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The notion of consent in the UN Treaty Bodies' general comments and jurisprudence

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Preface

Drawing on the jurisprudence of the UN human rights Treaty Bodies and their General Comments/ Recommendations, this paper seeks to shed light on the notion of consent and on the challenges that ensuring people's right to make autonomous decisions poses in two specific contexts: sexual conduct and the provision of and access to sexual and reproductive healthcare, goods and services. This research paper aims to elucidate these questions by presenting an analysis of some of the universal human rights standards applicable to the notion of consent. The consent-related human rights standards pinpointed in this paper derive, in turn, from a detailed research study of key criteria, principles and overarching considerations relevant to evidencing consent or absence thereof identified through key-word searches of UN Treaty Bodies' jurisprudence, and by analysing their General Comments/Recommendations. For reasons beyond the authors' control, a considerable period has elapsed from the completion of the research phase and the actual publication of this paper. Regrettably, it has not been possible to update the original research findings presented and analysed here, which date almost exclusively up to the end of March 2019. The authors acknowledge this limitation and, as a result, underscore that the findings and conclusions outlined and discussed in the present study would benefit from a revision based on additional key-word searches of the UN Treaty Bodies' jurisprudence and further analysis of their General Comments/Recommendations adopted since April 2019.

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Introduction [1]

This research paper seeks to shed light on the notion of consent and on the challenges that ensuring people's right to make autonomous decisions poses in two specific contexts:
-sexual conduct; and
-the provision of and access to sexual and reproductive healthcare, goods and services (SRHCGSs).[2]

The paper aims to elucidate these questions by presenting an analysis of some of the universal human rights standards applicable to the notion of consent in the context of sexual conduct and in relation to the provision of and access to SRHCGSs.

The present research seeks to identify these universal human rights standards by drawing on the jurisprudence of the UN human rights Treaty Bodies and their General Comments/Recommendations.

This paper focuses on the output of these expert human rights bodies because, at the global level, the UN human rights Treaty Bodies are among the principal and most authoritative sources of interpretation of treaty-based human rights standards of universal application, and thus contribute to the identification and emergence of treaty-based legal norms concerning States' obligations under international human rights law to respect, protect and fulfil human rights.

The consent-related human rights standards pinpointed in this paper derive, in turn, from a detailed research study of key criteria, principles and overarching considerations relevant to evidencing consent or absence thereof identified through key-word searches of UN Treaty Bodies' jurisprudence, and by analysing their General Comments/Recommendations.

The present paper strives to identify and provide an analysis of standards around the notion of consent with respect to sexual conduct and SRHCGSs, as well as, whenever relevant, in other contexts where consent arises. Indeed, as set out in greater detail below, the UN human rights Treaty Bodies have considered and expounded on one's right to make autonomous decisions – which, in turn, is premised on and entails one's consent – as well as on other issues that may relate to consent in contexts other than sexual conduct and the provision of and access to SRHCGSs. In this connection, the authors of this paper consider that, *mutatis mutandis*, there is merit in analysing what the Treaty Bodies may have affirmed about consent in these other contexts.

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[1] Unless when referring to and citing sources, this paper uses gender as an analytical category, as opposed to sex and, when citing directly from sources, the paper makes this clear through the use of quotation marks. In addition, while taking due note of the definition of the child in Article 1 of the UN Convention on the Rights of the Child (i.e., "a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier"), this paper, instead, generally refers to adolescents under eighteen years of age and to other younger children by using the term adolescents/children, unless citing directly from sources, or when child/children is apposite in any given context.

[2] The World Health Organization's (WHO) working definitions of sexual health and sexuality are as follows: "Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. Sexuality is a central aspect of being human throughout life; it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors." See, Sexual Health, Human Rights and the Law, WHO, June 2015, pp. 49, Box 1: Working definitions, p. 5, http://www.who.int/reproductivehealth/publications/sexual_health/sexual-health-human-rights-law/en/.

The authors further consider that those additional Treaty Bodies' pronouncements may assist in identifying an analysing the consent-related human rights standards drawn from the two primary focuses of the present study, namely, sexual conduct and the provision of and access to SRHCGSs.

With respect to this, however, it is worth already foreshadowing and underscoring that, as set out in greater detail below in relevant sections in this paper,[3] international human rights law and standards draw some clear distinctions between the kind of consent needed to meet, on the one hand, the standard of consent with respect to sexual conduct – namely, one that distinguishes sexual assault offences, including rape, from consensual sexual conduct free of criminal liability – from, on the other hand, the standard of consent – namely, autonomous and informed decision-making (hereafter also referred to as informed consent) – with regard to accessing, receiving or refusing SRHCGSs.[4] As a result, it is worth emphasizing that one is dealing with two distinct notions of consent. That said, both share a common core. Namely, both notions are manifestations of one's right to make autonomous decisions and of the right to control over one's body and, ultimately, one's destiny.[5]

These two distinct notions, i.e., consent and autonomous and informed decision-making, are often contested and conflated, with one another and with other notions, such as assent and legal capacity; the resulting murkiness has important implications with respect to human rights, equality and non-discrimination, and health. In light of this, one of the purposes of the research findings presented in this study is to:

a) identify gaps in understanding of and the evidence basis for the application of the concepts of consent and informed consent grounded in and consistent with human rights standards;

b) clarify how the notions of consent and informed consent are being used (e.g., in the different contexts), including how they are differently understood for different groups of people, for example, depending on age (e.g., children, adolescents under eighteen years of age, young persons), legal capacity, gender and disability status; and

c) in light of the above, attempt to chart a way forward that ensures greater conceptual clarity.

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[3] The section entitled: "Criteria regarding consent in the context of sexual conduct/relations", and the section entitled: "Criteria regarding consent in the context of healthcare, goods and services, in particular SRHCGSs", respectively.

[4] As Christina Zampas has noted, the term 'informed consent' in the context of sexual and reproductive health services is somewhat a misnomer as it implies that there will be consent, thereby betraying the biased patient-provider power dynamics in health care, which, in turn, run counter to the fundamental basis of the concept. Informed choice or autonomous and informed decision-making might more accurately describe the notion of consent applicable in the context of SRHCGSs — and, indeed, the WHO literature on sexual and reproductive health and rights often refers to informed choice/s, rather than informed consent.

[5] The International Commission of Jurists' "The 8 March Principles for a Human Rights-Based Approach to Criminal Law Proscribing Conduct Associated with Sex, Reproduction, Drug Use, HIV, Homelessness and Poverty" – a new set of legal principles elaborated by jurists for a human rights-based approach to criminal law published in March 2023 – observe: "at a minimum, consent sets the boundary between justifiable and unjustifiable State interference in certain conduct and contexts, and that ascertaining the presence or absence of consent is a matter of evidence and factual investigation, with due regard to the strictures of the law and one's capacity to consent". They also acknowledge that: "the absence of consent may give rise to criminal liability for the conduct concerned" and emphasize that: "with respect to the application of criminal law in connection with consent, international human rights law requires paying due regard to: a) the legal capacity of people with disabilities to consent, including through supported decision-making; b) adolescents' evolving capacity to consent in certain contexts, in fact, even if not in law, when they are below the prescribed minimum age of consent in domestic law; and c) non-discrimination and equality with respect to sex, sexual orientation, gender identity, gender expression, race, disability and other protected fundamental characteristics", The 8 March Principles, preamble, p. 12.

Limitations

There is a recognition that, from a human rights perspective, guidance available to health practitioners on the notion of consent in respect of sexual conduct and consent in the context of the provision of and access to SRHCGSs is very limited.

This paper does not, however, in and of itself, seek to provide guidance to healthcare service providers on what consent may or may not entail under international human rights law and standards, in recognition of the fact that it is national laws and policies – as well as domestic administrative and professional regulations and codes – that dictate healthcare workers' approach to consent, be it with respect to sexual conduct or the provision of SRHCGSs. Nonetheless, the paper's authors hope that its content may still be of interest to healthcare service providers – and to a wider readership – as standards harnessed from the UN Treaty Bodies' output may be usefully deployed in further analyses and assessments of whether or not national laws and policies, as well as domestic administrative and professional regulations and codes governing and applicable to one's right to make autonomous decisions in various contexts, meet or fall short of what international human rights standards require in relation to consent.

There are other contexts where the notion of consent arises, including, for example, in respect of individuals who are asked to provide their consent to participate in a particular health research effort. The present paper, however, sets out research findings arising almost exclusively with respect to consent in the context of the provision of and access to healthcare, goods and services, in particular SRHCGSs, and to the notion of consent in the relation to sexual conduct.

The Treaty Bodies' jurisprudence and their General Comments/Recommendations up until the end of March 2019 constitute the primary and almost exclusive sources in terms of the research material from which this study's findings are drawn. For reasons beyond the authors' control, a considerable period has elapsed from the completion of the research phase and the actual publication of this paper. Regrettably, it has not been possible to update the original research findings presented and analysed here. The authors acknowledge this limitation and, as a result, underscore that the findings and conclusions outlined and discussed in the present study would benefit from a revision based on additional key-word searches of the UN Treaty Bodies' jurisprudence and further analysis of their General Comments/Recommendations adopted since April 2019.

In addition, the authors recognize the limited scope of this research undertaking: the relevant output of the UN Special Procedures; of the regional human rights systems (in Europe, Africa and the Americas); of national sources, such as domestic human rights jurisprudence and legislation, have not been considered. Any of those additional sources are beyond the scope of this study. In light of this, in the conclusion section of the paper, the authors recommend a further research effort focused on the above-mentioned sources – whose consideration this study has omitted – with a view to offering a more comprehensive understanding of human rights standards relevant to consent.

In addition, as the conclusion section of this paper recommends, in light of the overarching State duty to comply with its obligations under international human rights law, including in the first instance through domestic implementation of treaty obligations, additional research on how national legal and administrative frameworks fare vis-à-vis international human rights law requirements in relation to consent is highly pertinent and desirable. Ultimately, however, such research endeavour is beyond the scope of the present paper.

Another limitation of the paper is that it does neither present nor engage with the underlying reasons for the domestic legal restrictions placed on one's right to make autonomous decisions and on the right to control over one's body – such as the purported protection of children and morality – that emerge from a review of the Treaty Bodies' jurisprudence and General Comments/Recommendations, particularly in respect of consent to sex and to SRHCGSs. Very often, these restrictions are not based on evidence but on harmful gender stereotypes.[6]
The authors hope the findings presented in this paper will be of some assistance to national healthcare practitioners as they, in turn, advocate for law and policy reform to deliver national human rights compliant approaches to consent. With respect to this, the authors would recommend that national health sector authorities and WHO take due heed of the standards around consent this paper has identified.

Moreover, while acknowledging that the following is as a bit of "pie in the sky" thinking on the authors' part, they hope that national health care practitioners may approach the question of consent with at least some awareness of the human rights standards pinpointed by the present study.

Background

The understanding and application of the concept of consent has profound implications in the area of sexual and reproductive health and rights, among others. Healthcare workers and service providers are often faced with challenging sets of circumstances raising consent considerations, whether in respect of sexual conduct, SRHCGSs or both, including, for example, in the following scenarios:

1) the provision of emergency contraceptives to adolescent girls under the legal minimum age of sexual consent in domestic law;[7]

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[6] "Gender stereotype is an overarching term that refers to a generalized view or preconception of attributes or characteristics possessed by, or the roles that are or should be performed by, men and women, respectively. Gender stereotypes are social and cultural constructions of men and women, due to their different physical, biological, cognitive, sexual and social functions. A gender stereotype is harmful when it limits an individual's capacity to develop their personal abilities, pursue their professional careers and make choices about their lives and life plans. Harmful stereotypes can be both hostile/negative (e.g., women are irrational) or seemingly benign (e.g., women are nurturing). Gender stereotyping is the practice of ascribing attributes, characteristics or roles to individuals, based on their presumed membership in a social group of women or men, and is a significant challenge to the practical realization of human rights." See, the OHCHR Background paper on the role of the judiciary in addressing the harmful gender stereotypes related to sexual and reproductive health and rights.

[7] A scenario that for healthcare workers may, in turn, raise issues concerning parental consent or notification or give rise to assumptions of sexual abuse, which, in some countries would trigger mandatory reporting requirements for healthcare workers, regardless of the wishes of the individuals concerned. For more on this, see, for example, the House of Lords authority Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112. In that case the facts were as follows: "Mrs Gillick was a mother of five children, one of whom had sought and received contraceptive advice from a local doctor whilst below the age at which she could lawfully consent to intercourse. This advice was provided pursuant to guidance issued by the Department of Health and Social Security. Mrs Gillick sought a declaration from the court that the Department's guidance was unlawful as, amongst other things, it adversely interfered with parental rights and duties." The House of Lords had to determine: a) whether parents have a right to control their minor children; b) whether such children could receive contraceptive advice; and c) whether they could "consent to medical treatment, against the wishes or knowledge of their parents". The House of Lords also had to decide whether "a doctor, in exercising his or her clinical duty, would be guilty of a criminal offence by providing contraception or advice to underage patients." In its decision the House of Lords held as follows "The application [sought by Mrs Gillick] for a declaration [from the court that the Department's guidance was unlawful] was dismissed. Parental rights, as such, did not exist, except insofar as necessary to safeguard the best interests of a minor. In some circumstances a minor would be able to give consent in their own right, without the knowledge or approval of their parents. The test proposed by Lord Scarman posits that a minor will be able to consent to treatment if they demonstrate "sufficient understanding and intelligence to understand fully what is proposed" ([1986] AC 112, 187[D]). The test is now often referred to as 'Gillick competence' and is an integral aspect of medical and family

2) when an underage married pregnant girl seeks to access pre-natal care;[8]
3) women seeking contraception in countries where married women are to obtain the consent or authorization of their husband to access contraceptive health services;
4) women asking for re-infibulation following childbirth;
5) persons with intellectual disabilities requiring sexual health information or services, for example, in connection with pregnancy;
6) the provision of SRHCGSs to sex workers in countries where buying and selling sex is criminalized and sex work is legally deemed non-consensual per se, or SRHCGS provision to persons engaged in same-sex consensual sexual conduct in countries where such conduct is criminalized.[9]

In light of the above, it is abundantly clear that consent issues arising in both the sexual conduct and the provision of SRHCGSs contexts are very often, therefore, of concern to healthcare workers and service providers.

Whatever the context, whenever one's right to make autonomous decisions and the right to control over one's body are at stake, national legal frameworks may conform to, fall below, violate or go beyond international human rights law and standards. For example, same-sex consensual sexual conduct among people who are over the age of consent is not criminalized in 123 UN Member States,[10] which leaves 70 remaining States in violation of international human rights law as a result of domestic legal frameworks still criminalizing such conduct.

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law." (emphasis added) Lord Fraser set out the following guidelines: "The doctor will, in my opinion, be justified in proceeding without the parents' consent or even knowledge provided he is satisfied on the following matters: 1. that the girl (although under 16 years of age [the age of consent, 16 in the UK, is the age at which domestic law deems individuals legally capable of consenting to sexual conduct] will understand his advice; 2. that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice; 3. that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; 4. that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; 5. that her best interests require him to give the contraceptive advice, treatment or both without the parental consent." With respect to this, The 8 March Principles affirm: "sexual conduct involving persons below the domestically prescribed minimum age of consent to sex may be consensual in fact, if not in law. In this context, the enforcement of criminal law should reflect the rights and capacity of persons under 18 years of age to make decisions about engaging in consensual sexual conduct and their right to be heard in matters concerning them. Pursuant to their evolving capacities and progressive autonomy, persons under 18 years of age should participate in decisions affecting them, with due regard to their age, maturity and best interests, and with specific attention to non-discrimination guarantees." The 8 March Principles, PRINCIPLE 16 – CONSENSUAL SEXUAL CONDUCT, pp. 22-23.

[8] A scenario that for healthcare workers may, in turn, give rise to the need to consider issues associated with consent, including potential coercion and limited autonomous decision-making; mandatory reporting of harmful practices, such as 'child and forced marriage'; and assumptions about and the need to assess the potential for sexual abuse.

[9] In both contexts, healthcare workers and service providers, often operating under a 'harm reduction framework', may expose themselves to criminal liability, including for abetting the crime of 'trafficking' in those national settings where no distinction is made between 'trafficking' and sex work, or where healthcare workers seek to provide services to individuals under the age of eighteen in sex sector settings.

[10] See, ILGA's 2019 State-sponsored Homophobia Report, p. 179.

The three legal doctrines on which consent notions are based

Consent is primarily a legal construct originating in three different legal doctrines.[11] The first is the doctrine of informed consent, which emerged primarily in response to coerced or involuntary medical experimentation carried out by the Nazis during World War II.[12]
Informed consent comprises the idea that one should first know about, and provide affirmative agreement to a procedure: be it a scientific experiment or a medical procedure. It entails the exercises of one's right to informed and autonomous decision-making. The second legal doctrine on which the concept of consent is based is the notion that before individuals enter into an agreement they have to have the legal capacity to consent to such an agreement; legal capacity, in turn, is grounded on the idea that one has to have the capacity, knowledge and ability to understand what one is promising to do, and what one is being promised in return. Different and varying notions of 'capacity' come into play depending on the context.[13] The third legal doctrine on which the notion of consent is based arises in criminal law and is premised on the idea that individuals are deemed incapable of being able to consent to forms of exploitation like slavery, torture and human trafficking.[14]

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[11] See, Consent and International Human Rights Law, adapted from presentations by Mindy Jane Roseman, Jaime Todd-Gher and Sara Hossain at the Global Dialogue on Decriminalisation, Choice and Consent, on file with the authors.

[12] Indeed, the prohibition on torture or other ill-treatment, enshrined in contemporary international human rights law, proscribes, in particular, the subjection of individuals to medical or scientific experimentation without their "free consent", see, e.g., Article 7 of the International Covenant on Civil and Political Rights and Article 15 of the Convention on the Rights of Persons with Disabilities.

[13] The 8 March Principles emphasize that "with respect to the application of criminal law in connection with consent, international human rights law requires paying due regard to: a) the legal capacity of people with disabilities to consent, including through supported decision-making; b) adolescents' evolving capacity to consent in certain contexts, in fact, even if not in law, when they are below the prescribed minimum age of consent in domestic law; and c) non-discrimination and equality with respect to sex, sexual orientation, gender identity, gender expression, race, disability and other protected fundamental characteristics", The 8 March Principles, preamble, p. 12.

[14] In this context, in particular, there is scope for contestation, as some deem activities such as sex work, among others, as inherently exploitative and, thus, consider anyone's participation in them as not being properly consensual. "But it is not just sex work. People with severe (or even moderate) intellectual disabilities are often treated under the law as being unable to consent to sexual relationships. They are seen as 'lacking the capacity'. But who gets to define what capacity is? Are the scales by which we determine who is mentally fit and unfit to enjoy sex immutable, or rather are they products of the law's ableism?" See Consent and International Human Rights Law, cited above. See, also The 8 March Principles cited above. With respect to sex work, The 8 March Principles affirm: "The exchange of sexual services between consenting adults for money, goods or services and communication with another about, advertising an offer for, or sharing premises with another for the purpose of exchanging sexual services between consenting adults for money, goods or services, whether in a public or private place, may not be criminalized, absent coercion, force, abuse of authority or fraud. Criminal law may not proscribe the conduct of third parties who, directly or indirectly, for receipt of a financial or material benefit, under fair conditions – without coercion, force, abuse of authority or fraud – facilitate, manage, organize, communicate with another, advertise, provide information about, provide or rent premises for the purpose of the exchange of sexual services between consenting adults for money, goods or services." The 8 March Principles, PRINCIPLE 17 – SEX WORK, p. 23.

Consent in the sexual conduct context

In the context of sexual conduct, 'consent' may be defined as the act of communicating voluntary agreement to the sexual activity in question by words or conduct when such consent is capable in law of being legally effective. In the sexual conduct context, consent, in a nutshell, is a "voluntary agreement".[15] However, for it to be valid, consent in the sexual activity context must be premised on the legal capacity of the parties willing to engage in such conduct to be able, legally speaking, to enter into such an agreement. The ability to consent to engage in sexual activity is integrally related to the concept of legal capacity, without which, some sexual acts may entail criminal liability.[16]

In the sexual conduct context, age is another critical notion. The age of consent is the age at which domestic law deems individuals legally capable of consenting to sexual conduct. In some instances, however, even when in law (*de iure*) people are not legally capable of consenting – as it is the case with adolescents under the legal minimum age of sexual consent in domestic law – they may, in actual fact (*de facto*), be able to give valid consent, depending on the circumstances, and their age may therefore not be a bar to their ability to do so in practice. Thus, it is possible that, on a case-by-case basis, the de jure presumption negating consent that applies to all adolescents below the legal minimum age of sexual consent be capable of rebuttal.

Gender and disability are two other key factors worth highlighting as a result of the role they may play in determining what counts as consent to sexual conduct.

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[15] And for clarity's sake, it is worth emphasizing that in the sexual conduct context reference is made to consent, not informed consent. See, for example, [full ref. to excerpt below, Beyond Virtue and Vice Rethinking Human Rights and Criminal Law. Edited by Alice M. Miller and Mindy Jane Roseman] "Consent emerged as the term garnering consensus among sexual rights advocates as the dividing line between "good" and "bad" sex in the modern regime of human rights. Promoting consent was meant to extract "good," voluntary sexual behavior from regulation by criminal law. It allowed for same and differentsex sexuality to be judged under the same standard, freed of "immorality." Moreover, the search for meaningful consent among feminist and women's human rights groups became the holy grail of "good sex." Many feminists distrust "consent" as a shibboleth of a liberal state, a legal fiction behind which unequal power flows; feminists thus seek to fill its content with more than "mere agreement" in order to counteract the tolerance for so much unwanted, but consented to, sex. But fewer and fewer actions by women and girls, or anyone in constrained circumstances, will meet this new standard of meaningful consent, as the circle of meaningful consent draws tight, producing even more criminalization. In NGO advocacy and documentation literatures, as well as a range of court decisions, one finds an expanding array of things and conditions postulated to vitiate meaningful consent. Poverty, discursively attributed to all women selling sex, negates meaningful consent, as does lack of information about health or, more particularly, HIV status. Age differentials, discussed in the next section, are also used to determine the boundaries of consent, with varying rationales for bright lines across hetero and homosexual sex, and with insidious race and class implications. Other key kinds of information whose denial or misapprehension can remove consent are, according to a British court, confusion about the gender of one's sexual partner. As Carole S. Vance notes, the role of information in consent is vexed: while more information on sexuality in general, and the sexual health and status of a partner in particular, is valuable, information's wholesale incorporation into criminal law as part of the standard ("informed consent") for sex is a serious mistake. Overall, criminal law remains the default regulator of sex, rendering women (and men) vulnerable to overprosecution." (emphasis added)

[16] With respect to both legal capacity and consent, see also The 8 March Principles mentioned above.

Consent in the context of healthcare, goods and services

In the context of the access to and the provision of healthcare, goods and services, on the other hand, WHO refers to informed consent in the following terms "To be able to provide informed consent, the individual must be provided sufficient information (and in language that is appropriate) about all available options and their benefits and consequences, in order to make choices; given an explanation of what will happen to them; informed about their right to refuse any part of the care; and told about what information will be shared and with whom and limits to confidentiality. The individual must also have the capacity to know and understand the nature of care being offered and its benefits and consequences. Parents or legal guardians are typically responsible for giving informed consent until their child or adolescent is legally able to give consent for obtaining relevant clinical care. However, in situations where it is in the best interests of the child or adolescent, informed consent should be sought from that child or adolescent."[17]

UNAIDS, UNFPA and WHO in 2004 pointed to the "need to address ethical issues around medical procedures, confidentiality and the age of consent. In many countries health workers are not able to offer tests for sexually transmitted diseases or treatment for children this age without the consent of parents or guardians. Sometimes, medical staff have to seek permission from the same adult who put the young person at risk in the first place. Such issues need resolving", and "clear policies are needed to allow health and other staff to support young adolescents."[8] Already in 1994, the "International Conference on Population and Development in Cairo declared that 'Information and services should be made available to adolescents that can help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility."[19] And still, years on since Cairo, "health staff still face a dilemma about offering a young adolescent an HIV test or a pregnancy test. Do they have to seek parental permission? To whom do they have to give the results? Do parents and adults always act in the best interests of the child? What happens if the rights of the child conflict with the rights of the parents? Countries need clear policies that allow young people who have used drugs or taken part in risky sex, to seek tests and, where necessary, treatment, without having to seek prior permission."[21]

It is worth emphasizing that, just as much as in relation to consent in the sexual conduct context, with respect to the provision of and access to healthcare, goods and services too, including SRHCGSs, considerations pertaining to legal capacity, age, gender and disability (at least) inform what may count as informed consent.

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[17] Responding to Children and Adolescents Who Have Been Sexually Abused: WHO Clinical Guidelines – Glossary, Consent to clinical care, https://www.ncbi.nlm.nih.gov/books/NBK493117/.

[18] Seen but not heard … Very young adolescents aged 10-14 years, Published by UNAIDS, UNFPA and WHO, August 2004, p. 21.

[19] Ibid, p. 31.

[20] Ibid, p. 31.

Methodology and sources

The majority of the findings presented below are drawn from both the General Comments/Recommendations and the jurisprudence of the United Nations human rights Treaty Bodies: the Human Rights Committee (CCPR); the Committee against Torture (CAT); the Committee on the Elimination of Discrimination against Women (CEDAW); the Committee on the Elimination of Racial Discrimination (CERD); the Committee on the Rights of Persons with Disabilities (CRPD); the Committee on Enforced Disappearances (CED); the Committee on Economic, Social and Cultural Rights (CESCR); the Committee on the Rights of the Child (CRC); and the Committee on Migrant Workers (CMW). For the sake of completeness, it should be noted that the individual complaint mechanism for the CMW has not yet entered into force. Therefore, unlike the other eight Treaty Bodies, the CMW has not generated any individual complaints jurisprudence.

All UN human rights Treaty Bodies' General Comments/Recommendations published before March 2019 were searched by using keywords. Keyword searches were also systematically carried out using the Treaty Bodies jurisprudence database (i.e., https://juris.ohchr.org/) covering the entire collection of cases from the Treaty Bodies' jurisprudence on individual complaints available up until the end of March 2019.

The keyword searches of the Treaty Bodies' jurisprudence yielded a total of 1322 cases – the breakdown of the hits returned is as follows: assent = 4 cases; authorization = 221 cases; authorize = 79 cases; capacity = 288 cases; consensual = 12 cases; consent = 237 cases; decision-making = 147 cases; free will = 32 cases; informed consent = 10 cases; voluntarily = 178 case; voluntary = 114 cases.

The keywords used were selected initially based on those identified and used for a WHO-commissioned review entitled "Consent related to sexual and reproductive rights, a review of discussion in World Health Organization publications".[21] Lucinda O'Hanlon and the authors then further refined the selection of keywords for the present study, partly based on their anecdotal knowledge of the sources. To be clear, while the purpose was to identify first and foremost documents for their relevance to the notion of consent as arising in relation to the two main research focuses of the present study – namely, SRHCGSs and sexual conduct – the keywords ultimately selected and used yielded a much larger pool of documents – as illustrated by the findings below. Moreover, while most of the keywords employed in the searches do not have any specificity per se with respect to SRHCGSs or sexual conduct, the authors carried out additional "spot-checks" with more specific keyword terms, such as abortion, contraception and rape, none of which returned any additional hits.

All documents that were returned as hits – both those found through keyword searching the General Comments/Recommendations and those found by keyword searching the Treaty Bodies' jurisprudence – were then searched again individually using the same keyword that had returned them as a hit and scanned for their relevance to consent. All those deemed relevant (e.g. those that discussed sexual and reproductive health and/or sexual activity) were then read and analysed in full. As far as the documents returned as hits by keyword searching and scanning the Treaty Bodies' jurisprudence, the vast majority was discarded as irrelevant for present purposes. Approximately 25 cases, as identified in detail in the following sections, constitute the primary source material of the research findings presented in this paper, together with the General Comments/Recommendations individually referred to below.

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[21] That review, on file with the authors, consisted of searching all publications by the Sexual and Reproductive Health programme at WHO under the topic Gender and Rights (https://www.who.int/reproductivehealth/publications/gender_rights/en/) using the following keywords: consent; consenting; consensual; informed consent; decision; informed decision; choice; informed choice; consent by minors; presumed consent; implied consent; third-party consent; third-party authorization; parental consent; parental authorization; guardian consent; guardian authorization; capacity; capacities; voluntary; voluntarily; voluntarism; assent; assenting; judicial role; legal; legal capacity; participation; participatory; participate; privacy; confidential; confidentiality; informed decision-making; supported decision-making; shared decision-making; rape; defilement; adolescent; persons with disabilities; people with disabilities; emancipation; emancipate; coerce; coercion; coerced; coercing.

Findings, scope and key questions

The material collected was reviewed and examined with particular care paid to consent notions in the areas related to sexual and reproductive health and sexual conduct. Thus, many of the research findings presented below pertain to the notion of consent as it arises in the two contexts – namely, the provision of and access to healthcare, goods and services, including SRHCGSs, and in respect of consent to sexual conduct.

However, with the exception of the two main areas of enquiry (i.e., consent to sex and consent in relation to SRHCGSs), the research findings are not presented on the basis of pre-determined categories as such, rather they are arranged as a result of an iterative research process. The way in which these research findings are organized has evolved overtime along with the authors' own thinking, including, to a large extent, based on their detailed review of the many insightful comments of external reviewers on a previous version of this paper, and on their own review and analysis of the research materials collected. The authors have attempted to present their research findings in a way that both reflects the treaty-based human rights standards they have identified, and one that seeks to highlight and summarize key criteria, principles and overarching considerations that may be relevant to evidencing consent or absence thereof that the keyword searches of Treaty Bodies' jurisprudence and General Comments/Recommendations have thrown up.

The authors have also decided to present the research findings focussing on three population groups for whom the right to make autonomous decisions whether in relation to sex or to sexual and reproductive health has historically been limited: adolescents, women and persons with disabilities.

It is hoped that the findings the research has thrown up help in the following ways:
- in answering some/all of the key questions listed below;
- in establishing criteria based on human rights law and standards which, in turn, assist in determining whether consent was provided in any given context (e.g., access to/provision of SRHCGSs; or sexual conduct; others).
- These criteria will be different depending on the context, and the notion of consent concerned, e.g. informed consent – or more accurately autonomous and informed decision-making – in the context of sexual and reproductive health and consent in the context of sexual conduct;
- by outlining States' human rights law obligations to respect, protect and fulfil one's right to make autonomous decisions and the right to control over one's body, and what these obligations entail in terms of implementation measures;
- by describing the instances where Treaty Bodies have found that consent was absent, characterizing such absence in terms of human rights violations, and setting out the actual provisions/articles/rights violated, as well as States' relevant human rights obligations;
- identifying remedial and redress measures, in the individual instances considered, as well as setting out general recommendations stemming from States' human rights obligations.

Key questions:
- Determine context first; consent to what? Sex? Provision of healthcare, goods and services? Or something else altogether?
- Once context has been identified/clarified, who may give consent? Who is consenting?
- What role may gender, age, disability status and other factors play, if any, on one's right to make autonomous decisions and on the right to control over one's body?
- What are they giving consent to? With whom? Where?
- Depending on the context, how is consent demonstrated/evidenced? What are the criteria for doing so?
- Who bears the burden of demonstrating it?
- If consent is deemed absent, who is harmed?

1) Overarching considerations

This section seeks to summarize key criteria, principles and overarching considerations that may be relevant to evidencing consent or absence thereof, which have been identified through key word searches of Treaty Bodies' jurisprudence and by analysing a number of Treaty Bodies General Comments/Recommendations. The topics addressed in this section of the paper do not address sex or SRHCGSs as such but, as overarching considerations, they may be relevant to evidencing consent in a variety of contexts, including in respect of sexual conduct and sexual and reproductive health (and, more broadly, in respect of consent as relevant to the provision of healthcare, goods and services).

Albeit not expressly addressing sex or SRHCGSs, the authors have still chosen to present these findings here because they represent the Treaty Bodies' output on one's right to make autonomous decisions as relevant to and arising from a variety of other contexts. The authors are aware of the fact that, while interesting, they may not – and certainly not always – assist in identifying human rights standards related to consent to sex or SRHCGSs.

Consent in marriage

While valid consent in marriage is never evidence of and should never be confused or equated with consent to sexual conduct with one's spouse, marriage is a context in which treaty-based human rights standards pertaining to consent exist, making it both a propitious and valid topic of examination for present purposes. In addition, as mentioned above, there are specific marriage-related scenarios where healthcare providers may face specific challenges pertaining to consent.[22]

- States have an obligation to ensure that marriage be entered into with the free and full consent of the intending spouses.
- Free and full personal consent should be provided in a form and under conditions prescribed by law.

Explanation

The Human Rights Committee has held that, according to Article 23(2) of the Covenant, "no marriage shall be entered into without the free and full consent of the intending spouses", and that, while the "Covenant does not establish a specific marriageable age either for men or for women, but that age should be such as to enable each of the intending spouses to give his or her free and full personal consent in a form and under conditions prescribed by law."[23]

CESCR has clarified that, "Article 10, paragraph 1, of the Covenant requires that States parties recognize that [….] marriage must be entered into with the free consent of the intending spouses."[24]

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[22] E.g., women seeking contraception in countries where married women are to obtain the consent or authorization of their husband to access contraceptive health services; or when an underage married pregnant girl seeks to access pre-natal care, a scenario that for healthcare workers may, in turn, give rise to the need to consider issues associated with consent, including potential coercion and limited autonomous decision-making; mandatory reporting of harmful practices, such as 'child and forced marriage'; and assumptions about and the need to assess the potential for sexual abuse.

[23] UN Human Rights Committee (HRC), CCPR General Comment No. 19: Article 23 (The Family) Protection of the Family, the Right to Marriage and Equality of the Spouses, 27 July 1990, para. 4.

[24] CESCR, General comment No. 16 (2005) The equal right of men and women to the enjoyment of all economic, social and cultural rights (art. 3 of the International Covenant on Economic, Social and Cultural Rights), para. 27.

Gender and age considerations relevant to consent in marriage

CEDAW has held that a "woman's right to choose a spouse and enter freely into marriage is central to her life and to her dignity and equality as a human being", and that "[s]ubject to reasonable restrictions based for example on a woman's youth or consanguinity with her partner, a woman's right to choose when, if, and whom she will marry must be protected and enforced at law".[25]

The Human Rights Committee has also clarified that "States have an obligation to protect the enjoyment of this right [i.e., the right to marry] on an equal basis. Many factors may prevent women from being able to make the decision to marry freely [....] criteria should ensure women's capacity to make an informed and uncoerced decision. A second factor in some States may be that either by statutory or customary law a guardian, who is generally male, consents to the marriage instead of the woman herself, thereby preventing women from exercising a free choice. [...] Another factor that may affect women's right to marry only when they have given free and full consent is the existence of social attitudes which tend to marginalize women victims of rape and put pressure on them to agree to marriage. A woman's free and full consent to marriage may also be undermined by laws which allow the rapist to have his criminal responsibility extinguished or mitigated if he marries the victim," and that "the right to choose one's spouse may be restricted by laws or practices that prevent the marriage of a woman of a particular religion to a man who professes no religion or a different religion. States should provide information on these laws and practices and on the measures taken to abolish the laws and eradicate the practices which undermine the right of women to marry only when they have given free and full consent."[26]

CESCR has clarified that, "Implementing article 3, in relation to article 10, requires States parties, *inter alia*, [....] to ensure that men and women have an equal right to choose if, whom and when to marry - in particular, the legal age of marriage for men and women should be the same, and boys and girls should be protected equally from practices that promote child marriage, marriage by proxy, or coercion".[27]

CEDAW has also made clear that it "considers that the minimum age for marriage should be 18 years for both man and woman. When men and women marry, they assume important responsibilities. Consequently, marriage should not be permitted before they have attained full maturity and capacity to act."[28]

CEDAW and the CRC have jointly held that "A child marriage is considered to be a form of forced marriage, given that one and/or parties have not expressed full, free and informed consent. As a matter of respecting the child's evolving capacities and autonomy in making decisions that affect her or his life, a marriage of a mature, capable child below 18 years of age may be allowed in exceptional circumstances, provided that the child is at least 16 years of age and that such decisions are made by a judge based on legitimate exceptional grounds defined by law and on the evidence of maturity, without deference to culture and tradition."[29]

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[25] CEDAW, General recommendation No. 21: Equality in marriage and family relations, 1994, para. 16.

[26] Human Rights Committee, General Comment No. 28Article 3 (The equality of rights between men and women), paras 23 and 24.

[27] CESCR, General comment No. 16 (2005) The equal right of men and women to the enjoyment of all economic, social and cultural rights (art. 3 of the International Covenant on Economic, Social and Cultural Rights), para. 27.

[28] CEDAW, General recommendation No. 21: Equality in marriage and family relations, 1994, para. 36.

[29] CEDAW and CRC, Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices, 2014, para. 20.

CEDAW and the CRC have called on States to ensure that "a minimum legal age of marriage for girls and boys, with or without parental consent, is established at 18 years. When a marriage at an earlier age is allowed in exceptional circumstances, the absolute minimum age must not be below 16 years, the grounds for obtaining permission must be legitimate and strictly defined by law and the marriage must be permitted only by a court of law upon the full, free and informed consent of the child or both children, who must appear in person before the court".[30]

A child marriage is a form of forced marriage, given that one and/or both parties have not expressed and/or not been deemed capable of expressing full, free and informed consent. However, it is the lack of legal capacity on the part of the spouse/s in child marriage in the first place that invalidates consent to it. One can express such consent, but still lack the relevant legal capacity for it to be valid.

Overarching considerations pertaining to children and adolescents relating to consent

The findings presented below concern States' treaty-based human rights obligations to ensure respect, protection and fulfilment of the right of adolescents under eighteen years of age – and younger children in some circumstances – to make autonomous decisions, including in instances when domestic legislation may deem them legally incapable to provide consent (e.g., when they are below the age of sexual consent).

Human rights treaty-based standards highlighted in the findings below – including chiefly certain key provisions in the Convention on the Rights of the Child (see in detail below) – may be harnessed to determine whether adolescents under eighteen years of age, in particular – but also younger children in certain instances – may actually be capable of making autonomous decisions – notwithstanding their position under domestic legislation – by focusing on whether they demonstrate sufficient understanding of what is proposed to them, of what their choices would entail, as well as about the consequences of such choices for them and others. They are not required to have comprehensive knowledge of all aspects of the matter affecting them. All is needed is that they have a sufficient understanding to be capable of appropriately forming their own views on the matter at hand. If this is the case, then – irrespective of their "legal incapacity" under domestic legislation and consistent with the above-mentioned human rights standards – they are entitled to be informed of their right to make autonomous decisions and may choose to exercise this right, e.g., by giving or withholding their consent.

- States have additional obligations towards adolescents/children stemming from the recognition that they differ from adults.
- Due weight is to be given to adolescents/children's special physical, psychological, emotional and educational development and needs.
- Adolescents/children are entitled to a "special protection" standard. States have obligations to take special measures of protection in respect of adolescents/children.
- Adolescents/children have a right to have their best interests assessed and taken into account as a primary consideration in respect of all actions or decisions concerning them.[31]
- Determining the best interests of the adolescent/child must include a process of weighing their wishes and views.[32]
- Adolescents/children have a right to be heard.

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[30] CEDAW and CRC, Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices, 2014, para. 55(f).

[31] Committee on the Rights of the Child, General Comments: CRC/C/GC/14, CRC/C/GC/12, CRC/C/GC/15, CRC/C/GC/7/Rev.1, CRC/C/GC/9.

[32] See CRC General Comments: CRC/C/GC/14, CRC/C/GC/12, CRC/C/GC/15, CRC/C/GC/7/Rev.1.

- Being too young does not deprive children of their right to express their views in connection with all matters affecting them, including in determining their best interests.
- Taking those principles into account must go hand in hand with an awareness of adolescents/children's evolving capacities – i.e., the weighting given to their views and wishes increases with time and maturity. [33]
- Adolescents/children must have a role in the decision-making process.
- There must be an individual assessment that assures a role to adolescents/children themselves in the decision-making process.
- Adolescents/children need not to have comprehensive knowledge of all aspects of the matter affecting them. All is needed is that they have a sufficient understanding to be capable of appropriately forming their own views on the matter at hand.
- Adolescents/children's age must be taken into consideration throughout, e.g., from the moment the health-care treatment/service/procedure is being contemplated onwards.
- Depending on age, etc., the child/adolescent must be informed of the possibility of objecting to, e.g., the said health-care treatment/service/procedure.
- Adolescents/children should also be informed of the possibility being accompanied by parents/legal guardian or other adults.
- At age twelve, children are likely to be able to give consent to the lodging of a complaint on their behalf (e.g., with a Treaty Body). By the same token, it should not be presumed that they would not object, let alone consent, to proceeding with such a complaint.

Explanation

States parties to human rights treaties have additional obligations stemming from the recognition that adolescents/children differ from adults. They are to give due weight to their special physical, psychological, emotional and educational development and needs.[34]

In addition, adolescents/children are entitled to "special measures of protection", which States parties are obliged to take.[35] Specific attention should be given to the need for the protection of their right to privacy.

Adolescents/children have a right to have their best interests assessed and taken into account as a primary consideration in respect of all actions or decisions concerning them.[36]

The Convention on the Rights of the Child imposes no age limit on the right of adolescents/children to express their views in in all matters affecting them. In *Y.B. and N.S. v. Belgium*, the Committee on the Rights of the Child observed that, "article 12 imposes no age limit on the right of the child to express her or his views".[37]

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[33] See, CRC General Comments: CRC/C/GC/12, CRC/GC/2003/4, CRC/C/GC/7/Rev.1, CRC/C/GC/20.

[34] N.K. v. The Netherlands, Human Rights Committee, CCPR/C/120/D/2326/2013/Rev.1, 10 January 2018, para. 9.10: "The Committee however considers that children differ from adults in their physical and psychological development, and their emotional and educational needs."

[35] N.K. v. The Netherlands, para. 9.10: "As provided for, in, among others, articles 24 and 14 (4) of the Covenant, State parties have the obligation to take special measures of protection."

[36] CRC/C/GC/14, CRC/C/GC/12, CRC/C/GC/15, CRC/C/GC/7/Rev.1, CRC/C/GC/9. N.K. v. The Netherlands, para. 9.10: "In particular, in all decisions taken within the context of the administration of juvenile justice, the best interest of the child should be a primary consideration."

[37] Y.B. and N.S. v. Belgium, 27 September 2018, Committee on the Rights of the Child, CRC/C/79/D/12/2017, para. 8.7, https://juris.ohchr.org/Search/Details/2421.

Furthermore, just because children are very young or are otherwise in a "vulnerable situation" (e.g., they belong to a minority group, are migrants, etc.) does not mean that they can be deprived of their right to express their views, or that the weight given to their views in determining their best interests can be reduced. [38]

In *Y.B. and N.S.*, the Committee also observed that "any decision that does not take into account the child's views or does not give their views due weight according to their age and maturity, does not respect the possibility for the child or children to influence the determination of their best interests".[39]

Again in *Y.B. and N.S.*, the Committee on the Rights of the Child held that, "[t]he adoption of specific measures to guarantee the exercise of equal rights for children in such situations must be subject to an individual assessment which assures a role to the children themselves in the decision-making process".[40]

In light of this, in the same case the Committee went on to conclude that, "the State party did not specifically consider the best interests of the child when it assessed the application for a visa for C.E. and did not allow her the right to be heard, in breach of articles 3 and 12 of the Convention".[41]

The Committee on the Rights of the Child has also held that States should not introduce any age limit on the right of adolescents/children to express their views in in all matters affecting them, either in law or practice. For example, in *Y.B. and N.S.*, the Committee noted that article 12 of the Convention "discourages States parties from introducing age limits either in law or in practice that would restrict the child's right to be heard in all matters affecting her or him".[42]

Again in *Y.B. and N.S.*, the Committee on the Rights of the Child observed that, "[i]t is not necessary that the child has comprehensive knowledge of all aspects of the matter affecting her or him, but that she or he has sufficient understanding to be capable of appropriately forming her or his own views on the matter".[43]

In *X v. Serbia*, the Human Rights Committee observed that the adolescent who was at the heart of the complaint being examined at the admissibility stage – and who was twelve years of age at the time of the lodging of the communication with the Committee – would have been "likely to be able to give his consent to the presentation of the complaint".[44] Nonetheless, in the same case, the Committee also held that, in circumstances where the adolescent in question had not given his consent to the submission of the communication, it could not "assume that the child does not object, let alone consent, to the author proceeding with a communication to the Committee".[45]

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[38] For example, again in Y.B. and N.S, the Committee on the Rights of the Child held that, "The fact that the child is very young or in a vulnerable situation (e.g. has a disability, belongs to a minority group, is a migrant, etc.) does not deprive him or her of the right to express his or her views, nor reduces the weight given to the child's views in determining his or her best interests". Y.B. and N.S. v. Belgium, para. 8.7.

[39] Y.B. and N.S. v. Belgium, para. 8.7.

[40] Y.B. and N.S. v. Belgium, para. 8.7.

[41] Y.B. and N.S. v. Belgium, para. 8.7.

[42] Y.B. and N.S. v. Belgium, para. 8.7.

[43] Y.B. and N.S. v. Belgium, para. 8.7.

[44] X v. Serbia, 22 May 2007, CCPR/C/89/D/1355/2005, para. 6.5, http://juris.ohchr.org/Search/Details/1296.

[45] X v. Serbia, para. 6.7.

Children/adolescents with disabilities

In its General Comment No. 5 on Persons with Disabilities, the CESCR has underscored that, because adolescents/children with disabilities are especially vulnerable to exploitation, abuse and neglect, they "are entitled to special protection."[46]

Just because children are in a vulnerable situation (e.g., they have a disability) does not mean that they can be deprived of their right to express their views, or that the weight given to their views in determining their best interests can be reduced. In Y.B. and N.S, the Committee on the Rights of the Child held that, "[t]he fact that the child is very young or in a vulnerable situation (e.g. has a disability, belongs to a minority group, is a migrant, etc.) does not deprive him or her of the right to express his or her views, nor reduces the weight given to the child's views in determining his or her best interests".[47]

Legal capacity

As mentioned above, the concept of consent is based on three legal doctrines, including legal capacity. This notion concerns the idea that before one is to enter into an agreement they have to have the legal capacity to consent to such an agreement; legal capacity, in turn, is grounded on the idea that one has to have the capacity, knowledge and ability to understand what one is promising to do, and what one is being promised in return. Different and varying notions of 'capacity' come into play depending on the context. As emphasized above, considerations pertaining to legal capacity – as with age, gender and disability – inform and are at the root of what may count as consent. In addition, as mentioned above, the ability to provide consent – e.g., to engage in sexual activity – is integrally related to the concept of legal capacity, without which, for example, some sexual acts may entail criminal liability. Legal capacity is a prerequisite for consent.

Denying a person's legal capacity may constitute prohibited discrimination. The Committee on Economic, Social and Cultural Rights (CESCR) has recognized that the denial of a person's legal capacity – for example, because they are in prison, or are involuntarily held in a psychiatric institution – may constitute a prohibited discrimination ground.[48]

Gender, age and legal capacity

Women, in particular older women, are at risk of exploitation and abuses in circumstances when, without their consent, their legal capacity is deferred to others. CEDAW has held that, "[o]lder women are particularly vulnerable to exploitation and abuse, including economic abuse, when their legal capacity is deferred to lawyers or family members without their consent."[49]

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[46] "Children with disabilities are especially vulnerable to exploitation, abuse and neglect and are, in accordance with article 10 (3) of the Covenant (reinforced by the corresponding provisions of the Convention on the Rights of the Child), entitled to special protection." CESCR, General Comment No. 5: Persons with Disabilities, 9 December 1994, E/1995/22, para. 32.

[47] Y.B. and N.S. v. Belgium, para. 8.7.

[48] "Other possible prohibited grounds could include the denial of a person's legal capacity because he or she is in prison, or is involuntarily interned in a psychiatric institution, or the intersection of two prohibited grounds of discrimination, e.g. where access to a social service is denied on the basis of sex and disability", CESCR, General Comment No. 20, Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), para. 27.

[49] CEDAW, General recommendation No. 27 on older women and protection of their human rights, 2010, para. 27.

Legal capacity in the disability context

- In the disability context, States must recognize and uphold the legal capacity of persons with disabilities on an equal basis with others in all aspects of life, including, therefore, in the context of access to and the provision of healthcare, goods and services or in the context of sexual conduct. States have a positive duty to take the necessary measures to guarantee to persons with disabilities the actual exercise of their legal capacity. People with disabilities are entitled to the support they may require to exercise their legal capacity.

- While States have a certain discretion in determining the arrangements required to enable persons with disabilities to exercise their legal capacity, the relevant rights of the person concerned must be respected. In particular, whenever people's capacity is diminished, such that it might affect their ability to take part effectively in proceedings/decisions/procedures/decision-making, the State should ensure assistance and representation in a way sufficient to safeguard their rights throughout. In addition, the procedures must be "appropriate, accessible and easy to understand and use".[50]

Explanation

Taking decisions on behalf of persons with disability, or deciding that they are unfit to make a decision (e.g., to plead to a criminal charge, and thus to consent to a criminal trial, or to decide whether to elect to have a certain medical procedure) deprives them of the possibility of exercising their legal capacity, and results in a denial of their right to exercise their legal capacity. This is contrary to article 12 (2) of the UN Convention on the Rights of Persons with Disabilities (UNCRPD), under which States have the obligation to recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

For example, in *Marlon James Noble v. Australia*, the CRPD held that "the decision that the author was unfit to plead because of his intellectual and mental disability resulted in a denial of his right to exercise his legal capacity to plead not guilty and to test the evidence against him. Furthermore, no adequate form of support was provided by the State party's authorities to enable him to stand trial and plead not guilty, despite his clear intention to do so. He therefore never had the opportunity to have the criminal charges against him determined and his status as an alleged sexual offender potentially cleared."[51]

The CRPD Committee has cautioned that, "[w]omen with disabilities, more often than men with disabilities and more often than women without disabilities, are denied the right to legal capacity."[52]

Under article 12 (3) of the Convention on the Rights of Persons with Disabilities, States parties have the obligation to provide access to the support that persons with disabilities may require to exercise their legal capacity.[53]

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[50] For instance, with respect to voting, in Bujdosó v. Hungary, the Committee on the Rights of Persons with Disabilities (CRPD) recalled that, "under article 29 of the Convention, the State party is required to adapt its voting procedures, by ensuring that they are "appropriate, accessible and easy to understand and use", Bujdosó v. Hungary, 9 September 2013, CRPD/C/10/D/4/2011, para. 9.6, http://juris.ohchr.org/Search/Details/1988.

[51] Marlon James Noble v. Australia, 10 October 2016, CRPD, CRPD/C/16/D/7/2012, para. 8.6, http://juris.ohchr.org/Search/Details/2144.

[52] The CRPD Committee, General comment No. 3 (2016) on women and girls with disabilities, 25 November 2016, CRPD/C/GC/3, para. 51.

[53] In Makarova v. Lithuania, the CRPD recalled that, "under article 12 (3) of the Convention, States parties have an obligation to 'take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'", Makarova v. Lithuania, 5 October 2017, CRPD/C/18/D/30/2015*, para. 7.6, http://juris.ohchr.org/Search/Details/2392.

While States have a certain margin of appreciation to determine the procedural arrangements to enable persons with disabilities to exercise their legal capacity, the relevant rights of the person concerned must be respected.[54] With respect to this, whenever people's capacity is diminished, such that it might affect their ability to take part effectively in proceedings/decisions/procedures/decision-making, the State should ensure assistance and representation in a way sufficient to safeguard their rights throughout. For example, in *Bozena Fijalkowska v. Poland*, the Human Rights Committee held that "the State party has a particular obligation to protect vulnerable persons within its jurisdiction, including the mentally impaired. It considers that as the author suffered from diminished capacity that might have affected her ability to take part effectively in the proceedings herself, the court should have been in a position to ensure that she was assisted or represented in a way sufficient to safeguard her rights throughout the proceedings".[55]

Extrapolating by analogy from the above, in the context of the provision of healthcare, goods and services, as well as in relation to sexual conduct, people whose capacity is diminished have a right to be assisted so as to ensure that their rights are sufficiently safeguarded. This is consistent, for example, with the CRPD Committee's recommendation that "States parties should reach out directly to women and girls with disabilities and establish adequate measures to guarantee that their perspectives are fully taken into account and that they will not be subjected to any reprisals for expressing their points of view and concerns, especially in relation to sexual and reproductive health and rights, as well as gender-based violence, including sexual violence."[56]

Consent to act on others' behalf

- Whenever someone purports to act on behalf of others, their capacity to do so legally speaking (i.e. their standing) depends on whether they can demonstrate that they have obtained consent to act on behalf of others.

Explanation

On the question of standing in the context of complaints lodged on behalf of others, the Treaty Bodies have held that the capacity to act on behalf of others – i.e. to have legal standing on behalf of others – depends on whether there is proof that the individuals on behalf of whom someone is purporting to act have given their consent.[57]

Consent, in turn, may be evidenced in different ways, e.g. signing onto the complaint or issuing a letter of authorization. In *Viktor Korneenko et al. v. Belarus*, the Human Rights Committee noted that, "[t]he author

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[54] In Makarova v. Lithuania, the CRPD further considered that, "while States parties have a certain margin of appreciation to determine the procedural arrangements to enable persons with disabilities to exercise their legal capacity, the relevant rights of the person concerned must be respected", para. 7.6.

[55] Bozena Fijalkowska v. Poland, 4 August 2005, Human Rights Committee, CCPR/C/84/D/1061/2002, para. 8.3, http://juris.ohchr.org/Search/Details/1194.

[56] The CRPD Committee, General comment No. 3 (2016) on women and girls with disabilities, 25 November 2016, CRPD/C/GC/3, para. 23.

[57] In Viktor Korneenko et al. v. Belarus, the Human Rights Committee stated: "On the question of standing, the Committee notes that the author has submitted the communication in his own name and on behalf of 105 other named individuals. At the same time, he has not presented to the Committee any proof whatsoever of their consent, by either requesting each of the other 105 individuals to sign up to the initial complaint or by having them issue a letter of authorisation. The Committee considers that the author has no standing before the Committee required by article 1 of the Optional Protocol with regard to these 105 individuals but considers that the communication is nevertheless admissible so far as the author himself is concerned", para. 6.3, Viktor Korneenko et al. v. Belarus, 10 November 2006, CCPR/C/88/D/1274/2004, http://juris.ohchr.org/Search/Details/1318.

claims to have received the prior consent of the 105 other co-authors to act on their behalf, and lists in relation to each co-author the full name, nationality, occupation, date and place of birth, and current address. He does not submit, however, letters authorising him to act on their behalf."[58]

While the foregoing jurisprudential considerations pertain to legal standing in respect of complaints lodged with the Treaty Bodies, they may, nonetheless, be relevant in other circumstances and contexts. Extrapolating by analogy from the above, for example, in cases where individuals purport to healthcare providers that another individual has given them authority to consent on their behalf to the provision of healthcare, goods and services, one may be able to argue that it would be incumbent on the healthcare providers to require that such consent be evidenced, and also to inquire into the circumstances as to why it is necessary that someone else represents the interests of the individual concerned and acts on their behalf.[58]

Circumstances vitiating consent

- Whatever the context, intimidation and coercion vitiate consent – consent is only valid when free and voluntary.
- An individual's "consent" is vitiated by any direct or indirect physical or psychological coercion or intimidation, including in relation to consent in the context of SRHCGSs.

Explanation

Treaty Bodies have held that, particularly in the context of custody cases, treatment at the hands of the authorities that amount to intimidation or coercion vitiates consent. They have clarified that, for there to be free and voluntary consent, there has to be no intimidation or coercion. In one particular case, the Committee against Torture found the detained person's refusal to have lawyers representing his interests; his refusal to testify further; his retraction of previous statements; and his declaration of no claim against the police to have all resulted from intimidation or coercion, as opposed to from his free and voluntary consent.[59] In particular, in its decision in that case, the Committee stated: "[i]n the light of the psychiatric evaluation conducted against the complainant's will during the renewed investigation, the pressure exercised on his family in order to persuade him to drop his complaints and the incidents of intimidation that had taken place in 2007, the Committee considers that the letters of February 2011 – by which the complainant refused the services of his lawyer and thereafter refused to testify further, retracted his previous statements and declared that he had no claims against the police – cannot be regarded as a result of his free and voluntary consent, without any intimidation or coercion."[60]

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[58] Viktor Korneenko et al. v. Belarus, para. 1.

[59] Alexander Gerasimov v. Kazakhstan, Committee against Torture, 24 May 2012, CAT/C/48/D/433/2010, http://juris.ohchr.org/Search/Details/26.

[60] Alexander Gerasimov v. Kazakhstan, para. 12.6.

2) Criteria regarding consent in the context of sexual conduct/relations

The following is a summary of key criteria/principles/considerations relevant to evidencing consent or absence thereof in respect of sexual conduct/relations.

Consent in sex

- Consent in the context of sexual conduct entails the existence throughout the sexual act in question of unequivocal and voluntary agreement to engage in such act.
- Consent can be withdrawn at any point while engaging in sexual act/s with others.

Explanation

The treaty bodies jurisprudence indicates that consent in the context of sexual conduct entails the existence of "unequivocal and voluntary agreement" to engage in such conduct.[61]

As mentioned in the background section, in the sexual conduct context, 'consent' may be defined as the act of communicating voluntary agreement to the sexual activity in question by words or conduct when such consent is capable in law of being legally effective. In relation to sexual acts, consent, in a nutshell, is a "voluntary agreement". However, for it to be valid in this context, consent must be premised on the legal capacity of the parties willing to engage in such conduct to be able, legally speaking, to enter into such an agreement.

In addition, and more specifically:
a) words or conduct communicating a voluntary agreement to participate in the sexual activity in question must be contemporaneous/simultaneous to the said activity, and no lack of agreement to continue to engage in the said activity is manifested while the said sexual activity is on-going;
b) those who are communicating their voluntary agreement to the said sexual activity must be legally[62] and factually capable of consenting to the sexual activity in question;
c) the agreement has not been procured through abusing a position of trust, power or authority;
d) no lack of agreement to engage in the sexual activity in question is otherwise communicated by words or conduct.[63]

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[61] See the recommendations made by the CEDAW Committee to the State party in the case of Karen Tayag Vertido v. Philippines, including "Removal of any requirement in the legislation that sexual assault be committed by force or violence," and reference to the fact that the act may "take place in "coercive circumstances", which in turn includes a broad range of "coercive circumstances"; Karen Tayag Vertido v. Philippines, the CEDAW Committee, 22 September 2010, CEDAW/C/46/D/18/2008, para. 8.9, http://juris.ohchr.org/Search/Details/1700.

[62] In some instances, however, as mentioned above (see section entitled "Consent in the sexual conduct context", even when in law (de jure) people are not legally capable of consenting – as it is the case with adolescents under the legal minimum age of sexual consent in domestic law – they may, in actual fact (de facto), be able to give valid consent, depending on the circumstances, and their age may therefore not be a bar to their ability to do so in practice. Thus, it is possible that, on a case-by-case basis, the de jure presumption negating consent that applies to all adolescents below the legal minimum age of sexual consent be capable of rebuttal.

[63] Some feminist legal scholars, however, have opined that, "consent [to sexual activity] is before anything 'a communication under conditions of inequality'. It is situated somewhere between what a woman really wanted, what she was able to say she wanted and what the man understood she wanted'", MacKinnon, 1989, cited by Fassin, 1997, p. 11, see Entrée dans la sexualité des adolescent·e·s : la question du consentement - Enquête en milieu scolaire auprès des jeunes et des intervenant·e·s en éducation à la sexualité, p. 43; and that, "to talk about consent in the context of an unequal situation is in some ways not to talk about consent, for in violence there can be no consent, whether the violence is symbolic or real, 'oppression is not a contract'", ibid, citing (Mathieu, 1984, p. 75).

Legally speaking, domestically, for example in the UK, deception has been found to vitiate consent in the sexual conduct context in the following circumstances: (a) intentional deceit as to the nature or purpose of the relevant sexual act (e.g., consent was obtained by intentionally and deceitfully purporting that sexual intercourse would take place with a condom or that ejaculation would not occur inside the body of the partner consenting to intercourse); and (b) intentionally inducing someone to consent to sex by impersonating a person known personally to that person.[64]

Sexual offences

- Sexual assault, including rape, constitutes a violation of the complainant/survivor's right to personal security, autonomy and bodily integrity (among other rights, including the right to be free from discrimination on the basis of sex/gender).
- Sexual assault, including rape, may occur whatever the relationship between the assailant and the complainant/survivor, the spectrum goes from no pre-existing relationship (e.g. stranger rape) to marital rape.
- A pre-existing relationship, including sexual, between perpetrator and complainant/survivor, does not evidence consent.
- The key definitional criterion for sexual offences, including rape, is the lack of/absence of consent, or the fact that consent is vitiated (for more on this see above).[65]
- Sexual assault, including rape, need not to be committed by force or violence.
- No need for the perpetrator to threaten to use or to use force.
- Sexual conduct may be unwanted, regardless of whether the perpetrator threatened to use or used physical violence.
- Physical resistance may be relevant, but it is not necessary to demonstrate absence of consent to sex.
- Complainant/survivor does not need to prove resistance.
- The fact that the complainant/survivor did not attempt to escape is in no way inconsistent with the absence of consent.
- Coercive circumstances negate consent.
- There is no "rational" or "ideal victim"/complainants/survivor of rape/sexual assault.

Explanation

The CEDAW Committee has characterized sexual offences, including rape, as human rights violations, and offences against the person as opposed to against honour and social mores. In particular, "the Committee has clarified time and again that rape constitutes a violation of women's right to personal security and bodily integrity, and that its essential element was lack of consent."[66] While the Treaty Bodies jurisprudence does not expressly address the fact that the existence or otherwise of a relationship between perpetrator and complainant in the context of sexual offences is not per se evidence of consent, some Treaty Bodies General Comments make this make this point (e.g., in respect of the criminalization of marital rape).

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[64] See, for example, R v Jheeta [2007] 2 Cr App R 34, R v Devonald [2008] EWCA Crim 527 and R v B [2013] EWCA Crim 823, and the discussion of those issues in McNally v R [2013] EWCA Crim 1051, para. 17 and following. In addition, in its judgment in the case of R v EB, the Court of Appeal of England and Wales considered whether failure to disclose HIV status could vitiate consent to sexual intercourse. The Court rejected this observing: "Where one party to sexual activity has a sexually transmissible disease which is not disclosed to the other party any consent that may have been given to that activity by the other party is not thereby vitiated. The act remains a consensual act. However, the party suffering from the sexual transmissible disease will not have any defence to any charge which may result from harm created by that sexual activity, merely by virtue of that consent, because such consent did not include consent to infection by the disease", R v EB, at para. 17, [2006] EWCA Crim 2945, [2007] 1 WLR 1567.

[65] The CEDAW Committee has called on States parties to conduct a "Review of the definition of rape in the legislation so as to place the lack of consent at its centre", Karen Tayag Vertido v. Philippines, para. 8.9.

[66] Karen Tayag Vertido v. Philippines, 22 September 2010, CEDAW/C/46/D/18/2008, para. 8.7, http://juris.ohchr.org/Search/Details/1700.

For example, the CEDAW Committee has called on States parties to "[e]nsure that sexual assault, including rape is characterised as a crime against women's right to personal security and their physical, sexual and psychological integrity. Ensure that the definition of sexual crimes, including marital and acquaintance/date rape is based on lack of freely given consent, and takes account of coercive circumstances."[67]

The Treaty Bodies jurisprudence confirms that violence or force are not necessary to prove the commission of sexual offences, including rape. It is the lack of consent that counts, and there should be no presumption that simply because the perpetrator did not resort to force or violence means that the complainant/survivor must have consented. For example, "the [CEDAW] Committee stresses that there should be no assumption in law or in practice that a woman gives her consent because she has not physically resisted the unwanted sexual conduct, regardless of whether the perpetrator threatened to use or used physical violence."[68]

Moreover, the CEDAW Committee has stressed that, while the complainant's physical resistance may be relevant, it is not necessary to demonstrate the absence of consent to sex. For example, CEDAW has held that, "physical resistance is not an element to establish a case of rape", and that "it is not necessary to establish that the accused had overcome the victim's physical resistance in order to prove lack of consent". [69]

In addition, the CEDAW Committee has also emphasized that the fact that the complainant/survivor did not attempt to escape is in no way inconsistent with the absence of consent. With respect to this, CEDAW has pointed out that, "... people react differently under emotional stress... the failure of the victim to try to escape does not negate the existence of the rape as well as to the fact that 'in any case, the law does not impose upon a rape victim the burden of proving resistance'".

The CEDAW Committee has also held that, if the sexual act/s take/s place is a context characterized by "coercive circumstances", then consent will be negated. The Committee has also held that there is a broad range of "coercive circumstances".[70]

The CEDAW Committee has characterized some of the above misconceptions as gender stereotypes: "[t]he [CEDAW] Committee further notes that the gender stereotypes and misconceptions employed by the trial court included, in particular, lack of resistance and consent on behalf of the rape victim and the use of force and intimidation by the perpetrator."[71]

The CEDAW Committee has also recalled "its jurisprudence that to expect the author to have resisted in the situation at stake reinforces in a particular manner the myth that women must physically resist the sexual assault."[72] Another common stereotype that the CEDAW Committee has identified is the failure of the survivor/complainant to escape as indicative of consent. The Committee has also held that there is no rational/ideal victim of rape. In particular, it has cautioned against judicial stereotyping and misconceptions, such as the existence of "a rational and ideal [rape] victim".

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[67] CEDAW Committee, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, 2017, para. 33 footnotes in the original omitted.

[68] Karen Tayag Vertido v. Philippines, 22 September 2010, CEDAW/C/46/D/18/2008, para. 8.5, http://juris.ohchr.org/Search/Details/1700.

[69] Karen Tayag Vertido v. Philippines, 22 September 2010, CEDAW/C/46/D/18/2008, para. 8.5, http://juris.ohchr.org/Search/Details/1700.

[70] E.g, R.P.B. v. Philippines, 12 March 2014, CEDAW/C/57/D/34/2011, para. 8.10, http://juris.ohchr.org/Search/Details/1875.

[71] R.P.B. v. Philippines, 12 March 2014, CEDAW/C/57/D/34/2011, para. 8.10, http://juris.ohchr.org/Search/Details/1875.

[72] R.P.B. v. Philippines, 12 March 2014, CEDAW/C/57/D/34/2011, para. 8.10, http://juris.ohchr.org/Search/Details/1875.

It has expressed particular concern about the consequences of such stereotypes and misconceptions on complainants/survivors. For example, it found that it was "clear from the judgement [of the domestic court] that the assessment of the credibility of the author's version of events was influenced by a number of stereotypes, the author in this situation not having followed what was expected from a rational and "ideal victim" or what the judge considered to be the rational and ideal response of a woman in a rape situation."[73]

Gender and sexual offences

Offences of sexual assault, including rape, may be perpetrated by and against anyone, regardless of their gender. Women, as well as men, may be perpetrators, as well as survivors/victims of sexual offences.The failure of many national laws to be gender neutral, for example, by failing to cater for the eventuality that men and boys be victims of sexual offences, is a discriminatory practice. Under international human rights standards and under international criminal law, sexual crimes are defied in gender neutral terms.[74]

As noted above, 70 domestic jurisdictions continue to criminalize consensual same-sex sexual conduct, and in some of them non-consensual sexual relations may be prosecuted under so-called sodomy statutes, as a result of a lack of adequately defined sexual offences.

The Treaty Bodies have affirmed the following essential features in defining sexual offences in law, regardless of the gender of the assailant/perpetrator or complainant/survivor:

- Essential element of sexual assault, including rape: lack of consent.
- No requirement in legislation that sexual assault, including rape, be committed by force or violence. Legislative definition of rape must place the lack of consent at its centre.
- Legislation must reflect the fact that there is no need to prove penetration for sexual assault.
- Legislative definition must reflect the fact that when the act takes place in "coercive circumstances" consent is absent; and that a broad range of circumstances may be coercive.
- In the criminal context, the burden to prove absence of consent should not be on the complainant/survivor.
- In the criminal context, for consent to be evidenced requires proof by the accused of steps taken to ascertain whether the complainant/survivor was consenting.

Explanation

The CEDAW jurisprudence features a number of recommendations to State parties to:
a) address the above-mentioned stereotypes;
b) ensure the proper definition and criminalization of sexual offences, including rape;
c) avoid the revictimization of complainants/survivors; and
d) enhance in law and practice understanding and awareness of sexual offences, in particular among judges, lawyers, law enforcement officers and medical personnel.

The CEDAW Committee has made the following recommendations:
"(i) Review of the definition of rape in the legislation so as to place the lack of consent at its centre;
(ii) Removal of any requirement in the legislation that sexual assault be committed by force or violence, and any requirement of proof of penetration, and minimization of secondary victimization of the complainant/survivor in proceedings by enacting a definition of sexual assault that either:

- Requires the existence of "unequivocal and voluntary agreement" and requires proof by the accused of steps taken to ascertain whether the complainant/survivor was consenting; or

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[73] Karen Tayag Vertido v. Philippines, 22 September 2010, CEDAW/C/46/D/18/2008, para. 8.5, http://juris.ohchr.org/Search/Details/1700.

[74] See, for example, the Elements of Crimes with respect to the Statute of the International Criminal Court, including the "Crime against humanity of rape" in Article 7(1)(g)-1 of the Statute.

- Requires that the act takes place in "coercive circumstances" and includes a broad range of coercive circumstances".[75]

The CEDAW Committee has also held that, "in any case, the law [must] not impose upon a rape victim the burden of proving resistance".[76]

The CEDAW Committee has also recommended that States parties should ensure that domestic legislation and institutions seeking to address gender-based violence against women, should do so "with due respect for women's privacy and confidentiality and with the victims/survivors' free and informed consent."[77] In particular, the CEDAW Committee has urged States parties to ensure that, "gender-based violence against women is not mandatorily referred to alternative dispute resolution procedures", and that the "use of these procedures should be strictly regulated and allowed only when a previous evaluation by a specialised team ensures the free and informed consent by the affected victim/survivor".[78]

Finally, the CEDAW Committee has recommended appropriate training for judges, lawyers, law enforcement officers and medical personnel in understanding crimes of rape and other sexual offences in a gender-sensitive manner so as to avoid re-victimization of survivors/complainants and to ensure that personal mores and values do not affect decision-making.

The CEDAW Committee has characterized the discriminatory treatment received by a rape survivor at the hands of the police and medical personnel as re-victimization. In the specifics of the case, the Committee considered "that the treatment she received in the police station and in the medical centre just after being assaulted, as well as during the court proceedings, when many discriminatory statements were made against her, contributed to her re-victimization, which was aggravated by the fact that she was a minor."[79]

Consent to sex and disability

- The ability to consent to engage in sexual activity is integrally related to the concept of legal capacity, without which, some sexual acts may entail criminal liability.
- Disability: Disability may affect ability to give valid consent – but just because a person has a disability, it absolutely does not entail automatically inability to consent to sex.

Explanation

One's legal capacity to provide voluntary consent to engage in acts of a sexual nature may be affected by disability, whether mental or physical or both, and/or by age (see also next criterion). In a particular case concerning the sexual assault of a minor girl who was deaf, the CEDAW Committee criticized the domestic court's failure to take into account her age and disability in assessing her ability to provide consent in the following terms: "[t]he court should therefore have considered the author's condition as a deaf minor as akin

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[75] Karen Tayag Vertido v. Philippines, 22 September 2010, CEDAW/C/46/D/18/2008, para. 8.9, http://juris.ohchr.org/Search/Details/1700; see, also, R.P.B. v. Philippines, 12 March 2014, CEDAW/C/57/D/34/2011, para. 8.10, http://juris.ohchr.org/Search/Details/1875.

[76] Karen Tayag Vertido v. Philippines, 22 September 2010, CEDAW/C/46/D/18/2008, para. 8.5, http://juris.ohchr.org/Search/Details/1700.

[77] CEDAW Committee, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, 2017, para. 38(c).

[78] CEDAW Committee, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, 2017, para. 45.

[79] L.N.P. v. Argentina, 16 August 2011CCPR/C/102/D/1610/2007*, para. 13.6, http://juris.ohchr.org/Search/Details/1617.

to situations in which the victim is incapable of giving valid consent".[80]

The CRPD Committee (see also above under overarching considerations) has cautioned against the idea that persons with disability would automatically be deemed as lacking the legal capacity to engage in consensual sex. In addition, the CRPD has also warned against "[h]armful stereotypes of women with disabilities [which] include the belief that they are asexual, incapable, irrational, lacking control and/or hypersexual. Like all women, women with disabilities have the right to choose the number and spacing of their children, as well as the right to have control over and decide freely and responsibly on matters related to their sexuality".[81] See also, by analogy, the overarching considerations relevant to disabled persons' ability to consent and legal capacity under the overarching considerations section above. Similar considerations apply with respect to minors.

Age of consent to sexual conduct

- While human rights standards set the age of marriage at eighteen for men and women, the age of consent for sex is generally understood in international human rights standards to be lower than the age of marriage.
- Age: being below the age of consent in respect of sexual relations *de iure* negates ability to give valid consent.
- However, being below the age of consent may not affect ability to give valid consent in practice.
- On a case-by-case basis, the *de iure* presumption negating consent may be capable of rebuttal.[82]

Explanation

The Committee on the Rights of the Child has explained that, "States parties should take into account the need to balance protection and evolving capacities, and define an acceptable minimum age when determining the legal age for sexual consent. States should avoid criminalizing adolescents of similar ages for factually consensual and non-exploitative sexual activity."[83] See, also, *mutatis mutandis*, the overarching considerations pertaining to children in the overarching considerations section.

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[80] R.P.B. v. Philippines, 12 March 2014, CEDAW Committee, CEDAW/C/57/D/34/2011, para. 3.2, http://juris.ohchr.org/Search/Details/1875.

[81] The CRPD Committee, General comment No. 3 (2016) on women and girls with disabilities, 25 November 2016, CRPD/C/GC/3, para. 38.

[82] In a domestic case in South Africa, Teddy Bear Clinic for Abused Children and RAPCAN v. Minister of Justice and Constitutional Development and the National Director of Public Prosecutions, the Constitutional Court held, "It cannot be doubted that the criminalisation of consensual sexual conduct is a form of stigmatisation which is degrading and invasive. In the circumstances of this case, the human dignity of the adolescents targeted by the impugned provisions is clearly infringed. If one's consensual sexual choices are not respected by society but are criminalised, one's innate sense of self worth will inevitably be diminished. Even when such criminal provisions are rarely enforced, their symbolic impact have a severe impact on the social lives and dignity of those targeted...There can be no doubt that the existence of a statutory provision that punishes forms of sexual expression that are developmentally normal degrades and inflicts a state of disgrace on adolescents...therefore, the stigma attached to adolescents by the impugned provisions is manifest."Furthermore, in finding the law contrary to the best interest principle, the Court debunked stereotypes by relying on scientific evidence to find that much of the conduct prohibited is normal for the healthy sexual development of adolescents: "The majority of South African adolescents between the ages of 12 and 16 are engaging in a variety of sexual behaviours as they begin to explore their sexuality. Sexual experiences during adolescence, in the context of some form of intimate relationship, are not only "developmentally significant, they are also developmentally normative." In summarizing expert opinions, the Court observed that "Children charged under the law will "feel a mixture of shame, embarrassment, anger and regret" which will "have an adverse impact on the individual and his or her development." These feelings may generally lead to a negative attitude to sexual relations...and "likely inhibit the individual for seeking help for issues about sex...in order to avoid the emotional distress and interpersonal or social problems, adolescents will avoid seeking help or being open about issues with their sexuality [such that] existing problems will grow and future problems are unlikely to be prevented." ...Far from achieving the positive outcome of deterring harmful effects of associated with early sexual conduct, the impugned provisions are likely to "increase risk for negative experience and outcomes...[and] contribute more to silencing and isolating adolescents which makes unhealthy behaviors and poor developmental outcomes more likely." See, Teddy Bear Clinic for Abused Children and RAPCAN v. Minister of Justice and Constitutional Development and the National Director of Public Prosecutions, Constitutional Court, Case CCT/12/13, [2013] ZACC 35, see paras. 46, 47 and 48.

[83] UNCRC, GC no.20, page 11, para. 40.

3) Criteria regarding consent in the context of healthcare, goods and services, in particular SRHCGSs

This section summarizes key criteria/principles relevant to evidencing consent or absence thereof in respect of access to and the provision of healthcare, goods and services, including, in particular, in the context of the access to and the provision of SRHCGSs.

- Everyone has "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation."[84]
- The right to health includes the right to make free, autonomous and informed decisions concerning any medical treatment, procedures, etc., a person might be subject to.
- Health-care facilities and services are acceptable only if they ensure full, autonomous and informed decision-making, respect for dignity and guarantee confidentiality.
- The right to make free, autonomous and informed decisions regarding one's sexual and reproductive health needs requires that States take measures to address the distinct sexual and reproductive health needs of particular groups, as well as any barriers that they may face.[85]
- Laws and policies that prescribe involuntary, coercive or forced medical interventions, including forced sterilization or mandatory HIV/AIDS, virginity or pregnancy testing, violate the State's responsibility to respect the right to the highest attainable standard of health and the right to physical integrity.[86] Forced sterilization; forced continuation of pregnancy (resulting from refusal to carry out abortions); and forced psychiatric treatment intrinsically and by definition are all non-consensual.
- In those circumstances consent is absent. In this context, States are obliged to remove laws and other legal barriers that interfere with the exercise of the right to sexual and reproductive health.
- States are to refrain from "applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases."
- To subject a person to an order to undergo medical treatment or examination without consent or against the will of that person constitutes an interference with their right to privacy, and may amount to an unlawful attack on his or her honour and reputation.
- Consent must be secured in conjunction with one's right to protection against any unwanted medical intervention, and one's right to make free decisions regarding one's own body.
- Consent to medical treatment must be capable of being withdrawn. The right to waive consent to treatment must be respected.
- Consent to health-care treatment/procedure, etc., must be full, autonomous, informed and explicit, in a way that provides express authorization for the same.
- For this to happen people must be given adequate information about the said treatment/procedure, etc., as well as the method that will be followed to administer/carry out the same.
- The right of the individual concerned to object to the said health-care treatment/procedure, etc., must be ensured.
- To do so, the individual must be informed of the possibility of objecting to the provision of the said health-care treatment/procedure, etc., and of their right to do so, if they so wish.
- Their express authorization to the said health-care treatment/procedure, etc., should be recorded.
- In certain circumstances, in order to ensure that the individual's opinion is taken into account, it will be essential for the legal framework to include a mechanism for rapid decision-making, with a view to limiting to the extent possible, risks to the health of individual, for their opinion be taken into account, for the decision to be well-founded, and to ensure that the individual had access to an effective right to appeal against the said decision.

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[84] CESCR, General comment No. 14: The right to the highest attainable standard of health (art. 12) (2000), para. 8.

[85] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 24.

[86] See, inter alia, CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 57.

- In any context in which health-care services/care/treatment, including in the context of sexual and reproductive heath, is provided, the burden is on the State to demonstrate that the individual has given informed consent to the said treatment, etc..
- Once a complaint about a health-care treatment/service/care procedure has been filed, the State must investigate it promptly and impartially, and it is incumbent on the State to produce evidence refuting the complainant's allegations.
- In absence of evidence demonstrating informed consent was given and/or in the absence of any thorough explanation from the State, due weight must be given to the complainant's allegations, which, accordingly, may disclose multiple human rights violations entailing, in turn, an obligation on the part of the State to provide effective remedies and redress.

Explanation

Human rights law expressly prohibits medical or scientific experimentation without the free consent of the person concerned. The Human Rights Committee has held that, "Article 7 expressly prohibits medical or scientific experimentation without the free consent of the person concerned", and has observed "that special protection in regard to such experiments is necessary in the case of persons not capable of giving valid consent, and in particular those under any form of detention or imprisonment. Such persons should not be subjected to any medical or scientific experimentation that may be detrimental to their health."[87]

As CESCR has clarified, the right to the highest attainable standard of health comprises one's freedom to control one's own health and body – including sexual and reproductive freedom and freedom from non-consensual procedures. CESCR has held 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 Covenant."[88]

CESCR has clarified that States are to ensure "privacy, confidentiality and free, informed and responsible decision-making, without coercion, discrimination or fear of violence, in relation to the sexual and reproductive needs and behaviours of individuals".[89] CESCR has further observed that violations of the right to respect one's right to sexual and reproductive health occur whenever States interfere "with an individual's freedom to control his or her own body and ability to make free, informed and responsible decisions in this regard."[90]

Consent is absent whenever laws and policies prescribe involuntary, coercive or forced medical interventions. In those circumstances, the absence of consent constitutes a violation of the right to health. CESCR has recalled that "the right to health includes the right to make free and informed decisions concerning any medical treatment a person might be subject to. Thus, laws and policies that prescribe involuntary, coercive or forced medical interventions violate the State's responsibility to respect the right to health."[91]

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[87] UN Human Rights Committee (HRC), CCPR General Comment No. 20: Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment), 10 March 1992, para. 7.

[88] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 5.

[89] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 49(d).

[90] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 56.

[91] S.C. and G.P. v. Italy, 7 March 2019, E/C.12/65/D/22/2017, para. 10.1, https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2FC.12%2F65%2FD%2F22%2F2017&Lang=en.

“Laws and policies that prescribe involuntary, coercive or forced medical interventions, including forced sterilization or mandatory HIV/AIDS, virginity or pregnancy testing, also violate the obligation to respect.”[92] CEDAW has held that “States parties should not permit forms of coercion, such as non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women’s rights to informed consent and dignity.”[93] In the case of *A.S. v. Hungary*, concerning the coerced sterilization of a Hungarian Roma woman, the CEDAW Committee found multiple violations of the CEDAW Convention, arising from the failure of the authorities to provide the complainant with “detailed information about the sterilization, including the risks involved and the consequences of the surgery, alternative procedures or contraceptive method”, as well as their failure to ensure that she had given “her fully informed consent to be sterilized”.[94]

Mandatory/compulsory treatment (e.g., collection of DNA material through compulsory DNA testing, mandatory HIV testing) refers to testing that is conducted on a person without their informed consent.[95] Compulsory HIV and drug test are sufficiently intrusive to constitute an “interference” with the one’s right to privacy (e.g., under article 17 of the ICCPR), in certain circumstances, such interference will be arbitrary or unlawful, and therefore violate the right to privacy (see also above).[96] Given that restrictions on entry, stay and residence based on positive HIV status alone do not serve to protect public health, but rather that such restrictions may harm public health, mandatory HIV/AIDS and drug testing amount to violations of the privacy rights under article 17 of the ICCPR.[97]

CESCR has held that, “[t]he obligation to respect [the right to sexual and reproductive health] requires States to refrain from directly or indirectly interfering with the exercise by individuals of the right to sexual and reproductive health.

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[92] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 57.

[93] CEDAW, General recommendation No. 24: Article 12 of the Convention (women and health), 1999, para. 22.

[94] CEDAW Committee, A.S. v. Hungary, CEDAW/C/36/D/4/2004, 29 August 2006, https://juris.ohchr.org/Search/Details/1716. “The Committee considers that the author has a right protected by article 10 (h) of the Convention to specific information on sterilization and alternative procedures for family planning in order to guard against such an intervention being carried out without her having made a fully informed choice. Furthermore, the Committee notes the description given of the author’s state of health on arrival at the hospital and observes that any counselling that she received must have been given under stressful and most inappropriate conditions. Considering all these factors, the Committee finds a failure of the State party, through the hospital personnel, to provide appropriate information and advice on family planning, which constitutes a violation of the author’s right under article 10 (h) of the Convention.” (para. 11.2). Also, “[w]ith regard to the question of whether the State party violated the author’s rights under article 12 of the Convention by performing the sterilization surgery without obtaining her informed consent, the Committee takes note of the author’s description of the 17 minute timespan from her admission to the hospital up to the completion of two medical procedures. Medical records revealed that the author was in a very poor state of health upon arrival at the hospital; she was feeling dizzy, was bleeding more heavily than average and was in a state of shock. During those 17 minutes, she was prepared for surgery, signed the statements of consent for the caesarean section, the sterilization, a blood transfusion and anaesthesia and underwent two medical procedures, namely, the caesarean section to remove the remains of the dead foetus and the sterilization. The Committee further takes note of the author’s claim that she did not understand the Latin term for sterilization that was used on the barely legible consent note that had been handwritten by the doctor attending to her, which she signed. The Committee also takes note of the averment of the State party to the effect that, during those 17 minutes, the author was given all appropriate information in a way in which she was able to understand it. The Committee finds that it is not plausible that during that period of time hospital personnel provided the author with thorough enough counselling and information about sterilization, as well as alternatives, risks and benefits, to ensure that the author could make a well-considered and voluntary decision to be sterilized. The Committee also takes note of the unchallenged fact that the author enquired of the doctor when it would be safe to conceive again, clearly indicating that she was unaware of the consequences of sterilization. According to article 12 of the Convention, States parties shall “ensure to women appropriate services in connexion with pregnancy, confinement, and the post-natal period”. The Committee explained in its general recommendation No. 24 on women and health that “[A]cceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity…” The Committee further stated that “States parties should not permit forms of coercion, such as non-consensual sterilization … that violate women’s rights to informed consent and dignity”. The Committee considers in the present case that the State party has not ensured that the author gave her fully informed consent to be sterilized and that consequently the rights of the author under article 12 were violated.” (para. 11.3).

[95] Human Rights Committee case, Andrea Vandom v. Republic of Korea.

[96] Human Rights Committee case, Andrea Vandom v. Republic of Korea.

[97] Human Rights Committee case, Andrea Vandom v. Republic of Korea.

States must reform laws that impede the exercise of the right to sexual and reproductive health. Examples include laws criminalizing abortion, non-disclosure of HIV status, exposure to and transmission of HIV, consensual sexual activities between adults, and transgender identity or expression."[98]

CESCR has further clarified that States have an obligation not to "refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters."[99] The taking of such measures would be contrary to one's freedom to control one's own health and body and against individuals' will.

Among others, CESCR has held that, under international human rights law, States have an obligation to respect the right to health. Pursuant to this obligation, States are to refrain "from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care."[100]

The Human Rights Committee has held that ordering people to subject themselves to a medical examination or treatment without their consent and/or clearly against their will, interferes with their right to privacy and may constitute a violation of this right. In order to determine whether such conduct is lawful or whether instead it violates the right to privacy, the Committee will consider on a case-by-case basis whether the following criteria are met: the interference must be provided by law, be in accordance with the Covenant, and be reasonable in the circumstances of the particular case, otherwise there will be a violation.[101]

The Human Rights Committee defines unlawful in the right to privacy context as meaning "that no interference can take place except in cases envisaged by law". The law itself must comply with the provisions, aims and objectives of the ICCPR, and should be, in any event, reasonable in the particular circumstances. Accordingly, any interference with privacy must be proportionate to the legitimate end sought and necessary in the circumstances of any given case.

In *M. G. v. Germany*, the Human Rights Committee found that the domestic court's order had effect of requiring the person concerned to undergo a medical examination of her physical and mental state of health without her consent and against her will. Moreover, it also found that "to issue such an order without having heard or seen the author in person and to base this decision merely on her procedural conduct and written court submissions was not reasonable in the particular circumstances of the case."[102]

States parties are obliged to establish the proper legal framework, and put in place the conditions necessary to enable individuals to access the provision of health-care, goods and services (such as fertilization treatments) based on their consent. Moreover, States parties must guarantee that individuals have a right to withdraw their consent to medical treatments, and that their right to waive consent will be respected.

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[98] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 40.

[99] CESCR, General comment No. 14: The right to the highest attainable standard of health (art. 12) (2000), para. 34.

[100] CESCR, General comment No. 14: The right to the highest attainable standard of health (art. 12) (2000), para. 34.

[101] For example, in M. G. v. Germany, the Committee stated: "As regards the author's claim under article 17 of the Covenant, the Committee observes that to subject a person to an order to undergo medical treatment or examination without the consent or against the will of that person constitutes an interference with privacy, and may amount to an unlawful attack on his or her honour and reputation.18 The issue before the Committee is therefore whether the interference with the author's privacy was arbitrary or unlawful, or whether the order of the Ellwangen Regional Court constituted an unlawful attack against her honour or reputation. For an interference to be permissible under article 17, it must cumulatively meet several conditions, i.e. it must be provided for by law, be in accordance with the provisions, aims and objectives of the Covenant, and be reasonable in the particular circumstances of the case." M. G. v. Germany, 2 September 2008, CCPR/C/93/D/1482/2006, para. 10.1, http://juris.ohchr.org/Search/Details/1435.

[102] M. G. v. Germany, para. 10.2.

States parties must ensure protection against any unwanted medical intervention, the right of individuals to make free decisions about their bodies, and respect for such right.[103] For example, in *S.C. and G.P. v. Italy*, CESCR found as follows: "The State party is under an obligation to provide the authors with an effective remedy, including by: (a) establishing the appropriate conditions to enable the authors' right to access in vitro fertilization treatments with trust that their right to withdraw their consent to medical treatments will be respected; (b) ensuring that the female author is protected from any unwanted medical intervention and that her right to make free decisions regarding her own body is respected; (c) awarding S.C. adequate compensation for the physical, psychological and moral damages suffered; and (d) reimbursing the authors for the legal costs reasonably incurred in the processing of this communication."

The fact that individuals may not object on their own initiative to a particular health-care treatment/procedure, etc., does not mean that they have explicitly consented to it.[104] Moreover, there should be no presumption that individuals are expected to be aware of the possibility of objecting to the said healthcare treatment/procedure, etc.. They should be given adequate information about the said treatment/procedure, who is going to carry it out, and the method, and should be explicitly asked for their consent.

In order to be able to exercise one's right to consent to the provision of healthcare, goods and services, including in the context of sexual and reproductive healthcare, one needs to be enabled to do so, and one way of enabling is to have access to an effective and accessible procedure to establish one's entitlement to medical services that one's physical and mental condition may require.[105]

In *M.T. v. Uzbekistan*, the Human Rights Committee considered that when forced sterilization is carried out in custody, not only by definition it is non-consensual, but also it entails an obligation on the State to provide an explanation for it. Therefore, the Committee has held that there is a burden on State to provide an adequate explanation, and in absence of such an explanation, the State will be held to have violated the Covenant. See also below custody cases, where ill-treatment allegations are not investigated adequately or at all, and where the State refutes such allegations without providing any evidence. In the absence of any information from the State party, due weight must be given to the complainant's claims.

Gendered considerations relevant to consent in the context of healthcare services, including SRHCGSs

- "The right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation"[106]entail obligations on the part of States to respect the right to make autonomous decisions about one's sexual and reproductive health.
- States are obliged to "require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice".[107]

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[103] S.C. and G.P. v. Italy, para. 13.

[104] See, generally, extrapolating by analogy from the Human Rights Committee case, N.K. v. The Netherlands, CCPR/C/120/D/2326/2013/Rev.1, 10 January 2018, [98] , in particular, paras. 9.2, 9.3, 9.6, 9.10 and 9.11.

[105] In L.C. v. Peru, the CEDAW Committee found that "owing to her condition as a pregnant woman, L.C. did not have access to an effective and accessible procedure allowing her to establish her entitlement to the medical services that her physical and mental condition required"; and that it was essential that the State party's legal framework "include a mechanism for rapid decision-making, with a view to limiting to the extent possible risks to the health of the pregnant mother, that her opinion be taken into account, that the decision be well-founded and that there be a right to appeal", L.C. v. Peru, CEDAW Committee, CEDAW/C/50/D/22/2009, 25 November 2011, para. 8.15 and 8.17, respectively, [98] .

[106] CESCR, General comment No. 14: The right to the highest attainable standard of health (art. 12) (2000), para. 8.

[107] CEDAW, General recommendation No. 24: Article 12 of the Convention (women and health), 1999, para. 31(e).

- Requiring lesbian, gay, bisexual, transgender and intersex individuals to undergo so-called "treatment" as mental or psychiatric patients, or requiring that they be "cured" by so-called "treatment", is non-consensual and violates their right to sexual and reproductive health.
- Laws that restrict the right of women undergoing treatment to waive their consent, leading to possible forced medical interventions or even forced pregnancies, violate the right to the highest attainable standard of health and the right to gender equality in the enjoyment of her right to health.
- Harmful traditional cultural practices and norms deny women and girls their full reproductive rights.
- CEDAW has held that health-care services are acceptable if they "are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives."[108]
- CESCR has held that "States parties must put in place laws, policies and programmes to prevent, address and remediate violations of the right of all individuals to autonomous decision-making on matters regarding their sexual and reproductive health, free from violence, coercion and discrimination",[109] and that they are required, in particular, "to respect the right of women to make autonomous decisions about their sexual and reproductive health."[110]
- The Human Rights Committee has observed that an area where States "may fail to respect women's privacy relates to their reproductive functions, for example, where there is a requirement for the husband's authorization to make a decision in regard to sterilization; where general requirements are imposed for the sterilization of women, such as having a certain number of children or being of a certain age, or where States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion."[111]
- Sterilization without a woman's consent constitutes a violation of the right to equality before the law and to equal protection of the law without discrimination, as it amounts to discrimination on the basis of her sex. In *M.T. v. Uzbekistan*,[112] the Human Rights Committee noted that, "the involuntary sterilization together with the rape committed against the author show the specific aggression against her as a woman. Accordingly, the Committee considers that, in the circumstances of the present case, the facts as presented by the author amount to a violation of the author's rights under article 26 of the Covenant", that is her rights to equality before the law and equal protection of the law. See also the decision referenced above of the CEDAW Committee in the case of *A.S. v. Hungary*.
- The CEDAW Committee has called on States parties to "[r]epeal all legal provisions that discriminate against women, and thereby enshrine, encourage, facilitate, justify or tolerate any form of gender-based violence against them; including in customary, religious and indigenous laws. In particular, repeal: a) Provisions that allow, tolerate or condone forms of gender-based violence against women, including child or forced marriage and other harmful practices [....] as well as legislation that criminalises abortion, being lesbian, bisexual, or transgender, women in prostitution, adultery or any other criminal provisions that affects women disproportionally".[113]
- CEDAW and CRC have jointly held that harmful practices "are imposed on women and children by family members, community members or society at large, regardless of whether the victim provides, or is able to provide, full, free and informed consent."[114]

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[108] CEDAW, General recommendation No. 24: Article 12 of the Convention (women and health), 1999, para. 22.

[109] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 29.

[110] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 28.

[111] Human Rights Committee, General Comment No. 28 Article 3 (The equality of rights between men and women), para. 20.

[112] M.T. v. Uzbekistan, CCPR/C/114/D/2234/2013, 21 October 2015, para. 7.6, http://juris.ohchr.org/Search/Details/2015.

[113] CEDAW Committee, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, 2017, para. 31, footnotes in the original omitted.

[114] CEDW and CRC, Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices, 2014, para. 16(d).

- Discrimination on the grounds of one's real or imputed sexual orientation, gender identity or expression, or sex characteristics has been interpreted as contrary to one's right to sexual and reproductive health, since this right, in turn, encompasses the right of all persons, including lesbian, gay, bisexual, transgender and intersex persons, to be fully respected for their sexual orientation, gender identity and intersex status. [115] "Likewise, regulations requiring that lesbian, gay, bisexual transgender and intersex persons be treated as mental or psychiatric patients, or requiring that they be "cured" by so-called "treatment", are a clear violation of their right to sexual and reproductive health."[116]
- Furthermore, CESCR has clarified that, "the establishment of legal barriers impeding access by individuals to sexual and reproductive health services, such as the criminalization of women undergoing abortions and the criminalization of consensual sexual activity between adults" violate States' obligations to respect the right to sexual and reproductive health", and that, "[b]anning or denying access in practice to sexual and reproductive health services and medicines, such as emergency contraception, also violates the obligation to respect."[117] In addition, CESCR has held that "private health-care providers should be prohibited from denying access to affordable and adequate services, treatments or information. For instance, where health practitioners are allowed to invoke conscientious objection to refuse to provide certain sexual and reproductive health services, including abortion, they should refer the women or girls seeking such services to another practitioner within reasonable geographical reach who is willing to provide such services."[118]
- The CESCR has also identified legislation that restricts the right of women undergoing medical treatment to waive their consent and has characterised these circumstances as violations of the right to the highest attainable standard of health and the right to gender equality in the enjoyment of her right to health.[119]
- CESCR has also observed that, "[r]eproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth."[120]
- CESCR has also noted that the "realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information",[121] and the need to protect "women from the impact of harmful traditional cultural practices and norms that deny them their

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[115] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 23.

[116] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 23.

[117] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 57.

[118] CESCR, General comment No. 24(2017) on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities, para. 21.

[119] "The Committee recalls that the requirement of equality between women and men, as guaranteed by article 3, requires that laws, policies and practices do not maintain, but rather alleviate, the inherent disadvantage that women experience in exercising their right to sexual and reproductive health and that, seemingly neutral laws, can perpetuate already existing gender inequalities and discrimination against women. The Committee notes that Law 40/2004, as interpreted in the authors' case, restricts the right of women undergoing the treatment to waive their consent, leading to possible forced medical interventions or even pregnancies for all women undergoing in vitro fertilisation treatments. It considers that, even if, presumably, this restriction on the right to withdraw one's consent affects both sexes, it places an extremely high burden on women. The Committee notes that the possible consequences on women are extremely grave, constituting a direct violation of their right to health and physical integrity. It concludes that the transfer of an embryo to S.C.'s uterus without her valid consent constituted a violation of her right to the highest attainable standard of health and her right to gender equality in her enjoyment of her right to health, constituting a violation of article 12, read alone and in conjunction with article 3 of the Covenant", S.C. and G.P. v. Italy, para. 10.3

[120] CESCR, General comment No. 14: The right to the highest attainable standard of health (art. 12) (2000), para. 14, footnote 12.

[121] CESCR, General comment No. 14: The right to the highest attainable standard of health (art. 12) (2000), para. 21.

full reproductive rights."[122] With respect to such practices, CESCR has clarified that "States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence."[123] CESCR has also held that "the failure to discourage the continued observance of harmful traditional medical or cultural practices" constitutes a violation of the State's obligation to protect the right to health.[124]

- In *L.C. v. Peru*, the CEDAW Committee found that, "owing to her condition as a pregnant woman, L.C. did not have access to an effective and accessible procedure allowing her to establish her entitlement to the medical services that her physical and mental condition required"; and that it was essential that the State party's legal framework "include a mechanism for rapid decision-making, with a view to limiting to the extent possible risks to the health of the pregnant mother, that her opinion be taken into account, that the decision be well-founded and that there be a right to appeal."[125]
- CESCR has held that the Covenant requires that "laws, policies and practices do not maintain, but rather alleviate, the inherent disadvantage that women experience in exercising their right to sexual and reproductive health and that, seemingly neutral laws, can perpetuate already existing gender inequalities and discrimination against women."[126] This requirement applies also to facially neutral laws.
- Refusal to carry out an abortion (including through failing to refer and more generally) gives rise to an unwanted continuation of pregnancy in violation of several rights, including the right to make free decisions regarding one's own body, the right to autonomy, and self-determination. Forced continuation of pregnancy resulting from failure to provide abortion is inherently and by definition non-consensual, and entails an obligation to provide effective remedies. When occurring to minors it also constitutes a lack of care towards a minor, entailing additional violations (see, for example, the case of *K.L. v. Peru*, mentioned below in the section entitled "Considerations relevant to consent by adolescents/children in the context of healthcare services, including SRHCGSs"). Omission on the part of the State in not enabling a therapeutic abortion causes prohibited suffering. Women's "free will", "autonomy", "dignity", "physical and psychological integrity", "freedom with regard to a matter concerning [...] reproductive functions", "free assessment" are denied.[127]
- In contexts where healthcare treatment, care, services disproportionately affect women, they may amount to discrimination on the basis of sex/gender. A fortiori, in the context of procedures/treatment/care/services, etc., that may only be carried out on women, e.g., abortion or that affect women disproportionately. Legislative bans on abortion run contrary to the right to non-discrimination on the basis of sex because they deny women the ability to exercise their free will in this area.

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[122] CESCR, General comment No. 14: The right to the highest attainable standard of health (art. 12) (2000), para. 21. With respect to such practices, CESCR has underscored the "need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children", see General comment No. 14: The right to the highest attainable standard of health (art. 12) (2000), para. 22.

[123] CESCR, General comment No. 14: The right to the highest attainable standard of health (art. 12) (2000), para. 34.

[124] CESCR, General comment No. 14: The right to the highest attainable standard of health (art. 12) (2000), para. 51.

[125] L.C. v. Peru, CEDAW Committee, CEDAW/C/50/D/22/2009, 25 November 2011, see paras 8.15 and 8.17, respectively, https://juris.ohchr.org/Search/Details/1704.

[126] S.C. and G.P. v. Italy, para. 10.3.

[127] Ben Achour's concurring opinion in Mellet v. Ireland, "By denying women their freedom with regard to a matter concerning their reproductive functions, this type of legislation runs contrary to the right to non-discrimination on the basis of sex because it denies women the ability to exercise their free will in this area. No similar restrictions are imposed on men. This type of legislation imposes a disproportionate, abnormal and unjust existential burden on women, by virtue of being women." para. 5 of Ben Achour's opinion; then again at para. 7 of the same: "in applying its internal legislation, [the State party] did not allow the author to terminate her pregnancy in accordance with her own, free assessment of the whole of her situation constitutes gender-based discrimination, which is one of the forms of discrimination on the grounds of sex referred to in articles 2 (1) and 3 of the Covenant."

Considerations relevant to consent by persons with disabilities in the context of healthcare services, including SRHCGSs

In the context of disability rights, Article 25 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) enshrines the principle of free and informed consent of the person concerned for health care by guaranteeing the right of persons with disabilities to enjoy the highest attainable standard of health without discrimination on the basis of disability, and directing States parties to take all appropriate measures, including, in particular, by "[r]equir[ing] health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, *inter alia*, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care".

Pursuant to Article 25 of the UNCRPD, persons with disabilities are to be provided with the same range, quality and standard of free or affordable health care and programmes provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.

In its General Comment No. 1, the CRPD has stated that, "States parties have an obligation to require all health and medical professionals (including psychiatric professionals) to obtain the free and informed consent of persons with disabilities prior to any treatment" and that, "decisions about medical and psychiatric treatment must be based on the free and informed consent of the person concerned and respect the person's autonomy, will and preferences."[128] The UNCRPD has also stated that, "States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment", and that "decisions relating to a person's physical or mental integrity can only be taken with the free and informed consent of the persons concerned."[129]

The UNCRPD has held that, "in conjunction with the right to legal capacity on an equal basis with others, States parties have an obligation not to permit substitute decision-makers to provide consent on behalf of persons with disabilities".[130] Further, all health and medical personnel should ensure appropriate consultation that directly engages the person with disabilities. They should also ensure, to the best of their ability, that assistants or support persons do not substitute or have undue influence over the decisions of persons with disabilities."[131] The same Committee has emphasized that the "[i]nvoluntary commitment in mental health facilities carries with it the denial of the person's legal capacity to decide about care, treatment, and admission to a hospital or institution, and therefore violates" the Convention,[132] and has urged States parties to "refrain from the practice of denying legal capacity of persons with disabilities and detaining them in institutions against their will, either without the free and informed consent of the persons concerned or with the consent of a substitute decision-maker, as this practice constitutes arbitrary deprivation of liberty and violates" the Convention.[133]

In respect of sexual and reproductive rights of persons with disabilities, the UNCRPD has held that "women and girls with disabilities face barriers in most areas of life.

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[128] CRPD/C/GC/1, para. 21 and 42. See also, Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities -The right to liberty and security of persons with disabilities - Adopted during the Committee's 14th session, held in September 2015.

[129] Ibid, para. 42

[130] Ibid, para. 41

[131] CRPD/C/GC/1, para. 41

[132] Ibid, para. 10.

[133] CRPD/C/GC/1, para.40.

These barriers create situations of multiple and intersecting forms of discrimination against women and girls with disabilities, in particular with regard to [….] the ability [...] to exercise control over their own lives across a range of contexts, for example with regard to health care, including sexual and reproductive health services"; [134] it has also held that, "[l]ike all women, women with disabilities have the right to choose the number and spacing of their children, as well as the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence".[135]

The Committee has expressed concern in connection with women with disabilities and "forced, coerced and otherwise involuntary pregnancy or sterilization; any medical procedure or intervention performed without free and informed consent, including procedures and interventions related to contraception and abortion", the "medical approach to disability [...] as were laws limiting legal capacity of persons with disabilities and depriving them of decision-making power with regard to their sexual and reproductive rights."[136]

The Committee on the Rights of the Child has also affirmed that, "[t]here should be no barriers to commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization. In addition, particular efforts need to be made to overcome barriers of stigma and fear experienced by, for example, adolescent girls, girls with disabilities and lesbian, gay, bisexual, transgender and intersex adolescents, in gaining access to such services."[137]

CESCR has further held that States should give tailored attention to the sexual and reproductive health needs of particular groups, including persons with disabilities. They "should be able to enjoy not only the same range and quality of sexual and reproductive health services but also those services which they would need specifically because of their disabilities. Further, reasonable accommodation must be made to enable persons with disabilities to fully access sexual and reproductive health services on an equal basis, such as physically accessible facilities, information in accessible formats and decision-making support, and States should ensure that care is provided in a respectful and dignified manner that does not exacerbate marginalization."[138]

CESCR has also noted that, "[w]omen with disabilities have the right to protection and support in relation to motherhood and pregnancy… The needs and desires in question should be recognized and addressed in both the recreational and procreational contexts."[139]

CESCR has stated that performing an abortion on or sterilizing a woman with disabilities without her prior informed consent constitute serious violations of her right to protection and support in relation to motherhood and pregnancy under article 10(2) of the ICESCR.[140]

The CEDAW Committee has called on States parties to "[r]epeal all legal provisions that discriminate against women, and thereby enshrine, encourage, facilitate, justify or tolerate any form of gender-based violence against them; including [….] provisions allowing medical procedures on women with disabilities without their informed consent".[141]

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[134] CRPD, General comment No. 3 (2016) on women and girls with disabilities, para. 2.

[135] CRPD, General comment No. 3 (2016) on women and girls with disabilities, para.38.

[136] See, Committee on the Rights of Persons with Disabilities considers initial report of Bolivia, 18 August 2016, https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=20393&LangID=E

[137] UNCRC, GC no.20, page 16, para. 60.

[138] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 24.

[139] CESCR General Comment 5, para. 31.

[140] CESCR, General Comment No. 5: Persons with disabilities (1995), "Both the sterilization of, and the performance of an abortion on, a woman with disabilities without her prior informed consent are serious violations of article 10 (2)", para. 31.

[141] CEDAW Committee, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, 2017, para. 31, footnotes in the original omitted.

Considerations relevant to consent by adolescents/children in the context of healthcare services, including SRHCGSs

The Committee on the Rights of the Child has affirmed that the human rights of adolescents include the right to provide informed consent to access health services. "In all cases, the right of any child below that minimum age and able to demonstrate sufficient understanding to be entitled to give or refuse consent should be recognized. The voluntary and informed consent of the adolescent should be obtained whether or not the consent of a parent or guardian is required for any medical treatment or procedure. [States parties should c]onsider introducing a legal presumption that adolescents are competent to seek and have access to preventive or time-sensitive sexual and reproductive health commodities and services",[142] and reaffirmed that "[a]ll adolescents have the right to have access to confidential medical counselling and advice without the consent of a parent or guardian, irrespective of age, if they so wish, and should not be subject to any age limit".[143]

Further, the Committee on the Rights of the Child has recognized that, "children's evolving capacities have a bearing on their independent decision-making on their health issues. It also notes that there are often serious discrepancies regarding such autonomous decision-making, with children who are particularly vulnerable to discrimination often less able to exercise this autonomy. It is therefore essential that supportive policies are in place and that children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality",[144] and that, "[i]n accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests. States should clarify the legislative procedures for the designation of appropriate caregivers for children without parents or legal guardians, who can consent on the child's behalf or assist the child in consenting, depending on the child's age and maturity. States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion."[145]

In this context, the Committee on the Rights of the Child has also affirmed that, "[t]here should be no barriers to commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization. In addition, particular efforts need to be made to overcome barriers of stigma and fear experienced by, for example, adolescent girls, girls with disabilities and lesbian, gay, bisexual, transgender and intersex adolescents, in gaining access to such services. The Committee urges States to decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services, review legislation with a view to guaranteeing the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions."[146]

In the case of *K.L. v. Peru*, the Human Rights Committee held that denial of a therapeutic abortion to a minor girl constituted a violation of article 7 of the Covenant, as well as a violation of article 24 of the Covenant, since the State party failed to provide to her the special care she needed as a minor.[147]

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[142] UNCRC, GC no.20, page 11, para. 39.

[143] Ibid, para. 39.

[144] UNCRC, GC no.15, page 7, para. 21.

[145] UNCRC, GC no.15, page 9, para. 31.

[146] UNCRC, GC no.20, page 16, para. 60.

[147] K.L. v. Peru, Human Rights Committee, 22 November 2005, CCPR/C/85/D/1153/2003, para. 6.3 and para.6.5, respectively, https://juris.ohchr.org/Search/Details/1215.

CESCR has held that "States are obliged to ensure that adolescents have full access to appropriate information on sexual and reproductive health, including family planning and contraceptives, the dangers of early pregnancy and the prevention and treatment of sexually transmitted diseases, including HIV/AIDS, regardless of their marital status and whether their parents or guardians consent, with respect for their privacy and confidentiality."[148] In addition, with respect to access to sexual and reproductive health information and services, CESCR has held that, "[i]n relation to young persons, unequal access by adolescents to sexual and reproductive health information and services amounts to discrimination."[149]

Adolescents/children's age must be taken into consideration throughout, from the moment the health-care treatment/service/procedure is being contemplated onwards. In addition, depending on age, maturity, etc., the adolescent/child must be informed of possibility of objecting to said health-care treatment/service/procedure.

The child/adolescent should also be informed of the possibility of being accompanied by parents/legal guardian, other adults (and, in custody context, additionally by legal representative).[150]

With respect to the notion of consent in the context of the provision of and access to SRHCGs for adolescents/children, adolescents/children of 12 years of age may well have the mental capacity to make decisions for themselves and, if so, would then be "likely to be able to give [their] consent"[151] even when, under domestic legislation, they may be below the age of consent (i.e., below the age at which one can lawfully consent to engage in sexual conduct with another person).[152]

Custodial cases, e.g., involuntary confinement

- Commitment to and treatment in a psychiatric institution against the will of a patient constitutes a form of deprivation of liberty[153] (i.e., involuntary commitment) and, as such, attracts all relevant rights and safeguards enshrined in the right to liberty and security of person.[154]
- In custody cases, whenever there are allegations of prima facie coercion regarding the voluntariness of a confession/retraction, etc., the burden is on the authorities to prove the voluntariness of the statements in question. By analogy, this principle could also apply to other contexts (e.g., the provision of healthcare, goods and services) where there is a recognized power relationship between the individual and the State.

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[148] CESCR, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 44.

[149] CESCR, General Comment No. 20, Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), para. 29.

[150] N.K. v. The Netherlands, para. 9.10: "As explained by the author, her age was never taken into consideration, including throughout the tissue sample collection process, where she was not informed of the possibility of objecting to the sample being collected by a police officer, nor was she informed of the possibility that she could be accompanied by her legal representative."

[151] X v. Serbia, 22 May 2007, CCPR/C/89/D/1355/2005, para. 6.5, http://juris.ohchr.org/Search/Details/1296.

[152] For more on this, see, for example, the House of Lords authority Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112, cited above at footnote 9.

[153] In Bozena Fijalkowska v. Poland, the Human Rights Committee noted "its prior jurisprudence that treatment in a psychiatric institution against the will of the patient constitutes a form of deprivation of liberty that falls under the terms of article 9 of the Covenant", para. 8.2. See also, T.V. and A.G. v. Uzbekistan, where the Human Rights Committee recalled that "commitment to and treatment in a psychiatric institution against the will of a patient constitutes a form of deprivation of liberty that falls under the terms of article 9 of the Covenant", para. 7.3, T.V. and A.G. v. Uzbekistan, 11 Mar 2016, CCPR/C/116/D/2044/2011, http://juris.ohchr.org/Search/Details/2101.

[154] In T.V. and A.G. v. Uzbekistan, for example, the Human Rights Committee observed that, "even though the right to liberty is not absolute, a detention of an individual is such a serious measure that it is justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest, which might require that the person concerned be detained", para. 7.8.

Explanation

The Human Rights Committee has held that involuntary hospitalization constitutes a deprivation of liberty.[155] As such, the following considerations would be relevant in the context of involuntary hospitalization in connection with the provision of healthcare, goods and services, including sexual and reproductive healthcare goods and services – whether it is an operating factor in the decision to hospitalize or not.

However, the Human Rights Committee has also confirmed that: "any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others."[156] In *T.V. and A.G. v. Uzbekistan*, the Human Rights Committee considered that, "involuntary hospitalization must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law."[157] In the same case, the Committee held that, "[t]he procedures should ensure respect for the views of the individual and should ensure that any representative genuinely represents and defends the wishes and interests of the individual."[158]

While involuntary hospitalization may be applied as a measure of last resort and, at times, may be justified to protect the life and health of individuals, illegal and arbitrary committal to hospital may cause mental and physical suffering and thus amount to inhuman and degrading treatment or punishment.[159] Involuntary hospitalization or forced treatment applied in order to punish or humiliate is contrary to the prohibition of torture or other ill-treatment.[160]

Particularly in the context of criminal trials and custody cases, once prima facie allegations of coercion/intimidation/duress/lack of voluntariness emerge, the Treaty Bodies have held that the burden of proving the voluntariness of the statement in question rests on the authorities. For example, in *Sultanova v. Uzbekistan*, the Human Rights Committee referred to "its previous jurisprudence that the wording, in article 14, paragraph 3 (g) [i.e., the right not to be compelled to testify against oneself or to confess guilt], that no one shall "be compelled to testify against himself or confess guilt", must be understood in terms of the absence of any direct or indirect physical or psychological coercion by the investigating authorities on the accused with a view to obtaining a confession of guilt […] The Committee considers that it is implicit in this principle that the burden of proof that the confession was made without duress is on the prosecution."[161] Furthermore, in *Nallaratnam Singarasa v. Sri Lanka*, the Human Rights Committee concluded that: "by placing the burden of proof that his confession was made under duress on the author, the State party violated article 14, paragraphs 2, and 3(g), read together with article 2, paragraph 3, and 7 of the Covenant."[162]

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[155] Human Rights Committee, General comment No. 35, Article 9 (Liberty and security of person), para. 5.

[156] T.V. and A.G. v. Uzbekistan, para. 7.7.

[157] T.V. and A.G. v. Uzbekistan, para. 7.4.

[158] T.V. and A.G. v. Uzbekistan, para. 7.4.

[159] In T.V. and A.G. v. Uzbekistan, the Human Rights Committee observed that, "illegal and arbitrary committal to hospital may cause mental and physical suffering and thus amount to inhuman and degrading treatment or punishment, with the meaning of article 7 of the Covenant", para. 7.10.

[160] In T.V. and A.G. v. Uzbekistan, the Human Rights Committee observed that "involuntary hospitalization or forced treatment applied in order to punish or humiliate is contrary to article 7 of the Covenant", para. 7.10.

[161] Sultanova v. Uzbekistan, 30 March 2006, CCPR/C/86/D/915/2000, http://juris.ohchr.org/Search/Details/1250; para. 7.3; see also, Nallaratnam Singarasa v. Sri Lanka, 21 July 2004, CCPR/C/81/D/1033/2001, para. 7.4, http://juris.ohchr.org/Search/Details/1125.

[162] Nallaratnam Singarasa v. Sri Lanka, para. 7.4.

Moving beyond the criminal justice/custody context, this jurisprudence could be relevant by analogy to assert that:
1) any time doubt has been cast on whether the consent obtained was truly informed, free and voluntary (e.g., in the context of medical procedures where allegations indicate that consent was vitiated/negated because of direct or indirect physical or psychological coercion, or intimidation or as a result of the provision of inadequate information about the procedure and its consequences); then
2) the burden of proving that consent was indeed informed, free and voluntary is on the authorities. This is because if someone asserts that consent was not given freely and voluntarily, then in most such circumstances, it would be invidious for them to have to prove that their consent was vitiated (e.g., by the failure to provide them with adequate information). Hence, in certain contexts (e.g., the provision of health-care, goods and services), the burden must be on the health-care providers to prove that the person consented – as opposed to the individual who received the service/health-care, etc. to prove that they did not consent.

Involuntary confinement and disability

- Intellectual or mental disability may not in itself justify deprivation of liberty. Procedural and substantive safeguards established by law must accompany any involuntary commitment, which, in any event, must be a measure of last resort and for the shortest time possible.
- "[C]onfinement of an individual to a psychiatric institution amounts to an acknowledgement of that individual's diminished capacity, legal and otherwise."[163]
- However, the views of the individual concerned should be respected.
- Procedures should ensure that any representative genuinely represents and defends the wishes and interests of the individual concerned.

Explanation

The existence of an intellectual or mental disability may not in itself justify a deprivation of liberty – rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others.[164]

People's mental health may be so impaired that, to avoid harm, they may have to be involuntarily committed. The Human Rights Committee has observed that, "an individual's mental health may be impaired to such an extent that, in order to avoid harm, the issuance of a committal order may be unavoidable".[165] Moreover, in *Bozena Fijalkowska v. Poland*, the Human Rights Committee went even as far as acknowledging that, "circumstances may arise in which an individual's mental health is so impaired that so as to avoid harm to the individual or others, the issuance of a committal order, without assistance or representation sufficient to safeguard her rights, may be unavoidable."[166] However, the Human Rights Committee has also held that persons with disabilities must have access to "adequate procedural and substantive safeguards established by law" whenever their deprivation of liberty is being contemplated. "The procedures should ensure respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual."[167]

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[163] Bozena Fijalkowska v. Poland, para. 8.3.

[164] In T.V. and A.G. v. Uzbekistan, the Human Rights Committee observed that, "even if the State party's diagnosis of the authors was accepted, the existence of an intellectual or mental disability may not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others", para. 7.7.

[165] T.V. and A.G. v. Uzbekistan, para. 7.4.

[166] Bozena Fijalkowska v. Poland, para. 8.3.

[167] Human Rights Committee, General comment No. 35, Article 9 (Liberty and security of person), para. 19.

Conclusion

This paper offers an insight into the jurisprudence and General Comments/Recommendations of the UN human rights Treaty Bodies relating to various notions of consent. As noted above, this research would benefit from being complemented by further research on regional and national jurisprudence to identify contextual variations on how the concept of consent is understood and applied. In addition, as noted above, the findings and conclusions outlined and discussed in the present study would benefit from a revision based on additional key-word searches of the UN Treaty Bodies' jurisprudence and further analysis of their General Comments/Recommendations adopted since April 2019.

As the research findings presented in this paper identify, there are significant normative gaps that are often filled with stereotypical notions, rather than with strong legal foundations. That said, the Treaty Bodies' jurisprudence and General Comments/Recommendations complement one another and provide a compelling analysis of key definitional criteria to evidence the notion of consent in various contexts, including, in particular, the two main focuses of this study, namely, consent with respect to the provision of and access to SRHCGSs and consent in relation to sexual conduct.

The research findings presented in this study have sought to highlight and unpack through a detailed analysis of Treaty Bodies' pronouncements several notions of consent. In conclusion, the concept of informed consent, and better still, informed choice or autonomous and informed decision-making, which more accurately describes the notion of consent applicable in the context of SRHCGSs, must not be confused with and used in relation to consent to sexual conduct, where a different notion of consent with distinct characteristics, as highlighted in the paper, should be applied. Different Treaty Bodies have stated different things, but on this issue, they are not at odds with one another and have kept the notions of consent distinct, according to the context in which they arise.

Apart from the various adjectives and qualifiers that are helpful in describing what consent actually means, what is very useful for present purposes is the findings in various Treaty Bodies' decisions as to cases where consent was lacking/absent and the identification by the Treaty Bodies of relevant violations of provisions of the treaty. The Committees recommendations as to remedial measures in the individual cases, as well as their recommendations as to broader systemic failures, are also worth highlighting.

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