**Center for Reproductive Rights - Written Contribution to the Committee on Economic, Social and Cultural Rights on Draft General Comment on Science and economic, social and cultural rights, Art. 15: 15.1.b, 15.2, 15.3 and 15.4**

**14 February 2020**

**Introduction**

The Center for Reproductive Rights, an international nonprofit legal advocacy organization headquartered in New York City, with regional offices in Bogotá, Geneva, Nairobi, and Washington, D.C.—uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill. Since its inception, the Center has advocated for the realization of women and girls’ human rights on a broad range of issues, including on the right to access sexual and reproductive health services; preventing and addressing sexual violence; and the eradication of harmful traditional practices

The Center for Reproductive Rights is grateful for the opportunity to make a written contribution to the Committee on Economic, Social and Cultural Rights as input towards the elaboration of Draft General Comment on Science and economic, social and cultural rights (Article 15: 15.1.b, 15.2, 15.3 and 15.4) of the International Covenant on Economic, Social and Cultural Rights (the Covenant). We appreciate that the Draft General Comment recognizes that women and girls have been traditionally discriminated against in their participation in the enjoyment of the benefits of scientific progress, that scientific research or new technologies is often “*gender biased and not sensitive to the particularities and special needs of women*”[[1]](#endnote-1), and reaffirms that that “*temporary special measures are necessary to remediate past inequalities and patterns of exclusion of women, and to eliminate biases against them*”. [[2]](#endnote-2)

We would like to add to these elements developed by the Committee, and provide further detail on the gendered implications of the right to enjoy the benefits of scientific progress by examining the interlinkages between this right and sexual and reproductive rights, particularly the right to sexual and reproductive health. This Draft General Comment affords the Committee an opportunity to explore in greater depth the specific measures that States must take in order to respect, protect and fulfill women and girls’ right to enjoy the benefits of scientific progress and its applications as an essential tool for the realization of the right to sexual and reproductive health, as previously defined by this Committee in its General Comment No. 22. In particular, we consider that there would be value in the Draft General Comment highlighting the important contribution that the right to enjoy the benefits of scientific progress can make in relation to ensuring access to affordable, quality, and acceptable medication for abortion, and assisted reproductive technologies (ART), on the basis of non-discrimination and equality. These topics are covered below, followed by a section providing some suggested edits/additional language to the Draft for consideration of the Committee.

**Interdependence of the right to enjoy the benefits of scientific progress with the right to sexual and reproductive health**

As this Committee has recognized, *“the realization of the right of women to sexual and reproductive health is essential to the realization of the full range of their human rights*”.[[3]](#endnote-3) Given the importance of the right to sexual and reproductive health to the realization of other rights of women and girls, it is important that the Draft General Comment details how the enjoyment of the benefits of scientific progress is inclusive of and applies to sexual and reproductive health and States’ obligations to address the discrimination against women and girls in relation to this right.

The Draft General Comment notes that “*the Committee has considered science as a component of quality, adequacy or acceptability which are essential elements of many of the Covenant rights*” (para. 19). In this regard, it may be useful to note the interdependence of Article 15 with the right to sexual and reproductive health and refer to existing standards from this Committee’s General Comment No. 22 on the right to sexual and reproductive health. General Comment No. 22 recognizes that:

* “*Facilities, goods, information and services related to sexual and reproductive health must be of good quality, meaning that they are evidence-based and scientifically and medically appropriate and up-to-date*”[[4]](#endnote-4);
* “*The failure or refusal to incorporate technological advances and innovations in the provision of sexual and reproductive health services, such as medication for abortion, assisted reproductive technologies and advances in the treatment of HIV and AIDS, jeopardizes the quality of care*”[[5]](#endnote-5).
* *“States must develop and enforce evidence-based standards and guidelines for the provision and delivery of sexual and reproductive health services, and such guidance must be routinely updated to incorporate medical advancements”*[[6]](#endnote-6)

States are also required to provide age-appropriate, evidence-based, scientifically accurate comprehensive information and education for all on sexual and reproductive health[[7]](#endnote-7), which highlights the importance of incorporating scientific progress into standards and guidelines pertaining to the provision and delivery of sexual and reproductive health education, information and services.[[8]](#endnote-8) Furthermore, the Committee has held that the Covenant requires States parties to *address “the ways in which gender roles affect access to determinants of health*,” including through the elimination of obstacles to women’s enjoyment of the benefits of scientific progress, such as those based on cultural and religious traditions.[[9]](#endnote-9)

***Medical Abortion***

The World Health Organization recognizes that medical abortion (i.e. the use of medical abortion pills - misoprostol alone or misoprostol in combination with mifepristone) plays a crucial role in the provision of access to safe, effective and acceptable abortion care.[[10]](#endnote-10) WHO evidence and recommendations outline that individuals with pregnancies less than 12 weeks may self-manage medical abortion when they have “a source of accurate information and access to a health-care provider should they need or want it at any stage of the process”.[[11]](#endnote-11) The WHO Guidelines note that many interventions in medical abortion care can now be provided at the primary-care level and on an outpatient basis, which further increases access to care.[[12]](#endnote-12) Medical abortion care reduces the need for skilled surgical abortion providers and offers a non-invasive and highly effective and acceptable option to pregnant individuals. It is also a way of the pregnant individual avoiding or reducing exposure to stigma and ensuring respect for their privacy and autonomy.

This Committee has made clear that equality in the context of the right to health “*requires at a minimum the removal of legal and other obstacles that prevent men and women from accessing and benefitting from health care on a basis of equality*”[[13]](#endnote-13), and as noted earlier, “*The failure or refusal to incorporate technological advances and innovations in the provision of sexual and reproductive health services, such as medication for abortion … jeopardizes the quality of care*”.[[14]](#endnote-14) General Comment No. 22 on the right to sexual and reproductive health affirms that “*The realization of the rights of women and gender equality, both in law and in practice, requires repealing or reforming discriminatory laws, policies and practices in the area of sexual and reproductive health*” and suggests that “*Preventing unintended pregnancies and unsafe abortions requires States to … liberalize restrictive abortion laws; to guarantee women and girls access to safe abortion services*”[[15]](#endnote-15). Taking into account the principles of integrity, autonomy and equality, the Committee has recognized that “*there exists a wide range of laws, policies and practices that undermine autonomy and right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health, for example criminalization of abortion or restrictive abortion laws*”[[16]](#endnote-16) and has urged States to “*Take all necessary measures to ensure that regulations on the termination of pregnancy are consistent with women’s integrity and autonomy*”.[[17]](#endnote-17)

This Committee has continued to affirm that States have a core obligation to provide essential medicines, including those listed in the WHO Essential Medicines List[[18]](#endnote-18), which lists medications for abortion (mifepristone and misoprostol).[[19]](#endnote-19) The Committee on the Elimination of Discrimination against Women (CEDAW Committee) has described the prohibition of misoprostol as *“indicative of the ideological environment”* and having a *“retrogressive impact”,* and urged a State to reintroduce misoprostol in order to reduce women's maternal mortality and morbidity rates.[[20]](#endnote-20)

The interplay between the right to enjoy the benefits of scientific progress and the right to sexual and reproductive health[[21]](#endnote-21), when applied to medical abortion, would mean that:

* States should decriminalize abortion, and legalize and ensure access to abortion at the request of the pregnant person, in order to fully respect their rights to health, privacy, decision-making, and bodily and mental integrity and autonomy.
* States Parties should ensure that their laws do not criminalize self-managed medical abortion and that medication for abortion is available, accessible, acceptable and of good quality and is provided in line with scientific evidence, free of discrimination, coercion and violence.
* State parties should eliminate all legal, policy or practical barriers, such as financial barriers, and ensure equal access to medication for abortion, paying particular attention to persons facing multiple and intersecting forms of discrimination

***Assisted Reproductive Technologies***

Recent advances in technology have made assisted reproductive technologies a topic of increasing global interest. Clinical infertility impacts an estimated 180 million men and women globally. This number does not account for individuals who are socially or situationally infertile based on their lack of a partner or their same-sex partnership. Notwithstanding its impact, information and education about infertility, as well as infertility care options, including ART, remain difficult to access for many individuals. Infertility can create devastating social stigma, particularly for women, that are rooted in harmful gender stereotypes. Couples and individuals seeking fertility care and treatment may not have access to available, acceptable, accessible and good quality sexual and reproductive health information and services, and therefore may not be able to exercise their right to health and informed consent. Infertility implicates multiple human rights including the rights to plan the timing and spacing of children, to enjoy the benefits of scientific progress, to health, including sexual and reproductive health, to non-discrimination, as well as to informed consent, privacy and confidentiality.

People impacted by infertility, whether clinical or social, have a right to benefit from scientific progress,[[22]](#endnote-22) and this Committee has recognized that “*States should aim to ensure universal access without discrimination for all individuals, including those from disadvantaged and marginalized groups, to a full range of quality sexual and reproductive health care, including … diagnosis and treatment of infertility*”.[[23]](#endnote-23) General Comment No. 22 affirms that “*The failure or refusal to incorporate technological advances and innovations in the provision of sexual and reproductive health services, such as …assisted reproductive technologies … jeopardizes the quality of care*”.[[24]](#endnote-24)

In *S.C. and G.P v. Italy* this Committee considered a case involving in vitro fertilization and recommended that "*States should update their regulations regularly to harmonize them with their human rights obligations and with the evolution of society and scientific progress*".[[25]](#endnote-25) The Human Rights Committee has called for the elimination of excessive restrictions on access to ART.[[26]](#endnote-26) It has expressed concern at legal restrictions on access to IVF that affect same-sex couples and lesbian, gay, bisexual, transgender and intersex persons, and has specified that *“equal access to in vitro fertilization*,” should be provided to lesbian, gay, bisexual, transsexual and intersex persons.[[27]](#endnote-27)

The CEDAW Committee has also expressed concerns about laws and policies that prevent single women or women in same sex relationships from accessing IVF services and has called on a State to, “*adopt legislative measures aimed at facilitating and expanding women’s right to decide freely and responsibly on the number of their children in accordance with article 16(e) of the Convention, and ensure access to assisted reproductive services, including in vitro fertilization, for all women without any restrictions*.”[[28]](#endnote-28) It has praised States for passing legislation that regulates and guarantees access to all scientific methods of ART.[[29]](#endnote-29)

These views reflect case-law from regional human rights systems, for example in the Inter-American Court of Human Rights in *Murillo v Costa Rica* the Court recognized that “*the right to have access to scientific progress in order to exercise reproductive autonomy and the possibility to found a family gives rise to the right to have access to the best health care services in assisted reproduction techniques, and, consequently, the prohibition of disproportionate and unnecessary restrictions, de jure or de facto, to exercise the reproductive decisions that correspond to each individual*.”[[30]](#endnote-30)

As with other reproductive health services, there is concern that access to ARTs is not available to everyone who needs them.[[31]](#endnote-31) Research has shown that areas of the world with the highest rates of infertility are often those with generally poor access to sexual and reproductive health care, including ART, such as sub-Saharan Africa, South and East Asia, the Pacific, and Central and Eastern Europe.[[32]](#endnote-32) Even in industrialized countries like the United States, well-documented disparities in access to infertility care reveal that people of color, low income people, people with disabilities, and LGBTQ communities receive treatment at disproportionately low rates.[[33]](#endnote-33)

Individuals impacted by infertility may, in addition to seeking infertility care, consider surrogacy arrangements to have children. As such, surrogacy implicates the right to enjoy the benefits of scientific progress. To ensure that this right is respected, protected, and fulfilled, States should implement a human-rights based regulatory framework on surrogacy. Such a framework also helps ensure that the human rights of all stakeholders involved in surrogacy arrangements, including those persons acting as surrogates, are respected, protected and fulfilled, and that the best interests of children born from surrogacy arrangements are guaranteed. Most recently, in 2019 CEDAW recommended that a State ensure that laws on surrogacy do not impose criminal liability or administrative sanctions on women who act as surrogates, and ensure that laws, regulations, and policies on surrogacy prevent deprivation of liberty and exploitation, as well as coercion, discrimination, and violence against them.[[34]](#endnote-34)

**Consent to research or medical interventions**

In many regions of the world, including in South America, Asia, Africa and Europe, there is a long history of forced and coerced sterilization of women from ethnic and racial minorities, those living with HIV/AIDS and women and girls with disabilities.[[35]](#endnote-35) Accordingly, para 29 of the Draft General Comment may be strengthened by including the right to refuse medical interventions, and the right to withdraw consent at any time.

The Draft General Comment also acknowledges that special measures may be required in relation to consent (para 48). It is suggested that the Draft General Comment should provide additional detail on the evolving capacities of children, based on Article 5 of the Convention on the Rights of the Child,[[36]](#endnote-36) to help ensure that children are able to voice their desire to participate in science and partake in the benefits thereof without limitations imposed by guardians.

**Proposed additions to the Draft General Comment**

In light of the above, the Center respectfully requests the Committee to consider to following edits to the Draft General Comment (edits in bold italics):

29. …research affects specific populations, such as indigenous peoples or ethnic minorities, their right to free, prior and informed consent, ***the right to refuse to participate or take up any medical interventions, and the right to withdraw one’s consent at any time must be protected…***

40.       A gender-sensitive approach is not a luxury for scientific research but a crucial tool in order that scientific progress and new technologies adequately take into account the special characteristics and needs of women and girls. ***This applies in particular to research relating to sexual and reproductive health, and recognizing that a gender-sensitive approach to scientific research on sexual and reproductive health must consider not only biological differences but also take account of gender-based discrimination and social and underlying determinants of health, since discrimination against women is often due to prejudices and stereotypes based on patriarchal notions of women’s sexual and reproductive roles and functions.***This approach should not be relegated to the last stages of research but should be incorporated from the first stage of research, such as the choice of the subject and the design of methodologies, and must be present throughout all steps of scientific research and its applications, including during the evaluation of its impacts. Decisions concerning funding or general policies must also be gender-sensitive.

***40bis The need for a gender-sensitive approach to scientific progress and new technology has particular relevance to the right to sexual and reproductive health, which requires that States parties ensure access to modern forms of contraception including emergency contraception, medication for abortion, assisted reproductive technologies, and other sexual and reproductive goods and services, on the basis of non-discrimination and equality. Furthermore, as outlined in General Comment No. 22 on the right to sexual and reproductive health, in addressing laws, policies and practices that undermine autonomy and right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health, States must eliminate gender‑based stereotypes, assumptions and expectations related to women being the subordinates of men and their role being solely as caregivers and mothers.***

***40ter States Parties must ensure that their laws do not criminalize self-managed abortion and that access to medication for abortion is non-discriminatory and based on scientific evidence. The full realization of rights under the Covenant require that States permit abortion on request, in order to fully respect the pregnant individual’s health, privacy, decision-making, and bodily and mental integrity and autonomy. State Parties must eliminate all legal, policy or practical barriers, and ensure access to affordable, acceptable, quality medication for abortion and related information.***

***40quater States Parties should guarantee equal access to infertility care, including ART, for lesbian, gay, bisexual, transsexual and intersex persons as well as single individuals and unmarried couples. States must also remove any discriminatory requirements for access to infertility care, including ART, and update their regulations regularly to harmonize them with their human rights obligations and with the evolution of society and scientific progress[[37]](#endnote-37). States parties should implement a human-rights based regulatory framework to surrogacy and ensure that the human rights of all stakeholders involved in surrogacy arrangements, including those of persons who act as surrogates, are respected, protected and fulfilled and that the best interests of children born from surrogacy are guaranteed. At a minimum States parties must ensure that laws, regulations, and policies on surrogacy do not impose penal or administrative sanctions on women who act as surrogates, and prevent deprivation of liberty and exploitation, as well as coercion, discrimination, and violence against them.***

***40quinquies States parties should also implement a human-rights based regulatory framework to surrogacy and ensure that the human rights of all stakeholders involved in surrogacy arrangements, including those of women who act as surrogates, are respected, protected and fulfilled. At a minimum States parties must ensure that laws, regulations, and policies on surrogacy do not impose penal or administrative sanctions on women who act as surrogates, and prevent deprivation of liberty and exploitation, as well as coercion, discrimination, and violence against them.***

48. ***…People who due to their age or capacity may require support in autonomous decision-making must be provided with appropriate support should they wish to receive it, to ensure respect for the views of the child, their evolving capacities, and appropriate levels of protection.***

56. “…To ensure that scientific education, ***including comprehensive sexuality education[[38]](#endnote-38)***, in both public and private schools respect the best scientific knowledge and that religious visions, when necessary, are presented in a different field….”

1. Committee on Economic, Social and Cultural Rights, *Draft General Comment on Article 15: 15.1.b, 15.2 15.3 and 15.4,* Draft version 2 January 2020, accessed at <https://www.ohchr.org/Documents/HRBodies/CESCR/Discussions/2020/DGC_Science/DraftGC_science.docx> , para. 36 [↑](#endnote-ref-1)
2. *Ibid.* para. 38 [↑](#endnote-ref-2)
3. Committee on Economic, Social and Cultural Rights, *General Comment No. 22:* *On the right to sexual and reproductive health (Art. 12 of the* *International Covenant on Economic, Social and Cultural Rights*), para. 25, U.N. Doc. E/C.12/GC/22 (2016) [↑](#endnote-ref-3)
4. *Ibid.*, para 21 [↑](#endnote-ref-4)
5. *Ibid.* [↑](#endnote-ref-5)
6. *Ibid.,* para 47 [↑](#endnote-ref-6)
7. Ibid., paras. 28, 44, 63; Committee on the Rights of the Child, *General Comment No. 20: The implementation of the rights of the child during adolescence*, para. 60, U.N. Doc. CRC/C/GC/20 (2016) [↑](#endnote-ref-7)
8. Committee on Economic, Social and Cultural Rights, *General Comment 16, Article 3: the equal right of men and women to the enjoyment of all economic, social and cultural rights*, para. 47, U.N. Doc. E/C.12/2005/3 (2005) [↑](#endnote-ref-8)
9. *Ibid*., para. 29. [↑](#endnote-ref-9)
10. <https://www.who.int/reproductivehealth/guideline-medical-abortion-care/en/> [↑](#endnote-ref-10)
11. World Health Organization, Medical management of abortion (2018), pp. 29, 30 available at <https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1> [↑](#endnote-ref-11)
12. <https://www.who.int/reproductivehealth/guideline-medical-abortion-care/en/> [↑](#endnote-ref-12)
13. *Ibid.* [↑](#endnote-ref-13)
14. Committee on Economic, Social and Cultural Rights, *General Comment No. 22*, para. 21 [↑](#endnote-ref-14)
15. *Ibid.,* para 28 [↑](#endnote-ref-15)
16. *Ibid.,* para 34 [↑](#endnote-ref-16)
17. Committee on Economic, Social and Cultural Rights, *Concluding Observations: Ecuador*, para. 52, U.N. Doc. CESCR/C/ECU/CO/4 (2019) [↑](#endnote-ref-17)
18. Committee on Economic, Social and Cultural Rights, *General Comment No. 22,* paras. 13, 49(g); Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12),* para 43(d)U.N. Doc. E/C.12/2000/4 (2000) [↑](#endnote-ref-18)
19. WHO Essential Medicines List, 21st edition, page 47 <https://apps.who.int/iris/bitstream/handle/10665/325771/WHO-MVP-EMP-IAU-2019.06-eng.pdf?ua=1> [↑](#endnote-ref-19)
20. Committee on the Elimination of Discrimination against Women (CEDAW Committee)*,* *Philippines Inquiry Summary (Article 8 of Optional Protocol to Convention on the Elimination of All Forms of Discrimination against Women)*, paras. 9, 52(v), U.N. Doc. CEDAW/C/OP.8/PHL/1 (2014) [↑](#endnote-ref-20)
21. See e.g. Committee on Economic, Social and Cultural Rights, *General Comment No. 22*, paras. 28, 34; Committee on Economic, Social and Cultural Rights, *Concluding Observations: Ecuador*, para. 52, U.N. Doc. CESCR/C/ECU/CO/4 (2019) [↑](#endnote-ref-21)
22. CEDAW Committee, *Concluding Observations: Costa Rica*, para. 33(b), U.N. Doc CEDAW/C/CRI/CO/5-6 (2011); Artavia Murillo et al. (“in vitro fertilization”) v. Costa Rica, Judgment of November 28, 2012, para. 150, Inter-Am. Ct. H.R. (Nov. 28, 2012), *available at* http://www.corteidh.or.cr/docs/casos/articulos/seriec\_257\_ing.pdf; [↑](#endnote-ref-22)
23. Committee on Economic, Social and Cultural Rights, *General Comment No. 22,* para. 45 [↑](#endnote-ref-23)
24. *Ibid,* para. 21 [↑](#endnote-ref-24)
25. *S.C. and G.P v.* *Italy,* CESCR Committee, Commc’n No. 22/2017, para. 11.4, U.N. Doc. E/C.12/65/D/22/2017 (2019) [↑](#endnote-ref-25)
26. Human Rights Committee, *Concluding Observations: Costa Rica*, paras. 19-20, U.N. Doc. CCPR/C/CRI/CO/6 (2016) [↑](#endnote-ref-26)
27. Human Rights Committee, *Concluding Observations: Italy*, paras. 10-11, (2017) [↑](#endnote-ref-27)
28. CEDAW Committee, *Concluding Observations: Portugal,* para. 45(c), CEDAW/C/PRT/CO/8-9 (2015). [↑](#endnote-ref-28)
29. CEDAW Committee, *Concluding Observations: Argentina,* paras. 4(d), 32, U.N. Doc. CEDAW/C/ARG/CO/7 (2016). [↑](#endnote-ref-29)
30. Artavia Murillo et al. (“in vitro fertilization”) v. Costa Rica, Judgment of November 28, 2012, para. 150, Inter-Am. Ct. H.R. (Nov. 28, 2012), *available at* http://www.corteidh.or.cr/docs/casos/articulos/seriec\_257\_ing.pdf [↑](#endnote-ref-30)
31. Committee on Economic, Social and Cultural Rights, *General Comment No. 22*, para. 39; CEDAW Committee, Concluding Observations: Lithuania, para. 36, U.N. Doc. CEDAW/C/LTU/CO/5 (2014). [↑](#endnote-ref-31)
32. Marcia Inhorn & Pasquale Patrizio, *Infertility Around the Globe: New Thinking on Gender, Reproductive Technologies and Global Movements in the 21st Century*, 21 Human Reproduction Update 4 (2015), <https://share-netinternational.org/wp-content/uploads/2018/12/Infertility-around-the-globe-new-thinking-on-gender-reproductive-technologies-and-global-movements-in-the-21st-century.pdf> [↑](#endnote-ref-32)
33. American Society for Reproductive Medicine (ASRM), *Disparities in Access to Effective Treatment for Infertility in the United States: An Ethics Committee Opinion*, 104 Fertility & Sterility 1104 (2015), <https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/ethics-committee-opinions/disparities_in_access_to_effective_treatment_for_infertility_in_the_us-pdfmembers.pdf>; Angela Kelley et al., *Disparities in Accessing Infertility Care in the United States: Results from the National Health and Nutrition Examination Survey, 2013-16*, 112 Fertility & Sterility 562 (Sept. 2019), [https://www.fertstert.org/article/S0015-0282(19)30423-6/fulltext](https://www.fertstert.org/article/S0015-0282%2819%2930423-6/fulltext); *Chapter 11: Assisted Reproductive Technologies, in* Rocking the Cradle: Ensuring the Rights of Parents with Disabilities and Their Children (National Council on Disability, 2012), <https://ncd.gov/publications/2012/Sep272012/Ch11>. [↑](#endnote-ref-33)
34. CEDAW Committee, *Concluding Observations: Cambodia*, para. 47, U.N. Doc. CEDAW/C/KHM/CO/6 (2019). [↑](#endnote-ref-34)
35. Patel, Forced sterilization of women as discrimination, <https://publichealthreviews.biomedcentral.com/articles/10.1186/s40985-017-0060-9> [↑](#endnote-ref-35)
36. Committee on the Rights of the Child, *General Comment No. 12: The right of the child to be heard*, paras. 84-85, U.N. Doc. CRC/C/GC/12 (2009), paras 84 – 85; Committee on the Rights of the Child, *General Comment No. 20*, *supra* note 7, paras. 20, 39; Committee on the Rights of the Child, *General Comment No. 15: The right of the child to the enjoyment of the highest attainable standard of health (Art. 24)*, para. 21, U.N. Doc. CRC/C/GC/15 (2013) [↑](#endnote-ref-36)
37. *S.C. and G.P v. Italy, supra* note 25, para 11.4 [↑](#endnote-ref-37)
38. The Draft General Comment makes reference to recommendations by UNESCO, stating that among the core obligations of States is “To ensure that scientific education in both public and private schools respect the best scientific knowledge…” (para 56). In line with para. 28 of General Comment No. 22, this Draft General Comment could also specify the need to include comprehensive sexuality education in schools on the basis of the UNESCO’s 2018 International Technical Guidance on Sexuality Education, available at [https://unesdoc.unesco.org/ark:/48223/pf0000260770](https://unesdoc.unesco.org/ark%3A/48223/pf0000260770) [↑](#endnote-ref-38)