

State obligations regarding sexual and reproductive health and rights and gender-based violence response during the COVID-19 pandemic

Reflections and lessons learned



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Introduction

Women and girls in the Asia-Pacific region have been disproportionately affected by the coronavirus disease 2019 (COVID-19) pandemic response, particularly with regard to their sexual and reproductive health and rights (SRHR) and access to gender-based violence (GBV) services. From 2020 to 2022, there was an increase in maternal mortality;¹ an increase in unmet need for family planning and contraception;² a reduction in access to human immunodeficiency virus (HIV) prevention methods, testing and treatment;³ and decreased access to GBV response services.⁴ The pandemic response compounded existing barriers to accessing SRHR and GBV services in the context of restrictions on freedom of movement and as health systems became overwhelmed. The effect was particularly profound for marginalized women and girls with multiple and intersecting forms of discrimination that interacted to exacerbate structural inequalities.

This research was commissioned to document state obligations regarding SRHR and GBV during the pandemic as part of our efforts to strengthen humanitarian preparedness and response going forward. The analysis focused on international normative guidance regarding the classification of essential services, challenges in accessing services and the continuity of service provision during the pandemic, and the strategies employed to adapt to the COVID-19 context. Human rights constitute a universal, normative and legally binding foundation to prevent, protect against and control public health threats, and a basis for equitable, accountable and effective public health and socioeconomic responses to COVID-19.⁵

This research has found that the **failure to classify appropriate SRHR and GBV services as essential, in line with international human rights law, has compounded challenges to accessing such services during the pandemic.** It is hoped that the lessons learned from this pandemic will foster improved preparedness and response going forward.

Defining sexual and reproductive health and rights

The Committee on Economic, Social and Cultural Rights, in General Comment No. 22 (2016) on the right to sexual and reproductive health, stated that the right to sexual and reproductive health entails a set of freedoms and entitlements:

The freedoms include 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. The entitlements include unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health under article 12 of the International Covenant on Economic, Social and Cultural Rights.⁶

The Committee noted that sexual health and reproductive health are distinct from each other but are closely linked to each other.

Sexual health and reproductive health are distinct from, but closely linked, to each other. Sexual health, as defined by the World Health Organization (WHO), is "a state of physical, emotional, mental and social well-being in relation to sexuality". Reproductive health, as described in the Programme of Action of the International Conference on Population and Development, concerns the capability to reproduce and the freedom to make informed, free and responsible decisions. It also includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behaviour.⁷

Moreover, Article 16 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) guarantees women equal rights in deciding "freely and responsibly on the number and spacing of their children and ... access to the information, education and means to enable them to exercise these rights". Article 10 of CEDAW also specifies that women's right to education includes "access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning".⁸

Understanding core sexual and reproductive health and rights obligations and essential services during an emergency

In October 2021, Tlaleng Mofokeng, the current United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, called on States "to respect and protect key principles of autonomy, bodily integrity, dignity and well-being of individuals, especially in relation to sexual and reproductive health rights".⁹ With regard to essential services, international human rights law provides that essential services must continue to be provided even in times of emergency and that certain SRHR and GBV response services should be classified as essential services, which would include:¹⁰

- guaranteed universal and equitable access to affordable, acceptable and high-quality sexual and reproductive health services, goods and facilities, in particular for women and disadvantaged and marginalized groups
- the enactment and enforcement of the legal prohibition of GBV, including domestic and sexual violence, and marital rape
- guaranteed access, for all individuals and groups, to comprehensive education and information on sexual and reproductive health that is non-discriminatory, unbiased and evidence based, and takes into account the evolving capacities of children and adolescents
- the provision of medicines, equipment and technology essential to sexual and reproductive health, based on the World Health Organization's Model Lists of Essential Medicines.¹¹

State obligations during the COVID-19 pandemic response

During humanitarian crises some international human rights treaties can allow for derogation, that is, they permit States to restrict some human rights during emergencies, but only where strictly necessary to address threats to “the life of the nation” or the “independence or security” of the State.¹² The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health reiterated in 2020 that it is essential that the measures adopted by States to combat the pandemic are in agreement with the **Siracusa Principles on the Limitation and Derogation Provisions** in the International Covenant on Civil and Political Rights (1984) and are therefore **time limited, reasonable, proportionate, non-discriminatory and grounded in law. This ensures that all human rights are protected, recognizing that human rights are indivisible and inalienable.**¹³

International human rights law: a lesson learned for future emergencies

In September 2020, the United Nations human rights treaty bodies provided a summary of what is expected of signatory States during the COVID-19 response.¹⁴ Each State party to a treaty has an obligation to take steps to ensure that everyone in the State can enjoy the rights set out in the treaty.¹⁵ For example, the Committee on Economic, Social and Cultural Rights reminded States that “measures must be necessary to combat the public health crisis posed by COVID-19, and be reasonable and proportionate. Emergency measures and powers adopted by States parties to address the pandemic should not be abused, and should be lifted as soon as they are no longer necessary for protecting public health.”¹⁶



| Obligation | Key points |
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| Treaty body: Committee on the Elimination of Discrimination against Women | |
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| <p>Obligation to provide sexual and reproductive health services as essential services</p> | <p>States parties must continue to provide gender-responsive sexual and reproductive health services, including maternity care, as part of their COVID-19 responses. Full consent to receive services must be guaranteed for women and girls at all times. Confidential access to sexual and reproductive health information and services, such as modern forms of contraception, toll-free hotlines and free and easy access to facilities such as online prescriptions, if necessary, free of charge.¹⁷</p> |
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| <p>Obligation to provide sexual and reproductive health services as essential services</p> | <p>The committee reminded States that during lockdowns women and girls were at increased risk of domestic, sexual, economic, psychological and other forms of GBV by abusive partners, family members and carers, especially in rural communities. States parties have an obligation to prevent and protect women from, and hold perpetrators accountable for, GBV against women.¹⁸</p> <p>Moreover, the committee, in its General Recommendation No. 35 (2017) on gender-based violence against women, affirmed that Article 2 of CEDAW provides that the overarching obligation of States parties is to pursue by all appropriate means and without delay a policy of eliminating discrimination against women, including GBV against women. Actions in line with this obligation must be carried out immediately; delays cannot be justified on any ground.</p> |
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| Treaty body: Human Rights Committee | |
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| <p>Article 19(2) of the International Covenant on Civil and Political Rights provides that “[e]veryone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds” (emphasis added). This right includes the freedom to seek, receive and impart information about SRHR.</p> | <p>States parties cannot resort to emergency powers or implement derogating measures in a manner that is discriminatory, or that violates other obligations they have undertaken under international law, including under other international human rights treaties from which no derogation is allowed.¹⁹</p> |
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| <p>Article 6 (right to life) and Article 7 (prohibition of torture or cruel, inhuman or degrading punishment, or of medical or scientific experimentation without consent) of the International Covenant on Civil and Political Rights</p> | <p>States parties cannot deviate from the non-derogable provisions of the covenant – for example, Article 6 (right to life) and Article 7 (prohibition of torture or cruel, inhuman or degrading punishment, or of medical or scientific experimentation without consent) – or from other rights that are essential for upholding the non-derogable rights found in the aforementioned provisions and for ensuring respect for the rule of law and the principle of legality even in times of public emergency. This includes the right of access to court, due process guarantees and the right of victims to obtain an effective remedy.²⁰</p> |
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Overview of findings

The United Nations Population Fund's Asia and the Pacific Regional Office, in partnership with the Asian Population and Development Association, reviewed SRHR and GBV laws, policies and implementation practices during the pandemic response²¹ in six countries in the Asia-Pacific region, namely Bangladesh, Fiji, India, Indonesia, Nepal and the Philippines. The United Nations Population Fund and the Asian Population and Development Association documented promising practices for increasing the availability, accessibility, acceptability and quality of essential SRHR and GBV services during the COVID-19 pandemic response.

The study focused on four thematic areas, namely maternal health; family planning and modern contraception; HIV and other sexually transmitted infection (STI) prevention, testing and treatment; and the GBV response.²²

To increase access to essential SRHR and GBV services, countries adapted to the COVID-19 context through a number of promising practices. These can be grouped into the following categories:

- classifying certain medications as well as SRHR and GBV services as essential
- ensuring the continuity of SRHR and GBV services through remote delivery, and peer-led and community-based service provision
- developing COVID-19-adapted guidelines for inclusive SRHR and GBV service provision, with virtual training on the guidelines for providers
- courts ordering the continuity of SRHR and GBV essential services
- ensuring SRHR and GBV service provision for those left behind, vulnerable groups and key populations.

The following sections summarize the normative international human rights law position in each thematic area, and provide an overview of challenges, promising practices and recommendations.

Maternal health



Fast facts: International human rights law and normative guidance on maternal health

- States have an immediate obligation to take deliberate, concrete and targeted steps towards fulfilling the right to health in the context of pregnancy and childbirth.²³ Lowering rates of maternal mortality and morbidity requires emergency obstetric care and skilled birth attendance, including in rural and remote areas.²⁴
- States are required to ensure the availability of maternal health services and equality in accessing health services: denying services that only women need is a form of discrimination.²⁵
- The Committee on Economic, Social and Cultural Rights, in its General Comment No. 14 (2000) on the right to the highest attainable standard of health (Article 12 of the covenant), states that the provision of maternal health services is a core obligation.²⁶
- States cannot, under any circumstances, justify their non-compliance with the core obligations, which are non-derogable.²⁷ This means that States must comply with the core obligations even in emergency situations, such as during pandemics. The committee reiterated this advice at the onset of the pandemic response in 2020.²⁸
- The obligations that States are under to prevent maternal mortality and morbidity are not subject to progressive realization but are of immediate effect.²⁹ This means that States must take immediate action rather than taking steps or action over a period of time.



Key findings

Reduced access to antenatal and postnatal care, and a reduction in the number of skilled birth attendants, during the pandemic led to **increased maternal mortality**.³⁰ The combination of lockdown measures, redeployment of midwives to other health services, lack of personal protective equipment (PPE), fear of infection, burnout, and other factors lead to the reduction in the number of skilled birth attendants during the pandemic.³¹

For example, in July 2021, Department of Health Services Nepal reported a huge rise in maternal deaths. According to the Department of Health Services, 258 women died as a result of pregnancy or childbirth between March 2020 and June 2021, of whom 33 had COVID-19. For comparison, in the year up to March 2020, Nepal recorded only 51 maternal deaths.³² Key barriers to women accessing antenatal and postnatal care and safe delivery included limited coverage of essential health services,³³ fear of getting COVID-19 at hospitals or health centres, a lack of transport,³⁴ and the diversion of financial and human resources from SRHR services to manage the COVID-19 outbreak. Midwives and birth centre workers reported an increase in the number of pregnant women considering delivery options outside hospital settings owing to a fear of infection, overcrowding, supply shortages and visitor restriction which increases the risk of unsafe and unskilled birthing practices that may lead to infant and maternal deaths. This is especially likely to be the case for women and girls in disadvantaged and hard-to-reach areas.³⁵



Promising practices: Maternal health during the COVID-19 pandemic from a human rights perspective

Although the pandemic had a negative impact on maternal mortality, the study documented promising practices in addressing maternal health during the pandemic. Identified through key informant interviews, focus group discussions and desk research, these practices demonstrate the capacity of countries and communities to address maternal health needs during the pandemic. Examples of promising practices included the following.

Policy and advocacy:

- the creation of national guidelines for providing essential maternal health services and virtual training for health-care professionals on the Minimum Initial Service Package in Bangladesh³⁶
- the development of public interest litigation to establish access to maternal health rights for pregnant women in India and Nepal.³⁷

Increased availability, accessibility, acceptability and quality of care:

- the provision of antenatal and postnatal care through teleconsultations and home visits in India and Nepal³⁸
- the [improvement in and expansion of midwifery care to increase maternal health-care coverage in Indonesia](#)
- the provision of cash voucher assistance and obstetric triage tents for pregnant women³⁹ in the Philippines
- [midwifery mentoring to establish and monitor safe maternity services for women during the COVID-19 pandemic in Bangladesh.](#)



Preparing for the future: Maternal health recommendations⁴⁰

- Advocate with governments to include antenatal care, skilled birth attendance and postnatal care as essential health services.
- Provide for antenatal and postnatal care through telemedicine where appropriate and home visits to ensure continuity of care.
- Ensure a continuous supply of life-saving maternal health medicines and develop strategies to prevent and overcome stock-outs.
- Protect those who provide sexual, reproductive, maternal, newborn, child and adolescent health care by ensuring that they are not deployed in other areas of the health system and they have sufficient personal protective equipment.
- Maintain and protect maternal health systems, including maternal and perinatal death surveillance systems, to alert ministries of health to increased deaths and causes of death so that urgent measures can be taken to prevent further mortality and morbidity at subnational levels.
- Ensure that health management information systems capture declining/missed antenatal care and postnatal care attendance and trigger urgent outreach to ensure continuity of care and prevent maternal and neonatal mortality and morbidity.

Family planning and access to modern contraception



Fast facts: International human rights law and normative guidance on family planning and access to modern contraception

The Committee on Economic, Social and Cultural Rights, in its General Comment No. 22 (2016), in Article 12, states, “The right to sexual and reproductive health is an integral part of the right of everyone to the highest attainable physical and mental health.”⁴¹

- The right to sexual and reproductive health is an integral part of the right of everyone to the highest attainable physical and mental health.⁴²
- Accessible, affordable and acceptable evidence-based information on all aspects of sexual and reproductive health, including contraceptives, and family planning and essential medicines, including a wide range of modern contraceptive methods should it be available to all individuals and groups, including adolescents and young people, without discrimination:
- States should repeal, and refrain from enacting, laws and policies that create barriers to accessing sexual and reproductive health services. This includes third-party authorization requirements, such as parental and spousal authorization requirements for access to sexual and reproductive health services and information, including on contraception.



Key findings

During the COVID-19 pandemic, **there was an unmet need for family planning and contraception**⁴³ because health facilities were closed or limited services were available, and women refrained from visiting health facilities owing to fear of COVID-19 exposure or because of travel restrictions. Moreover, vital supplies for sexual and reproductive health, including **modern contraceptives, were less readily available given the closure of production sites and the disruption of global and local supply chains.**⁴⁴ The availability of contraceptives has still yet to reach pre-COVID-19 levels in most countries in the Asia and the Pacific region.⁴⁵



Promising practices: Family planning and contraception during the COVID-19 pandemic from a human rights perspective⁴⁶

Although the pandemic had a negative impact on access to family planning and modern contraception, the study documented actions taken in the study countries to address gaps in family planning. Examples of promising practices included the following.

Policy and advocacy:

- advocating with governments to develop guidelines on contraceptive availability and to ensure continuity of family planning services during the pandemic in Fiji, India, Indonesia, Nepal and the Philippines
- the implementation of a **model policy on the inclusion of women and girls with disabilities in the COVID-19 response in Indonesia.**

Increased availability, accessibility, acceptability and quality of care:

- the establishment of virtual family planning services and delivery of contraceptives in the community in the Philippines
- the provision of community-based family planning services in Nepal's remote quarantine centres
- the expansion of m-health for family planning in Bangladesh.



Preparing for the future: Family planning and modern contraception recommendations⁴⁷

- Advocate with governments to classify family planning services and access to contraception as essential services, and to ensure that such services are accessible to and inclusive of those who are left behind.
- Support ministries of health and civil society to provide online screening and virtual family planning information and services.
- Extend modern contraceptive commodity distribution from clinical settings to communities, such as through community-based family planning services in quarantine centres, and community-based contraceptive delivery through community depot holders (women from the community who promote good health practices and the use of clinics).
- Encourage partnerships between family planning services, private health-care providers and pharmacies to improve access to information and modern contraception.



HIV prevention, testing and treatment



Fast facts: International human rights law and normative guidance on sexual and reproductive health and rightseption

- States should ensure universal access without discrimination for all individuals, including those from disadvantaged and marginalized groups, to a range of high-quality sexual and reproductive health services, including preventing, diagnosing and treating STIs such as HIV.⁴⁸
- Essential medicines, including a wide range of contraceptive methods, for example condoms and emergency contraception, and medicines for treating STIs such as HIV, should be universally available.⁴⁹
- All individuals and groups, including adolescents and young people, have the right to evidence-based information on all aspects of sexual and reproductive health, including the prevention and treatment of STIs, including HIV.⁵⁰



Key findings

The study found that **access to HIV and other STI prevention, testing and treatment has been negatively affected by the pandemic** owing to travel and transport restrictions, the prohibitive cost of courier services for delivering antiretroviral drugs (ARVs) and inadequate stocks of medicines due to global supply chain disruptions.



Promising practices for HIV and other STI during the COVID-19 pandemic from a human rights perspective⁵¹

Notwithstanding the difficult access to HIV and other STI prevention, testing and treatment during the pandemic, the study documented the following promising practices:

- the provision of HIV prevention, testing and treatment for female sex workers in Indonesia and the expansion of access to humanitarian cash and voucher assistance to those most left behind
- the establishment of interim guidance and regulations on the delivery of health services, including self-testing for HIV, and home delivery of antiretroviral medicines in the Philippines
- the provision of telecounselling and the delivery of ARVs to children and adolescents living with HIV in India



Preparing for the future: HIV and other STI prevention, testing and treatment recommendations

The following recommendations relate to increasing the availability, accessibility, acceptability and quality of care.

- Issue guidelines to recognize HIV and other STI prevention, testing and treatment as essential services during the COVID-19 pandemic and any future pandemics. Ensure that HIV self-testing kits, ARVs, and STI testing and treatments are included in national essential medicine lists.

- Scale up the provision of condoms and lubricants, HIV self-testing kits, multi-month ARVs, and contraception prescriptions and deliveries for people living with HIV and key populations at high risk. Establish clear pathways for further testing services and links to sexual health care.
- Expand community outreach to key populations through peer leaders through both tele-health and physical outreach, where possible and safe. Develop outreach guidelines to be applied during pandemics and virtual training on the guidelines.
- Increase social contracting mechanisms to facilitate and sustain community-led HIV/STI and GBV prevention and care.

Gender-based violence



Fast facts: International human rights law and normative guidance on GBV

- States have a legal obligation to ensure access to legal aid, medical, psychosocial and counselling services for survivors of violence. Health-care services should include sexual and reproductive health services, such as emergency contraception and post-exposure prophylaxis for HIV.⁵²
- States should provide specialized women's support services, such as free helplines operating around the clock; sufficient numbers of safe and adequately equipped crisis, support and referral centres; and adequate number and quality of shelters for women, their children and other family members.⁵³
- States must guarantee the availability of physical and mental health care for survivors of sexual and domestic violence in all situations, including access to post-exposure prophylaxis and emergency contraception.⁵⁴
- The *Essential Services Package for Women and Girls Subject to Violence*⁵⁵ provides international normative guidance on essential services for survivors of GBV, including health care, social services, and police and justice responses, and coordinating the multisectoral services.
- Article 2 of CEDAW provides that the overarching obligation of States parties is to pursue by all appropriate means and without delay a policy of eliminating discrimination against women, including GBV against women. Actions in line with this obligation must be carried out immediately; delays cannot be justified on any ground.⁵⁶



Key findings

Women's rights activists and civil society partners flagged reports of the **increased incidence of GBV and heightened demand for emergency shelter** during the pandemic.⁵⁷ The study found that restrictions put in place to limit the spread of COVID-19 increased the risks of GBV but also limited the ability of survivors to distance themselves from their abusers and access GBV response services. Accessing help was more difficult if women were locked down with their abusers; some hotlines reported a decrease in calls, but an increase in the number of text messages and emails they received, which they attributes to women finding it difficult to make calls in private.⁵⁸ At the same time, support services struggled. Judicial, police and health services, which are the first responders for women, were overwhelmed and shifted their priorities elsewhere or were otherwise unable to help. Civil society groups were affected by lockdowns and the reallocation of resources. Some domestic violence shelters were full; others had to close or were repurposed as health centres.⁵⁹

Promising practices: GBV response during the COVID-19 pandemic from a human rights perspective⁶⁰

Despite these challenges, the study documented promising practices implemented during the pandemic to address the increase in GBV and demand for prevention and response services.

Increased availability, accessibility, acceptability and quality of GBV referral pathways:

- [the development of national referral pathway guidelines for GBV survivors in Bangladesh](#)
- the development of a COVID-19 adaptation kit for the national GBV service delivery protocol together with a national communication campaign to ensure that GBV survivors know where to get help during the pandemic in Fiji
- the adjustment of the GBV case management protocol and referral pathway during the pandemic in Indonesia
- the development of disability-inclusive guidelines for GBV prevention and response during the pandemic in Indonesia
- a court-ordered multisectoral GBV response in Nepal
- [support for a multisectoral GBV response through a protection cluster or GBV sub-cluster in the Philippines' COVID-19 Humanitarian Response Plan.](#)

Increased availability, accessibility, acceptability and quality of physical, mental and sexual health service delivery for GBV survivors:

- the creation of national service delivery protocol one-stop service centres in Fiji
- the establishment of the clinical management of rape as an essential service in the Philippines
- [the development of a GBV resource kit for front-line workers and community response guidelines, and virtual training on these, in Fiji](#)
- [the creation of a one-stop service centres in Bangladesh hospitals, and multiple free 24-hour psychosocial counselling hotlines.](#)

Increased availability, accessibility, acceptability and quality of shelters and safe spaces:

- the designation of empty hotels and educational institutions as safe spaces/shelters for survivors of violence in Jammu and Kashmir, India
- the [development of Fiji's national GBV shelter standards during the COVID-19 pandemic](#)

Increased access to justice:

- the provision of safe spaces to report GBV in India
- the issuance by the Supreme Court of an order requiring the government to establish online case registration and hearing mechanisms for survivors of violence in Nepal.



Preparing for the future: GBV response recommendations

- Ensure that information on operational multisectoral GBV response services and referral mechanisms is available and adapted to the pandemic context.
- Verify that essential services for women and girls subject to violence are classified as such in line with international guidance.
- Ensure that the clinical management of rape is classified as an essential service.
- Ensure the availability of multiple free 24-hour psychosocial counselling hotlines operated by trained counsellors.
- Adapt guidelines for existing services, such as shelters, one-stop crisis centres, safe spaces, case management services, hotlines and justice services, to ensure that the services are accessible remotely (where possible) and that adequate support is provided to front-line service providers for their protection and self-care.
- Work to ensure that no one is left behind, for example people with disabilities; indigenous people; ethnic minorities; lesbian, gay, bisexual, transgender, queer and intersex people; internally displaced people and refugees; people in humanitarian settings; and people facing multiple intersecting forms of discrimination. Do so by ensuring that vulnerable groups have the information they need to respond to GBV, and that they have access to essential life-saving services.





Conclusion

A joint statement initiated by then Special Rapporteur on the right to health, Dainius Puras, and issued by over 60 United Nations special procedures mandate holders in March 2020, observed that “the COVID-19 crisis cannot be solved with public health and emergency measures only; all other human rights must be addressed too”. Responses to the COVID-19 pandemic in all its phases must avoid isolating the rights to health and health care from all other rights. Rather, responses **must acknowledge that the right to health can be fulfilled only when all other rights are respected and protected, and that advancing other rights promotes the right to health.**⁶¹

The right to health requires that health goods, services, information and facilities are available in adequate numbers to be able to provide the population with the fullest possible range of sexual and reproductive health care; physically, economically (affordable) and geographically accessible on a consensual and non-discriminatory basis; acceptable, including by ensuring that sexual and reproductive health services are respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender, age, disability, sexual diversity and life-cycle requirements, as well as being designed to respect confidentiality and improve the sexual and reproductive health status of those concerned; and of good quality, meaning that they are evidence based and scientifically and medically appropriate and up to date. This requires trained and skilled health-care personnel and scientifically approved and unexpired drugs and equipment.⁶² The requirement to ensure that sexual and reproductive health services are respectful of the culture of individuals, however, cannot be used to justify the refusal to provide tailored facilities, goods, information and services to specific groups. As well as being guided by civil, political, economic, social and cultural human rights, health-related policies, including responses to COVID-19, must apply the human rights principles of equality, non-discrimination, participation, transparency and accountability. Achieving universal health coverage, or containing a pandemic, is not possible if discrimination excludes different segments of society from information or services.⁶³ The right to health recognizes that inequality and discrimination are major contributors to poor health outcomes.

The global spread of COVID-19 and the impact of measures to contain it illustrate the interdependence, interrelatedness and indivisibility of human rights, or that one set of rights cannot be enjoyed fully without the other. During a pandemic or other public health emergency, promoting and protecting all human rights, especially of people in vulnerable situations, is crucial and a **legal obligation**. Human rights are a powerful tool to address health-related issues and contribute to the realization of the right to sexual and reproductive health and the right to freedom from all forms of violence.



Endnotes

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