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Promotion and protection of human rights: human rights questions, including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms

Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, submitted in accordance with Human Rights Council resolutions 6/29 and [42/16](#).

* [A/76/150](#).



Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng

Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic

Summary

In her first report to the General Assembly, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, focuses on sexual and reproductive health rights and the opportunities and challenges arising during the COVID-19 pandemic. Adopting the standpoint that patriarchal oppression is universal and at the origin of control of women's bodies and sexuality, she examines the multifaceted historical impact of colonialism on these rights. She reflects on the importance of the underlying and social determinants of health and substantive equality for the realization of sexual and reproductive health rights and clarifies the nature of the legal framework that recognizes sexual and reproductive rights, with a focus on the right to sexual and reproductive health as an integral part of the right to health.

The Special Rapporteur demonstrates how the COVID-19 pandemic has further thwarted the realization of the sexual and reproductive health rights of women, adolescents, girls and all persons capable of getting pregnant. Within an intersectionality framework, she examines the impact of legislation and policy, services and funding in maternal, new-born and child health services, family planning and contraception, adolescent sexual and reproductive health, comprehensive support for sexual and gender-based violence survivors, HIV/AIDS and reproductive cancers. She identifies the important positive opportunities that are offered by digital health if the digital global and gender divide is breached. The Special Rapporteur reaffirms the key principles of non-discrimination, equality and privacy.

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I. Introduction: sexual and reproductive health rights through the lens of colonialism and its living legacy

1. Controlling sexuality and, in particular, women's sexuality has its origins in patriarchy. Patriarchal oppression is not specific to any country or region: it is universal. It has permeated all societies across the globe and its impact has been devastating. Colonialism has perpetuated the patriarchal control and oppression of societies and the control of sexuality.¹ Bodies of women, girls and gender-diverse people have long been subjected to discrimination, violence and oppression where human rights violations have occurred unabated. As indicated in the first thematic report, outlining strategic priorities, of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, the right to sexual and reproductive health is an integral part of the right to health.² Many obstacles stand between individuals and their enjoyment of sexual and reproductive health rights. These obstacles are interrelated and entrenched, operating at different levels: in clinical care, at the level of health systems and in the context of the underlying determinants of health. The key principles that shape human rights, especially non-discrimination, equality and privacy, as well as the integrity, autonomy, dignity and well-being of individuals, especially in relation to sexual and reproductive health rights, are integral to the realization of the right to health.

2. The historical impacts of colonialism on sexual and reproductive health rights are multifaceted. Broadly, colonial regimes have seen reproduction primarily in instrumentalist terms, promoting it when it was deemed valuable for economic or political objectives and discouraging it when it was deemed undesirable. Maternal health programmes created by European colonial powers in Africa and the Caribbean in the early twentieth century, for example, were driven largely by a perceived shortage of labour needed to work on plantations and in export industries.³ Colonial and postcolonial regimes, as well as many international organizations, then shifted to discouraging reproduction and promoting family planning in the mid-twentieth century, when smaller families were deemed more conducive to national economic development and global security.⁴ The connections among fertility, family size and broader social and economic development continued to be debated, strengthened by the resurgence of the rhetoric of population control in the context of climate change.⁵ In the era of climate change, it must be noted that these resurgent discourses make their way into social and policy discussions and attribute environmental destruction

¹ A/HRC/29/40, paras. 13–14.

² A/HRC/47/28, para. 65.

³ Lynn M. Thomas, *Politics of the Womb: Women, Reproduction, and the State in Kenya* (Berkeley, California, University of California Press, 2003); Juanita De Barros, *Reproducing the British Caribbean: Sex, Gender, and Population Politics After Slavery* (Chapel Hill, North Carolina, University of North Carolina Press, 2014).

⁴ Rickie Solinger and Mie Nakachi, eds., *Reproductive States: Global Perspectives on the Invention and Implementation of Population Policy* (Oxford, Oxford University Press, 2016); Betsy Hartmann, *Reproductive Rights and Wrongs: The Global Politics of Population Control* (Boston, Massachusetts, South End Press, 1995); Matthew Connelly, *Fatal Misconception: The Struggle to Control World Population* (Cambridge, Massachusetts, Belknap Press of Harvard University Press, 2008); Laura Briggs, *Reproducing Empire: Race, Sex, Science, and U.S. Imperialism in Puerto Rico* (Berkeley, California, University of California Press, 2003); Susanne Klausen, *Race, Maternity, and the Politics of Birth Control in South Africa, 1910–39* (Basingstoke, United Kingdom, Palgrave Macmillan, 2004); Sanjam Ahluwalia, *Reproductive Restraints: Birth Control in India, 1877–1947* (Urbana, Illinois, University of Illinois Press, 2008); and Nicole Bourbonnais, *Birth Control in the Decolonizing Caribbean: Reproductive Politics and Practices on Four Islands, 1930–1970* (New York, Cambridge University Press, 2016).

⁵ See themed section: Populationism, in *Gender, Place and Culture*, vol. 27, No. 3 (March 2020).

to the reproduction of poor, indigenous people and people of African descent. A de-colonial approach would refuse the instrumentalist terms of this debate altogether, calling for full access to reproductive and sexual health-based services as a fundamental human right in and of itself, rather than as a means to an end determined by State priorities.

3. Colonialism and its effect on laws and policies also point to the importance of the brutal history of fertility control based on the application of the concept of eugenics through which poor Black women and women of marginalized ethnicities in the global South and indigenous people in the global North⁶ were targeted in the name of containing “over-population”. The motivations driving this concept, which is still invoked today, are rooted in racism and classism, as illuminated by the concept of “stratified reproduction”, a term coined by Shellee Colen.⁷

4. On the basis of the concept of stratified reproduction, certain people are encouraged or coerced to reproduce, while others are systematically discouraged. States’ encouragement of high fertility rates among “desired” populations emerges through pro-natalist policies, to ensure national strength, economic growth and protection from outside aggression, as well as to preserve a “national identity”.⁸ The capacity to control one’s reproductive choices is unequally distributed across race, sexual orientation, gender identity, sex characteristics, gender, class and socioeconomic status. Stratified reproduction also extends beyond aspects of reproduction to include conception, contraception, prenatal medical care, childcare and the role of mothers in their child’s life. How women experience these parameters of sexual and reproductive health depends on which intersections of privilege and oppression they live at, including their position vis-à-vis their partners. Findings of the United Nations Population Fund (UNFPA), under Sustainable Development Goal 5, target 5.6, on the legal and regulatory framework for sexual and reproductive health rights and women’s reproductive decision-making, show that in early 2020, in 57 countries, one quarter of women were not able to make their own decisions on accessing health care and were not empowered to say no to sex with their husband or partner and nearly 1 in 10 had no choice with respect to using contraception.

5. Also, Black women, women of colour and indigenous women in the global South who have been historically framed primarily as victims of sexual violence or vectors of sexual illness, rather than as potentially empowered claimants of sexual rights/pleasure, must be centred in conversations regarding the protection and fulfilment of and respect for sexual and reproductive health rights.⁹

6. European colonial regimes set in place specific laws, including restrictions on abortion and consensual same-sex acts, which remain on the books today in formerly colonized countries. Indeed, in contrast to the popular narrative that the advancement of sexual rights and abortion rights internationally are modern forms of “colonization” by the West, in fact State-sponsored homophobia, the privileging of heterosexuality and restrictions on women’s rights to bodily autonomy are a more precise legacy of colonial rule. They shape contemporary geopolitics of financing, services and audit regimes for sexual and reproductive health rights which enforce power disparities in health aid between bilateral donors and implementing countries. As M. Jacqui Alexander argues, in failing to overturn these laws, the postcolonial or

⁶ Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (Berkeley, California, University of California Press, 2017).

⁷ Faye D. Ginsburg and Rayna Rapp, “Introduction: conceiving the new world order”, in *Conceiving the New World Order: The Global Politics of Reproduction*, Faye D. Ginsburg and Rayna Rapp, eds. (Berkeley, California, University of California Press, 1995), p. 3.

⁸ A/HRC/32/44, paras. 61–62.

⁹ Susie Jolly, Andrea Cornwall and Kate Hawkins, *Women, Sexuality and the Political Power of Pleasure* (London, Zed Books, 2013).

“neo-colonial” State “continues the policing of sexualized bodies ... as if the colonial masters were still looking on”.¹⁰ A de-colonial approach would require full bodily and erotic autonomy, allowing all people to make decisions free of intervention from States – colonial or otherwise.

II. Underlying and social determinants of health and substantive equality

7. In light of the strategic priorities of the Special Rapporteur, the importance of substantive equality in the area of sexual and reproductive health rights is underscored.

8. The Special Rapporteur agrees with Amartya Sen when he asserts the following: “(H)ealth equity has many aspects, and is best seen as a multidimensional concept. It includes concerns about achievement of health and the capability to achieve good health, not just the distribution of health care. But it also includes the fairness of processes and thus must attach importance to non-discrimination in the delivery of health care.”¹¹

9. The Special Rapporteur underscores that, beyond the goal of health equity which States may or not pursue,¹² human rights law legally binds States to ensure non-discrimination and equality in the provision of sexual and reproductive health care for all. She echoes the Working Group on the issue of discrimination against women in law and in practice in recognizing that this “requires a differential approach to women and men, in accordance with their biological needs” and that “meeting these different needs requires substantive equality and thus obliges States to provide differential sexual and reproductive health services, treatment and medicines for women and girls throughout their life cycle”.¹³ Likewise, substantive equality requires as well that the specific sexual and reproductive health needs of individuals with diverse gender identities be addressed.

10. Linked to health equity and substantive equality is the framework developed by the World Health Organization (WHO) for the social determinants of health, defined as the non-medical factors that influence health outcomes, that is, “the conditions in which people are born, grow, work, live, and age”.¹⁴ Particularly, the Committee on Economic, Social and Cultural rights has recognized that the “social determinants of health affect the realization of the right to sexual and reproductive health”.¹⁵ Both between and within countries, patterns related to sexual and reproductive health rights typically reflect social inequalities and power distributions based on income, gender, origin, citizenship status, age, disability status, systematic discrimination and other factors. For example, persons living within low- and middle-income countries face much higher rates of morbidity and mortality related to sexual and reproductive health

¹⁰ M. Jacqui Alexander, “Erotic autonomy as a politics of decolonization: an anatomy of feminist and state practice in the Bahamas tourist economy”, in *Feminist Genealogies, Colonial Legacies, Democratic Futures*, M. Jacqui Alexander and Chandra Talpade Mohanty, eds. (New York, Routledge, 1997), p. 83.

¹¹ “Why health equity?”, *Health Economics*, vol. 11, No. 8 (December 2002), pp. 659–666.

¹² See https://cdn.who.int/media/docs/default-source/world-health-day-2021/health-equity-and-its-determinants.pdf?sfvrsn=6c36f0a5_1&download=true.

¹³ On the meaning of substantive equality in the area of health for women and girls, see [A/HRC/32/44](#), paras. 13, 16, 22–27 and 100; and [A/HRC/47/38](#).

¹⁴ World Health Organization, “Social determinants of health”. Available at www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

¹⁵ Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016).

rights than persons in high-income countries.¹⁶ Yet within all countries, marginalized individuals such as low-income, lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) people, adolescents, migrants, persons experiencing homelessness, persons living with disabilities, people living with HIV and sex workers confront greater barriers to sexual and reproductive health rights compared with national averages.¹⁷

11. The COVID-19 pandemic has further underscored the health impacts of social inequalities, with already marginalized populations experiencing higher rates of COVID-19 pandemic-related illness and death and greater disruption of other health services including for sexual and reproductive health.¹⁸ In many parts of the world, COVID-19 pandemic emergency measures were adopted, not always in conformity with human rights law.¹⁹ Amendments of laws and other measures have been used opportunistically to implement draconian measures which further curtail human rights, especially as related to sexual and reproductive health rights and the rights of LGBTIQ+ people.²⁰ For instance, in Hungary, a new bill was introduced that would “deny trans and gender diverse people the right to legal recognition and self-determination”,²¹ and in Poland, a fast-tracked amendment to criminal law was passed which increases the penalties for HIV exposure, non-disclosure and transmission.²²

12. The COVID-19 pandemic containment measures have taken a heavy toll on sex workers.²³ They have been treated as “vectors” of the virus;²⁴ their source of income has been cut off, as in many countries brothels were closed and sex work was banned; and many sex workers were arrested globally.²⁵ Furthermore, they were often ineligible for financial support owing to the legal status of their work or the general stigma associated with sex work.²⁶ A survey conducted by the Global Network of Sex Work Projects of 156 sex workers from 55 countries found that most respondents in every region except Europe reported reduced access to condoms, lubricants, and testing and treatment for sexually transmitted infections.²⁷

13. Over a year into the COVID-19 pandemic, retrogressive measures that are still being applied and maintained must be repealed. The pandemic has already been shown to be fostering a context perpetuating deep inequality, best demonstrated by the roll-out processes of COVID-19 vaccines which have favoured wealthier countries at the expense of low- and middle-income countries. In this regard, the Committee on Economic, Social and Cultural Rights has underlined the right of everyone to enjoy the benefits of scientific progress. The Committee stresses that pandemics offer crucial evidence of the need for international scientific cooperation in facing transnational threats. Viruses and other pathogens cannot be apprehended at borders and through diplomatic controls. Inequality persists, with billions of people

¹⁶ World Health Organization, *Social Determinants of Sexual and Reproductive Health: Informing Future Research and Programme Implementation* (Geneva, 2010).

¹⁷ Ibid.

¹⁸ Lauren Paremoer and others, “Covid-19 pandemic and the social determinants of health”, *BMJ*, vol. 372, No. 129 (29 January 2021). Available at www.bmj.com/content/372/bmj.n129.

¹⁹ Office of the United Nations High Commissioner for Human Rights, “COVID-19: States should not abuse emergency measures to suppress human rights – UN experts” (Geneva, 16 March 2020).

²⁰ See www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25832&LangID=E.

²¹ See www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25844.

²² See www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2020/april/2-0200409_laws-covid19.

²³ See submission by Switzerland, p. 2.

²⁴ See submission by Global Network of Sex Work Projects (NSWG), p. 2.

²⁵ See www.unaids.org/sites/default/files/media_asset/prevaling-against-pandemics_en.pdf, p. 22 and 31.

²⁶ See submission by Switzerland.

²⁷ See www.unaids.org/sites/default/files/media_asset/prevaling-against-pandemics_en.pdf, p. 32.

in the global South excluded from accessing COVID-19 vaccines, while developed countries protect their own nationals and the profit of pharmaceuticals, all hiding behind the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), unwilling to utilize the flexibility of its application and to enable low- and medium-income countries to scale up their own manufacturing, distribution and vaccination programmes.²⁸

III. Methodology

14. The present report is based on discussions held by the Special Rapporteur with right holders, civil society and other relevant stakeholders, including Member States, since the beginning of her mandate in August 2020; information continuously received on sexual and reproductive health rights, including on alleged violations of these rights; and communications sent to Member States and businesses in this regard.²⁹

15. The Special Rapporteur issued a call for written submissions, inviting relevant stakeholders, in particular Member States, international organizations and civil society, including medical practitioners and academics.³⁰ The Special Rapporteur thanks all those who contributed to the report.

16. Available literature and research materials on sexual and reproductive health rights and related issuances were used. Other sources included previous reports issued under the mandate.³¹

IV. Legal framework

17. Over the years, binding human rights treaties, jurisprudence and consensus outcome documents of international conferences have shed light on the content of sexual and reproductive rights.

18. In essence, sexual and reproductive rights include the right to a pleasurable, satisfying and safe sex life free from discrimination, coercion and violence; and the freedom to decide whether, when and how often to reproduce, as well as the right to have the information and means to make this decision, in addition to the right to

²⁸ Office of the United Nations High Commissioner for Human Rights, “UN experts: G7 Governments must ensure vaccines’ access in developing countries” (Geneva, 9 June 2021).

²⁹ Chile 4/2021 (and related to these: Brazil, 5/2021; China, 6/2021; Germany, 5/2021; United States of America, 22/2021; other, 194/2021; other, 195/2021; other, 196/2021; other, 197/2021; other, 198/2021; other, 199/2021); Colombia 1/2021; Argentina 4/2020; Brazil, 9/2020; El Salvador, 2/2020; United States of America, 11/2020; Slovakia, 1/2019 (and past communications related to the same topic: El Salvador, 3/2016; El Salvador, 2/2016; El Salvador, 1/2016; El Salvador, 1/2014; El Salvador, 1/2013; Poland, 1/2018).

³⁰ Submissions of stakeholders are available at www.ohchr.org/EN/Issues/Health/Pages/sexual-reproductive-health-covid.aspx.

³¹ See country visit reports: [A/HRC/47/28/Add.1](#) (Fiji, 2020), [A/HRC/41/34/Add.2](#) (Canada, 2018) [A/HRC/34/Add.1](#) (Kyrgyzstan, 2018) and [A/HRC/35/21/Add.2](#) (Croatia, 2016). See also thematic reports [A/HRC/32/32](#) on the right to health of adolescents (2016), [A/66/254](#) on the criminalization of sexual and reproductive health (2011), [A/HRC/14/20](#) on the criminalization of same-sex conduct and sexual orientation, sex work and HIV transmission (2010), [A/61/338](#) on the right to health and the reduction of maternal mortality (2006) and [E/CN.4/2004/49](#) on the right to sexual and reproductive health (2004).

sexual and reproductive health.³² The right to sexual and reproductive health is recognized in article 12 of the International Covenant on Economic, Social and Cultural Rights and regional instruments.³³ Sexual and reproductive rights are also grounded in the right to life, to dignity, to education and information, to equality before the law and non-discrimination; the right to decide on the number and spacing of children; the right to privacy; the right to health; the right to freedom of opinion and expression; the right to consent to marriage and equality in marriage; and the right to be free from gender-based violence, harmful practices and torture and ill treatment as well as the right to an effective remedy for violations of fundamental rights.³⁴

19. In 2016, the Committee on Economic, Social, and Cultural Rights clarified in general comment No. 22 that the right to sexual and reproductive health, as an integral part of the right to health, entails a set of freedoms and entitlements. Sexual and reproductive freedoms include “the right to control one’s health and body”³⁵ and “the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one’s body and sexual and reproductive health”.³⁶ The entitlements encompass unhindered access to a whole range of quality sexual and reproductive health facilities, services, goods, including essential medicines, and programmes that are available in adequate number, within safe physical and geographical reach, affordable for all and “respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender, age, disability, sexual diversity and life-cycle requirements”.³⁷

20. Sexual and reproductive health encompasses maternal health care; contraceptive information, goods and services; safe abortion care; and prevention, diagnosis and treatment of infertility, reproductive cancers, sexually transmitted infections and HIV/AIDS, including with generic medicines.³⁸ Entitlements include physical and mental health care for survivors of sexual and domestic violence in all situations, including access to post-exposure prevention, emergency contraception and safe abortion services and the availability of trained medical and professional personnel and skilled providers, as well as the right to evidence-based information on all aspects

³² Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 10; [A/66/254](#), para. 10; Programme of Action of the International Conference on Population and Development, United Nations publication (([A/CONF.171/13/Rev.1](#)), 1994, chap VII.A, paras. 7.2–7.3); Beijing Declaration and Platform for Action, 1995 (Platform for Action, paras. 30, 74, 83 (k) and 92–100); 2005 World Summit Outcome, para. 57 (g); and the commitment to taking steps to realize the right of everyone to both sexual and reproductive health in the outcome document of the High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (September 2010), para. 75 (a).

³³ See article 16 on the right to health of the African Charter on Human and Peoples’ Rights; article 14 of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa and its corresponding general comment No. 2 on sexual and reproductive health rights; and article 10 on the right to health of the Protocol of San Salvador to the Inter-American Convention on Human Rights.

³⁴ See articles 5, 10 (h), 11 (f), 12 and 16 of the Convention on the Elimination of All Forms of Discrimination against Women; articles 17, 23–25 and 27 of the Convention on the Rights of the Child; article 12 of the International Covenant on Economic, Social and Cultural Rights; articles 23 and 25 of the Convention on the Rights of Persons with Disabilities; and articles 2 (3), 3, 6, 7, 17 and 19 of the International Covenant on Civil and Political Rights. See also, Committee on Economic, Social and Cultural Rights, general comment No. 3 (1990), para. 5.

³⁵ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 8.

³⁶ Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 5. See submission by the Sexual Rights Initiative (SRI) on the increasing recognition by United Nations bodies of the right to bodily autonomy, p. 2.

³⁷ Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), paras. 15–21.

³⁸ *Ibid.*, paras. 5 and 45.

of sexual and reproductive health.³⁹ The Special Rapporteur emphasizes the importance of including hormonal treatment for older women and for persons with diverse gender identities, and gender affirming surgery and treatment, as well as of safeguarding the bodily integrity of children and adults with intersex traits and protection from harmful practices, including as related to and impacting on their autonomy and sexual and reproductive health rights.⁴⁰ In this regard:

“All individuals and groups should be able to enjoy equal access to the same range, quality and standard of sexual and reproductive health facilities, information, goods and services, and to exercise their rights to sexual and reproductive health without experiencing any discrimination.”⁴¹

21. Non-discrimination requires substantive equality as well, and thus the specific health needs and barriers faced by individuals or groups, women, girls, adolescents, lesbian, gay, bisexual, transgender and intersex persons, and persons with disabilities, and in particular those that experience multiple and intersectional forms of discrimination, must be addressed and differential treatment provided.

22. Under the right to sexual and reproductive health, States have three primary obligations. The obligation to respect requires that States “refrain from directly or indirectly interfering” with individuals’ exercise of this right, including through reforming laws that impede the right to sexual and reproductive health, such as “laws criminalizing abortion, non-disclosure of HIV status, exposure to and transmission of HIV, consensual sexual activities between adults and transgender identity or expression”.⁴² The obligation to protect in turn requires that States prevent third parties, such as private sector entities, from imposing barriers to the enjoyment of this right. The obligation to fulfil is the most proactive of the three obligations, requiring States to adopt measures to “ensure the full realization of the right to sexual and reproductive health”. The Committee on Economic, Social and Cultural Rights recognized that while the full realization of this right is achieved progressively over time, it also requires that certain steps be taken immediately (for example, to eliminate discrimination) and that retrogressive measures, such as revoking public funding for sexual and reproductive health, be avoided.

23. The Special Rapporteur recalls that States have clear legal obligations under current human rights standards to ensure respect for and protection and fulfilment of sexual and reproductive health rights in the midst of the COVID-19 pandemic. The Committee on the Elimination of Discrimination against Women has recognized sexual and reproductive health as entailing essential services and has stressed that States must continue to provide confidential access to gender-responsive sexual and reproductive health services, including maternity care, modern forms of contraception and safe abortion and post-abortion services, as part of their COVID-19 pandemic response.⁴³

³⁹ Ibid. paras. 18–19.

⁴⁰ See www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20739&LangID=E.

⁴¹ Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), paras. 7–9 and 22.

⁴² Ibid., para 40.

⁴³ Committee on the Elimination of Discrimination against Women guidance note on CEDAW and COVID-19, April 2020, Available at www.ohchr.org/EN/HRBodies/Pages/COVID-19-and-TreatyBodies.aspx.

V. Right to sexual and reproductive health: challenges and opportunities during the COVID-19 pandemic

24. The COVID-19 pandemic further thwarted the realization of sexual and reproductive health rights. In some parts of the world, health-care facilities are reported to have reduced or interrupted their provision of sexual and reproductive health rights-related services, while in other areas, service providers were redirected towards responding to the COVID-19 pandemic.⁴⁴ Even when countries classified sexual and reproductive health services as essential, barriers such as transportation and mobility bans prevented patients and providers from travelling to clinics, particularly at initial stages of the pandemic where exceptions for seeking emergency medical care were not in place. This affected patients' ability to protect their sexual and reproductive health, avoid unwanted pregnancies and prevent or manage HIV and other sexually transmitted infections and delayed access to screening for and treatment of reproductive cancers. While many innovative policies allowed for continuity of sexual and reproductive health services during the pandemic, persons already marginalized in society were often left out and experienced the worst harms, in particular persons in a persistent state of crisis owing to poverty or ongoing discrimination on multiple grounds including of race, ethnicity and other historical factors.

25. The impacts of policy, services and funding associated with specific aspects of sexual and reproductive health rights, both before and during the pandemic, including their impacts on the realization of those rights, are examined below.

A. Maternal, newborn and child health services

26. Access to high-quality and timely maternal, newborn and child health services is a right that States have a legal and moral duty to protect even in times of crisis.⁴⁵ As guaranteed in the Convention on the Elimination of All Forms of Discrimination against Women, States must provide access to appropriate services in connection with pregnancy, confinement and the postnatal period, which are free, where necessary, and include adequate nutrition during pregnancy and lactation.⁴⁶ Reducing maternal mortality and morbidity requires emergency obstetric treatment, emergency obstetric care and skilled birth attendance, including in rural and remote areas, and prevention of unsafe abortions, and post-partum care free from coercion, discrimination or violence.⁴⁷ Additionally, States must guarantee women in rural areas, "access to adequate health-care facilities, including information, counselling and services in family planning".⁴⁸ Under the right to health, States also have the obligation "to

⁴⁴ Taylor Riley and others, "Estimates of the potential impact of the COVID-19 pandemic on sexual and reproductive health in low- and middle-income countries", *International Perspectives on Sexual and Reproductive Health*, vol. 46 (Guttmacher Institute, 2020), pp. 73–76.

⁴⁵ See article 12 (2) of the Convention on the Elimination of All Forms of Discrimination against Women and article 12 (2) (a) of the International Covenant on Economic, Social and Cultural Rights. See also Committee on the Rights of the Child, general comment No. 20 (2016), para. 59; and Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 44 (a); the International Covenant on Economic, Social and Cultural Rights; the Programme of Action of the International Conference on Population and Development, paras. 8.12–8.27; and Office of the United Nations High Commissioner for Human Rights, "Maternal mortality and morbidity", information series on sexual and reproductive health and rights (2020).

⁴⁶ Convention on the Elimination of All Forms of Discrimination against Women, article 12 (2).

⁴⁷ Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 28. See also [A/HRC/21/22](#) (2012).

⁴⁸ Article 14 (b) of the Convention on the Elimination of All Forms of Discrimination against Women.

ensure reproductive, maternal (prenatal as well as postnatal) and child health care” and to “reduce maternal mortality and morbidity”.⁴⁹

27. Reducing maternal mortality and morbidity remains key to national and international commitments. Under the Sustainable Development Goals framework, States have agreed to reduce the maternal mortality ratio to less than 70 per 100,000 live births by 2030 (Sustainable Development Goal 3, targets 3.1 and 3.2). Still, in 2017, every day 810 women died from preventable causes related to pregnancy and childbirth. The Special Rapporteur would like to echo the United Nations High Commissioner for Human Rights in stressing that “deaths and grievous injuries sustained by women during pregnancy and childbirth are not inevitable events, but rather a direct result of discriminatory laws and practices, failures to establish and maintain functioning health systems and services, and a lack of accountability”.⁵⁰

Impact of the COVID-19 pandemic on maternal, newborn and child health

28. There is limited evidence on the impact of the COVID-19 pandemic on pregnancy and the newborn.⁵¹ According to UNFPA, maternal health services (pregnancy- and postnatal-related services) were to a certain extent guaranteed in a majority of countries, and there have been positive examples of State initiatives in this regard including the explicit recognition of the need for continuity of maternal health care and services by China and India through guidelines, and by Georgia and Tunisia through a formal declaration and ministerial circular, respectively.⁵² Similarly, other countries such as Mexico⁵³ have recognized maternal health care as an essential service. Guatemala adopted a COVID-19 pandemic guide for indigenous peoples recognizing the role of indigenous midwives and introducing an exception to curfew regulations to allow them to provide maternal and child health care.⁵⁴

29. However, as a result of restrictions on movement due to the pandemic, maternal and newborn health-care services have become less available, inaccessible or unaffordable for millions of women globally.⁵⁵ For example, in a study carried out for Bangladesh, Nigeria and South Africa between March and May 2020, it was noted that the uptake and utilization of maternal and newborn health-care services such as antenatal care, family planning and immunization were reduced.⁵⁶ Similar

⁴⁹ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 14 and 21. See also [A/61/338](#) (2006); Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999), para. 27; Programme of Action of the International Conference on Population and Development, paras. 8.21–8.25.

⁵⁰ [A/HRC/45/19](#).

⁵¹ See www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Maternity_Services_TB_Package_UPDATE_2_14072020_SBZ.pdf

⁵² See submission by United Nations Population Fund, pp. 2 and 4. Available at www.ohchr.org/EN/Issues/Health/Pages/sexual-reproductive-health-covid.aspx.

⁵³ See https://coronavirus.gob.mx/wp-content/uploads/2020/07/Lineamientos_Prevencion_COVID19_Embarazos_V2.pdf.

⁵⁴ See oacnudh.org.gt/images/CONTENIDOS/ARTICULOS/INFORMESANTERIORES/2020.pdf.

⁵⁵ Dorit Stein, Kevin Ward and Catherine Cantelmo, “Estimating the potential impact of COVID-19 on mothers and newborns in low- and middle-income countries” (2020), Health Policy Plus website.

⁵⁶ Tanvir Ahmed and others, “The effect of COVID-19 on maternal newborn and child health (MNCH) services in Bangladesh, Nigeria and South Africa: call for a contextualised pandemic response in LMICs”, *International Journal for Equity in Health*, vol. 20, No. 1 (15 March 2021), p. 77. Available at <https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-021-01414-5>.

developments were observed in several Eastern and Southern Africa countries.⁵⁷ During the lockdown in Zimbabwe, there was a marked decrease in the utilization of maternity services and access to programming for obstetric fistula (that is, access to repair surgery) was reduced.⁵⁸

30. Additionally, evidence gathered from four low- and middle-income countries, India, Indonesia, Nigeria and Pakistan, suggests that current approaches taken by most countries in addressing the pandemic are likely to result in a more than 30 per cent increase in maternal and newborn deaths.⁵⁹ An increase in maternal deaths had already been observed in other countries such as Mongolia and Nepal,⁶⁰ and in the Central and Latin American region, the COVID-19 pandemic became the main cause of death of pregnant women in Mexico (10.5), Peru (10.3), Bolivia (Plurinational State of) (10.1) and the Dominican Republic (9.2).⁶¹ In South Asia, the Lao People's Democratic Republic also reported an expected rise in maternal deaths due to the impact of the COVID-19 pandemic; and Myanmar and Nepal have already registered an increase, with Nepal reporting a 50 per cent increase during the first eight months of the pandemic.

31. According to findings by the Global Financing Facility, the number of women who made the recommended medical visits during pregnancy dropped by 18 per cent in Liberia and the initiation of women seeking medical care during pregnancy fell by 16 per cent in Nigeria. In the Democratic Republic of the Congo and Nigeria, an additional 1,280 and 6,700 maternal deaths, respectively, are expected to add to the respective 16,000 and 67,000 maternal deaths that already occur each year. The results of this research established that childhood vaccination was the service that was most disrupted among the countries studied.⁶²

32. Mistreatment, violence and obstetric violence directed against women in reproductive health services have been documented by human rights mechanisms.⁶³ Reports from Europe and Latin America indicate that the pandemic has only exacerbated this.⁶⁴

⁵⁷ UNFPA and UN-Women, "Impact of COVID-19 on gender equality and women's empowerment in East and Southern Africa", abridged version (Nairobi, UN Women East and Southern Africa Regional Office, March 2021), Available at https://esaro.unfpa.org/sites/default/files/pub-pdf/abridged_-_impact_of_covid19_on_gender_equality_and_women_empowerment_in_east_and_southern_africa.pdf.

⁵⁸ See www.amnesty.org/download/Documents/AFR4641122021ENGLISH.pdf, p. 15.

⁵⁹ Dorit Stein, Kevin Ward and Catherine Cantelmo, "Estimating the potential impact of COVID-19 on mothers and newborns in low- and middle-income countries" (2020), Health Policy Plus website. Available at www.healthpolicyplus.com/covid-mnh-impacts.cfm.

⁶⁰ See submission by UNFPA, p. 5. Available at www.ohchr.org/EN/Issues/Health/Pages/sexual-reproductive-health-covid.aspx.

⁶¹ See AvisoEpidemiologicoEmbarazo-COVID28enero12hrs.pdf (www.gob.mx/).

⁶² Global Financing Facility, "New findings confirm global disruptions in essential health services for women and children from COVID-19" (2020). Available at <https://www.globalfinancingfacility.org/new-findings-confirm-global-disruptions-essential-health-services-women-and-children-covid-19>.

⁶³ See [A/74/137](https://www.unhcr.org/refugees-and-migrants/2018/12/18/5c138200-138-2018); and decision adopted by the Committee on the Elimination of All Forms of Discrimination against Women under article 4 (2) (c) of the Optional Protocol, concerning communication No. 138/2018 ([CEDAW/C/75/D/138/2018](https://www.unhcr.org/refugees-and-migrants/2018/12/18/5c138200-138-2018)).

⁶⁴ See submission by El Parto es nuestro. See also <https://the-citizen.medium.com/obstetric-violence-in-latin-america-the-pandemic-only-made-things-worse-93c5031eee01>.

B. Family planning, contraception, including emergency contraception, and abortion

33. Access to family planning, contraception including emergency contraception, safe abortion services and post-abortion care is a component of the right to health and, in particular, the right to sexual and reproductive health.⁶⁵ The Convention on the Elimination of All Forms of Discrimination against Women guarantees women's rights in respect of deciding "freely and responsibly on the number and spacing of their children" and having "access to the information, education and means to enable them to exercise these rights".⁶⁶

34. Under Sustainable Development Goal 3, target 3.7, States shall by 2030 ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.⁶⁷ According to UNFPA, in 2021, 49 per cent of women aged 15–49 years worldwide, and 32 per cent in least developed countries, were using some type of method of contraception.⁶⁸

Impact of the COVID-19 pandemic on family planning and contraception

35. The COVID-19 pandemic exacerbated the typical barriers faced by adolescent girls with respect to access to sexual and reproductive health services: higher rates of unmet need for health services, greater social and logistic hurdles to accessing care and limited access to protective programmes, including legal services.

36. According to a survey carried out by the World Health Organization (WHO) across 105 countries, 90 per cent have experienced disruptions in health services, and 68 per cent in family planning services, as a result of the COVID-19 pandemic.⁶⁹ For instance, as a consequence of the COVID-19 pandemic, in Ecuador, family planning care decreased by 26.5 per cent⁷⁰ prenatal control by 45 per cent and access to contraception by 60 per cent.⁷¹

37. Twelve million women lost access to contraception, leading to 1.4 million unintended pregnancies, and disruptions remain a concern in light of limited data and some inconsistencies across countries requiring ongoing monitoring and analysis.⁷²

⁶⁵ International Covenant on Economic, Social and Cultural Rights, article 12 (2) (a); Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 14, and general comment No. 14 (2000), paras. 34–35; and Office of the United Nations High Commissioner for Human Rights, "Contraception and family planning", information series on sexual and reproductive health and rights (2020).

⁶⁶ Convention on the Elimination of All Forms of Discrimination against Women, article 16.

⁶⁷ United Nations, Department of Economic and Social Affairs, Population Division, *Family Planning and the 2030 Agenda for Sustainable Development*, data booklet (2019). Available at www.un.org/en/development/desa/population/publications/pdf/family/familyPlanning_DataBooklet_2019.pdf.

⁶⁸ UNFPA, World population dashboard (2021).

⁶⁹ See www.who.int/news/item/31-08-2020-in-who-global-pulse-survey-90-of-countries-report-disruptions-to-essential-health-services-since-covid-19-pandemic.

⁷⁰ Post-Disaster Needs Assessment PDNA 2020. Available at https://sni.gob.ec/documents/10180/4534845/Informe+Evaluaci%C3%B3n+Socio+Economica_PDNA.pdf/bf1ff6a4-4a67-4f5f-abab-5512f821d270.

⁷¹ See www.latinamerica.undp.org/content/rblac/en/home/climate-and-disaster-resilience/resilient-recovery/PDNA-and-CRNA-Assessments/Socioeconomic-Assessment-COVID-19-PDNA-Ecuador.html.

⁷² A/HRC/47/38. See also www.unfpa.org/news/one-year-pandemic-unfpa-estimates-12-million-women-have-seen-contraceptive-interruptions.

38. The WHO survey also revealed the disproportionate impact on women and youth, placing them at heightened direct and indirect risks of unintended pregnancy as a result of lockdowns, service disruptions, stockouts and financial hardships.⁷³ In El Salvador, the Ministry of Health recorded 258 pregnancies of girls, aged 10–14 years; and 6,577 pregnancies of girls and young women aged 15–19 years, from January to June 2020.⁷⁴

39. Available data suggest that the COVID-19 pandemic is having a direct impact on women's fertility intentions, with approximately 34 per cent of women in the United States of America reportedly either delaying pregnancy or choosing to have fewer children.⁷⁵ A similar pattern has also been recorded in Kenya, Burkina Faso and the Democratic Republic of the Congo where between 9 and 14 per cent of women have reportedly changed their minds about becoming pregnant owing to COVID-19 pandemic-related concerns, thereby highlighting the importance of family planning.⁷⁶

Abortion

40. Women, adolescents, girls and all persons capable of becoming pregnant have a right to make informed, free and responsible decisions concerning their reproduction, their body and sexual and reproductive health, free of discrimination, coercion and violence.⁷⁷ This right, which is anchored on the rights to bodily autonomy and self-determination, guarantees all persons capable of becoming pregnant meaningful control over whether or not to reproduce.⁷⁸ States "have a core obligation to ensure, at the very least, minimum essential levels of satisfaction of the right to sexual and reproductive health which includes measures to prevent unsafe abortion".⁷⁹ Safe and legal abortion is a necessary component of comprehensive health services.

41. In its general comment No. 36 (2018), the Human Rights Committee underscored the duty of States to provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl are at risk, and where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or is not viable. According to the Human Rights Committee, although States parties may adopt measures designed to regulate voluntary terminations of pregnancy, those measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the International Covenant on Civil and Political Rights.⁸⁰ The Committee buttressed this statement with the assertion that States parties should not regulate pregnancy or abortion in a manner that runs contrary to their duty to ensure

⁷³ Ibid.

⁷⁴ Instituto Salvadoreño para el Desarrollo de la Mujer (ISDEMU), *Informe sobre el estado y situación de la violencia contra las mujeres en El Salvador 2020*, p. 20.

⁷⁵ Laura D. Lindberg and others, "Early impacts of the COVID-19 pandemic: findings from the 2020 Guttmacher survey of reproductive health experiences" (June 2020). Available at www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health.

⁷⁶ PMA data: COVID-19 and PMA. Available at results dashboard (www.pmadata.org/technical-areas/covid-19).

⁷⁷ Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 5, and No. 14 (2000), para. 8; article 16 of the Convention on the Elimination of all Forms of Discrimination against Women; and Programme of Action of the International Conference on Population and Development (1994) (A/CONF.171/13/Rev.1), chap. VII. See also A/HRC/32/44 and A/HRC/47/38.

⁷⁸ Charles Ngwena and Ebenezer Durojaye, eds., *Strengthening the Protection of Sexual and Reproductive Health and Rights in the African Region Through Human Rights* (Pretoria, South Africa, Pretoria University Law Press (PULP), 2014), p. 263. See also www.ohchr.org/EN/Issues/Women/WGWomen/Pages/WomensAutonomyEqualityReproductiveHealth.aspx.

⁷⁹ Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 49.

⁸⁰ Human Rights Committee, general comment No. 36 (2011), para. 8.

that women and girls do not have to undertake unsafe abortions, and that they should revise their abortion laws accordingly.⁸¹

42. According to an analysis by the Center for Reproductive Rights, some 90 million women of reproductive age live in countries that do not permit abortion under any circumstances, including when the women's life or health is at risk.⁸² WHO has declared that the provision of safe comprehensive abortion care is a time-sensitive essential health service.⁸³

43. Some States have provided an enabling environment for accessing these services, while others have continued to create more barriers.⁸⁴ Several States have either imposed restrictions or reintroduced regulations and family planning practices or requirements that have made abortion, which is time-sensitive, more inaccessible.⁸⁵ While a number of States around the world have recognized sexual and reproductive health rights as essential services during the pandemic,⁸⁶ in Europe, Austria, Croatia, Germany and Romania have not⁸⁷ and 11 States in the United States of America have put forth the contrary view at some point during the pandemic.⁸⁸ Poland has taken steps to pass more regressive abortion legislation and to silence dissenting voices;⁸⁹ in Brazil, the Ministry of Health introduced compulsory reporting to police with respect to accessing abortion in cases of rape; and women in Italy and the Russian Federation have faced obstacles which restricted or delayed access to safe abortion.⁹⁰ At the same time, the introduction of telemedicine for abortion in Brazil, Ireland and the United Kingdom of Great Britain and Northern Ireland; the legalization of abortion in Argentina; the relaxation of regulations in France and Germany; and ad hoc measures in South Africa enabled greater access to safe and legal abortion in the midst of the pandemic.⁹¹ Recently, the United States Administration announced that it would not enforce the dispensing restrictions on medicines for abortion during the nationwide public health emergency.⁹²

⁸¹ Ibid.

⁸² According to the Center for Reproductive Rights these include Andorra, Congo (Brazzaville), Dominican Republic, Egypt, El Salvador, Haiti, Honduras, Iraq, Jamaica, Lao People's Democratic Republic, Madagascar, Malta, Mauritania, Nicaragua, Palau, Philippines, San Marino, Senegal, Sierra Leone, Suriname and Tonga. Abortion is also prohibited on all grounds in Aruba, Curaçao and the West Bank. See https://oltem1bixlohb0d4busw018c-wpengine.netdna-ssl.com/wp-content/uploads/2019/05/WALM_2021update_V1-1.pdf.

⁸³ World Health Organization, *Maintaining Essential Health Services: Operational Guidance for the COVID-19 Context - Interim Guidance, 1 June 2020*, pp. 29–30). See also World Health Organization, United Nations Population Fund and United Nations Children's Fund, "Continuing essential sexual, reproductive, maternal, neonatal, child and adolescent health services during COVID-19 pandemic: operational guidance for South and South-East Asia and Pacific regions", 2020.

⁸⁴ Elizabeth Chloe Romanis and Jordan A. Parsons, "Legal and policy responses to the delivery of abortion care during COVID-19" (15 September 2020). See <https://doi-org.uplib.idm.oclc.org/10.1002/ijgo>.

⁸⁵ Ibid.

⁸⁶ See www.partners-popdev.org/wp-content/uploads/2020/05/Joint-Press-Statement-052020..pdf.

⁸⁷ Ibid.

⁸⁸ Alabama, United States of America, November 2020. See also submission by Plan International, p. 2.

⁸⁹ See www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26434&LangID=. See also submission of Plan International, p. 2.

⁹⁰ See submissions by Clacai (pp. 5 and 18–19); Human Rights Watch, p. 2; AWID, pp. 2–4; and Italy.

⁹¹ See submissions by MSI Reproductive Choices, p. 2; Brazil, pp. 2–3; and Argentina, pp. 3–5. Telemedicine for abortion is now being contested in Brazil. See submission by Anis and others.

⁹² See submission by Plan C.

C. Adolescent sexual and reproductive health

44. Adolescents have a right to express views on all matters related to health and sexuality, and to access free, confidential and adolescent-responsive sexual and reproductive health services, information and education available both online and in person.⁹³ “Lack of access to such services contributes to adolescent girls being the group most at risk of dying or suffering serious or lifelong injuries in pregnancy and childbirth.”⁹⁴ Health services for adolescents should include HIV-related information, testing, diagnostics, care and treatment; and information on contraception and the use of condoms, as well as safe abortion and post-abortion.⁹⁵

45. The Committee on the Rights of the Child has clarified further that “there should be no barriers such as requirements for third-party consent or authorization” and that States should undertake efforts to overcome barriers of stigma attached to accessing these services by adolescent girls, adolescents with disabilities and LGBTIQ+ adolescents.

46. It is also important to eliminate abusive requirements as prerequisites for change of name, legal sex or gender, including forced, coerced or otherwise involuntary sterilization; medical procedures related to transition, including surgeries and hormonal therapies; undergoing medical diagnosis, psychological appraisals or other medical or psychosocial procedures or treatment; requirements relating to economic status, health status or marital, family or parental status; and any third-party opinion. This should extend to ensuring that a person’s criminal record, immigration status or other status is not used to prevent a change of name, legal sex or gender.⁹⁶

47. The Special Rapporteur emphasizes the importance of access to dignified gender affirming treatment for trans and gender-diverse children and adolescents, and the criticality of access to education and information in accessible formats, for adolescents with disabilities.

Impact of the COVID-19 pandemic on adolescent sexual and reproductive health

48. During the COVID-19 pandemic, a number of factors worsened adolescents’ already limited access to sexual and reproductive health rights.⁹⁷ Lockdown measures impact adolescents’ ability to travel to health facilities and have disrupted supply chains for contraception, further restricting adolescents’ access to sexual health information and care.⁹⁸ School closures have led to diminished access to interventions offered at school, such as menstrual education and provision of sanitary pads or comprehensive sexuality education, which was also forgotten in online education.⁹⁹ For instance, in Eastern and Southern Africa, girls (and women) have had limited access to or lacked sanitary hygiene during the pandemic.¹⁰⁰

⁹³ Committee on the Rights of the Child, general comment No. 20 (2016), paras. 23, 59 and 61.

See also [A/HRC/32/32](#).

⁹⁴ *Ibid.*, para. 59.

⁹⁵ *Ibid.*, paras. 60–63.

⁹⁶ See [A/73/152](#), para. 81 (b).

⁹⁷ Zara Ahmed, “COVID-19 could have devastating effects on adolescents’ sexual and reproductive health and rights” (Guttmacher Institute, June 2020). Available at www.guttmacher.org/article/2020/06/covid-19-could-have-devastating-effects-adolescents-sexual-and-reproductive-health.

⁹⁸ *Ibid.*

⁹⁹ See <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2770536>. See also submission by Plan International, p. 2.

¹⁰⁰ See https://esaro.unfpa.org/sites/default/files/pub-pdf/impact_of_covid-19_on_gender_equality_and_women_empowerment_in_east_and_southern_africa0704202101_1.pdf, p. 22.

49. For adolescent girls, conditions are even more adverse, especially in sub-Saharan Africa where many of them are at high risk of exposure to violence, early marriage, teenage pregnancy, sexual violence and exploitation, and female genital mutilation.¹⁰¹

50. The Special Rapporteur has previously noted the value of youth-centred digital health interventions to enable young people to address the many health challenges they may face as they transition to adulthood.

D. Comprehensive support for survivors of sexual and gender-based violence of all genders: prevention and response

51. Access to comprehensive physical and mental care for survivors of sexual and domestic violence of all genders is part of the full range of quality sexual and reproductive health care that States have the obligation to provide, including access to post-exposure prevention, emergency contraception and safe abortion services.¹⁰² The Committee on the Elimination of Discrimination against Women has recognized that this comprehensive support is also a form of reparation for survivors of gender-based violence, which constitutes a form of discrimination against women prohibited under customary law, and a violation of their rights, that may amount to torture or ill treatment, and in certain cases may constitute an international crime.¹⁰³

52. Despite global efforts to achieve gender equity and to eliminate all forms of violence against women and girls by 2030,¹⁰⁴ gender-based violence persists in all regions of the world and has intensified worldwide since the outbreak of the COVID-19 pandemic,¹⁰⁵ in particular in the Latin American region.¹⁰⁶ Submissions received in response to the call for inputs for this report, have also documented an increase of gender-based violence during the pandemic in countries in all regions of the world.¹⁰⁷ Lockdowns and other measures restricting the movement of people and increasing stress caused by security, health and money worries have increased the isolation of women and girls and placed them in abusive situations and at increased risk of control by their abusers and subjection to the restrictions their abusers impose. These measures have also resulted in lack of or restricted access to specialized services and support systems including women's shelters. In the Asia and Pacific region, 12 per cent of civil society organizations working towards eliminating violence against women completely suspended their services and 71 per cent are only partially operational".¹⁰⁸

53. An increase in sexual and gender- and sexuality-based violence stemming from the pandemic affects adolescents who are particularly vulnerable to intimate-partner violence. According to a survey conducted by the International Community of Women Living with HIV-Asia Pacific (ICWAP), with support from the UNAIDS Regional

¹⁰¹ Ibid.

¹⁰² Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 45.

¹⁰³ Committee on the Elimination of Discrimination against Women, general comment No. 35 (2017), paras. 1–2 and 18.

¹⁰⁴ Sustainable Development Goal 5, targets 5.2 and 5.3 (see <https://sdg-tracker.org/gender-equality>).

¹⁰⁵ See [issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf](#) (unwomen.org).

¹⁰⁶ Plan International, "Surge in violence against girls and women in Latin America and Caribbean". Available at plan-international.org. See also www.cepal.org/sites/default/files/publication/files/46422/S2000875_es.pdf.

¹⁰⁷ See submissions by ARROW, p. 8; GHJRU, p. 6; Elizka Relief Foundation, p. 4; Plan International, pp. 2–3; South Korean Civic Society; We Lead - Community of Action Facilitator in Lebanon, p. 2; and MSI UK Reproductive Choices, p. 5.

¹⁰⁸ United Nations Population Fund, *State of World Population 2021*. Report available at www.unfpa.org/sites/default/files/pub-pdf/SoWP2021_Report_-_EN_web.3.21_0.pdf, p. 127.

Support Team for Asia and the Pacific, in June 2020 almost 30 per cent of respondents had experienced some form of gender-based violence, including stigma and discrimination.¹⁰⁹

54. For LGBTIQ+ youth, who were in some instances already estranged or alienated from their families owing to discrimination and violence, lockdowns have proved especially challenging. Such youths now have no choice but to endure violence owing to their dependency on their families or experiences homelessness. Access to counselling services and shelters was already limited before the pandemic and the situation has worsened, leaving LGBTIQ+ youth destitute and vulnerable to more violence.

E. HIV/AIDS

55. Under the right to health, States must ensure HIV/AIDS prevention, treatment, care and support for children and adults; and discrimination in access to health care on the grounds of HIV/AIDS health status is proscribed.¹¹⁰

56. Since the start of the HIV/AIDS epidemic, about 77.5 million people have become infected, 34.7 million people have died and 37.6 million people globally were living with HIV/AIDS in 2020.¹¹¹

57. Biomedical methods of HIV/AIDS prevention, namely, HIV/AIDS treatment as prevention (TasP) and oral HIV pre-exposure prophylaxis (PrEP), hold out the promise of achieving HIV/AIDS epidemic control. Nevertheless, inequality remains an important driver of HIV infection. In countries practising criminalization, high levels of gender inequality and gender-based violence, including rape and child, early and forced marriage, place women, adolescents, LGBTIQ+ people and those in vulnerable situations at increased risk of HIV infection.

58. If the current legal and policy environments remain unchanged, ending the AIDS epidemic by 2030, as envisioned in the Agenda for Sustainable Development and the global commitment to fast-track the HIV response, will not be possible. It is essential that there be stronger investment in social enablers, community-led responses and human rights as strategies for enhancing the legal and policy environments, which in turn will contribute to HIV prevention efforts.¹¹²

Impact of the COVID-19 pandemic on HIV/AIDS

59. The Joint United Nations Programme on HIV/AIDS (UNAIDS) has documented the impact of COVID-19 pandemic-related lockdowns, travel restrictions, border closures and cutbacks and diversion of resources on persons with HIV and vulnerable and marginalized groups.¹¹³ HIV services have been disrupted and supply chains for key commodities have been stretched; HIV diagnoses and treatment initiations have been reduced and fewer people are starting antiretroviral therapy, although treatment

¹⁰⁹ See www.unaids.org/en/resources/presscentre/featurestories/2021/march/20210308_gender-inequalities-asia-pacific. See also submission by UNAIDS.

¹¹⁰ See International Covenant on Economic, Social and Cultural Rights, article 12 (2) (a); Human Rights Committee, general comment No. 14 (1984), paras. 16–18; and Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), paras. 13, 30 and 45.

¹¹¹ UNAIDS, “Global HIV and AIDS statistics”, fact sheet.

¹¹² M. Stacey and others, *Expanding Needs, Diminishing Means: Mapping of Trends in Funding Social Enablers in Southern and East Africa* (AIDS and Rights Alliance of Southern Africa (ARASA), 2020), p. 5.

¹¹³ See UNAIDS, *Prevailing against Pandemics by Putting People at the Center*, World AIDS Day Report 2020 (Geneva, November 2020), p. 10. Available at www.unaids.org/sites/default/files/media_asset/prevailing-against-pandemics_en.pdf. See also submission by UNAIDS.

retention has been better. It is estimated that 4 million people needing treatment have been left without.¹¹⁴ From the data reported to UNAIDS by countries, projections made indicate that “COVID-19-related disruptions may result in 123,000 to 293,000 additional HIV infections and 69,000 to 148,000 additional AIDS-related deaths globally”.¹¹⁵

60. Sub-Saharan Africa continues to bear the burden of HIV prevalence, and the COVID-19 pandemic has further exacerbated the situation, as evidenced by the reduction in HIV testing and in provisions of other services including life-saving medications.¹¹⁶ A report of the Global Fund to Fight AIDS, Tuberculosis and Malaria reveals that the COVID-19 pandemic is having a serious impact on health systems – particularly with respect to HIV, tuberculosis and malaria of countries in Africa and Asia. According to the report, HIV testing, prevention and care remain the worst affected by lockdowns and COVID-19-related restrictions. As nearly two thirds of the countries in Africa and Asia are experiencing one form of disruption or another.¹¹⁷

61. An online survey undertaken by UNAIDS of 2,300 people in 28 countries in Latin America and the Caribbean found that 7 in 10 respondents do not currently have enough antiretroviral medicines for a lockdown of more than 60 days and 56 per cent of respondents reported fear of HIV-related discrimination due to their living with HIV in the midst of the COVID-19 pandemic.¹¹⁸

F. Neglected diseases: reproductive cancers

62. Despite concerns related to shifting global health priorities during the COVID-19 pandemic, on 3 August 2020, the Seventy-third World Health Assembly adopted resolution WHA73.2, which paved the way for the launch of the Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem for the period 2020–2030, signifying the impact of advocacy efforts for sexual and reproductive health rights.

63. The Special Rapporteur underlines that cervical cancer is the fourth most common cancer in women worldwide, and regrets the lack of equitable access to human papilloma virus (HPV) vaccines in low- and middle-income countries.¹¹⁹ Ninety-five per cent of adolescent girls receiving HPV vaccine doses between 2006 and 2017 (an estimated 100 million) are in high-income countries.¹²⁰ Still, through an analysis of paediatric electronic health records in the United States, it was found that during the COVID-19 pandemic, from February to early April of 2020, HPV vaccinations declined by 68 per cent. This decline was greater than that observed for other paediatric vaccines.¹²¹ In Kenya, owing to COVID-19-related closures, 400,000 girls aged 10 years missed out on participation in the Government’s cervical cancer immunization programme offered in primary school.¹²² The latest data of WHO and the United Nations Children’s Fund (UNICEF) estimate that “improvements such as

¹¹⁴ UNAIDS, *Prevailing against Pandemics by Putting People at the Center*, p. 28.

¹¹⁵ *Ibid.*, p. 35.

¹¹⁶ Chris Beyer, “A pandemic anniversary: 40 years of HIV/AIDS”, *Lancet*, vol. 397, No. 10290 (5 June 2021), pp. 2142–2143. See also ARASA, “Impact of the COVID-19 national measures on community-led HIV responses in SADC” (2020), draft report.

¹¹⁷ *Ibid.*

¹¹⁸ See <http://onusidalac.org/1/images/infographic2-survey-ENG.pdf>.

¹¹⁹ A/HRC/47/29, paras. 105–106.

¹²⁰ See <https://ascopubs.org/doi/full/10.1200/GO.20.00504>.

¹²¹ Laura D. Lindberg, David L. Bell and Leslie M. Kantor, “The sexual and reproductive health of adolescents and young adults during the COVID-19 pandemic”, *Perspectives on Sexual and Reproductive Health*, vol. 52, No. 2 (Guttmacher Institute, June 2020), pp. 75–79. Available at <https://onlinelibrary.wiley.com/doi/full/10.1363/psrh.12151>.

¹²² Aggrey Omboki, “Kenya: Covid-19 hampers Kenya’s cervical cancer vaccination campaign”, *AllAfrica.com* (28 July 2020).

the expansion of the HPV vaccine to 106 countries” are at risk owing to the decline in vaccinations during the COVID-19 pandemic.¹²³

64. Adolescents mature into adults whose future right to health and good health outcomes are negatively impacted owing to historical and ongoing violations and lack of comprehensive and stigma-free services. Strengthening interventions like HPV vaccination for this age group, as well as screening and management even in times of health crises, will help create essential pathways towards routine integration of adolescents into the public health system.

G. Digital innovation and intervention: opportunities and risks

65. “Digital health” is a term used to cover diverse information and communications technologies used in health systems, ranging from mobile applications to health management information systems and beyond. Digital health should improve availability, accessibility, acceptability and quality of health services for all. These technologies should help meet the specific needs of diverse populations by providing access to information and services to people who might otherwise face barriers. Committee on Economic, Social and Cultural Rights general comment No. 14 emphasizes that health facilities, goods and services must be accessible to all, “especially the most vulnerable or marginalized”, without discrimination.¹²⁴ However, widespread social and political inequalities may create specific vulnerabilities in digital tools used in the area of sexual and reproductive health rights.

66. The global digital divide mirrors broader socioeconomic inequalities: gaps that exist between and within countries, between men and women, between generations, across social groups and between those with different levels of access to education. Owing to their reduced access to education and employment, women globally are less likely than men to use the Internet to download software or to engage online.¹²⁵ According to the global association of mobile operators, over 300 million fewer women than men access the Internet through a mobile phone. The gender gap is widest in South Asia, followed by sub-Saharan Africa.¹²⁶ The digital literacy of women is overall lower than that of their male counterparts.¹²⁷ As a result, girls are significantly less likely than boys to consider a career in tech.¹²⁸

67. To combat the digital gender divide, States Members of the United Nations have committed, under Sustainable Development Goal 5, to increasing access of women and girls to enabling technologies.

68. The Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance has highlighted examples of racial discrimination in the realm of emerging digital technologies.¹²⁹ One review found that in the area of health, the most widely used biomedical artificial intelligence technologies ignore sex

¹²³ World Health Organization, “WHO and UNICEF warn of a decline in vaccinations during COVID-19”, news release, 15 July 2020.

¹²⁴ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 12 (b).

¹²⁵ GSMA Connected Women, *The Mobile Gender Gap Report 2020* (March 2020). Available at www.gsma.com/mobilefordevelopment/wp-content/uploads/2020/05/GSMA-The-Mobile-Gender-Gap-Report-2020.pdf.

¹²⁶ Ibid.

¹²⁷ Organisation for Economic Co-operation and Development, *Bridging the Digital Gender Divide: Include, Upskill, Innovate* (2018). Available at www.oecd.org/digital/bridging-the-digital-gender-divide.pdf.

¹²⁸ Ibid.

¹²⁹ Human Rights Council, “Racial discrimination and emerging digital technologies: a human rights analysis” (A/HRC/44/57, 18 June 2020), report of the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance, para. 12.

and gender, and the ways in which those factors may shape health and disease differences.¹³⁰

69. Algorithmic biases may derive in part from biased data sets. Stigmatization and criminalization can create hidden populations, which are left uncounted in health data used to set priorities and design interventions, reinforcing existing forms of discrimination.¹³¹

70. Privacy International has found that young women have been targeted online by organizations that aimed at constraining their sexual and reproductive health choices.¹³²

71. On 18 December 2013, the General Assembly adopted resolution [68/167](#), in which it expressed deep concern at the negative impact that surveillance may have on the exercise and enjoyment of human rights. The Global Commission on HIV and the Law has raised concerns regarding expansive State surveillance and how online surveillance may undermine the trust needed in providing health information online.¹³³

72. Notwithstanding the above-mentioned concerns, digital health offers important positive opportunities to actively address and overcome social inequalities by empowering women and marginalized groups and addressing their real needs. A growing body of studies shows that mobile health can extend health service coverage in hard-to-reach areas, helping those groups that face difficulties in accessing the formal health system, including through offering sexual and reproductive health-related information via text messages, building trust and relationships with health providers, documenting rights violations and establishing peer networks for mutual support.

73. The Special Rapporteur has received information on a number of innovative initiatives supporting sexual and reproductive health rights during the pandemic.¹³⁴ The Safe Delivery smartphone application has been used in 40 countries worldwide, equipping midwives in low-resources settings to protect themselves, mothers and newborns.¹³⁵

H. Health funding, global support and philanthropy for sexual and reproductive health rights

74. Donor funding, from national Governments, multilateral donors (e.g., the Global Fund and UNFPA) and philanthropy, is a significant source of health

¹³⁰ David Cirillo and others, “Sex and gender differences and biases in artificial intelligence for biomedicine and healthcare”, *npj Digital Medicine*, vol. 3, No. 81 (1 June 2020). Available at <https://doi.org/10.1038/s41746-020-0288-5>.

¹³¹ Sara L.M. Davis, *The Uncounted: Politics of Data in Global Health* (Cambridge, United Kingdom, Cambridge University Press, 2020).

¹³² Privacy International, “How anti-abortion activism is exploiting data”. Available at <https://privacyinternational.org/long-read/3096/how-anti-abortion-activism-exploiting-data>.

¹³³ Global Commission on HIV and the Law, *Risks, Rights and Health*, Supplement (July 2018), p. 23. Available at https://hivlawcommission.org/wp-content/uploads/2020/06/Hiv-and-the-Law-supplement_EN_2020.pdf.

¹³⁴ See submissions at www.ohchr.org/EN/Issues/Health/Pages/sexual-reproductive-health-covid.aspx.

¹³⁵ This was developed in partnership with Maternity Foundation, Plan International, University of Copenhagen, Laerdal Global Health and UNFPA. See submission by Plan International, p. 6.

financing, accounting for an average of 30 per cent of health spending in low-income countries and over half of the health spending of four low-income countries.¹³⁶

75. In 2019, official development assistance (ODA) for the realization of sexual and reproductive health rights amounted to US\$ 7.9 billion, down from an all-time high of US\$ 11.3 billion in 2017.¹³⁷ Donor funding for sexual and reproductive health rights as an overall portion of health funding has also declined, with donors allocating 42 per cent of donated health funds for sexual and reproductive health rights in 2017, compared with 52 per cent in 2011.¹³⁸ In 2019, experts predicted that donor investments in sexual and reproductive health rights would continue to stagnate owing to slowing global economic growth and competing priorities such as climate change and needs of other sectors.¹³⁹ The COVID-19 pandemic has only further threatened sexual and reproductive health rights funding with the redirection of funds to the pandemic response and recovery.

Challenges: donor funding for sexual and reproductive health rights

76. Even before the COVID-19 pandemic, there was a high level of unmet need for sexual and reproductive health services. In 2019, an estimated 218 million women of reproductive age in low- and middle-income countries had an unmet need for contraception.¹⁴⁰ Tens of millions of persons give birth every year without access to adequate pregnancy-related and newborn care.¹⁴¹ It is estimated that during the COVID-19 pandemic, tens of millions of women – largely those among the world’s poorest and most vulnerable – lost access to family planning supplies and services,¹⁴² The two world subregions accounting for the highest level of unmet need for sexual and reproductive health rights-related services are sub-Saharan Africa and South Asia.¹⁴³

77. Reliance on donor funding for sexual and reproductive health services in low- and middle-income countries imperils the achievement of sexual and reproductive health rights. There is a need to de-colonize aid. The amount of funding is highly dependent on political agendas, a neo-colonialist trend, and funding levels can vary

¹³⁶ Partnership for Maternal, Newborn, and Child Health, “Funding for sexual and reproductive health and rights in Low- and middle-income countries: threats, outlook and opportunities” (Geneva, 23 December 2019). Available at www.who.int/pmnch/media/news/2019/srhr_forecast_web.pdf?ua=1. See also World Health Organization, *New Perspectives on Global Health Spending for Universal Health Coverage*, Global report (Geneva, 2017). Available at <http://apps.who.int/iris/bitstream/handle/10665/259632/WHO-HIS-HGF-HFWorkingPaper-17.10-eng.pdf?ua=1>.

¹³⁷ Kalila Jaeger and Zoe Johnson, “Generation equality? trends from a decade of donor Funding for SRHR”, Donor Tracker (1 March 2021). Available at <https://donortracker.org/insights/generation-equality-trends-decade-donor-funding-srhr>.

¹³⁸ Ibid.

¹³⁹ Partnership for Maternal, Newborn, and Child Health, “Funding for sexual and reproductive health and rights in low- and middle-income countries: threats, outlook and opportunities” (Geneva, 23 December 2019). Available at www.who.int/pmnch/media/news/2019/srhr_forecast_web.pdf?ua=1.

¹⁴⁰ Elizabeth Sully and others, *Adding It Up: Investing in Sexual and Reproductive Health 2019* (New York, Guttmacher Institute, July 2020). Available at www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health-2019#.

¹⁴¹ Ibid.

¹⁴² United Nations, Department of Economic and Social Affairs, “Impact of COVID-19 on SDG progress: a statistical perspective”, UN/DESA Policy Brief No. 81 (27 August 2020). Available at www.un.org/development/desa/dpad/publication/un-desa-policy-brief-81-impact-of-covid-19-on-sdg-progress-a-statistical-perspective/.

¹⁴³ Elizabeth Sully and others, *Adding It Up: Investing in Sexual and Reproductive Health 2019* (New York, Guttmacher Institute, July 2020). Available at www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health-2019#.

substantially from year to year. Further, the ways in which sexual and reproductive health rights-related funds are spent is largely determined by funders' priorities rather than by the needs of recipient countries and organizations. An event like the COVID-19 pandemic can drastically increase the need for sexual and reproductive health rights funding, while at the same time driving donors to redirect funds elsewhere to back the emergency response.

78. The United Kingdom reduced international development spending from 0.7 to 0.5 per cent of gross national income (GNI), representing a cut of 4 billion pounds, 40 per cent in the area of health. This decision had a direct impact on aid to UNFPA and its country offices and to the Women's Integrated Sexual Health programme of the International Planned Parenthood Federation and will cause disruptions in the area of sexual and reproductive health services.¹⁴⁴

VI. Conclusions and recommendations

79. **The COVID-19 pandemic deepened the cracks in health systems, particularly with respect to those services important for affirming and realizing sexual and reproductive health rights. Many national responses to the COVID-19 pandemic demanded policy change, innovation and agility, and in some regions, this has resulted in a demonstration of the ability to enable the delivery of health care while upholding human rights. Where rights must be limited under exigent circumstances, such limitations must be in accordance with international human rights law, which requires that measures be strictly necessary, proportionate, reasonable and the least restrictive available.¹⁴⁵ As policy changes during emergencies often become incorporated in long-standing, non-emergency law, it is critical that policy changes be examined during this pandemic for their impact on equality and equitable access to sexual and reproductive health rights moving forward.**

80. **The Special Rapporteur views the practice of medicine as in itself a tool for the promotion of human rights and thus health-care workers are key to changing the patriarchal and paternalistic systems of medical practice.**

81. **Much of the discrimination faced by women and girls in relation to their sexual and reproductive health rights can be ascribed to the instrumentalization and politicization of their bodies.**

82. **The Special Rapporteur observes a global patriarchal culture, a regressive climate and pushback in the area of sexual and reproductive health rights and opposition to gender equality. Gains made in the past decades in these areas are at risk of being rolled back, with the rights and perspectives of women, girls and LGBTIQ+ persons sidelined.**

83. **While adolescents themselves have the capacity to contribute to their own health and well-being, they can achieve this goal only if States respect and protect their rights.**

¹⁴⁴ See submission by MSI UK Reproductive Choices, p. 6.

¹⁴⁵ Office of the United Nations High Commissioner for Human Rights, "UN human rights treaty bodies call for human rights approach in fighting COVID-19", Geneva, 24 March 2020; R. Rima Jolivet and others., "Upholding rights under COVID-19: the respectful maternity care charter", *Health and Human Rights Journal*, vol. 22, No. 1 (June 2020), available at www.hhrjournal.org/2020/05/upholding-rights-under-covid-19-the-respectful-maternity-care-charter; Andrea Boggio and others., "Limitations on human rights: are they justifiable to reduce the burden of TB in the era of MDR- and XDR-TB?" *Health and Human Rights Journal*, vol. 10, No. 2 (December 2008), pp.121–126.

84. The Special Rapporteur reminds States that they need to provide them with access to the necessary conditions, services and information.¹⁴⁶ However, beyond sheer survival, children have a right to thrive, develop holistically to their full potential and enjoy good physical and mental health in a sustainable world.¹⁴⁷
85. The contemporary landscape of health financing is characterized by persistent deficits and recurring challenges in financing health systems throughout the world.¹⁴⁸ While domestic health spending in low- and middle-income countries is rising, it is likely that those countries will continue to rely heavily on donor funding for sexual and reproductive health rights through the near future.¹⁴⁹
86. The Special Rapporteur recommends that States strive to be less dependent on donor aid in order to meet their obligations.
87. The Special Rapporteur recommends that biomedical artificial intelligence (AI) technologies must not perpetuate racism, sexism, ableism or discrimination based on sexual orientation or gender. States must eliminate social and political inequalities in order to bridge the gendered digital divide, taking into account the needs of people with disabilities, which includes offering protections from discrimination and violence related to utilization of digital tools and technology.
88. The adoption of innovation and technology can be a tool for advancing substantive equality.
89. The Special Rapporteur underscores that: “Civil society plays a key role as agent of change. Trustful partnerships between government agencies, State-run health-care services and the non-profit sector, including civil society, constitute one of the cornerstones of effective health systems and act as a guarantee for the effective realization of health-related human rights.”¹⁵⁰
90. The Special Rapporteur recommends that States respect and protect key principles of non-discrimination, equality and privacy, as well as the integrity, autonomy, dignity and well-being of individuals, especially in relation to sexual and reproductive health rights.

¹⁴⁶ A/HRC/32/32 (2016).

¹⁴⁷ See www.ohchr.org/EN/Issues/Health/Pages/GroupsInVulnerableSituations.aspx.

¹⁴⁸ A/67/302 (2012).

¹⁴⁹ Partnership for Maternal, Newborn, and Child Health, “Funding for sexual and reproductive health and rights in low- and middle-income countries: threats, outlook and opportunities” (Geneva, 23 December 2019). Available at www.who.int/pmnch/media/news/2019/srhr_forecast_web.pdf?ua=1.

¹⁵⁰ A/HRC/29/33 (2015).