lithuania*, ¶ 36, U.N. Doc. CEDAW/C/LTU/CO/5 (2014); *Iraq*, ¶ 42, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); *Solomon Islands*, ¶ 36, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014); *Hungary*, ¶ 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Former Yugoslav Republic of Macedonia*, ¶ 33, U.N. Doc. CEDAW/C/MKD/CO/4-5 (2013); *Greece*, ¶ 30, U.N. Doc. CEDAW/C/GRC/CO/7 (2013); *Congo*, ¶ 35, U.N. Doc. CEDAW/C/COG/CO/6 (2012); *Belarus*, ¶ 35, U.N. Doc. CEDAW/C/BLR/CO/7 (2011); *Montenegro*, ¶ 30, U.N. Doc. CEDAW/C/MNE/CO/1 (2011); *Djibouti*, ¶ 30, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011); *Oman*, ¶ 40, U.N. Doc. CEDAW/C/OMN/CO/1 (2011); *Sri Lanka*, ¶ 36, U.N. Doc. CEDAW/C/LKA/CO/7 (2011); *Russian Federation*, ¶ 38, U.N. Doc. CEDAW/C/USR/CO/7 (2010); *Tuvalu*, ¶ 43, U.N. Doc. CEDAW/C/TUV/CO/2 (2009); *Former Yugoslav Republic of Macedonia*, ¶ 31, U.N. Doc. CEDAW/C/MKD/CO/3 (2006); *Philippines*, ¶ 27, U.N. Doc. CEDAW/C/PHI/CO/6 (2006).
- ⁶⁵⁵ CEDAW Committee, *Concluding Observations: Nepal*, ¶ 31, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
- ⁶⁵⁶ CEDAW Committee, *Concluding Observations: Myanmar*, ¶ 38, U.N. Doc. CEDAW/C/MMR/CO/4-5 (2016); *Croatia*, ¶ 30, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015); *Malawi*, ¶ 34, U.N. Doc. CEDAW/C/MWI/CO/7 (2015); *Ecuador*, ¶ 32, U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015); *Concluding Observations: India*, ¶ 30, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Dominican Republic*, ¶ 36, U.N. Doc. CEDAW/C/DOM/CO/6-7 (2014); *Cyprus*, ¶ 29, U.N. Doc. CEDAW/C/CYP/CO/6-7 (2013); *Chile*, ¶ 34, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012); *Indonesia*, ¶ 36, U.N. Doc. CEDAW/C/IDN/CO/5 (2007); *Philippines*, ¶ 27, U.N. Doc. CEDAW/C/PHI/CO/6 (2006).
- ⁶⁵⁷ CEDAW Committee, *Concluding Observations: United Republic of Tanzania*, ¶ 34, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016); *Russian Federation*, ¶ 35, U.N. Doc. CEDAW/C/RUS/CO/8 (2015); *Lithuania*, ¶ 24, U.N. Doc. CEDAW/C/LTU/CO/4 (2008).
- ⁶⁵⁸ CEDAW Committee, *Concluding Observations: Kazakhstan*, ¶ 25, U.N. Doc. CEDAW/C/KAZ/CO/2 (2007).
- ⁶⁵⁹ CEDAW Committee, *Concluding Observations: Uzbekistan*, ¶ 27, U.N. Doc. CEDAW/C/UZB/CO/5 (2015); *Dominican Republic*, ¶ 36, U.N. Doc. CEDAW/C/DOM/CO/6-7 (2014).
- ⁶⁶⁰ CEDAW Committee, *Concluding Observations: Kazakhstan*, ¶ 25, U.N. Doc. CEDAW/C/KAZ/CO/2 (2007).
- ⁶⁶¹ CEDAW Committee, *Concluding Observations: Uzbekistan*, ¶ 27, U.N. Doc. CEDAW/C/UZB/CO/5 (2015).
- ⁶⁶² CEDAW Committee, *Concluding Observations: Afghanistan*, ¶ 36, U.N. Doc. CEDAW/C/AFG/CO/1-2 (2013); *Indonesia*, ¶ 41, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012).
- ⁶⁶³ CEDAW Committee, *Concluding Observations: Philippines*, ¶ 39, U.N. Doc. CEDAW/C/PHL/CO/7-8 (2016).
- ⁶⁶⁴ CEDAW Committee, *Concluding Observations: Liechtenstein*, ¶ 38, U.N. Doc. CEDAW/C/LIE/CO/4 (2011).
- ⁶⁶⁵ CEDAW Committee, *Concluding Observations: Croatia*, ¶ 30, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015).
- ⁶⁶⁶ CEDAW Committee, *Concluding Observations: Ecuador*, ¶ 32, U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015).
- ⁶⁶⁷ CEDAW Committee, *Concluding Observations: United Republic of Tanzania*, ¶ 35, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016); *Russian Federation*, ¶ 36, U.N. Doc. CEDAW/C/RUS/CO/8 (2015); *Malawi*, ¶ 35, U.N. Doc. CEDAW/C/MWI/CO/7 (2015); *Croatia*, ¶ 31, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015); *Iraq*, ¶ 43, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); *Chile*, ¶ 35, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012); *Nepal*, ¶ 32, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011); *Haiti*, ¶ 37, U.N. Doc. CEDAW/C/HTI/CO/7 (2009).
- ⁶⁶⁸ CEDAW Committee, *Concluding Observations: Peru*, ¶ 36, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014); *Nepal*, ¶ 32, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011); *Concluding Observations: Uganda*, ¶ 35, U.N. Doc. CEDAW/C/UGA/CO/7 (2010).
- ⁶⁶⁹ CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *Uruguay*, ¶ 36, U.N. Doc. CEDAW/C/URY/CO/8-9 (2016); *Vietnam*, ¶ 33, U.N. Doc. CEDAW/C/VNM/CO/7-8 (2015); *Gabon*, ¶ 35, U.N. Doc. CEDAW/C/GAB/CO/6 (2015); *Liberia*, ¶ 40, U.N. Doc. CEDAW/C/LBR/CO/7-8 (2015); *Gambia*, ¶ 37, U.N. Doc. CEDAW/C/GMB/CO/4-5 (2015); *Bolivia*, ¶ 29, U.N. Doc. CEDAW/C/BOL/CO/5-6 (2015); *Ecuador*, ¶ 33, U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015); *Georgia*, ¶ 31, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014); *Iraq*, ¶ 43, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); *Lithuania*, ¶ 37, U.N. Doc. CEDAW/C/LTU/CO/5 (2014); *Former Yugoslav Republic of Macedonia*, ¶ 34, U.N. Doc. CEDAW/C/MKD/CO/4-5 (2013); *Hungary*, ¶ 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Bulgaria*, ¶ 36, U.N. Doc. CEDAW/C/BGR/CO/4-7 (2012); *Paraguay*, ¶ 32, U.N. Doc. CEDAW/C/PRY/CO/6 (2011); *Kenya*, ¶ 38, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); *Concluding Observations: Russian Federation*, ¶ 39, U.N. Doc. CEDAW/C/USR/CO/7 (2010); *Ukraine*, ¶ 39, U.N. Doc. CEDAW/C/UKR/CO/7 (2010); *Egypt*, ¶ 39, U.N. Doc. CEDAW/C/EGY/CO/7 (2010); *Uganda*, ¶ 36, U.N. Doc. CEDAW/C/UGA/CO/7 (2010); *Lithuania*, ¶ 24, U.N. Doc. CEDAW/C/LTU/CO/4 (2008); *Honduras*, ¶ 24, U.N. Doc. CEDAW/C/HON/CO/6 (2007).

- ⁶⁷⁰ CEDAW Committee, *Concluding Observations: Tuvalu*, ¶ 31, U.N. Doc. CEDAW/C/TUV/CO/3-4 (2015); *Dominican Republic*, ¶ 37, U.N. Doc. CEDAW/C/DOM/CO/6-7 (2014); *Solomon Islands*, ¶ 37, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014); *Belarus*, ¶ 36, U.N. Doc. CEDAW/C/BLR/CO/7 (2011).
- ⁶⁷¹ CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *Kyrgyzstan*, ¶ 30, U.N. Doc. CEDAW/C/KGZ/CO/4 (2015); *Poland*, ¶ 37, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014).
- ⁶⁷² CEDAW Committee, *Concluding Observations: Vietnam*, ¶ 33, U.N. Doc. CEDAW/C/VNM/CO/7-8 (2015); *Hungary*, ¶ 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Belarus*, ¶ 36, U.N. Doc. CEDAW/C/BLR/CO/7 (2011).
- ⁶⁷³ CEDAW Committee, *Concluding Observations: Cyprus*, ¶ 30, U.N. Doc. CEDAW/C/CYP/CO/6-7 (2013); *Hungary*, ¶ 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Belarus*, ¶ 36, U.N. Doc. CEDAW/C/BLR/CO/7 (2011).
- ⁶⁷⁴ CEDAW Committee, *Concluding Observations: Hungary*, ¶ 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Belarus*, ¶ 36, U.N. Doc. CEDAW/C/BLR/CO/7 (2011).
- ⁶⁷⁵ CEDAW Committee, *Concluding Observations: Vietnam*, ¶ 33, U.N. Doc. CEDAW/C/VNM/CO/7-8 (2015).
- ⁶⁷⁶ CEDAW Committee, *Concluding Observations: Uzbekistan*, ¶ 28, U.N. Doc. CEDAW/C/UZB/CO/5 (2015); *Dominican Republic*, ¶ 37, U.N. Doc. CEDAW/C/DOM/CO/6-7 (2014).
- ⁶⁷⁷ CEDAW Committee, *Concluding Observations: India*, ¶ 31, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Greece*, ¶ 31, U.N. Doc. CEDAW/C/GRC/CO/7 (2013).
- ⁶⁷⁸ CEDAW Committee, *Concluding Observations: Paraguay*, ¶ 32, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).
- ⁶⁷⁹ CEDAW Committee, *Concluding Observations: Slovakia*, ¶ 31, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); *Croatia*, ¶ 31, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015); *Poland*, ¶ 37, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014); *Hungary*, ¶ 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- ⁶⁸⁰ CEDAW Committee, *Concluding Observations: Azerbaijan*, ¶ 33, U.N. Doc. CEDAW/C/AZE/CO/5 (2015); *Dominican Republic*, ¶ 37, U.N. Doc. CEDAW/C/DOM/CO/6-7 (2014); *Serbia*, ¶ 33, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013).
- ⁶⁸¹ CEDAW Committee, *Concluding Observations: Saint Lucia*, ¶ 32, U.N. Doc. CEDAW/C/LCA/CO/6 (2006).
- ⁶⁸² CEDAW Committee, *Concluding Observations: Indonesia*, ¶ 42, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012).
- ⁶⁸³ CEDAW Committee, *Concluding Observations: Russian Federation*, ¶ 35, U.N. Doc. CEDAW/C/RUS/CO/8 (2015).
- ⁶⁸⁴ CEDAW Committee, *Concluding Observations: Serbia*, ¶ 32, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013).
- ⁶⁸⁵ CEDAW Committee, *Concluding Observations: Hungary*, ¶ 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- ⁶⁸⁶ CEDAW Committee, *Concluding Observations: Solomon Islands*, ¶ 36, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014).
- ⁶⁸⁷ CEDAW Committee, *Concluding Observations: Uruguay*, ¶ 36, U.N. Doc. CEDAW/C/URY/CO/8-9 (2016); *Mongolia*, ¶ 29, U.N. Doc. CEDAW/C/MNG/CO/8-9 (2016); *Bolivia*, ¶ 29, U.N. Doc. CEDAW/C/BOL/CO/5-6 (2015); *Gabon*, ¶ 35, U.N. Doc. CEDAW/C/GAB/CO/6 (2015); *Liberia*, ¶ 40, U.N. Doc. CEDAW/C/LBR/CO/7-8 (2015); *Iraq*, ¶ 43, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); *Djibouti*, ¶ 31, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011); *Montenegro*, ¶ 31, U.N. Doc. CEDAW/C/MNE/CO/1 (2011).
- ⁶⁸⁸ CEDAW Committee, *Concluding Observations: Hungary*, ¶ 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013);
- ⁶⁸⁹ CEDAW Committee, *Concluding Observations: Russian Federation*, ¶ 36, U.N. Doc. CEDAW/C/RUS/CO/8 (2015).
- ⁶⁹⁰ CEDAW Committee, *Concluding Observations: Solomon Islands*, ¶ 37, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014).
- ⁶⁹¹ CEDAW Committee, *Concluding Observations: Belarus*, ¶ 36, U.N. Doc. CEDAW/C/BLR/CO/7 (2011); *Montenegro*, ¶ 31, U.N. Doc. CEDAW/C/MNE/CO/1 (2011); *Liechtenstein*, ¶ 38, U.N. Doc. CEDAW/C/LIE/CO/4 (2011).
- ⁶⁹² See, e.g., CEDAW Committee, *Concluding Observations: Bolivia*, ¶ 28, U.N. Doc. CEDAW/C/BOL/CO/5-6 (2015); *India*, ¶ 30, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Hungary*, ¶ 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Costa Rica*, ¶ 32, U.N. Doc. CEDAW/C/CRI/CO/5-6 (2012); *Egypt*, ¶ 39, U.N. Doc. CEDAW/C/EGY/CO/7 (2010).
- ⁶⁹³ CEDAW Committee, *Concluding Observations: Peru*, ¶ 35, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014).
- ⁶⁹⁴ CEDAW Committee, *Concluding Observations: Central African Republic*, ¶ 39, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014); *Syria*, ¶ 39, U.N. Doc. CEDAW/C/SYR/CO/2 (2014); *Mexico*, ¶ 33, U.N. Doc. CEDAW/C/MEX/CO/7-8 (2012).
- ⁶⁹⁵ CEDAW Committee, *Concluding Observations: Saint Vincent and the Grenadines*, ¶ 36, U.N. Doc. CEDAW/C/VCT/CO/4-8 (2015).
- ⁶⁹⁶ See, e.g., CEDAW Committee, *Concluding Observations: Eritrea*, ¶ 35, U.N. Doc. CEDAW/C/ERI/CO/5 (2015); *Gambia*, ¶ 37, U.N. Doc. CEDAW/C/GMB/CO/4-5 (2015); *Central African Republic*, ¶ 40, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014); *Hungary*, ¶ 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Cyprus*, ¶ 30, U.N. Doc. CEDAW/C/CYP/CO/6-7 (2013); *Chile*, ¶ 35, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012); *Lithuania*, ¶ 25, U.N. Doc. CEDAW/C/LTU/CO/4 (2008).
- ⁶⁹⁷ CEDAW Committee, *Concluding Observations: Nepal*, ¶ 32, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
- ⁶⁹⁸ CEDAW Committee, *Concluding Observations: Turkey*, ¶ 48, U.N. Doc. CEDAW/C/TUR/CO/7 (2016); *Concluding Observations: Venezuela*, ¶ 31, U.N. Doc. CEDAW/C/VEN/CO/7-8 (2014).
- ⁶⁹⁹ CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *Egypt*, ¶ 40, U.N. Doc. CEDAW/C/EGY/CO/7 (2010).
- ⁷⁰⁰ CEDAW Committee, *Concluding Observations: Peru*, ¶ 36, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014).

- ⁷⁰¹ CEDAW Committee, *Concluding Observations: Hungary*, ¶ 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- ⁷⁰² CEDAW Committee, *Concluding Observations: Egypt*, ¶ 40, U.N. Doc. CEDAW/C/EGY/CO/7 (2010).
- ⁷⁰³ CEDAW Committee, *Concluding Observations: Albania*, ¶ 32, U.N. Doc. CEDAW/C/ALB/CO/4 (2016); *Haiti*, ¶ 33, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *Russian Federation*, ¶ 35, U.N. Doc. CEDAW/C/RUS/CO/8 (2015); *Azerbaijan*, ¶ 32, U.N. Doc. CEDAW/C/AZE/CO/5 (2015); *Georgia*, ¶ 30, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014); *Former Yugoslav Republic of Macedonia*, ¶ 33, U.N. Doc. CEDAW/C/MKD/CO/4-5 (2013); *Serbia*, ¶ 32, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013); *Greece*, ¶ 30, U.N. Doc. CEDAW/C/GRC/CO/7 (2013); *Bulgaria*, ¶ 35, U.N. Doc. CEDAW/C/BGR/CO/4-7 (2012); *Belarus*, ¶ 35, U.N. Doc. CEDAW/C/BLR/CO/7 (2011); *Armenia*, ¶ 34, U.N. Doc. CEDAW/C/ARM/CO/4/Rev.1 (2009); *Kazakhstan*, ¶ 25, U.N. Doc. CEDAW/C/KAZ/CO/2 (2007); *Former Yugoslav Republic of Macedonia*, ¶ 31, U.N. Doc. CEDAW/C/MKD/CO/3 (2006); *Cuba*, ¶ 27, U.N. Doc. CEDAW/C/CUB/CO/6 (2006); *Moldova*, ¶ 30, U.N. Doc. CEDAW/C/MDA/CO/3 (2006).
- ⁷⁰⁴ CEDAW Committee, *Concluding Observations: Japan*, ¶ 38, U.N. Doc. CEDAW/C/JPN/CO/7-8 (2016); *Vietnam*, ¶ 32, U.N. Doc. CEDAW/C/VNM/CO/7-8 (2015); *Bulgaria*, ¶ 35, U.N. Doc. CEDAW/C/BGR/CO/4-7 (2012); *Vietnam*, ¶ 24, U.N. Doc. CEDAW/C/VNM/CO/6 (2007).
- ⁷⁰⁵ CEDAW Committee, *Concluding Observations: Russian Federation*, ¶ 35, U.N. Doc. CEDAW/C/RUS/CO/8 (2015); *Georgia*, ¶ 30, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014); *Greece*, ¶ 30, U.N. Doc. CEDAW/C/GRC/CO/7 (2013); *Cuba*, ¶ 27, U.N. Doc. CEDAW/C/CUB/CO/6 (2006).
- ⁷⁰⁶ CEDAW Committee, *Concluding Observations: Albania*, ¶ 33, U.N. Doc. CEDAW/C/ALB/CO/4 (2016); *Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016).
- ⁷⁰⁷ CEDAW Committee, *Concluding Observations: Albania*, ¶ 33, U.N. Doc. CEDAW/C/ALB/CO/4 (2016); *Georgia*, ¶ 31, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014); *India*, ¶ 31, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Greece*, ¶ 31, U.N. Doc. CEDAW/C/GRC/CO/7 (2013); *Serbia*, ¶ 33, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013); *Vietnam*, ¶ 25, U.N. Doc. CEDAW/C/VNM/CO/6 (2007); *Former Yugoslav Republic of Macedonia*, ¶ 32, U.N. Doc. CEDAW/C/MKD/CO/3 (2006); *Cuba*, ¶ 28, U.N. Doc. CEDAW/C/CUB/CO/6 (2006); *Moldova*, ¶ 30, U.N. Doc. CEDAW/C/MDA/CO/3 (2006).
- ⁷⁰⁸ CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016).
- ⁷⁰⁹ CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016).
- ⁷¹⁰ CEDAW Committee, *Concluding Observations: Former Yugoslav Republic of Macedonia*, ¶ 34, U.N. Doc. CEDAW/C/MKD/CO/4-5 (2013).
- ⁷¹¹ CEDAW Committee, *Concluding Observations: Former Yugoslav Republic of Macedonia*, ¶ 31, U.N. Doc. CEDAW/C/MKD/CO/3 (2006).
- ⁷¹² CEDAW Committee, *Concluding Observations: France*, ¶ 36, U.N. Doc. CEDAW/C/FRA/CO/7-8 (2016); *Ukraine*, ¶ 38, U.N. Doc. CEDAW/C/UKR/CO/7 (2010).
- ⁷¹³ CEDAW Committee, *Concluding Observations: Saint Lucia*, ¶ 31, U.N. Doc. CEDAW/C/LCA/CO/6 (2006).
- ⁷¹⁴ CEDAW Committee, *Concluding Observations: Kyrgyzstan*, ¶ 29, U.N. Doc. CEDAW/C/KGZ/CO/4 (2015); *Solomon Islands*, ¶ 36, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014); *Afghanistan*, ¶ 36, U.N. Doc. CEDAW/C/AFG/CO/1-2 (2013); *Djibouti*, ¶ 30, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011); *Nepal*, ¶ 31, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
- ⁷¹⁵ CEDAW Committee, *Concluding Observations: Kyrgyzstan*, ¶ 29, U.N. Doc. CEDAW/C/KGZ/CO/4 (2015); *Solomon Islands*, ¶ 36, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014).
- ⁷¹⁶ CEDAW Committee, *Concluding Observations: Haiti*, ¶ 33, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016).
- ⁷¹⁷ CEDAW Committee, *Concluding Observations: Haiti*, ¶ 33, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *Tuvalu*, ¶ 30, U.N. Doc. CEDAW/C/TUV/CO/3-4 (2015); *India*, ¶ 30, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014).
- ⁷¹⁸ CEDAW Committee, *Concluding Observations: India*, ¶ 30, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014).
- ⁷¹⁹ CEDAW Committee, *Concluding Observations: Nepal*, ¶ 31, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
- ⁷²⁰ CEDAW Committee, *Concluding Observations: France*, ¶ 37, U.N. Doc. CEDAW/C/FRA/CO/7-8 (2016).
- ⁷²¹ CEDAW Committee, *Concluding Observations: Tuvalu*, ¶ 31, U.N. Doc. CEDAW/C/TUV/CO/3-4 (2015); *Solomon Islands*, ¶ 37, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014).
- ⁷²² CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016).
- ⁷²³ CEDAW Committee, *Concluding Observations: India*, ¶ 31, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014).
- ⁷²⁴ CEDAW Committee, *Concluding Observations: Nepal*, ¶ 32, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
- ⁷²⁵ CEDAW Committee, *Concluding Observations: Greece*, ¶ 30, U.N. Doc. CEDAW/C/GRC/CO/7 (2013).
- ⁷²⁶ CEDAW Committee, *Concluding Observations: Czech Republic*, ¶ 30, U.N. Doc. CEDAW/C/CZE/CO/6 (2016); *Slovakia*, ¶ 30, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); *Portugal*, ¶ 36, U.N. Doc. CEDAW/C/PRT/CO/8-9 (2015); *Croatia*, ¶ 30, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015).
- ⁷²⁷ CEDAW Committee, *Concluding Observations: Czech Republic*, ¶ 30, U.N. Doc. CEDAW/C/CZE/CO/6 (2016); *Hungary*, ¶ 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- ⁷²⁸ CEDAW Committee, *Concluding Observations: Portugal*, ¶ 36, U.N. Doc. CEDAW/C/PRT/CO/8-9 (2015).
- ⁷²⁹ CEDAW Committee, *Concluding Observations: Czech Republic*, ¶ 30, U.N. Doc. CEDAW/C/CZE/CO/6 (2016).
- ⁷³⁰ CEDAW Committee, *Concluding Observations: Greece*, ¶ 31, U.N. Doc. CEDAW/C/GRC/CO/7 (2013).

- ⁷³¹ CEDAW Committee, *Concluding Observations: Czech Republic*, ¶ 31, U.N. Doc. CEDAW/C/CZE/CO/6 (2016).
- ⁷³² CEDAW Committee, *Concluding Observations: Czech Republic*, ¶ 31, U.N. Doc. CEDAW/C/CZE/CO/6 (2016); *Croatia*, ¶ 31, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015); *Hungary*, ¶ 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
- ⁷³³ CEDAW Committee, *Concluding Observations: Croatia*, ¶ 31, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015).
- ⁷³⁴ See, e.g., CEDAW Committee, *Concluding Observations: Haiti*, ¶ 33, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *United Republic of Tanzania*, ¶ 34, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016); *Bolivia*, ¶ 28, U.N. Doc. CEDAW/C/BOL/CO/5-6 (2015); *Gabon*, ¶ 34, U.N. Doc. CEDAW/C/GAB/CO/6 (2015); *Gambia*, ¶ 36, U.N. Doc. CEDAW/C/GMB/CO/4-5 (2015); *India*, ¶ 30, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Dominican Republic*, ¶ 36, U.N. Doc. CEDAW/C/DOM/CO/6-7 (2014); *Central African Republic*, ¶ 39, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014); *Venezuela*, 30, U.N. Doc. CEDAW/C/VEN/CO/7-8 (2014); *Afghanistan*, ¶ 36, U.N. Doc. CEDAW/C/AFG/CO/1-2 (2013); *Djibouti*, ¶ 30, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011); *Uganda*, ¶ 35, U.N. Doc. CEDAW/C/UGA/CO/7 (2010); *Indonesia*, ¶ 36, U.N. Doc. CEDAW/C/IDN/CO/5 (2007); *Nicaragua*, ¶ 17, U.N. Doc. CEDAW/C/NIC/CO/6 (2007); *Moldova*, ¶ 30, U.N. Doc. CEDAW/C/MDA/CO/3 (2006).
- ⁷³⁵ CEDAW Committee, *Concluding Observations: Mali*, ¶ 33, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016); *Vietnam*, ¶ 32, U.N. Doc. CEDAW/C/VNM/CO/7-8 (2015); *Nepal*, ¶ 31, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
- ⁷³⁶ See, e.g., CEDAW Committee, *Concluding Observations: Vietnam*, ¶ 32, U.N. Doc. CEDAW/C/VNM/CO/7-8 (2015); *Kyrgyzstan*, ¶ 29, U.N. Doc. CEDAW/C/KGZ/CO/4 (2015); *Indonesia*, ¶ 41, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012); *Nepal*, ¶ 31, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011); *India*, ¶ 40, U.N. Doc. CEDAW/C/IND/CO/3 (2007); *Moldova*, ¶ 30, U.N. Doc. CEDAW/C/MDA/CO/3 (2006).
- ⁷³⁷ See, e.g., CEDAW Committee, *Concluding Observations: Trinidad and Tobago*, ¶ 32, U.N. Doc. CEDAW/C/TTO/CO/4-7 (2016); *Myanmar*, ¶ 38, U.N. Doc. CEDAW/C/MMR/CO/4-5 (2016); *India*, ¶ 30, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Swaziland*, ¶ 34, U.N. Doc. CEDAW/C/SWZ/CO/1-2 (2014); *Sri Lanka*, ¶ 36, U.N. Doc. CEDAW/C/LKA/CO/7 (2011); *Djibouti*, ¶ 30, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011); *Paraguay*, ¶ 30, U.N. Doc. CEDAW/C/PRY/CO/6 (2011); *Kenya*, ¶ 37, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); *Uganda*, ¶ 35, U.N. Doc. CEDAW/C/UGA/CO/7 (2010); *Tuvalu*, ¶ 43, U.N. Doc. CEDAW/C/TUV/CO/2 (2009); *Nicaragua*, ¶ 17, U.N. Doc. CEDAW/C/NIC/CO/6 (2007); *Moldova*, ¶ 30, U.N. Doc. CEDAW/C/MDA/CO/3 (2006); *Philippines*, ¶ 27, U.N. Doc. CEDAW/C/PHI/CO/6 (2006).
- ⁷³⁸ CEDAW Committee, *Concluding Observations: Djibouti*, ¶ 30, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011).
- ⁷³⁹ CEDAW Committee, *Concluding Observations: Kyrgyzstan*, ¶ 29, U.N. Doc. CEDAW/C/KGZ/CO/4 (2015); *Ecuador*, ¶ 32, U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015); *Djibouti*, ¶ 30, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011).
- ⁷⁴⁰ CEDAW Committee, *Concluding Observations: Kyrgyzstan*, ¶ 29, U.N. Doc. CEDAW/C/KGZ/CO/4 (2015).
- ⁷⁴¹ CEDAW Committee, *Concluding Observations: Kenya*, ¶ 37, U.N. Doc. CEDAW/C/KEN/CO/7 (2011).
- ⁷⁴² CEDAW Committee, *Concluding Observations: Nepal*, ¶ 31, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
- ⁷⁴³ CEDAW Committee, *Concluding Observations: India*, ¶ 30, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014).
- ⁷⁴⁴ CEDAW Committee, *Concluding Observations: Liberia*, ¶ 39, U.N. Doc. CEDAW/C/LBR/CO/7-8 (2015).
- ⁷⁴⁵ CEDAW Committee, *Concluding Observations: India*, ¶ 30, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014).
- ⁷⁴⁶ CEDAW Committee, *Concluding Observations: Azerbaijan*, ¶ 32, U.N. Doc. CEDAW/C/AZE/CO/5 (2015).
- ⁷⁴⁷ CEDAW Committee, *Concluding Observations: Ukraine*, ¶ 39, U.N. Doc. CEDAW/C/UKR/CO/7 (2010); *Armenia*, ¶ 34, U.N. Doc. CEDAW/C/ARM/CO/4/Rev.1 (2009).
- ⁷⁴⁸ CEDAW Committee, *Concluding Observations: Armenia*, ¶ 34, U.N. Doc. CEDAW/C/ARM/CO/4/Rev.1 (2009).
- ⁷⁴⁹ CEDAW Committee, *Concluding Observations: Indonesia*, ¶ 41, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012).
- ⁷⁵⁰ See, e.g., CEDAW Committee, *Concluding Observations: Mali*, ¶ 34, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016); *Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *United Republic of Tanzania*, ¶ 35, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016); *Azerbaijan*, ¶ 33, U.N. Doc. CEDAW/C/AZE/CO/5 (2015); *Gambia*, ¶ 37, U.N. Doc. CEDAW/C/GMB/CO/4-5 (2015); *Malawi*, ¶ 34, U.N. Doc. CEDAW/C/MWI/CO/7 (2015); *Vietnam*, ¶ 33, U.N. Doc. CEDAW/C/VNM/CO/7-8 (2015); *Solomon Islands*, ¶ 37, U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014); *Venezuela*, ¶ 31, U.N. Doc. CEDAW/C/VEN/CO/7-8 (2014); *Afghanistan*, ¶ 37, U.N. Doc. CEDAW/C/AFG/CO/1-2 (2013); *Nepal*, ¶ 32, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011); *India*, ¶ 41, U.N. Doc. CEDAW/C/IND/CO/3 (2007).
- ⁷⁵¹ CEDAW Committee, *Concluding Observations: Swaziland*, ¶ 35, U.N. Doc. CEDAW/C/SWZ/CO/1-2 (2014); *India*, ¶ 41, U.N. Doc. CEDAW/C/IND/CO/3 (2007); *Moldova*, ¶ 31, U.N. Doc. CEDAW/C/MDA/CO/3 (2006).
- ⁷⁵² CEDAW Committee, *Concluding Observations: Swaziland*, ¶ 35, U.N. Doc. CEDAW/C/SWZ/CO/1-2 (2014).
- ⁷⁵³ CEDAW Committee, *Concluding Observations: Venezuela*, ¶ 31, U.N. Doc. CEDAW/C/VEN/CO/7-8 (2014); *India*, ¶ 41, U.N. Doc. CEDAW/C/IND/CO/3 (2007).
- ⁷⁵⁴ CEDAW Committee, *Concluding Observations: Mali*, ¶ 34, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016); *Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *United Republic of Tanzania*, ¶ 35, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016); *Gambia*, ¶ 37, U.N. Doc. CEDAW/C/GMB/CO/4-5 (2015); *Vietnam*, ¶ 33, U.N. Doc. CEDAW/C/VNM/CO/7-8 (2015); *Malawi*, ¶ 35, U.N. Doc. CEDAW/C/MWI/CO/7 (2015); *Venezuela*, ¶ 31, U.N. Doc. CEDAW/C/VEN/CO/7-8 (2014).
- ⁷⁵⁵ CEDAW Committee, *Concluding Observations: Dominican Republic*, ¶ 37, U.N. Doc. CEDAW/C/DOM/CO/6-7 (2014); *Venezuela*, ¶ 31, U.N. Doc. CEDAW/C/VEN/CO/7-8 (2014).
- ⁷⁵⁶ CEDAW Committee, *Concluding Observations: India*, ¶ 31, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014).

- ⁷⁵⁷ CEDAW Committee, *Concluding Observations: Azerbaijan*, ¶ 33, U.N. Doc. CEDAW/C/AZE/CO/5 (2015).
- ⁷⁵⁸ CEDAW Committee, *Concluding Observations: Chile*, ¶ 35, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012).
- ⁷⁵⁹ CEDAW Committee, *Concluding Observations: Egypt*, ¶ 40, U.N. Doc. CEDAW/C/EGY/CO/7 (2010).
- ⁷⁶⁰ See, e.g., CEDAW Committee, *Concluding Observations: France*, ¶ 36, U.N. Doc. CEDAW/C/FRA/CO/7-8 (2016); *United Republic of Tanzania*, ¶ 34, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016); *Mali*, ¶ 33, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016); *Haiti*, ¶ 33, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016); *Gabon*, ¶ 34, U.N. Doc. CEDAW/C/GAB/CO/6 (2015); *Slovakia*, ¶ 30, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); *Gambia*, ¶ 36, U.N. Doc. CEDAW/C/GMB/CO/4-5 (2015); *Venezuela*, 30, U.N. Doc. CEDAW/C/VEN/CO/7-8 (2014); *Bulgaria*, ¶ 35, U.N. Doc. CEDAW/C/BGR/CO/4-7 (2012); *Chile*, ¶ 34, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012); *Uganda*, ¶ 35, U.N. Doc. CEDAW/C/UGA/CO/7 (2010); *Armenia*, ¶ 34, U.N. Doc. CEDAW/C/ARM/CO/4/Rev.1 (2009); *Kazakhstan*, ¶ 25, U.N. Doc. CEDAW/C/KAZ/CO/2 (2007); *Honduras*, ¶ 24, U.N. Doc. CEDAW/C/HON/CO/6 (2007); *Nicaragua*, ¶ 17, U.N. Doc. CEDAW/C/NIC/CO/6 (2007).
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- ⁷⁶² CEDAW Committee, *Concluding Observations: Sri Lanka*, ¶ 36, U.N. Doc. CEDAW/C/LKA/CO/7 (2011).
- ⁷⁶³ CEDAW Committee, *Concluding Observations: Indonesia*, ¶ 36, U.N. Doc. CEDAW/C/IDN/CO/5 (2007).
- ⁷⁶⁴ CEDAW Committee, *Concluding Observations: United Republic of Tanzania*, ¶ 34, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016).
- ⁷⁶⁵ CEDAW Committee, *Concluding Observations: Chile*, ¶ 34, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012).
- ⁷⁶⁶ CEDAW Committee, *Concluding Observations: Bolivia*, ¶ 28, U.N. Doc. CEDAW/C/BOL/CO/5-6 (2015); *Venezuela*, 30, U.N. Doc. CEDAW/C/VEN/CO/7-8 (2014).
- ⁷⁶⁷ CEDAW Committee, *Concluding Observations: Turkey*, ¶ 47, U.N. Doc. CEDAW/C/TUR/CO/7 (2016).
- ⁷⁶⁸ CEDAW Committee, *Concluding Observations: Mali*, ¶ 33, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016).
- ⁷⁶⁹ CEDAW Committee, *Concluding Observations: France*, ¶ 37, U.N. Doc. CEDAW/C/FRA/CO/7-8 (2016).
- ⁷⁷⁰ CEDAW Committee, *Concluding Observations: France*, ¶ 37, U.N. Doc. CEDAW/C/FRA/CO/7-8 (2016); *Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016).
- ⁷⁷¹ CEDAW Committee, *Concluding Observations: Haiti*, ¶ 34, U.N. Doc. CEDAW/C/HTI/CO/8-9 (2016);
- ⁷⁷² CEDAW Committee, *Concluding Observations: United Republic of Tanzania*, ¶ 35, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016).
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- ⁷⁷⁵ CEDAW Committee, *Concluding Observations: Honduras*, ¶ 24, U.N. Doc. CEDAW/C/HON/CO/6 (2007); *Philippines*, ¶ 27, U.N. Doc. CEDAW/C/PHI/CO/6 (2006).
- ⁷⁷⁶ CEDAW Committee, *Concluding Observations: Uruguay*, ¶ 31, U.N. Doc. CEDAW/C/URY/CO/8-9 (2016); *Trinidad and Tobago*, ¶ 28, U.N. Doc. CEDAW/C/TTO/CO/4-7 (2016); *Liberia*, ¶ 35, U.N. Doc. CEDAW/C/LBR/CO/7-8 (2015); *Costa Rica*, ¶ 26, U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011).
- ⁷⁷⁷ CEDAW Committee, *Concluding Observations: Uruguay*, ¶ 31, U.N. Doc. CEDAW/C/URY/CO/8-9 (2016); CEDAW Committee, *Concluding Observations: Turkey*, ¶ 47, U.N. Doc. CEDAW/C/TUR/CO/7 (2016);
- ⁷⁷⁸ CEDAW Committee, *Concluding Observations United Republic of Tanzania*, ¶ 30, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016).
- ⁷⁷⁹ CEDAW Committee, *Concluding Observations: Uruguay*, ¶ 32, U.N. Doc. CEDAW/C/URY/CO/8-9 (2016); *Trinidad and Tobago*, ¶ 29, U.N. Doc. CEDAW/C/TTO/CO/4-7 (2016); *Liberia*, ¶ 36, U.N. Doc. CEDAW/C/LBR/CO/7-8 (2015); *India*, ¶ 27, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Cape Verde*, ¶ 25, U.N. Doc. CEDAW/C/CPV/CO/7-8 (2013); *Chile*, ¶ 29, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012).
- ⁷⁸⁰ CEDAW Committee, *Concluding Observations: United Republic of Tanzania*, ¶ 31, U.N. Doc. CEDAW/C/TZA/CO/7-8 (2016); *India*, ¶ 27, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Cape Verde*, ¶ 25, U.N. Doc. CEDAW/C/CPV/CO/7-8 (2013).
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- ⁷⁸⁸ CEDAW Committee, *Concluding Observations: Serbia*, ¶ 29, U.N. Doc. CEDAW/C/SRB/CO/2-3 (2013); *Cape Verde*, ¶ 25, U.N. Doc. CEDAW/C/CPV/CO/7-8 (2013).
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- ⁷⁹⁰ CEDAW Committee, *Concluding Observations: France*, ¶ 33, U.N. Doc. CEDAW/C/FRA/CO/7-8 (2016); *Turkey*, ¶ 44, U.N. Doc. CEDAW/C/TUR/CO/7 (2016).
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- ⁷⁹⁴ CEDAW Committee, *Concluding Observations: Mali*, ¶ 34, U.N. Doc. CEDAW/C/MLI/CO/6-7 (2016); *Paraguay*, ¶ 19, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).
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- ⁷⁹⁶ CEDAW Committee, *Concluding Observations: Japan*, ¶ 24, U.N. Doc. CEDAW/C/JPN/CO/7-8 (2016); *Belgium*, ¶ 34, U.N. Doc. CEDAW/C/BEL/CO/7 (2014); *Cape Verde*, ¶ 28, U.N. Doc. CEDAW/C/CPV/CO/7-8 (2013).
- ⁷⁹⁷ CEDAW Committee, *Concluding Observations: Japan*, ¶ 24, U.N. Doc. CEDAW/C/JPN/CO/7-8 (2016).
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- ⁷⁹⁹ CEDAW Committee, *Concluding Observations: India*, ¶ 37, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Kuwait*, ¶ 49, U.N. Doc. CEDAW/C/KWT/CO/3-4 (2011).
- ⁸⁰⁰ CEDAW Committee, *Concluding Observations: Myanmar*, ¶ 44, U.N. Doc. CEDAW/C/MMR/CO/4-5 (2016); *Peru*, ¶ 21, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014).
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- ⁸⁰⁴ CEDAW Committee, *Concluding Observations: Finland*, ¶ 28, U.N. Doc. CEDAW/C/FIN/CO/7 (2014); *Belgium*, ¶ 44, U.N. Doc. CEDAW/C/BEL/CO/7 (2014).
- ⁸⁰⁵ CEDAW Committee, *Concluding Observations: Namibia*, ¶ 36, U.N. Doc. CEDAW/C/NAM/CO/4-5 (2015); *Chile*, ¶ 34, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012).
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- ⁸¹⁴ CEDAW Committee, *Concluding Observations: Uzbekistan*, ¶ 28, U.N. Doc. CEDAW/C/UZB/CO/5 (2015); *Namibia*, ¶ 37, U.N. Doc. CEDAW/C/NAM/CO/4-5 (2015).
- ⁸¹⁵ CEDAW Committee, *Concluding Observations: Uzbekistan*, ¶ 28, U.N. Doc. CEDAW/C/UZB/CO/5 (2015); *Namibia*, ¶ 37, U.N. Doc. CEDAW/C/NAM/CO/4-5 (2015).
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- ⁸¹⁷ CEDAW Committee, *Concluding Observations: Finland*, ¶ 29, U.N. Doc. CEDAW/C/FIN/CO/7 (2014); *Hungary*, ¶ 33, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).
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- ⁸²⁸ CEDAW Committee, *Concluding Observations: Japan*, ¶ 25, U.N. Doc. CEDAW/C/JPN/CO/7-8 (2016).
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- ⁸⁵³ *L.C. v. Peru*, CEDAW Committee, Commc'n No. 22/2009, ¶¶ 2.2 & 2.4, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).
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- ⁸⁶⁵ CRC Committee, *General Comment No. 3: HIV/AIDS and the rights of the child*, ¶ 20, U.N. Doc. CRC/GC/2003/3 (2003).
- ⁸⁶⁶ CRC Committee, *General Comment No. 3: HIV/AIDS and the rights of the child*, ¶ 21, U.N. Doc. CRC/GC/2003/3 (2003).
- ⁸⁶⁷ CRC Committee, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, ¶ 28, U.N. Doc. CRC/GC/2003/4 (2003).
- ⁸⁶⁸ CRC Committee, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, ¶ 31, U.N. Doc. CRC/GC/2003/4 (2003).
- ⁸⁶⁹ CRC Committee, *General Comment No. 7: Implementing child rights in early childhood*, ¶ 10 & 27(b), U.N. Doc. CRC/C/GC/7/Rev.1 (2006).
- ⁸⁷⁰ CRC Committee, *General Comment No. 9: The rights of children with disabilities*, ¶ 59, U.N. Doc. CRC/C/GC/9 (2007).
- ⁸⁷¹ CRC Committee, *General Comment No. 9: The rights of children with disabilities*, ¶ 60, U.N. Doc. CRC/C/GC/9 (2007).
- ⁸⁷² CRC Committee, *General Comment No. 9: The rights of children with disabilities*, ¶ 59, U.N. Doc. CRC/C/GC/9 (2007).
- ⁸⁷³ CRC Committee, *General Comment No. 9: The rights of children with disabilities*, ¶ 60, U.N. Doc. CRC/C/GC/9 (2007).
- ⁸⁷⁴ CRC Committee, *General Comment No. 11: Indigenous children and their rights under the Convention*, ¶ 54, U.N. Doc. CRC/C/GC/11 (2009).
- ⁸⁷⁵ CRC Committee, *General Comment No. 12: The right of the child to be heard*, ¶¶ 98 & 100, U.N. Doc. CRC/C/GC/9 (2009).
- ⁸⁷⁶ CRC Committee, *General Comment No. 12: The right of the child to be heard*, ¶ 100, U.N. Doc. CRC/C/GC/9 (2009).
- ⁸⁷⁷ CRC Committee, *General Comment No. 12: The right of the child to be heard*, ¶ 101, U.N. Doc. CRC/C/GC/9 (2009).
- ⁸⁷⁸ CRC Committee, *General Comment No. 12: The right of the child to be heard*, ¶ 102, U.N. Doc. CRC/C/GC/9 (2009).
- ⁸⁷⁹ CRC Committee, *General Comment No. 13: The right of the child to freedom from all forms of violence*, ¶ 23(a), U.N. Doc. CRC/C/GC/13 (2011).
- ⁸⁸⁰ CRC Committee, *General Comment No. 13: The right of the child to freedom from all forms of violence*, ¶ 15(a), U.N. Doc. CRC/C/GC/13 (2011).
- ⁸⁸¹ CRC Committee, *General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)*, ¶ 78, U.N. Doc. CRC/C/GC/14 (2013).
- ⁸⁸² CRC Committee, *General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, ¶ 24, U.N. Doc. CRC/C/GC/15 (2013).
- ⁸⁸³ CRC Committee, *General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, ¶ 31, U.N. Doc. CRC/C/GC/15 (2013).
- ⁸⁸⁴ CRC Committee, *General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, ¶ 31, U.N. Doc. CRC/C/GC/15 (2013).
- ⁸⁸⁵ CRC Committee, *General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, ¶ 31, U.N. Doc. CRC/C/GC/15 (2013).
- ⁸⁸⁶ CRC Committee, *General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence*, ¶ 39, U.N. Doc. CRC/C/GC/20 (2016).
- ⁸⁸⁷ CRC Committee, *General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence*, ¶ 39, U.N. Doc. CRC/C/GC/20 (2016).
- ⁸⁸⁸ CRC Committee, *General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence*, ¶ 31, U.N. Doc. CRC/C/GC/20 (2016).
- ⁸⁸⁹ CRC Committee, *General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence*, ¶¶ 32 & 61, U.N. Doc. CRC/C/GC/20 (2016).
- ⁸⁹⁰ CRC Committee, *Concluding Observations: Sierra Leone*, ¶ 31, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); *Zimbabwe*, ¶ 60, U.N. Doc. CRC/C/ZWE/CO/2 (2016); *Zambia*, ¶ 49, U.N. Doc. CRC/C/ZMB/CO/2-4 (2016); *India*, ¶ 65, U.N. Doc. CRC/C/IND/CO/3-4 (2014).
- ⁸⁹¹ CRC Committee, *Concluding Observations: Kazakhstan*, ¶ 46, U.N. Doc. CRC/C/KAZ/CO/4 (2015).
- ⁸⁹² CRC Committee, *Concluding Observations: Pakistan*, ¶ 51, U.N. Doc. CRC/C/PAK/CO/5 (2016); *Oman*, ¶ 53, U.N. Doc. CRC/C/OMN/CO/3-4 (2016); *Afghanistan*, ¶ 51, U.N. Doc. CRC/C/AFG/CO/1 (2011).
- ⁸⁹³ CRC Committee, *Concluding Observations: Afghanistan*, ¶ 51, U.N. Doc. CRC/C/AFG/CO/1 (2011).
- ⁸⁹⁴ CRC Committee, *Concluding Observations: Zimbabwe*, ¶ 60, U.N. Doc. CRC/C/ZWE/CO/2 (2016); *Peru*, ¶ 55, U.N. Doc. CRC/C/PER/CO/4-5 (2016); *Jamaica*, ¶ 48, U.N. Doc. CRC/C/JAM/CO/3-4 (2015).

- ⁸⁹⁵ CRC Committee, *Concluding Observations: Greece*, ¶ 56, U.N. Doc. CRC/C/GRC/CO/2-3 (2012); *Bahrain*, ¶ 59, U.N. Doc. CRC/C/BHR/CO/2-3 (2011).
- ⁸⁹⁶ See, e.g., CRC Committee, *Concluding Observations: Suriname*, ¶ 31(c), U.N. Doc. CRC/C/SUR/CO/3-4 (2016); *South Africa*, ¶ 50, U.N. Doc. CRC/C/ZAF/CO/2 (2016); *Bulgaria*, ¶ 45, U.N. Doc. CRC/C/BGR/CO/3-5 (2016); *Dominican Republic*, ¶ 52, U.N. Doc. CRC/C/DOM/CO/3-5 (2015); *India*, ¶ 66, U.N. Doc. CRC/C/IND/CO/3-4 (2014); *China*, ¶ 70, U.N. Doc. CRC/C/CHN/CO/3-4 (2013); *Andorra*, ¶ 42, U.N. Doc. CRC/C/AND/CO/2 (2012); *Greece*, ¶ 57, U.N. Doc. CRC/C/GRC/CO/2-3 (2012); *Ecuador*, ¶ 61, U.N. Doc. CRC/C/OPSC/ECU/CO/4 (2010); *Grenada*, ¶ 46, U.N. Doc. CRC/C/GRD/CO/2 (2010); *Georgia*, ¶ 48, U.N. Doc. CRC/C/GEO/CO/3 (2008); *Greece*, ¶ 61, U.N. Doc. CRC/C/15/Add.170 (2007); *Uruguay*, ¶ 52, U.N. Doc. CRC/C/URY/CO/2 (2007); *Algeria*, ¶ 59, U.N. Doc. CRC/C/15/Add.269 (2005); *Bosnia and Herzegovina*, ¶ 51, U.N. Doc. CRC/C/15/Add.260 (2005); *Concluding Observation: Antigua and Barbuda*, ¶ 54, U.N. Doc. CRC/C/15/Add.247 (2004); *Bangladesh*, ¶ 60, U.N. Doc. CRC/C/15/Add.221 (2003); *Brunei Darussalam*, ¶ 46, U.N. Doc. CRC/C/15/Add.219 (2003); *Argentina*, ¶ 51, U.N. Doc. CRC/C/15/Add.187 (2002); *Burkina Faso*, ¶ 41, U.N. Doc. CRC/C/15/Add.193 (2002); *Belarus*, ¶ 44, U.N. Doc. CRC/C/15/Add.180 (2002); *Guatemala*, ¶ 45, U.N. Doc. CRC/C/15/Add.154 (2001); *Tajikistan*, ¶ 41, U.N. Doc. CRC/C/15/Add.136 (2000).
- ⁸⁹⁷ CRC Committee, *Concluding Observations: Suriname*, ¶ 31(a), U.N. Doc. CRC/C/SUR/CO/3-4 (2016); *South Africa*, ¶ 50, U.N. Doc. CRC/C/ZAF/CO/2 (2016); *Saudi Arabia*, ¶ 35, U.N. Doc. CRC/C/SAU/CO/3-4 (2016); *United Kingdom of Great Britain and Northern Ireland*, ¶ 64, U.N. Doc. CRC/C/GBR/CO/5 (2016); *Slovakia*, ¶ 41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016); *Samoa*, ¶ 47, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); *Pakistan*, ¶ 52, U.N. Doc. CRC/C/PAK/CO/5 (2016); *Nepal*, ¶ 54, U.N. Doc. CRC/C/NPL/CO/3-5 (2016); *Gabon*, ¶ 47, U.N. Doc. CRC/C/GAB/CO/2 (2016); *Honduras*, ¶ 65, U.N. Doc. CRC/C/HND/CO/4-5 (2015); *Ghana*, ¶ 52, U.N. Doc. CRC/C/GHA/CO/3-5 (2015); *Bahrain*, ¶ 60, U.N. Doc. CRC/C/BHR/CO/2-3 (2011); *Burundi*, ¶ 57, U.N. Doc. CRC/C/BDI/CO/2 (2010); *Grenada*, ¶ 46, U.N. Doc. CRC/C/GRD/CO/2 (2010); *Bangladesh*, ¶ 64, U.N. Doc. CRC/C/BGD/CO/4 (2009).
- ⁸⁹⁸ CRC Committee, *Concluding Observations: South Africa*, ¶ 50, U.N. Doc. CRC/C/ZAF/CO/2 (2016); *Benin*, ¶ 56, U.N. Doc. CRC/C/BEN/CO/2 (2006).
- ⁸⁹⁹ CRC Committee, *Concluding Observations: Holy See*, ¶ 57, U.N. Doc. CRC/C/VAT/CO/2 (2014).
- ⁹⁰⁰ CRC Committee, *Concluding Observations: South Africa*, ¶ 49, U.N. Doc. CRC/C/ZAF/CO/2 (2016); *United Republic of Tanzania*, ¶ 58, U.N. Doc. CRC/C/TZA/CO/3-5 (2015).
- ⁹⁰¹ CRC Committee, *Concluding Observations: Georgia*, ¶ 47, U.N. Doc. CRC/C/GEO/CO/3 (2008); *Belize*, ¶ 23, U.N. Doc. CRC/C/15/Add.252 (2005).
- ⁹⁰² CRC Committee, *Concluding Observations: Sierra Leone*, ¶ 31, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); *Algeria*, ¶ 33, U.N. Doc. CRC/C/DZA/CO/3-4 (2012).
- ⁹⁰³ CRC Committee, *Concluding Observations: Sierra Leone*, ¶ 32, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); *Algeria*, ¶ 34, U.N. Doc. CRC/C/DZA/CO/3-4 (2012).
- ⁹⁰⁴ CRC Committee, *Concluding Observations: Algeria*, ¶¶ 33-34, U.N. Doc. CRC/C/DZA/CO/3-4 (2012).
- ⁹⁰⁵ CRC Committee, *Concluding Observations: Zambia*, ¶ 29, U.N. Doc. CRC/C/ZMB/CO/2-4 (2016).
- ⁹⁰⁶ CRC Committee, *Concluding Observations: Australia*, ¶ 41, U.N. Doc. CRC/C/OPSC/AUS/CO/1 (2012).
- ⁹⁰⁷ CRC Committee, *Concluding Observations: Pakistan*, ¶ 64, U.N. Doc. CRC/C/PAK/CO/3-4 (2009).
- ⁹⁰⁸ CRC Committee, *Concluding Observations: Philippines*, ¶ 61, U.N. Doc. CRC/C/PHL/CO/3-4 (2009).
- ⁹⁰⁹ CRC Committee, *Concluding Observations: Zimbabwe*, ¶ 61, U.N. Doc. CRC/C/ZWE/CO/2 (2016); *Belarus*, ¶ 48, U.N. Doc. CRC/C/BGR/CO/2 (2008); *Georgia*, ¶ 48, U.N. Doc. CRC/C/GEO/CO/3 (2008); *Argentina*, ¶ 51, U.N. Doc. CRC/C/15/Add.187 (2002);
- ⁹¹⁰ CRC Committee, *Concluding Observations: Bangladesh*, ¶ 60, U.N. Doc. CRC/C/15/Add.221 (2003); *Belarus*, ¶ 44, U.N. Doc. CRC/C/15/Add.180 (2002); *Argentina*, ¶ 51, U.N. Doc. CRC/C/15/Add.187 (2002); *Guatemala*, ¶ 45, U.N. Doc. CRC/C/15/Add.154 (2001).
- ⁹¹¹ CRC Committee, *Concluding Observations: Kenya*, ¶ 50, U.N. Doc. CRC/C/KEN/CO/3-5 (2016).
- ⁹¹² CRC Committee, *Concluding Observations: Algeria*, ¶ 34, U.N. Doc. CRC/C/DZA/CO/3-4 (2012).
- ⁹¹³ CRC Committee, *Concluding Observation: Antigua and Barbuda*, ¶ 54, U.N. Doc. CRC/C/15/Add.247 (2004).
- ⁹¹⁴ See, e.g., CRC Committee, *Concluding Observations: Ghana*, ¶ 52, U.N. Doc. CRC/C/GHA/CO/3-5 (2015).
- ⁹¹⁵ CRC Committee, *Concluding Observations: Australia*, ¶ 42, U.N. Doc. CRC/C/OPSC/AUS/CO/1 (2012).
- ⁹¹⁶ CRC Committee, *Concluding Observations Ethiopia*, ¶ 60, U.N. Doc. CRC/C/ETH/CO/4-5 (2015); *Uzbekistan*, ¶ 49, U.N. Doc. CRC/C/UZB/CO/3-4 (2013); *Australia*, ¶ 67, U.N. Doc. CRC/C/OPSC/AUS/CO/1 (2012).
- ⁹¹⁷ CRC Committee, *Concluding Observations: Liberia*, ¶ 60, U.N. Doc. CRC/C/LBR/CO/2-4 (2012).
- ⁹¹⁸ CRC Committee, *Concluding Observations: Slovakia*, ¶ 41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).
- ⁹¹⁹ CRC Committee, *Concluding Observations: Ghana*, ¶ 51, U.N. Doc. CRC/C/GHA/CO/3-5 (2015); *India*, ¶ 65, U.N. Doc. CRC/C/IND/CO/3-4 (2014); *Republic of Korea*, ¶ 10, U.N. Doc. CRC/C/KOR/CO/3-4 (2012); *Costa Rica*, ¶ 63, U.N. Doc. CRC/C/CRI/CO/4 (2011); *Armenia*, ¶ 38, U.N. Doc. CRC/C/15/Add.119 (2000).
- ⁹²⁰ CRC Committee, *Concluding Observations: Ukraine*, ¶ 56, U.N. Doc. CRC/C/UKR/CO/3-4 (2011); *Pakistan*, ¶ 64, U.N. Doc. CRC/C/PAK/CO/3-4 (2009); *Peru*, ¶ 52, U.N. Doc. CRC/C/PER/CO/3 (2006).

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- ⁹²² CRC Committee, *Concluding Observations: Argentina*, ¶ 59, U.N. Doc. CRC/C/ARG/CO/3-4 (2010).
- ⁹²³ CRC Committee, *Concluding Observations: Ghana*, ¶ 52, U.N. Doc. CRC/C/GHA/CO/3-5 (2015).
- ⁹²⁴ CRC Committee, *Concluding Observations: Zimbabwe*, ¶ 60, U.N. Doc. CRC/C/ZWE/CO/2 (2016); *Maldives*, ¶ 56, U.N. Doc. CRC/C/MDV/CO/4-5 (2016); *Ireland*, ¶ 57, U.N. Doc. CRC/C/IRL/CO/3-4 (2016); *Haiti*, ¶ 50, U.N. Doc. CRC/C/HTI/CO/2-3 (2016); *Brunei Darussalam*, ¶ 53, U.N. Doc. CRC/C/BRN/CO/2-3 (2016); *Gambia*, ¶ 62, U.N. Doc. CRC/C/GMB/CO/2-3 (2015); *Honduras*, ¶ 64, U.N. Doc. CRC/C/HND/CO/4-5 (2015); *United Arab Emirates*, ¶ 57, U.N. Doc. CRC/C/ARE/CO/2 (2015); *Venezuela*, ¶ 56, U.N. Doc. CRC/C/VEN/CO/3-5 (2014); *Andorra*, ¶ 41, U.N. Doc. CRC/C/AND/CO/2 (2012); *Republic of Korea*, ¶ 10, U.N. Doc. CRC/C/KOR/CO/3-4 (2012); *Uruguay*, ¶ 51, U.N. Doc. CRC/C/URY/CO/2 (2007); *Palau*, ¶ 46, U.N. Doc. CRC/C/15/Add.149 (2001);
- ⁹²⁵ CRC Committee, *Concluding Observations: Sierra Leone*, ¶ 31, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); *Samoa*, ¶ 46, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); *Pakistan*, ¶ 51, U.N. Doc. CRC/C/PAK/CO/5 (2016); *Zambia*, ¶ 49, U.N. Doc. CRC/C/ZMB/CO/2-4 (2016); *Benin*, ¶ 56, U.N. Doc. CRC/C/BEN/CO/3-5 (2016); *Uruguay*, ¶ 51, U.N. Doc. CRC/C/URY/CO/2 (2007).
- ⁹²⁶ CRC Committee, *Concluding Observations: Samoa*, ¶ 46, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); *Pakistan*, ¶ 51, U.N. Doc. CRC/C/PAK/CO/5 (2016); *Zimbabwe*, ¶ 60, U.N. Doc. CRC/C/ZWE/CO/2 (2016); *Haiti*, ¶ 50, U.N. Doc. CRC/C/HTI/CO/2-3 (2016); *Benin*, ¶ 56, U.N. Doc. CRC/C/BEN/CO/3-5 (2016); *Dominican Republic*, ¶ 51, U.N. Doc. CRC/C/DOM/CO/3-5 (2015); *Gambia*, ¶ 62, U.N. Doc. CRC/C/GMB/CO/2-3 (2015); *Honduras*, ¶ 64, U.N. Doc. CRC/C/HND/CO/4-5 (2015); *Mexico*, ¶ 49, U.N. Doc. CRC/C/MEX/CO/4-5 (2015).
- ⁹²⁷ CRC Committee, *Concluding Observations: Pakistan*, ¶ 51, U.N. Doc. CRC/C/PAK/CO/5 (2016); *Mexico*, ¶ 49, U.N. Doc. CRC/C/MEX/CO/4-5 (2015).
- ⁹²⁸ CRC Committee, *Concluding Observations: Andorra*, ¶ 41, U.N. Doc. CRC/C/AND/CO/2 (2012).
- ⁹²⁹ CRC Committee, *Concluding Observations: Maldives*, ¶ 56, U.N. Doc. CRC/C/MDV/CO/4-5 (2016).
- ⁹³⁰ CRC Committee, *Concluding Observations: Gambia*, ¶ 53, U.N. Doc. CRC/C/GMB/CO/2-3 (2015).
- ⁹³¹ CRC Committee, *Concluding Observations: Latvia*, ¶ 50, U.N. Doc. CRC/C/LVA/CO/3-5 (2016).
- ⁹³² CRC Committee, *Concluding Observations: Honduras*, ¶ 64, U.N. Doc. CRC/C/HND/CO/4-5 (2015).
- ⁹³³ CRC Committee, *Concluding Observations: Bulgaria*, ¶ 45, U.N. Doc. CRC/C/BGR/CO/3-5 (2016); *Uruguay*, ¶ 52, U.N. Doc. CRC/C/URY/CO/2 (2007).
- ⁹³⁴ CRC Committee, *Concluding Observations: Peru*, ¶ 56, U.N. Doc. CRC/C/PER/CO/4-5 (2016); *Mexico*, ¶ 50, U.N. Doc. CRC/C/MEX/CO/4-5 (2015); *Venezuela*, ¶ 57, U.N. Doc. CRC/C/VEN/CO/3-5 (2014); *Andorra*, ¶ 42, U.N. Doc. CRC/C/AND/CO/2 (2012); *Costa Rica*, ¶ 64, U.N. Doc. CRC/C/CRI/CO/4 (2011).
- ⁹³⁵ CRC Committee, *Concluding Observations: Sierra Leone*, ¶ 32, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); *Saudi Arabia*, ¶ 35, U.N. Doc. CRC/C/SAU/CO/3-4 (2016); *United Kingdom of Great Britain and Northern Ireland*, ¶ 65, U.N. Doc. CRC/C/GBR/CO/5 (2016); *Senegal*, ¶ 54, U.N. Doc. CRC/C/SEN/CO/3-5 (2016); *Maldives*, ¶ 57, U.N. Doc. CRC/C/MDV/CO/4-5 (2016); *Kenya*, ¶ 50, U.N. Doc. CRC/C/KEN/CO/3-5 (2016); *Ireland*, ¶ 57, U.N. Doc. CRC/C/IRL/CO/3-4 (2016); *Haiti*, ¶ 50, U.N. Doc. CRC/C/HTI/CO/2-3 (2016); *Benin*, ¶ 57, U.N. Doc. CRC/C/BEN/CO/3-5 (2016); *Chile*, ¶ 60, U.N. Doc. CRC/C/CHL/CO/4-5 (2015); *Honduras*, ¶ 65, U.N. Doc. CRC/C/HND/CO/4-5 (2015); *United Arab Emirates*, ¶ 58, U.N. Doc. CRC/C/ARE/CO/2 (2015).
- ⁹³⁶ CRC Committee, *Concluding Observations: Saudi Arabia*, ¶ 35, U.N. Doc. CRC/C/SAU/CO/3-4 (2016); *United Kingdom of Great Britain and Northern Ireland*, ¶ 65, U.N. Doc. CRC/C/GBR/CO/5 (2016); *Samoa*, ¶ 47, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); *Pakistan*, ¶ 52, U.N. Doc. CRC/C/PAK/CO/5 (2016); *Zimbabwe*, ¶ 61, U.N. Doc. CRC/C/ZWE/CO/2 (2016); *Maldives*, ¶ 57, U.N. Doc. CRC/C/MDV/CO/4-5 (2016); *Ireland*, ¶ 57, U.N. Doc. CRC/C/IRL/CO/3-4 (2016); *United Arab Emirates*, ¶ 58, U.N. Doc. CRC/C/ARE/CO/2 (2015); *Republic of Korea*, ¶ 11, U.N. Doc. CRC/C/KOR/CO/3-4 (2012).
- ⁹³⁷ CRC Committee, *Concluding Observations: Senegal*, ¶ 54, U.N. Doc. CRC/C/SEN/CO/3-5 (2016); *Ghana*, ¶ 52, U.N. Doc. CRC/C/GHA/CO/3-5 (2015); *Republic of Korea*, ¶ 11, U.N. Doc. CRC/C/KOR/CO/3-4 (2012).
- ⁹³⁸ CRC Committee, *Concluding Observations: Sierra Leone*, ¶ 32, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); *United Kingdom of Great Britain and Northern Ireland*, ¶ 65, U.N. Doc. CRC/C/GBR/CO/5 (2016); *Samoa*, ¶ 47, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); *Pakistan*, ¶ 52, U.N. Doc. CRC/C/PAK/CO/5 (2016); *Maldives*, ¶ 57, U.N. Doc. CRC/C/MDV/CO/4-5 (2016); *Latvia*, ¶ 51, U.N. Doc. CRC/C/LVA/CO/3-5 (2016); *Kenya*, ¶ 49, U.N. Doc. CRC/C/KEN/CO/3-5 (2016); *Ireland*, ¶ 57, U.N. Doc. CRC/C/IRL/CO/3-4 (2016); *Haiti*, ¶ 50, U.N. Doc. CRC/C/HTI/CO/2-3 (2016); *Venezuela*, ¶ 57, U.N. Doc. CRC/C/VEN/CO/3-5 (2014); *India*, ¶ 66, U.N. Doc. CRC/C/IND/CO/3-4 (2014); *Ukraine*, ¶ 57, U.N. Doc. CRC/C/UKR/CO/3-4 (2011).
- ⁹³⁹ CRC Committee, *Concluding Observations: Zimbabwe*, ¶ 61, U.N. Doc. CRC/C/ZWE/CO/2 (2016).
- ⁹⁴⁰ CRC Committee, *Concluding Observations: Uruguay*, ¶ 50, U.N. Doc. CRC/C/URY/CO/3-5 (2015).
- ⁹⁴¹ CRC Committee, *Concluding Observations: Zimbabwe*, ¶ 60, U.N. Doc. CRC/C/ZWE/CO/2 (2016); *Poland*, ¶ 38, U.N. Doc. CRC/C/POL/CO/3-4 (2015); *Costa Rica*, ¶ 63, U.N. Doc. CRC/C/CRI/CO/4 (2011); *Argentina*, ¶ 58, U.N. Doc. CRC/C/ARG/CO/3-4 (2010).
- ⁹⁴² CRC Committee, *Concluding Observations: Poland*, ¶ 38, U.N. Doc. CRC/C/POL/CO/3-4 (2015).
- ⁹⁴³ CRC Committee, *Concluding Observations: Zimbabwe*, ¶ 60, U.N. Doc. CRC/C/ZWE/CO/2 (2016); *Argentina*, ¶ 58, U.N. Doc. CRC/C/ARG/CO/3-4 (2010).

- ⁹⁴⁴ CRC Committee, *Concluding Observations: Slovakia*, ¶ 40, U.N. Doc. CRC/C/SVK/CO/3-5 (2016); *Ukraine*, ¶ 56, U.N. Doc. CRC/C/UKR/CO/3-4 (2011).
- ⁹⁴⁵ CRC Committee, *Concluding Observations: Maldives*, ¶ 56, U.N. Doc. CRC/C/MDV/CO/4-5 (2016).
- ⁹⁴⁶ CRC Committee, *Concluding Observations: Mexico*, ¶ 50, U.N. Doc. CRC/C/MEX/CO/4-5 (2015).
- ⁹⁴⁷ CRC Committee, *Concluding Observations: Slovakia*, ¶ 41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016); *Maldives*, ¶ 57, U.N. Doc. CRC/C/MDV/CO/4-5 (2016); *Mexico*, ¶ 50, U.N. Doc. CRC/C/MEX/CO/4-5 (2015).
- ⁹⁴⁸ CRC Committee, *Concluding Observations: Argentina*, ¶ 59, U.N. Doc. CRC/C/ARG/CO/3-4 (2010).
- ⁹⁴⁹ CRC Committee, *Concluding Observations: Slovakia*, ¶ 40, U.N. Doc. CRC/C/SVK/CO/3-5 (2016); *Latvia*, ¶ 50, U.N. Doc. CRC/C/LVA/CO/3-5 (2016).
- ⁹⁵⁰ CRC Committee, *Concluding Observations: Slovakia*, ¶ 40, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).
- ⁹⁵¹ CRC Committee, *Concluding Observations: Slovakia*, ¶ 41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).
- ⁹⁵² CRC Committee, *Concluding Observations: Argentina*, ¶ 59, U.N. Doc. CRC/C/ARG/CO/3-4 (2010).
- ⁹⁵³ CRC Committee, *Concluding Observations: Costa Rica*, ¶ 64, U.N. Doc. CRC/C/CRI/CO/4 (2011).
- ⁹⁵⁴ CRC Committee, *Concluding Observations: Slovakia*, ¶¶ 40-41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).
- ⁹⁵⁵ CRC Committee, *Concluding Observations: Slovakia*, ¶¶ 40-41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).
- ⁹⁵⁶ CRC Committee, *Concluding Observations: Slovakia*, ¶ 40, U.N. Doc. CRC/C/SVK/CO/3-5 (2016); *Colombia*, ¶ 43, U.N. Doc. CRC/C/COL/CO/4-5 (2015).
- ⁹⁵⁷ CRC Committee, *Concluding Observations: Colombia*, ¶ 43, U.N. Doc. CRC/C/COL/CO/4-5 (2015).
- ⁹⁵⁸ CRC Committee, *Concluding Observations: Slovakia*, ¶ 41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).
- ⁹⁵⁹ CRC Committee, *Concluding Observations: Colombia*, ¶ 44, U.N. Doc. CRC/C/COL/CO/4-5 (2015).
- ⁹⁶⁰ CRC Committee, *Concluding Observations: Sierra Leone*, ¶ 32, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); *United Kingdom of Great Britain and Northern Ireland*, ¶ 65, U.N. Doc. CRC/C/GBR/CO/5 (2016); *Samoa*, ¶ 47, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); *Pakistan*, ¶ 52, U.N. Doc. CRC/C/PAK/CO/5 (2016); *Peru*, ¶ 56, U.N. Doc. CRC/C/PER/CO/4-5 (2016); *Honduras*, ¶ 65, U.N. Doc. CRC/C/HND/CO/4-5 (2015); *Mexico*, ¶ 50, U.N. Doc. CRC/C/MEX/CO/4-5 (2015); *United Arab Emirates*, ¶ 58, U.N. Doc. CRC/C/ARE/CO/2 (2015).
- ⁹⁶¹ CRC Committee, *Concluding Observations: Samoa*, ¶ 47, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); *Dominican Republic*, ¶ 52, U.N. Doc. CRC/C/DOM/CO/3-5 (2015); *Mexico*, ¶ 50, U.N. Doc. CRC/C/MEX/CO/4-5 (2015).
- ⁹⁶² CRC Committee, *Concluding Observations: Costa Rica*, ¶ 64, U.N. Doc. CRC/C/CRI/CO/4 (2011).
- ⁹⁶³ CRC Committee, *Concluding Observations: Nepal*, ¶ 53, U.N. Doc. CRC/C/NPL/CO/3-5 (2016).
- ⁹⁶⁴ CRC Committee, *Concluding Observations: Zambia*, ¶ 50, U.N. Doc. CRC/C/ZMB/CO/2-4 (2016).
- ⁹⁶⁵ CRC Committee, *Concluding Observations: Poland*, ¶ 38, U.N. Doc. CRC/C/POL/CO/3-4 (2015); *Costa Rica*, ¶ 63, U.N. Doc. CRC/C/CRI/CO/4 (2011).
- ⁹⁶⁶ CRC Committee, *Concluding Observations: Peru*, ¶ 56, U.N. Doc. CRC/C/PER/CO/4-5 (2016); *Kenya*, ¶ 50, U.N. Doc. CRC/C/KEN/CO/3-5 (2016); *Costa Rica*, ¶ 64, U.N. Doc. CRC/C/CRI/CO/4 (2011).
- ⁹⁶⁷ CRC Committee, *Concluding Observations: Poland*, ¶ 39, U.N. Doc. CRC/C/POL/CO/3-4 (2015).
- ⁹⁶⁸ CRC Committee, *Concluding Observations: Poland*, ¶ 39, U.N. Doc. CRC/C/POL/CO/3-4 (2015).
- ⁹⁶⁹ CRC Committee, *Concluding Observations: India*, ¶ 33, U.N. Doc. CRC/C/IND/CO/3-4 (2014); *China*, ¶ 27, U.N. Doc. CRC/C/CHN/CO/3-4 (2013).
- ⁹⁷⁰ CRC Committee, *Concluding Observations: Armenia*, ¶ 18, U.N. Doc. CRC/C/ARM/CO/3-4 (2013).
- ⁹⁷¹ CRC Committee, *Concluding Observations: India*, ¶ 33, U.N. Doc. CRC/C/IND/CO/3-4 (2014); *India*, ¶ 33, U.N. Doc. CRC/C/15/Add.228 (2004).
- ⁹⁷² CRC Committee, *Concluding Observations: India*, ¶ 33, U.N. Doc. CRC/C/IND/CO/3-4 (2014); *China*, ¶ 27, U.N. Doc. CRC/C/CHN/CO/3-4 (2013).
- ⁹⁷³ CRC Committee, *Concluding Observations: Armenia*, ¶ 19, U.N. Doc. CRC/C/ARM/CO/3-4 (2013).
- ⁹⁷⁴ CRC Committee, *Concluding Observations: India*, ¶ 33, U.N. Doc. CRC/C/IND/CO/3-4 (2014); *China*, ¶ 28, U.N. Doc. CRC/C/CHN/CO/3-4 (2013).
- ⁹⁷⁵ CRC Committee, *Concluding Observations: India*, ¶ 34, U.N. Doc. CRC/C/IND/CO/3-4 (2014); *China*, ¶ 28, U.N. Doc. CRC/C/CHN/CO/3-4 (2013).
- ⁹⁷⁶ CRC Committee, *Concluding Observations: India*, ¶ 34, U.N. Doc. CRC/C/IND/CO/3-4 (2014).
- ⁹⁷⁷ CRC Committee, *Concluding Observations: Slovakia*, ¶ 40, U.N. Doc. CRC/C/SVK/CO/3-5 (2016); *Poland*, ¶ 38, U.N. Doc. CRC/C/POL/CO/3-4 (2015); *United Republic of Tanzania*, ¶ 48, U.N. Doc. CRC/C/15/Add.156 (2001).
- ⁹⁷⁸ CRC Committee, *Concluding Observations: Poland*, ¶ 38, U.N. Doc. CRC/C/POL/CO/3-4 (2015); *United Republic of Tanzania*, ¶ 48, U.N. Doc. CRC/C/15/Add.156 (2001).
- ⁹⁷⁹ CRC Committee, *Concluding Observations: Ecuador*, ¶ 61, U.N. Doc. CRC/C/OPSC/ECU/CO/4 (2010).
- ⁹⁸⁰ CRC Committee, *Concluding Observations: Slovakia*, ¶ 41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).

- ⁹⁸¹ CRC Committee, *Concluding Observations: Samoa*, ¶ 46, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); *Nepal*, ¶ 53, U.N. Doc. CRC/C/NPL/CO/3-5 (2016); *Gabon*, ¶ 47, U.N. Doc. CRC/C/GAB/CO/2 (2016); *Senegal*, ¶ 53, U.N. Doc. CRC/C/SEN/CO/3-5 (2016); *Dominican Republic*, ¶ 51, U.N. Doc. CRC/C/DOM/CO/3-5 (2015); *India*, ¶ 65, U.N. Doc. CRC/C/IND/CO/3-4 (2014).
- ⁹⁸² CRC Committee, *Concluding Observations: Benin*, ¶ 56, U.N. Doc. CRC/C/BEN/CO/3-5 (2016); *Angola*, ¶ 51, U.N. Doc. CRC/C/AGO/CO/2-4 (2010); *Pakistan*, ¶ 64, U.N. Doc. CRC/C/PAK/CO/3-4 (2009); *Philippines*, ¶ 61, U.N. Doc. CRC/C/PHL/CO/3-4 (2009).
- ⁹⁸³ CRC Committee, *Concluding Observations: Latvia*, ¶ 50, U.N. Doc. CRC/C/LVA/CO/3-5 (2016).
- ⁹⁸⁴ CRC Committee, *Concluding Observations: Samoa*, ¶ 46, U.N. Doc. CRC/C/WSM/CO/2-4 (2016).
- ⁹⁸⁵ CRC Committee, *Concluding Observations: Grenada*, ¶ 45, U.N. Doc. CRC/C/GRD/CO/2 (2010).
- ⁹⁸⁶ CRC Committee, *Concluding Observations: Chile*, ¶ 60, U.N. Doc. CRC/C/CHL/CO/4-5 (2015).
- ⁹⁸⁷ CRC Committee, *Concluding Observations: Slovakia*, ¶ 40, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).
- ⁹⁸⁸ CRC Committee, *Concluding Observations: India*, ¶ 65, U.N. Doc. CRC/C/IND/CO/3-4 (2014).
- ⁹⁸⁹ CRC Committee, *Concluding Observations: Suriname*, ¶ 31(c), U.N. Doc. CRC/C/SUR/CO/3-4 (2016); *Pakistan*, ¶ 52, U.N. Doc. CRC/C/PAK/CO/5 (2016); *Gabon*, ¶ 47, U.N. Doc. CRC/C/GAB/CO/2 (2016); *Bulgaria*, ¶ 45, U.N. Doc. CRC/C/BGR/CO/3-5 (2016); *India*, ¶ 66, U.N. Doc. CRC/C/IND/CO/3-4 (2014); *Guinea*, ¶ 68, U.N. Doc. CRC/C/GIN/CO/2 (2013); *Guinea-Bissau*, ¶ 55, U.N. Doc. CRC/C/GNB/CO/2-4 (2013); *Greece*, ¶ 57, U.N. Doc. CRC/C/GRC/CO/2-3 (2012); *Guatemala*, ¶ 75, U.N. Doc. CRC/C/GTM/CO/3-4 (2010); *Philippines*, ¶ 62, U.N. Doc. CRC/C/PHL/CO/3-4 (2009); *Bhutan*, ¶ 66, U.N. Doc. CRC/C/BTN/CO/2 (2008); *United Kingdom of Great Britain and Northern Ireland*, ¶ 44, U.N. Doc. CRC/C/15/Add.188 (2002); *Uzbekistan*, ¶ 52, U.N. Doc. CRC/C/15/Add.167 (2001).
- ⁹⁹⁰ CRC Committee, *Concluding Observations: Suriname*, ¶ 31(c), U.N. Doc. CRC/C/SUR/CO/3-4 (2016); *Slovakia*, ¶ 41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016); *Jamaica*, ¶ 49, U.N. Doc. CRC/C/JAM/CO/3-4 (2015).
- ⁹⁹¹ CRC Committee, *Concluding Observations: Pakistan*, ¶ 52, U.N. Doc. CRC/C/PAK/CO/5 (2016).
- ⁹⁹² CRC Committee, *Concluding Observations: Andorra*, ¶ 42, U.N. Doc. CRC/C/AND/CO/2 (2012).
- ⁹⁹³ CRC Committee, *Concluding Observations: South Africa*, ¶ 50, U.N. Doc. CRC/C/ZAF/CO/2 (2016); CRC Committee, *Concluding Observations: Zambia*, ¶ 50, U.N. Doc. CRC/C/ZMB/CO/2-4 (2016); *Latvia*, ¶ 51, U.N. Doc. CRC/C/LVA/CO/3-5 (2016); *Dominican Republic*, ¶ 52, U.N. Doc. CRC/C/DOM/CO/3-5 (2015).
- ⁹⁹⁴ CRC Committee, *Concluding Observations: Slovakia*, ¶ 41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).
- ⁹⁹⁵ CRC Committee, *Concluding Observations: South Africa*, ¶ 50, U.N. Doc. CRC/C/ZAF/CO/2 (2016).
- ⁹⁹⁶ CRC Committee, *Concluding Observations: Slovakia*, ¶ 41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).
- ⁹⁹⁷ See, e.g., CRC Committee, *Concluding Observations: Pakistan*, ¶ 65, U.N. Doc. CRC/C/PAK/CO/3-4 (2009); *Georgia*, ¶ 48, U.N. Doc. CRC/C/GEO/CO/3 (2008); *Uganda*, ¶ 54, U.N. Doc. CRC/C/UGA/CO/2 (2005); *United Republic of Tanzania*, ¶ 49, U.N. Doc. CRC/C/15/Add.156 (2001); *Uzbekistan*, ¶ 52, U.N. Doc. CRC/C/15/Add.167 (2001); *Tajikistan*, ¶ 41, U.N. Doc. CRC/C/15/Add.136 (2000).
- ⁹⁹⁸ See, e.g., CRC Committee, *Concluding Observations: Palau*, ¶ 49, U.N. Doc. CRC/C/15/Add.149 (2001); *Georgia*, ¶ 47, U.N. Doc. CRC/C/15/Add.124 (2000); *Grenada*, ¶ 22, U.N. Doc. CRC/C/15/Add.121 (2000); *United Kingdom of Great Britain and Northern Ireland*, ¶ 38, U.N. Doc. CRC/C/15/Add.135 (2000).
- ⁹⁹⁹ CRC Committee, *Concluding Observations: Slovakia*, ¶ 40, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).
- ¹⁰⁰⁰ CRC Committee, *Concluding Observations: Ecuador*, ¶ 60, U.N. Doc. CRC/C/OPSC/ECU/CO/4 (2010).
- ¹⁰⁰¹ CRC Committee, *Concluding Observations: Philippines*, ¶ 62, U.N. Doc. CRC/C/15/Add.259 (2005).
- ¹⁰⁰² CRC Committee, *Concluding Observations: Zimbabwe*, ¶ 60, U.N. Doc. CRC/C/ZWE/CO/2 (2016).
- ¹⁰⁰³ CRC Committee, *Concluding Observations: Samoa*, ¶ 47, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); CRC Committee, *Concluding Observations: Zambia*, ¶ 50, U.N. Doc. CRC/C/ZMB/CO/2-4 (2016).
- ¹⁰⁰⁴ CRC Committee, *Concluding Observations: Samoa*, ¶ 47, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); CRC Committee, *Concluding Observations: Zambia*, ¶ 50, U.N. Doc. CRC/C/ZMB/CO/2-4 (2016).
- ¹⁰⁰⁵ CRC Committee, *Concluding Observations: Senegal*, ¶ 54, U.N. Doc. CRC/C/SEN/CO/3-5 (2016).
- ¹⁰⁰⁶ CRC Committee, *Concluding Observations: Peru*, ¶ 55, U.N. Doc. CRC/C/PER/CO/4-5 (2016); *Ireland*, ¶ 57, U.N. Doc. CRC/C/IRL/CO/3-4 (2016).
- ¹⁰⁰⁷ CRC Committee, *Concluding Observations: Costa Rica*, ¶ 63, U.N. Doc. CRC/C/CRI/CO/4 (2011).
- ¹⁰⁰⁸ CRC Committee, *Concluding Observations: Ecuador*, ¶ 60, U.N. Doc. CRC/C/OPSC/ECU/CO/4 (2010).
- ¹⁰⁰⁹ CRC Committee, *Concluding Observations: Peru*, ¶ 56, U.N. Doc. CRC/C/PER/CO/4-5 (2016); *Costa Rica*, ¶ 64, U.N. Doc. CRC/C/CRI/CO/4 (2011).
- ¹⁰¹⁰ CRC Committee, *Concluding Observations: Costa Rica*, ¶ 64, U.N. Doc. CRC/C/CRI/CO/4 (2011).
- ¹⁰¹¹ CRC Committee, *Concluding Observations: Ecuador*, ¶ 61, U.N. Doc. CRC/C/OPSC/ECU/CO/4 (2010).
- ¹⁰¹² CRC Committee, *Concluding Observations: Bulgaria*, ¶ 44, U.N. Doc. CRC/C/BGR/CO/3-5 (2016); *Hungary*, ¶ 48, U.N. Doc. CRC/C/HUN/CO/3-5 (2014); *Kazakhstan*, ¶ 46, U.N. Doc. CRC/C/KAZ/CO/4 (2015); *Pakistan*, ¶ 64, U.N. Doc.

- CRC/C/PAK/CO/3-4 (2009); Georgia, ¶ 47, U.N. Doc. CRC/C/GEO/CO/3 (2008); Belarus, ¶ 43, U.N. Doc. CRC/C/15/Add.180 (2002); Uzbekistan, ¶ 51, U.N. Doc. CRC/C/15/Add.167 (2001).
- ¹⁰¹³ CRC Committee, *Concluding Observations: Belarus*, ¶ 47, U.N. Doc. CRC/C/BGR/CO/2 (2008); Greece, ¶ 60, U.N. Doc. CRC/C/15/Add.170 (2007); Albania, ¶ 56, U.N. Doc. CRC/C/15/Add.249 (2005); Armenia, ¶ 36, U.N. Doc. CRC/C/15/Add.119 (2000);
- ¹⁰¹⁴ CRC Committee, *Concluding Observations: Hungary*, ¶ 49, U.N. Doc. CRC/C/HUN/CO/3-5 (2014); Pakistan, ¶ 65, U.N. Doc. CRC/C/PAK/CO/3-4 (2009); Belarus, ¶ 48, U.N. Doc. CRC/C/BGR/CO/2 (2008); Greece, ¶ 61, U.N. Doc. CRC/C/15/Add.170 (2007).
- ¹⁰¹⁵ CRC Committee, *Concluding Observations: Tajikistan*, ¶ 41, U.N. Doc. CRC/C/15/Add.136 (2000).
- ¹⁰¹⁶ CRC Committee, *Concluding Observations: Gambia*, ¶ 61, U.N. Doc. CRC/C/GMB/CO/2-3 (2015).
- ¹⁰¹⁷ CRC Committee, *Concluding Observations: Bulgaria*, ¶ 41, U.N. Doc. CRC/C/BGR/CO/3-5 (2016).
- ¹⁰¹⁸ CRC Committee, *Concluding Observations: Oman*, ¶ 50, U.N. Doc. CRC/C/OMN/CO/3-4 (2016).
- ¹⁰¹⁹ See, e.g., CRC Committee, *Concluding Observations: Suriname*, ¶ 28, U.N. Doc. CRC/C/SUR/CO/3-4 (2016); Pakistan, ¶ 22, U.N. Doc. CRC/C/PAK/CO/5 (2016); Haiti, ¶ 48, U.N. Doc. CRC/C/HTI/CO/2-3 (2016); Eritrea, ¶ 55, U.N. Doc. CRC/C/ERI/CO/4 (2015); Timor-Leste, ¶ 46, U.N. Doc. CRC/C/TLS/CO/2-3 (2015); Ghana, ¶ 49, U.N. Doc. CRC/C/GHA/CO/3-5 (2015); India, ¶ 63, U.N. Doc. CRC/C/IND/CO/3-4 (2014); Angola, ¶ 49, U.N. Doc. CRC/C/AGO/CO/2-4 (2010); Burundi, ¶ 52, U.N. Doc. CRC/C/BDI/CO/2 (2010); Argentina, ¶ 58, U.N. Doc. CRC/C/ARG/CO/3-4 (2010); Azerbaijan, ¶ 49, U.N. Doc. CRC/C/AZE/CO/2 (2006); Benin, ¶ 51, U.N. Doc. CRC/C/BEN/CO/2 (2006); Algeria, ¶ 56, U.N. Doc. CRC/C/15/Add.269 (2005); Botswana, ¶ 48, U.N. Doc. CRC/C/15/Add.242 (2004).
- ¹⁰²⁰ CRC Committee, *Concluding Observations: South Africa*, ¶ 49, U.N. Doc. CRC/C/ZAF/CO/2 (2016); Kenya, ¶ 49, U.N. Doc. CRC/C/KEN/CO/3-5 (2016); Colombia, ¶ 43, U.N. Doc. CRC/C/COL/CO/4-5 (2015); Dominican Republic, ¶ 51, U.N. Doc. CRC/C/DOM/CO/3-5 (2015); Ghana, ¶ 49, U.N. Doc. CRC/C/GHA/CO/3-5 (2015); Mexico, ¶ 49, U.N. Doc. CRC/C/MEX/CO/4-5 (2015); Venezuela, ¶ 56, U.N. Doc. CRC/C/VEN/CO/3-5 (2014); Costa Rica, ¶ 63, U.N. Doc. CRC/C/CRI/CO/4 (2011); Grenada, ¶ 22, U.N. Doc. CRC/C/15/Add.121 (2000); Peru, ¶ 1, U.N. Doc. CRC/C/15/Add.120 (2000).
- ¹⁰²¹ CRC Committee, *Concluding Observations: Colombia*, ¶ 43, U.N. Doc. CRC/C/COL/CO/4-5 (2015); Mexico, ¶ 49, U.N. Doc. CRC/C/MEX/CO/4-5 (2015); Guatemala, ¶ 70, U.N. Doc. CRC/C/GTM/CO/3-4 (2010).
- ¹⁰²² CRC Committee, *Concluding Observations: Philippines*, ¶ 61, U.N. Doc. CRC/C/PHL/CO/3-4 (2009);
- ¹⁰²³ CRC Committee, *Concluding Observations: South Africa*, ¶ 49, U.N. Doc. CRC/C/ZAF/CO/2 (2016); Samoa, ¶ 46, U.N. Doc. CRC/C/WSM/CO/2-4 (2016).
- ¹⁰²⁴ CRC Committee, *Concluding Observations: Ukraine*, ¶ 56, U.N. Doc. CRC/C/UKR/CO/3-4 (2011); Argentina, ¶ 58, U.N. Doc. CRC/C/ARG/CO/3-4 (2010); Burkina Faso, ¶ 64, U.N. Doc. CRC/C/BFA/CO/3-4 (2010); Pakistan, ¶ 64, U.N. Doc. CRC/C/PAK/CO/3-4 (2009); Peru, ¶ 52, U.N. Doc. CRC/C/PER/CO/3 (2006); Guatemala, ¶ 40, U.N. Doc. CRC/C/15/Add.154 (2001).
- ¹⁰²⁵ CRC Committee, *Concluding Observations: South Africa*, ¶ 50, U.N. Doc. CRC/C/ZAF/CO/2 (2016); Venezuela, ¶ 57, U.N. Doc. CRC/C/VEN/CO/3-5 (2014).
- ¹⁰²⁶ CRC Committee, *Concluding Observations: South Africa*, ¶ 50, U.N. Doc. CRC/C/ZAF/CO/2 (2016).
- ¹⁰²⁷ CRC Committee, *Concluding Observations: South Africa*, ¶ 50, U.N. Doc. CRC/C/ZAF/CO/2 (2016); Kenya, ¶ 50, U.N. Doc. CRC/C/KEN/CO/3-5 (2016); Colombia, ¶ 44, U.N. Doc. CRC/C/COL/CO/4-5 (2015); Dominican Republic, ¶ 52, U.N. Doc. CRC/C/DOM/CO/3-5 (2015); Eritrea, ¶ 56, U.N. Doc. CRC/C/ERI/CO/4 (2015); Mexico, ¶ 50, U.N. Doc. CRC/C/MEX/CO/4-5 (2015); Ghana, ¶ 50, U.N. Doc. CRC/C/GHA/CO/3-5 (2015); Venezuela, ¶ 57, U.N. Doc. CRC/C/VEN/CO/3-5 (2014).
- ¹⁰²⁸ CRC Committee, *Concluding Observations: Ghana*, ¶ 50, U.N. Doc. CRC/C/GHA/CO/3-5 (2015); Benin, ¶ 56, U.N. Doc. CRC/C/BEN/CO/2 (2006); Guatemala, ¶ 41, U.N. Doc. CRC/C/15/Add.154 (2001).
- ¹⁰²⁹ CRC Committee, *Concluding Observations: Colombia*, ¶ 44, U.N. Doc. CRC/C/COL/CO/4-5 (2015); Dominican Republic, ¶ 52, U.N. Doc. CRC/C/DOM/CO/3-5 (2015); Mexico, ¶ 50, U.N. Doc. CRC/C/MEX/CO/4-5 (2015); Timor-Leste, ¶ 47, U.N. Doc. CRC/C/TLS/CO/2-3 (2015); United Republic of Tanzania, ¶ 55, U.N. Doc. CRC/C/TZA/CO/3-5 (2015); Venezuela, ¶ 57, U.N. Doc. CRC/C/VEN/CO/3-5 (2014); China, ¶ 63, U.N. Doc. CRC/C/CHN/CO/3-4 (2013).
- ¹⁰³⁰ CRC Committee, *Concluding Observations: Burkina Faso*, ¶ 65, U.N. Doc. CRC/C/BFA/CO/3-4 (2010).
- ¹⁰³¹ CRC Committee, *Concluding Observations: Timor-Leste*, ¶ 47, U.N. Doc. CRC/C/TLS/CO/2-3 (2015); Algeria, ¶ 57, U.N. Doc. CRC/C/15/Add.269 (2005); Botswana, ¶ 49, U.N. Doc. CRC/C/15/Add.242 (2004).
- ¹⁰³² CRC Committee, *Concluding Observations: United Republic of Tanzania*, ¶ 55, U.N. Doc. CRC/C/TZA/CO/3-5 (2015).
- ¹⁰³³ CRC Committee, *Concluding Observations: Haiti*, ¶ 49, U.N. Doc. CRC/C/HTI/CO/2-3 (2016).
- ¹⁰³⁴ CRC Committee, *Concluding Observations: Venezuela*, ¶ 57, U.N. Doc. CRC/C/VEN/CO/3-5 (2014); Argentina, ¶ 59, U.N. Doc. CRC/C/ARG/CO/3-4 (2010).
- ¹⁰³⁵ See, e.g., CRC Committee, *Concluding Observations: Venezuela*, ¶ 57, U.N. Doc. CRC/C/VEN/CO/3-5 (2014); Burkina Faso, ¶ 55, U.N. Doc. CRC/C/BFA/CO/3-4 (2010); Burundi, ¶ 53, U.N. Doc. CRC/C/BDI/CO/2 (2010); Azerbaijan, ¶ 49, U.N. Doc. CRC/C/AZE/CO/2 (2006); Benin, ¶ 56, U.N. Doc. CRC/C/BEN/CO/2 (2006); Algeria, ¶ 57, U.N. Doc. CRC/C/15/Add.269 (2005); Armenia, ¶ 46, U.N. Doc. CRC/C/15/Add.225 (2004); Belarus, ¶ 41, U.N. Doc. CRC/C/15/Add.180 (2002).

- ¹⁰³⁶ See, e.g., CRC Committee, *Concluding Observations: Sierra Leone*, ¶ 31, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); *Nauru*, ¶ 46, U.N. Doc. CRC/C/NRU/CO/1 (2016); *United Kingdom of Great Britain and Northern Ireland*, ¶ 64, U.N. Doc. CRC/C/GBR/CO/5 (2016); *Slovakia*, ¶ 40, U.N. Doc. CRC/C/SVK/CO/3-5 (2016); *Samoa*, ¶ 46, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); *Nepal*, ¶ 53, U.N. Doc. CRC/C/NPL/CO/3-5 (2016); *Gabon*, ¶ 47, U.N. Doc. CRC/C/GAB/CO/2 (2016); *Bulgaria*, ¶ 44, U.N. Doc. CRC/C/BGR/CO/3-5 (2016); *Zimbabwe*, ¶ 60, U.N. Doc. CRC/C/ZWE/CO/2 (2016); *Zambia*, ¶ 49, U.N. Doc. CRC/C/ZMB/CO/2-4 (2016); *Chile*, ¶ 60, U.N. Doc. CRC/C/CHL/CO/4-5 (2015); *Ghana*, ¶ 51, U.N. Doc. CRC/C/GHA/CO/3-5 (2015); *Dominican Republic*, ¶ 51, U.N. Doc. CRC/C/DOM/CO/3-5 (2015); *Jamaica*, ¶ 48, U.N. Doc. CRC/C/JAM/CO/3-4 (2015); *Mauritius*, ¶ 53, U.N. Doc. CRC/C/MUS/CO/3-5 (2015); *Mexico*, ¶ 49, U.N. Doc. CRC/C/MEX/CO/4-5 (2015); *Venezuela*, ¶ 56, U.N. Doc. CRC/C/VEN/CO/3-5 (2014); *India*, ¶ 65, U.N. Doc. CRC/C/IND/CO/3-4 (2014); *Guyana*, ¶ 49, U.N. Doc. CRC/C/GUY/CO/2-4 (2013); *Costa Rica*, ¶ 63, U.N. Doc. CRC/C/CRI/CO/4 (2011); *Argentina*, ¶ 62, U.N. Doc. CRC/C/ARG/CO/3-4 (2010); *Guatemala*, ¶ 74, U.N. Doc. CRC/C/GTM/CO/3-4 (2010); *Ecuador*, ¶ 60, U.N. Doc. CRC/C/OPSC/ECU/CO/4 (2010); *Grenada*, ¶ 45, U.N. Doc. CRC/C/GRD/C/2 (2010); *Angola*, ¶ 51, U.N. Doc. CRC/C/AGO/CO/2-4 (2010); *Bolivia*, ¶ 55, U.N. Doc. CRC/C/BOL/CO/4 (2009); *Benin*, ¶ 55, U.N. Doc. CRC/C/BEN/CO/2 (2006); *Belize*, ¶ 54, U.N. Doc. CRC/C/15/Add.252 (2005); *Bangladesh*, ¶ 59, U.N. Doc. CRC/C/15/Add.221 (2003); *Argentina*, ¶ 50, U.N. Doc. CRC/C/15/Add.187 (2002).
- ¹⁰³⁷ CRC Committee, *Concluding Observations: Zimbabwe*, ¶ 60, U.N. Doc. CRC/C/ZWE/CO/2 (2016); *Timor-Leste*, ¶ 50, U.N. Doc. CRC/C/TLS/CO/2-3 (2015); *Uganda*, ¶ 53, U.N. Doc. CRC/C/UGA/CO/2 (2005); *Burkina Faso*, ¶ 40, U.N. Doc. CRC/C/15/Add.193 (2002).
- ¹⁰³⁸ CRC Committee, *Concluding Observations: Mexico*, ¶ 49, U.N. Doc. CRC/C/MEX/CO/4-5 (2015); *Observations: United Republic of Tanzania*, ¶ 58, U.N. Doc. CRC/C/TZA/CO/3-5 (2015).
- ¹⁰³⁹ CRC Committee, *Concluding Observations: Honduras*, ¶ 64, U.N. Doc. CRC/C/HND/CO/4-5 (2015).
- ¹⁰⁴⁰ CRC Committee, *Concluding Observations: Grenada*, ¶ 45, U.N. Doc. CRC/C/GRD/C/2 (2010); *Philippines*, ¶ 61, U.N. Doc. CRC/C/PHL/CO/3-4 (2009).
- ¹⁰⁴¹ CRC Committee, *Concluding Observations: Timor-Leste*, ¶ 50, U.N. Doc. CRC/C/TLS/CO/2-3 (2015).
- ¹⁰⁴² CRC Committee, *Concluding Observations: Ecuador*, ¶ 60, U.N. Doc. CRC/C/OPSC/ECU/CO/4 (2010).
- ¹⁰⁴³ CRC Committee, *Concluding Observations: Holy See*, ¶¶ 56-57, U.N. Doc. CRC/C/VAT/CO/2 (2014).
- ¹⁰⁴⁴ CRC Committee, *Concluding Observations: Slovakia*, ¶ 40, U.N. Doc. CRC/C/SVK/CO/3-5 (2016); *Zimbabwe*, ¶ 68, U.N. Doc. CRC/C/ZWE/CO/2 (2016); *South Africa*, ¶ 59, U.N. Doc. CRC/C/ZAF/CO/2 (2016); *Zambia*, ¶ 53, U.N. Doc. CRC/C/ZMB/CO/2-4 (2016).
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- ¹⁰⁴⁶ CRC Committee, *Concluding Observations: Sierra Leone*, ¶ 34, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); *United Republic of Tanzania*, ¶ 62, U.N. Doc. CRC/C/TZA/CO/3-5 (2015).
- ¹⁰⁴⁷ CRC Committee, *Concluding Observations: Guyana*, ¶ 49, U.N. Doc. CRC/C/GUY/CO/2-4 (2013); *Republic of Korea*, ¶ 10, U.N. Doc. CRC/C/KOR/CO/3-4 (2012); *Uruguay*, ¶ 51, U.N. Doc. CRC/C/URY/CO/2 (2007).
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- ¹⁰⁴⁹ CRC Committee, *Concluding Observations: United Republic of Tanzania*, ¶ 62, U.N. Doc. CRC/C/TZA/CO/3-5 (2015).
- ¹⁰⁵⁰ CRC Committee, *Concluding Observations: Sierra Leone*, ¶ 31, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); *Samoa*, ¶ 46, U.N. Doc. CRC/C/WSM/CO/2-4 (2016); *Guyana*, ¶ 49, U.N. Doc. CRC/C/GUY/CO/2-4 (2013).
- ¹⁰⁵¹ CRC Committee, *Concluding Observations: Kenya*, ¶ 49, U.N. Doc. CRC/C/KEN/CO/3-5 (2016).
- ¹⁰⁵² CRC Committee, *Concluding Observations: Costa Rica*, ¶ 64, U.N. Doc. CRC/C/CRI/CO/4 (2011).
- ¹⁰⁵³ CRC Committee, *Concluding Observations: Pakistan*, ¶ 65, U.N. Doc. CRC/C/PAK/CO/3-4 (2009).
- ¹⁰⁵⁴ CRC Committee, *Concluding Observations: Slovakia*, ¶ 41, U.N. Doc. CRC/C/SVK/CO/3-5 (2016); *Pakistan*, ¶ 52, U.N. Doc. CRC/C/PAK/CO/5 (2016); *Maldives*, ¶ 57, U.N. Doc. CRC/C/MDV/CO/4-5 (2016); *Brunei Darussalam*, ¶ 53, U.N. Doc. CRC/C/BRN/CO/2-3 (2016); *Ghana*, ¶ 52, U.N. Doc. CRC/C/GHA/CO/3-5 (2015); *Guyana*, ¶ 50, U.N. Doc. CRC/C/GUY/CO/2-4 (2013); *Costa Rica*, ¶ 64, U.N. Doc. CRC/C/CRI/CO/4 (2011).
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- ¹⁰⁵⁶ CRC Committee, *Concluding Observations: Suriname*, ¶ 31(c), U.N. Doc. CRC/C/SUR/CO/3-4 (2016);
- ¹⁰⁵⁷ CRC Committee, *Concluding Observations: Oman*, ¶ 51, U.N. Doc. CRC/C/OMN/CO/3-4 (2016); *Timor-Leste*, ¶ 51, U.N. Doc. CRC/C/TLS/CO/2-3 (2015).
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- ¹⁰⁶⁴ CRC Committee, *Concluding Observations: Saudi Arabia*, ¶ 35, U.N. Doc. CRC/C/SAU/CO/3-4 (2016).
- ¹⁰⁶⁵ CRC Committee, *Concluding Observations: Bulgaria*, ¶ 44, U.N. Doc. CRC/C/BGR/CO/3-5 (2016); CRC Committee, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland*, ¶ 65, U.N. Doc. CRC/C/GBR/CO/5 (2016); Poland, ¶ 39, U.N. Doc. CRC/C/POL/CO/3-4 (2015); Algeria, ¶ 60, U.N. Doc. CRC/C/DZA/CO/3-4 (2012); Costa Rica, ¶ 64, U.N. Doc. CRC/C/CRI/CO/4 (2011).
- ¹⁰⁶⁶ CRC Committee, *Concluding Observations: Zimbabwe*, ¶ 61, U.N. Doc. CRC/C/ZWE/CO/2 (2016); United Kingdom of Great Britain and Northern Ireland, ¶ 65, U.N. Doc. CRC/C/GBR/CO/5 (2016);
- ¹⁰⁶⁷ CRC Committee, *Concluding Observations: Ukraine*, ¶ 57, U.N. Doc. CRC/C/UKR/CO/3-4 (2011);
- ¹⁰⁶⁸ CRC Committee, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland*, ¶ 65, U.N. Doc. CRC/C/GBR/CO/5 (2016);
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- ¹⁰⁷⁶ CRC Committee, *Concluding Observations: China*, ¶ 67, U.N. Doc. CRC/C/CHN/CO/3-4 (2013).
- ¹⁰⁷⁷ CRC Committee, *Concluding Observations: Chile*, ¶ 56, U.N. Doc. CRC/C/CHL/CO/4-5 (2015); Mexico, ¶ 45, U.N. Doc. CRC/C/MEX/CO/4-5 (2015).
- ¹⁰⁷⁸ CRC Committee, *Concluding Observations: Chile*, ¶ 56, U.N. Doc. CRC/C/CHL/CO/4-5 (2015).
- ¹⁰⁷⁹ CRC Committee, *Concluding Observations: Australia*, ¶ 58, U.N. Doc. CRC/C/OPSC/AUS/CO/1 (2012); Australia, ¶ 46, U.N. Doc. CRC/C/15/Add.268 (2005).
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- ¹⁰⁸¹ CRC Committee, *Concluding Observations: Australia*, ¶ 57, U.N. Doc. CRC/C/OPSC/AUS/CO/1 (2012).
- ¹⁰⁸² CRC Committee, *Concluding Observations: South Africa*, ¶ 40, U.N. Doc. CRC/C/ZAF/CO/2 (2016); New Zealand, ¶ 25, U.N. Doc. CRC/C/NZL/CO/5 (2016); Nepal, ¶ 41, U.N. Doc. CRC/C/NPL/CO/3-5 (2016).
- ¹⁰⁸³ CRC Committee, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland*, ¶ 46, U.N. Doc. CRC/C/GBR/CO/5 (2016); Nepal, ¶ 41, U.N. Doc. CRC/C/NPL/CO/3-5 (2016); Ireland, ¶ 39, U.N. Doc. CRC/C/IRL/CO/3-4 (2016).
- ¹⁰⁸⁴ CRC Committee, *Concluding Observations: Nepal*, ¶ 41, U.N. Doc. CRC/C/NPL/CO/3-5 (2016); Ireland, ¶ 39, U.N. Doc. CRC/C/IRL/CO/3-4 (2016).
- ¹⁰⁸⁵ CRC Committee, *Concluding Observations: South Africa*, ¶ 40, U.N. Doc. CRC/C/ZAF/CO/2 (2016).
- ¹⁰⁸⁶ CRC Committee, *Concluding Observations: South Africa*, ¶ 40, U.N. Doc. CRC/C/ZAF/CO/2 (2016); New Zealand, ¶ 25, U.N. Doc. CRC/C/NZL/CO/5 (2016).

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- ¹⁰⁹² CRC Committee, *Concluding Observations: Slovakia*, ¶ 25, U.N. Doc. CRC/C/SVK/CO/3-5 (2016). *Concluding Observations: China*, ¶ 68, U.N. Doc. CRC/C/CHN/CO/3-4 (2013).
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- ¹⁰⁹⁹ CRC Committee, *Concluding Observations: South Africa*, ¶ 40, U.N. Doc. CRC/C/ZAF/CO/2 (2016); *New Zealand*, ¶ 25, U.N. Doc. CRC/C/NZL/CO/5 (2016); *United Kingdom of Great Britain and Northern Ireland*, ¶ 47, U.N. Doc. CRC/C/GBR/CO/5 (2016); *Nepal*, ¶ 42, U.N. Doc. CRC/C/NPL/CO/3-5 (2016); *Ireland*, ¶ 40, U.N. Doc. CRC/C/IRL/CO/3-4 (2016).
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- ¹¹⁰² CAT Committee, *General Comment No. 2: Implementation of article 2 by States parties*, ¶ 3, U.N. Doc. CAT/C/GC/2 (2008).
- ¹¹⁰³ CAT Committee, *General Comment No. 2: Implementation of article 2 by States parties*, ¶ 22, U.N. Doc. CAT/C/GC/2 (2008).
- ¹¹⁰⁴ CAT Committee, *General Comment No. 2: Implementation of article 2 by States parties*, ¶ 22, U.N. Doc. CAT/C/GC/2 (2008) (emphasis added).
- ¹¹⁰⁵ CAT Committee, *General Comment No. 3: Implementation of article 15 by States parties*, ¶ 2, U.N. Doc. CAT/C/GC/3 (2012).
- ¹¹⁰⁶ CAT Committee, *General Comment No. 3: Implementation of article 15 by States parties*, ¶ 35, U.N. Doc. CAT/C/GC/3 (2012).
- ¹¹⁰⁷ CAT Committee, *General Comment No. 3: Implementation of article 15 by States parties*, ¶ 35, U.N. Doc. CAT/C/GC/3 (2012).
- ¹¹⁰⁸ See, e.g., CAT Committee, *Concluding Observations: Iraq*, ¶ 13, U.N. Doc. CAT/C/IRQ/CO/1 (2015); *Sierra Leone*, ¶ 14, U.N. Doc. CAT/C/SLE/CO/1 (2014); *Bolivia*, ¶¶ 15 & 16, U.N. Doc. CAT/C/BOL/CO/2 (2014); *Peru*, ¶ 14, U.N. Doc. CAT/C/PER/CO/5-6 (2013); *Cambodia*, ¶ 21, U.N. Doc. CAT/C/KHM/CO/2 (2011); *Yemen*, ¶ 24, U.N. Doc. CAT/C/YEM/CO/2/Rev.1 (2010).
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- ¹¹¹⁰ CAT Committee, *Concluding Observations: Yemen*, ¶ 24, U.N. Doc. CAT/C/YEM/CO/2/Rev.1 (2010).
- ¹¹¹¹ CAT Committee, *Concluding Observations: Bolivia*, ¶ 16, U.N. Doc. CAT/C/BOL/CO/2 (2014).
- ¹¹¹² CAT Committee, *Concluding Observations: Peru*, ¶ 14, U.N. Doc. CAT/C/PER/CO/5-6 (2013).
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- ¹¹¹⁴ CAT Committee, *Concluding Observations: Philippines*, ¶¶ 39-40, U.N. Doc. CAT/C/PHL/CO/3 (2016);
- ¹¹¹⁵ CAT Committee, *Concluding Observations: Philippines*, ¶¶ 39-40, U.N. Doc. CAT/C/PHL/CO/3 (2016); *Sierra Leone*, ¶ 17, U.N. Doc. CAT/C/SLE/CO/1 (2014); *Nicaragua*, ¶ 16, U.N. Doc. CAT/C/NIC/CO/1 (2009);
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- ¹¹¹⁷ CAT Committee, *Concluding Observations: Kenya*, ¶ 28, U.N. Doc. CAT/C/KEN/CO/2 (2013); *Peru*, ¶ 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013); *Ireland*, ¶ 26, U.N. Doc. CAT/C/IRL/CO/1 (2011);
- ¹¹¹⁸ CAT Committee, *Concluding Observations: Ireland*, ¶ 26, U.N. Doc. CAT/C/IRL/CO/1 (2011); CAT Committee, *Concluding Observations: Nicaragua*, ¶ 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).
- ¹¹¹⁹ CAT Committee, *Concluding Observations: Ireland*, ¶ 26, U.N. Doc. CAT/C/IRL/CO/1 (2011);
- ¹¹²⁰ CAT Committee, *Concluding Observations: Paraguay*, ¶ 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); *Ireland*, ¶ 26, U.N. Doc. CAT/C/IRL/CO/1 (2011); *El Salvador*, ¶ 23, U.N. Doc. CAT/C/SLV/CO/2 (2009); *Nicaragua*, ¶ 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).

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- ¹¹²³ See, e.g., CAT Committee, *Concluding Observations: Honduras*, ¶¶ 47-48, U.N. Doc. CAT/C/HND/CO/2 (2016); *Kenya*, ¶ 28, U.N. Doc. CAT/C/KEN/CO/2 (2013); *Peru*, ¶ 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013); *Paraguay*, ¶ 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011);
- ¹¹²⁴ CAT Committee, *Concluding Observations: Nicaragua*, ¶ 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).
- ¹¹²⁵ CAT Committee, *Concluding Observations: Peru*, ¶ 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013).
- ¹¹²⁶ CAT Committee, *Concluding Observations: Former Yugoslav Republic of Macedonia*, ¶ 17, U.N. Doc. CAT/C/MKD/CO/3 (2015); *Kenya*, ¶ 28, U.N. Doc. CAT/C/KEN/CO/2 (2013); *Bolivia*, ¶ 23, U.N. Doc. CAT/C/BOL/CO/2 (2013);
- ¹¹²⁷ CAT Committee, *Concluding Observations: Kenya*, ¶ 28, U.N. Doc. CAT/C/KEN/CO/2 (2013); *Bolivia*, ¶ 23, U.N. Doc. CAT/C/BOL/CO/2 (2013);
- ¹¹²⁸ CAT Committee, *Concluding Observations: Kenya*, ¶ 28, U.N. Doc. CAT/C/KEN/CO/2 (2013).
- ¹¹²⁹ CAT Committee, *Concluding Observations: Bolivia*, ¶ 23, U.N. Doc. CAT/C/BOL/CO/2 (2013).
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- ¹¹³¹ CAT Committee, *Concluding Observations: Bolivia*, ¶ 23, U.N. Doc. CAT/C/BOL/CO/2 (2013).
- ¹¹³² CAT Committee, *Concluding Observations: Philippines*, ¶ 39, U.N. Doc. CAT/C/PHL/CO/3 (2016); *Sierra Leone*, ¶ 17, U.N. Doc. CAT/C/SLE/CO/1 (2014); *Peru*, ¶ 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013); *Paraguay*, ¶ 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011);
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- ¹¹³⁴ CAT Committee, *Concluding Observations: Peru*, ¶ 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013); *Paraguay*, ¶ 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011);
- ¹¹³⁵ CAT Committee, *Concluding Observations: Philippines*, ¶ 40, U.N. Doc. CAT/C/PHL/CO/3 (2016);
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- ¹¹³⁷ CAT Committee, *Concluding Observations: Peru*, ¶ 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013); CAT Committee, *Concluding Observations: Chile*, ¶ 7, U.N. Doc. CAT/C/CR/32/5 (2004).
- ¹¹³⁸ CAT Committee, *Concluding Observations: Paraguay*, ¶ 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011).
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Women Enabled International (WEI) works at the intersection of women's rights and disability rights to advance the rights of women and girls with disabilities around the world. Through advocacy and education, WEI increases international attention to—and strengthens international human rights standards on—issues such as violence against women, sexual and reproductive health and rights, access to justice, education, legal capacity, and humanitarian emergencies. Working in collaboration with women with disabilities rights organizations and women's rights organizations worldwide, WEI fosters cooperation across movements to improve understanding and develop cross-cutting advocacy strategies to realize the rights of all women and girls.