

# Women's Rights to Reproductive and Sexual Health in a Global Context

Joanna N. Erdman, BA, JD, LLM<sup>1</sup> Rebecca J. Cook, AB, MA, MPA, JD, LLM, JSD<sup>2</sup>

<sup>1</sup>Research Associate, Faculty of Law, University of Toronto, Toronto ON

<sup>2</sup>Faculty of Law, Faculty of Medicine and The Centre for Research in Women's Health, University of Toronto, Toronto ON

## Abstract

The worldwide burden of reproductive and sexual ill-health falls disproportionately on women belonging to vulnerable and disadvantaged groups. Women's rights to reproductive and sexual health, as protected under national constitutions as well as regional and international human rights treaties, require that health systems account for the distinctive needs and circumstances both of and among women. The purpose of this article is to investigate what we can do as advocates to ensure that the reproductive and sexual health rights of all women are respected, protected, and enforced, both internationally and in Canada.

## Résumé

Le fardeau que représentent les problèmes de santé sexuelle et génésique dans le monde accable principalement les femmes appartenant à des groupes vulnérables et défavorisés. Les droits des femmes en matière de santé sexuelle et génésique, protégés en vertu de constitutions nationales et de traités régionaux et internationaux sur les droits de la personne, ne peuvent être respectés que si les systèmes de santé tiennent compte de la situation et des besoins particuliers des femmes. L'objectif du présent article est d'étudier les diverses mesures pouvant être prises sur le plan de la défense des droits afin de s'assurer que les droits sexuels et génésiques de toutes les femmes sont respectés, protégés et observés, au Canada comme à l'étranger.

J Obstet Gynaecol Can 2006;28(11):991-997

## INTRODUCTION

Women's reproductive and sexual health is more than a matter of health policy. It is a human right. Women enjoy the right to decide freely and responsibly matters concerning their reproductive and sexual health, the right to the information and means needed to make those decisions, and the right to make decisions without discrimination, coercion, or violence.<sup>1</sup> Moreover, women's right to

reproductive and sexual health is enforceable through regional and international human rights treaties, including the Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention).<sup>2</sup> Canada and other member states are legally obligated to respect, protect, and ensure women's rights to the highest attainable standard of health throughout their lives.

We have made much progress in the promotion and protection of women's rights to reproductive and sexual health. Progress has been slow, however, where it is most needed.

The worldwide burden of reproductive and sexual ill-health falls disproportionately on women least able to bear its consequences. The distinctive needs of women facing multiple and compounding forms of discrimination, structural poverty, and violence are too often ignored. In its General Recommendation 24 on Women and Health, the Committee on the Elimination of Discrimination against Women (CEDAW) requires that special attention be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups.<sup>3</sup>

Women enjoy the right to more than health services. Women are entitled to the social, economic, and political conditions that will allow them access to services. The right to sexual and reproductive health requires that health systems account for the distinctive needs and circumstances both of and among women. The purpose of this article is to investigate what we can do internationally and in Canada to ensure that the rights of all women to reproductive and sexual health are respected, protected, and enforced.

The article focuses on the distinctive needs of poor and low-income women, adolescent and young women, indigenous, ethnic, and racialized women, women living with HIV/AIDS, and women subjected to violence. We recognize that such groups are themselves diverse and that many women are members of more than one group.

**Key Words:** Human rights, reproductive and sexual health, international, constitutional

Competing Interests: None declared.

Received on May 23, 2006

Accepted on June 14, 2006

## **THE RIGHTS OF POOR AND LOW-INCOME WOMEN**

The right to enjoyment of the highest attainable standard of health under the International Covenant on Economic, Social and Cultural Rights<sup>4</sup> requires that health care services are affordable for all, including socially disadvantaged groups.<sup>5</sup> Women often face significant economic barriers to care. In 2004, the World Bank reported that, on average, a country's wealthiest women are four times more likely than the poorest to use contraception.<sup>6</sup>

Legal restrictions on abortion services disproportionately affect poor and low-income women. In Northern Ireland, abortion is a criminal offence except where necessary to protect the life or health of the pregnant woman.<sup>7</sup> Given that no guidelines indicate when the exception applies, physicians and hospitals are often unwilling to perform any abortion. Every year, thousands of women are forced to travel to other parts of the United Kingdom to receive care. Ineligible for public funding, women must pay £500 to £1200 in medical fees and travel expenses. Abortion services are thus accessible only at a great financial cost. For low-income women or women living on social assistance, abortion services are effectively unavailable. In 2004, the Court of Appeal of Northern Ireland held the government legally accountable for its failure to ensure that integrated health and personal social services were available for women entitled to lawful abortions.<sup>8</sup> The government was required to investigate and issue guidelines on the availability of legal abortions.

Canadian women's access to legal abortion services is similarly impeded by economic barriers. First-trimester abortion services are unavailable in Prince Edward Island and Nunavut. Women must travel interprovincially to receive care. Because of limitations on reciprocal billing arrangements, not all services received outside a woman's province of residence are publicly funded.<sup>9,10</sup> Moreover, neither Quebec nor New Brunswick publicly funds the full costs of clinic abortions. Although Manitoba began insuring clinic services in July 2004, a regulation remains in force excluding the service from public coverage.<sup>11</sup> In 2004, the Court of Queen's Bench of Manitoba held that the failure to fund clinic abortions violated women's freedom of conscience and religion, their right to life, liberty, and security of the person, and their equality rights under Canadian Charter of Rights and Freedoms.<sup>12</sup> Although the case was returned for trial, the judgement is significant insofar as it recognizes an obligation of government to ensure that women have access to the resources necessary to meaningfully exercise their reproductive rights. Similar challenges are currently pending against the governments of Quebec and New Brunswick.

Given the increasing inaccessibility of surgical abortions in Canada, the approval of mifepristone and misoprostol for use in medication abortions could significantly improve women's access to timely and affordable care.<sup>13</sup> In 2004, the Royal College of Obstetricians and Gynaecologists in the United Kingdom advised that "Medical abortion using mifepristone plus prostaglandin is the most effective method of abortion at gestations of less than 7 weeks."<sup>14</sup>

## **THE RIGHTS OF ABORIGINAL, ETHNIC, AND RACIALIZED WOMEN**

The International Convention on the Elimination of All Forms of Racial Discrimination<sup>15</sup> guarantees the right to medical care, social security, and social services without discrimination on the basis of race, colour, descent, or national or ethnic origin. Nevertheless, compared with the general population, indigenous, ethnic, and racialized women experience higher rates of infant and maternal mortality and are more vulnerable to HIV/AIDS, sexual abuse, and violence.<sup>16</sup> In its 2005 Resolution on the Elimination of Violence Against Women, the UN Commission on Human Rights calls upon states to address "the specific circumstances facing indigenous women and girls in relation to gender-based violence, especially sexual violence, arising from multiple, intersecting and aggravated forms of discrimination, including racism, paying particular attention to the structural causes of violence."<sup>17</sup>

The health of Canadian indigenous women is in a state of crisis.<sup>18</sup> Death caused by cervical cancer is six times the national average for First Nations women in British Columbia, and three times as common among Inuit women in Nunavik.<sup>19</sup> Indigenous women suffer from higher rates of sexually transmitted diseases (STDs) such as chlamydia and gonorrhoea, sometimes up to 10 times higher than the national average.<sup>20</sup> The proportion of Aboriginal women among adult AIDS cases is almost twice that of non-Aboriginal women.<sup>21</sup> New HIV infections among indigenous women have increased over the past twenty years, making up 50% of new HIV cases, compared with only 16% in the non-indigenous population.<sup>22</sup>

In rural and northern areas, women must often travel away from their families and communities to receive abortion and birthing services.<sup>23</sup> Traditional Inuit midwifery, for example, has been replaced by nursing stations staffed by health professionals who are not Inuit.<sup>24</sup> In 2003, CEDAW advised Canada to accelerate its efforts to eliminate discrimination against Aboriginal women, particularly with respect to equal rights to physical and psychological well-being.<sup>25</sup>

Members of minority ethnic and racial groups are also particularly vulnerable to forced sterilization and other coercive measures.<sup>26</sup> CEDAW's General Recommendation 19

on Violence against Women calls on member states "to ensure that measures are taken to prevent coercion in regard to fertility and reproduction."<sup>27</sup> In 2003, an NGO report documented the coercive sterilization and extensive racism, verbal and physical, suffered by Roma women in Slovakia.<sup>28</sup>

In 2006, the report of the Committee on Elimination of Racial Discrimination praised the Mexican government's criminalization of forced sterilization but reiterated its concern regarding the forced sterilization of indigenous men and women in Chiapas, Guerrero, and Oaxaca. The government was encouraged to investigate and punish the perpetrators of such practices and to provide compensation for victims.<sup>29</sup>

### **THE RIGHTS OF ADOLESCENT AND YOUNG WOMEN**

Article 24 of the Convention on the Rights of the Child requires member states to ensure that "no child is deprived of his or her right of access to ... health care services."<sup>30</sup> Several countries have adopted policies to address adolescent reproductive health. In others, adolescents are misinformed about or denied access to reproductive and sexual health care.

Worldwide, 15 to 24-year-olds exhibit the highest reported rates of STDs. Up to 60% of all newly infected people and one half of all people living with HIV are in this age group.<sup>31</sup> In sub-Saharan Africa, young women are three times more likely than young men to be HIV positive.<sup>32</sup> In 2001, the UN General Assembly Special Session on HIV/AIDS recognized young persons as a priority group for prevention.<sup>33</sup> The persistence, and in some countries the increase, of teenage abortions and pregnancies further indicate that young women's needs for contraceptive services are unmet. More than 14 million women and girls under 20 give birth each year.<sup>34</sup> In Japan, the reported number of abortions performed on teenaged girls nearly doubled between 1995 and 2001.<sup>35</sup>

CEDAW observes that a lack of confidentiality "may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases where they have suffered sexual or physical violence."<sup>33</sup> This is particularly true for young and adolescent women. Emergency contraception (EC), for example, is a valuable preventative therapy for adolescent pregnancy. Girls aged 15 to 19 are more likely than older women not to plan intercourse and to use contraception intermittently or not at all.<sup>36,37</sup> Because of concerns about privacy and confidentiality, however, adolescents are

hesitant to seek EC. Adolescents fear judgement and parental notification.<sup>38-40</sup> Mandatory pharmacist consultation for EC, as currently required across Canada, is unlikely to lessen adolescents' reluctance to seek care. Most pharmacies do not have areas where a pharmacist can hold a private discussion.<sup>41</sup> Recent studies indicate that pharmacists feel unprepared to address adolescent reproductive and sexual health concerns.<sup>42</sup> Even among pharmacists trained to provide EC, many reported inadequate training to deal with parental inquiries about the provision of EC to their children.<sup>10,43</sup>

Although the Convention on the Rights of the Child requires member states to respect the responsibilities, rights, and duties of parents in a manner consistent with the evolving capacities of the child,<sup>44</sup> access to abortion services is dependent on mandatory parental involvement in 24 countries worldwide.<sup>45</sup> In 43 states across the United States, laws deny adolescents access to abortion services without parental notification or consent. In 2004, the South African High Court confirmed that the provisions of the South African Choice on Termination of Pregnancy Act, 1996 allow pregnant women under the age of 18 to give their informed consent to abortion.<sup>46</sup>

In other circumstances, adolescent and young women require greater protection. In 2002, the UN General Assembly Special Session on Children affirmed that adolescent girls need special attention in policymaking and service provision.<sup>47</sup> The forced pregnancies of adolescent girls were the subject of two recent landmark legal developments. In October 2005, the UN Human Rights Committee held the government of Peru responsible for multiple violations of the United Nations International Covenant on Civil and Political Rights<sup>48</sup> for denying a 17-year-old a legal abortion despite the diagnosis of an anencephalic fetus. The young woman was compelled to carry the fetus to term and to breast feed it until its predictable death several days later. In addition to other violations, the Committee held Peru responsible for failing to provide measures of health protection required by the young woman's status as a minor.<sup>49</sup>

In 2002, a claim was filed against Mexico before the Inter-American Commission on Human Rights on behalf of a 13-year-old who became pregnant following a rape but was denied a legal abortion under the discretion of state officials.<sup>50</sup> A landmark settlement was reached in March 2006, under which the Mexican government agreed not only to provide compensation but also to issue a decree regulating guidelines for access to legal abortion. These cases confirm that under human rights law, governments are responsible, at a minimum, for requiring health care providers and facilities to ensure women's reasonable access to safe abortion and related services, as the law permits.

## **THE RIGHTS OF WOMEN LIVING WITH HIV/AIDS**

Women are twice as likely as men to contract HIV infection during vaginal intercourse.<sup>51</sup> Women's reproductive role and their subordinate position in some societies, especially with respect to sexual relations, render them at even greater risk. Approximately one half of the 40 million people living with HIV today are women.<sup>52</sup> The highest female infection rates are in countries where transmission is primarily heterosexual, often in the context of marriage.<sup>53</sup> For this reason, CEDAW encourages governments to give special attention to the rights and needs of women in their programs to combat AIDS.

Women living with HIV/AIDS enjoy the same rights as all other women to engage in sexual relations, to have access to contraceptive and abortion services without coercion, and to become mothers. Reproductive and sexual health services should be delivered in a manner responsive to the particular needs of women living with HIV/AIDS to allow them to exercise these rights responsibly and safely. The WHO estimates that 2.2 million HIV-positive women give birth each year.<sup>54</sup> Antiretroviral treatment can help safeguard a mother's health and well-being and prevent mother-to-child transmission. In 2002, the Constitutional Court of South Africa interpreted a constitutional right to access health care services as requiring the government to extend antiretroviral treatment to mothers and children living with HIV/AIDS.<sup>55</sup> The following year, only 2% of pregnant women testing HIV-positive worldwide received antiretroviral drugs to improve their health.<sup>56</sup>

Respect for the rights of women living with HIV/AIDS to privacy, confidentiality, and non-discrimination in the provision of reproductive and sexual health care are vital. Hundreds of thousands of HIV-positive women avoid testing and treatment services for fear of disclosure to their husbands, families, and communities and the blame, abuse, and ostracism that often follow.<sup>57</sup> The Policy Guideline for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault developed by the South African Department of National Health affirms that survivors of sexual assault and pregnant women should be informed about the benefits of HIV/AIDS testing and treatment, but their right to refuse testing or treatment must be respected.<sup>58</sup>

Government prevention and treatment programs often disregard the needs of marginalized women affected by HIV/AIDS, such as sex workers and injection drug users. These women are stigmatized and discriminated against as vectors in the HIV/AIDS epidemic rather than being respected as individuals entitled to the protection of their sexual health rights. Although the 2005 Federal Initiative to Address HIV/AIDS in Canada recognizes the need to

develop discrete approaches to addressing the epidemic for people living with HIV/AIDS, sex workers are notably omitted from the initiative.<sup>59</sup>

## **THE RIGHTS OF WOMEN SUBJECTED TO VIOLENCE**

CEDAW regards gender-based violence as a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men.<sup>60</sup> Governments are obligated to eliminate all forms of violence against women in private and public life, whether perpetrated by the State or private persons. Nevertheless, gender-based violence remains an acute problem worldwide. It is perhaps the most widespread and socially tolerated violation of human rights.

It is estimated that one in five women worldwide will be a victim of rape or attempted rape in her lifetime. One in three women has been beaten, coerced into unwanted sexual relations, or sexually abused, often by a family member or acquaintance.<sup>61</sup> The consequences of rape and sexual violence account for approximately 5% of the global disease burden in women. Sexual coercion is considered a significant factor in the continuing rise of HIV among young women.

Unintended pregnancy, especially in adolescents, has been linked with coerced sexual intercourse. Nearly 50% of sexual assaults worldwide are perpetrated against girls 15 years of age or younger.<sup>62</sup> Moreover, women who are subject to domestic violence often cannot discuss infidelity or negotiate contraception to protect against pregnancy and sexually transmitted infections. Policies that fail to respect women's rights to autonomy and privacy in the seeking of contraception or other reproductive and sexual health services by requiring spousal authorization can further limit women's access to services.

Gender-based violence also contributes to higher abortion rates. Clinical studies in Hong Kong, China,<sup>63</sup> and Uganda<sup>64</sup> found that approximately 30% of women who had abortions reported abuse as the main reason for terminating their pregnancies. A 2005 Canadian study found that women who seek repeat abortions are more likely to report physical abuse by a male partner or a history of sexual abuse or violence.<sup>65</sup> Over the last decade, however, significant cuts have been made to abused women's community services and supports in many Canadian provinces.<sup>66</sup> SOGC guidelines on intimate partner violence encourage the development of coordinated and comprehensive health and social service provision.<sup>67</sup>

## CONCLUSION

The formal guarantees of international treaties, constitutional rights, and other legal entitlements cannot alone improve women's reproductive and sexual health. Political will is required. We must commit ourselves to ensure that laws, policies, and guidelines, both internationally and in Canada, respond to the distinctive needs and circumstances both of and among women. Health care professionals can play an important role in this regard. In May 2005, more than 50 participants, including obstetrician-gynaecologists, family physicians, nurses, family planning officers, and health inspectors, from 14 Caribbean countries adopted the Declaration of Health Professionals, Scientists and Advocates For Decriminalization of Abortion in the Caribbean. The declaration called for accountability of civil society and government to Caribbean women and to all strata of Caribbean societies by assuring access to sexual and reproductive health care, regardless of age, marital status, social class, or national origin.

We encourage health care providers and their professional associations to continue invoking human rights in their advocacy for better services, policies and guidelines respecting the reproductive and sexual health of all women, especially women belonging to vulnerable and disadvantaged groups.

## REFERENCES

- UN Population and Development. Programme of Action adopted at the International Conference on Population and Development, Cairo, Egypt, September 5–13, 1994. New York: United Nations, Department for Economic and Social Information and Policy Analysis, ST/ESA/SER.A/149; 1994. UN, Department of Public Information, Platform for Action and Beijing Declaration. Fourth World Conference on Women, Beijing, China, September 4–15, 1995. New York: UN; 1995.
- United Nations General Assembly. Convention on the Elimination of All Forms of Discrimination Against Women, adopted 18 December 1979, entered into force 3 September 1981. United Nations General Assembly Resolution 34/180. Ratification by Canada 10 December 1981.
- Committee for the Elimination of Discrimination Against Women, General Recommendation 24, Article 12, women and health, para 6. UN Division for the Advancement of Women. CEDAW/C/1999/1/W.G.II/WP.2/Rev.1. Available at: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#top>. Accessed: July 28, 2006.
- United Nations Treaty Series. 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976), ratification by Canada 19 August 1976.
- UN Committee on Economic, Social and Cultural Rights. General Comment 14, The right to the highest attainable standard of health: 04/07/2000, E/C.12/2000/4, para 12(b)(iii). Available at: [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument). Accessed: August 3, 2006.
- The World Bank. Round II country reports on health, nutrition and population among the poor and better off in 56 countries (2004). Available at: <http://www1.worldbank.org/prem/poverty/health/data/round2.htm>. Accessed: July 31, 2006.
- Offences Against the Person Act, 1861, amended in Great Britain by the Infant Life Preservation Act, 1929 and in Northern Ireland by the Criminal Justice (Northern Ireland) Act, 1945.
- Family Planning Association of Northern Ireland v. Minister for Health, Social Services and Public Safety, [2005] Northern Ireland Law Reports 188 (Court of Appeal).
- Rodgers S. Abortion denied: bearing the limits of law. In: Flood CM, ed. Just Medicare: what's in, what's out, how we decide. Toronto: University of Toronto Press; 2006: 107–36.
- Kouri RP. Achieving reproductive rights: access to emergency oral contraception and abortion in Quebec. In: Flood CM, ed. Just Medicare: what's in, what's out, how we decide. Toronto: University of Toronto Press; 2006: 168–92.
- Excluded Services Regulation 46/93, enacted pursuant to the Health Services Insurance Act C.C.S.M. c.H35.
- Jane Doe 1 v. Manitoba, [2004] M.J. No. 45.
- Limacher JJ, Daniel I, Isaacksz S, Payne GJ, Dunn S, Coyte PC. Early abortion in Ontario: options and costs. J Obstet Gynaecol Can 2006;28:142–8.
- Royal College of Obstetricians and Gynaecologists. The care of women requesting induced abortion. National Evidence-Based Clinical Guideline. London: Royal College of Obstetricians and Gynaecologists; 2004. Available at: <http://www.rcog.org.uk/index.asp?PageID=662>. Accessed: August 3, 2006.
- United Nations Treaty Series. 21 December 1965, 660 UNTS 195 at 216, 5 I.L.M. 352 (entered into force 4 January 1969, ratified by Canada 15 November 1970).
- United Nations. Report of the Secretary-General on the Preliminary Review by the Coordinator of the International Decade of the World's Indigenous People on the Activities of the United Nations System in Relation to the Decade (E/2004/82). New York: United Nations; 2004.
- UN Commission on Human Rights. Resolution on the elimination of violence against women, 61st Session, 20 April 2005, E.CN.4/RES/2005/41.
- Women's Environmental and Development Organization. Beijing betrayed: women worldwide report that governments have failed to turn the platform into action. New York: Women's Environment and Development Organization; 2005:154.
- Public Health Agency of Canada. Cervical cancer screening in Canada: 1998 surveillance report. Ottawa: PHAC;1998.
- Steenbeek A. Empowering health promotion: a holistic approach in preventing sexually transmitted infections among First Nations and Inuit adolescents in Canada. J Holist Nurs 2004; 22(3):254–66.
- Canadian Feminist Alliance for International Action. Canada's failure to act: women's inequality deepens. Submission of the Canadian Feminist Alliance for International Action to the United Nations Committee on the Elimination of Discrimination Against Women on the Occasion of the Committee's Review of Canada's 5th Report; 2003. Available at: <http://www.fafia-afai.org/proj/ce/CEDAWAltReportJan03En.doc>. Accessed: July 31, 2006.
- Prentice T. HIV/AIDS and Aboriginal women, children and families. Ottawa: The Canadian Aboriginal AIDS Network; 2004 3. Available at: [http://www.caan.ca/english/grfx/resources/publications/Women\\_and\\_HIV.pdf](http://www.caan.ca/english/grfx/resources/publications/Women_and_HIV.pdf). Accessed: July 31, 2006.
- Action Canada for Population and Development (ACPD) and Planned Parenthood Federation of Canada (PPFC). Report on Canada's compliance with the convention on the rights of the child in response to Canada's second periodic report to the Committee on the Rights of the Child. Ottawa: ACPD and PPFC; 2003.
- Smylie J, Aboriginal Health Issues Committee. A guide for health professionals working with Aboriginal people. SOGC Clinical Practice Guidelines, No. 100, January 2001. J Soc Obstet Gynaecol Can 2000;22:1070–81. Available at: <http://www.sogc.org/guidelines/public/100E-PS2-December2000.pdf> Accessed July 25, 2006.

25. United Nations General Assembly. United Nations Report of the Committee on the Elimination of Discrimination against Women. 28th Session 13–21 January 2003, General Assembly, Official Records, 58th Session, Supplement No 38 (A/58/380), 362, 56, 2003.
26. United Nations. Report of the Special Rapporteur on violence against women on policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women, E/CN.4/1999/68/Add.4. 21 January 1999: paras 52, 55.
27. Committee for the Elimination of Discrimination Against Women, General Recommendation 19, violence against women, para 24(m). UN Division for the Advancement of Women. CEDAW/C/1992/L.1/Add.15, para 24(m).
28. Center for Reproductive Rights. Body and soul: forced sterilization and other assaults on Roma reproductive freedom. CRR: New York; 2003.
29. United Nations Committee on the Elimination of Racial Discrimination. Periodic Report, Mexico, UN Doc. CERD/C/473/Add.1 (2006), para. 17.
30. 20 November 1989, Can. T.S. 1992 No. 3 (entered into force 2 September 1990, ratified by Canada 12 January 1992). Available at: <http://www.unhchr.ch/html/menu3/b/k2crc.htm>. Accessed: August 3, 2006.
31. Dehne KL, Riedner G. Sexually transmitted infections among adolescents: the need for adequate health services. Geneva, Switzerland: WHO; 2005.
32. UNAIDS. Report on the Global AIDS Epidemic 2004: 4th Global Report (UNAIDS/04.16E). Geneva, Switzerland: UNAIDS; 2004.
33. United Nations. Resolution Adopted by the General Assembly: S-26.2: Declaration of Commitment on HIV/AIDS (A/RES/S-26/2), paras 47, 53. New York: United Nations; 2001.
34. United Nations Population Fund (UNFPA). The state of world population 2004: the Cairo consensus at ten: population, reproductive health and the global effort to end poverty. New York: UNFPA; 2004:76. Available at: <http://www.unfpa.org/publications/detail.cfm?ID=197&filterListType=> Accessed: July 31, 2006.
35. Women's Environment and Development Organization (WEDO). Beijing betrayed: women worldwide report that governments have failed to turn the platform into action. New York: Women's Environment and Development Organization; 2005. Available at: [http://www.wedo.org/files/gmr\\_pdfs/gmr2005\\_asiapac.pdf](http://www.wedo.org/files/gmr_pdfs/gmr2005_asiapac.pdf). Accessed: July 31, 2006.
36. Lindberg CE. Emergency contraception for prevention of adolescent pregnancy. *MCN Am J Matern Child Nurs* 2003; 28(3):199–204.
37. Hillard PJ. Oral contraceptive non-compliance: the extent of the problem. *Adv Contracept* 1992;8(Suppl 1):1–13.
38. Kartoz CR. New options for teen pregnancy prevention. *MCN Am J Matern Child Nurs* 2004;29(1):30–5.
39. Reddy DA, Fleming R, Swain C. Effect of mandatory parental notification on adolescent girls' use of sexual health care services. *JAMA* 2002; 288 710.
40. Wilson KW, Klein JD. Health care and contraceptive use among adolescents reporting unwanted sexual intercourse. *Arch Pediatr Adolesc Med* 2002;156:4 341.
41. Erdman JN, Cook RJ. Protecting fairness in women's health: the case of emergency contraception. In Flood C, ed. *Just Medicare: what's in, what's out, how we decide*. Toronto: University of Toronto Press; 2006:137–67.
42. Sommers SD, Chaiyakunapruk N, Gardner JS, Winkler J. The emergency contraception collaborative prescribing experience in Washington state. *J Am Pharm Assoc (Wash)* 2001; 41(1):60–4.
43. Conard LAE, Fortenberry JD, Blythe MJ, Orr DP. Pharmacists' attitudes toward and practices with adolescents. *Arch Pediatr Adolesc Med* 2003;157(4):317–8.
44. 20 November 1989, Can. T.S. 1992 No. 3 (entered into force 2 September 1990, ratified by Canada 12 January 1992), at Article 5.
45. De Bruyn M, Packer S. Adolescents, unwanted pregnancy and abortion. Policies, counseling and clinical care. Chapel Hill: Ipas; 2004. Available at: [http://www.ipas.org/publications/en/ADOLPOL\\_E04\\_en.pdf](http://www.ipas.org/publications/en/ADOLPOL_E04_en.pdf). Accessed: July 28, 2006.
46. Christian Lawyers' Association v. National Minister of Health and Others 2004 (1) SA 509 (South African High Court), summarized in K. Isaacs, *Legal Grounds: Reproductive and Sexual Rights in African Commonwealth Courts*. New York and Toronto: Center for Reproductive Rights, University of Toronto; 2005:47–8. Available at: [http://www.reproductiverights.org/pub\\_bo\\_legalgrounds.html](http://www.reproductiverights.org/pub_bo_legalgrounds.html). Accessed: December 19, 2005.
47. United Nations General Assembly. Report of the Ad Hoc Committee of the Whole of the Twenty-Seventh Special Session of the General Assembly. Supplement No. 19 (A/S-27/19/Rev.1). New York: United Nations; 2002.
48. United Nations Treaty Series. 21 December 1966, 999 UNTS 171 (entered into force 23 March 1976, ratification by Canada 19 May 1976).
49. Karen Llontoy v. Peru. Human Rights Committee 85th Session. Case No. CCPR/C/85/D/1153/2003.
50. United Nations Treaty Series 22 November 1969, OAS Treaty Series No. 36, 1144 UNTS. 123 (entered into force July 18, 1978).
51. Comparison of female to male and male to female transmission of HIV in 563 stable couples. European Study Group on Heterosexual Transmission of HIV. *BMJ* 1992;304(6830):809–13.
52. United Nations Population Fund (UNFPA). State of world population 2005. The promise of equality: gender equity, reproductive health and the MDGs. New York: UNFPA; 2005: 37. Available at: [http://www.unfpa.org/swp/2005/pdf/en\\_swp05.pdf](http://www.unfpa.org/swp/2005/pdf/en_swp05.pdf). Accessed: July 31, 2006.
53. UN Millennium Project. Combating AIDS in the Developing World. London: Earthscan; 2005:22,32. Available at: <http://www.unmillenniumproject.org/documents/HIVAIDS-complete.pdf>. Accessed: July 31, 2006.
54. World Health Organization. World Health Report 2004. Geneva: WHO; 2004:13. Available at: [http://www.who.int/whr/2004/en/report04\\_en.pdf](http://www.who.int/whr/2004/en/report04_en.pdf). Accessed: July 19, 2006.
55. Minister of Health v Treatment Action Campaign 2002 (10) BCLR 1033 (Constitutional Court of South Africa).
56. Coverage of selected services for HIV/AIDS prevention, care, and support in low and middle income countries in 2003. Washington, DC: POLICY Project; 2004. Available at: <http://www.futuresgroup.com/Documents/CoverageSurveyReport.pdf>. Accessed: July 31, 2006.
57. Ogden J, Nyblade L. Common at its core: HIV-related stigma across contexts. Washington, DC: International Center for Research on Women; 2005. International Community of Women Living with HIV/AIDS. Visibility, voices and visions: a call for action from HIV positive women to policy makers. London: International Community of Women Living with HIV/AIDS; 2004.
58. Government of South Africa, Department of Health. Policy guideline for management of transmission of human immunodeficiency virus (HIV) and sexually transmitted infections in sexual assault. Government of South Africa; 2003. Available at: <http://www.doh.gov.za/search/index.html>. Accessed: July 31, 2006.
59. Canadian HIV/AIDS Legal Network. Sex, work, rights: reforming Canadian criminal laws on prostitution. Toronto: Canadian HIV/AIDS Legal Network; 2005. Available at: <http://www.aidslaw.ca/Maincontent/issues/sexwork/SWreport.pdf>. Accessed: July 26, 2006.
60. Committee for the Elimination of Discrimination Against Women. General Recommendation 19, violence against women, CEDAW/C/1992/L.1/Add.15.
61. UN Millennium Project. Taking action: achieving gender equality and empowering women. Task Force on Education and Gender Equality. London: Earthscan; 2005.

62. United Nations Population Fund (UNFPA). UNFPA and young people: imagine. New York: UNFPA; 2003. Available at: [http://www.unfpa.org/upload/lib\\_pub\\_file/582\\_filename\\_unfpa\\_and\\_young\\_people.pdf](http://www.unfpa.org/upload/lib_pub_file/582_filename_unfpa_and_young_people.pdf). Accessed, July 31, 2006.
63. Leung TW, Leung WC, Chan PL, Ho PC. A comparison of the prevalence of domestic violence between patients seeking termination of pregnancy and other gynecology patients. *Int J Gynaecol Obstet* 2002;77(1):47–54.
64. Kaye D. Domestic violence among women seeking post-abortion care. *Int J Gynaecol Obstet* 2003;75(3):323–5.
65. Fisher W, Singh SS, Shuper PA, Carey M, Otchet F, MacLane-Brine D, Dal Bello D. Characteristics of women undergoing repeat induced abortion. *CMAJ* 2005;172(5):637–41.
66. Morrow M, Hankivsky O, Varcoe C. Women and violence: the effects of dismantling the welfare state. *Critical Social Policy* 2004;24(3).
67. Cherniak D, Grant L, Mason R, Moore B, Pellizzari R; Social Sexual Issues Committee. Intimate partner violence consensus statement. SOGC Clinical Practice Guideline, No.157, April 2005. *J Obstet Gynaecol Can* 2005;27(4):365–388. Available at: <http://www.sogc.org/guidelines/public/157E-CP>.