CENTER *for* REPRODUCTIVE RIGHTS

FIGO International Federation of Gynecology and Obstetrics
the Global Voice for Women's Health

The Center for Reproductive Rights and FIGO are pleased to share this submission with the Office of the High Commissioner for Human Rights (OHCHR) to help inform its report '*on promoting, protecting and fulfilling women's and girls' full enjoyment of human rights in humanitarian situations'*, pursuant to Human Rights Council (HRC) resolution 45/29.

The Center for Reproductive Rights (the Center)—an international non-profit legal advocacy organization headquartered in New York City, with regional offices in Nairobi, Bogotá, Geneva, and Washington, D.C.—uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfil. Since its inception 27 years ago, the Center has advocated for the realization of women and girls' human rights on a broad range of issues, including on the right to access sexual and reproductive health services free from coercion, discrimination and violence; on the right to bodily autonomy; preventing and addressing sexual violence; and the eradication of harmful traditional practices.

The International Federation of Gynecology and Obstetrics (FIGO) brings together more than 130 obstetrical and gynaecological (OB-GYN) associations from all over the world. FIGO's vision is that women and girls of the world achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives. FIGO leads on global programme activities, with a particular focus on sub-Saharan Africa and South East Asia. FIGO advocates on a global stage, especially in relation to the Sustainable Development Goals (SDGs) pertaining to reproductive, maternal, newborn, child and adolescent health and non-communicable diseases (SDG3). FIGO also works to raise the status of women and girls and enable their active participation to achieve their reproductive and sexual rights, including addressing female-genital mutilation (FGM) and gender-based violence (SDG5).

This submission will look at the international legal frameworks on sexual and reproductive rights applicable in humanitarian situations and on states' obligations to continue to provide sexual and reproductive health information and services in times of crisis, as well as at the issue of accountability both under international human rights and international humanitarian law. The submission will also look at the impact of restrictive legislative frameworks on SRHR on the lives and health of women and girls. The submission will also briefly look at the impact of the COVID-19 pandemic on women's and girls' access to sexual and reproductive health information and services and will then look at some regional examples before making some recommendations. The Center and FIGO urge the Working Group to address all these issues in its forthcoming report.

I) Sexual and reproductive health and rights in crisis: international legal frameworks and global commitments

Human rights law and international humanitarian law are complementary and mutually reinforcing, and States must therefore respect, protect, and fulfill sexual and reproductive health and rights (SRHR) during armed conflict and other humanitarian emergencies, including ensuring access to services for women and girls who are survivors of gender-based violence.[1] The treaty monitoring bodies have developed extensive guidance for States which reinforce and complement State's obligations.

[1] CEDAW Committee, *General Recommendation No. 30: Women in conflict prevention, conflict and post-conflict situations*, para. 2, U.N. Doc. CEDAW/C/GC/30 (2013) [hereinafter CEDAW Committee, *Gen. Recommendation No. 30*]; CRC Committee, *Gen. Comment No. 20*, para. 79; CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo* (advanced unedited version), para. 10(d), U.N. Doc. CEDAW/C/COD/CO/8 (2019); Human Rights Committee, *Gen. Comment No. 36*, paras. 2, 10, 64; CESCR Committee, *Gen. Comment No. 14*, paras. 40, 65; CESCR Committee, *Gen. Comment No. 3*, para 10; Human Rights

In conflict-affected settings, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) has called on States to:

- Ensure access to maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission and emergency obstetric care,[2]
- Give priority to the provision of sexual and reproductive health services, including safe abortion services, noting with concern the effects of armed conflict on SRHR and maternal mortality[3].

The CEDAW Committee and the Committee on Economic, Social and Cultural Rights (CESCR Committee) have noted that refugees, stateless persons, asylum seekers and undocumented migrants, are in a situation of vulnerability due to their legal status which requires the State to take additional steps to ensure their access to affordable and quality sexual and reproductive information, goods and healthcare[4].

Principles of equality and equity, participation, transparency, and accountability are foundational to international human rights law and are necessary to guide and inform all aspects of humanitarian service provision to ensure that it reflects and meets the needs of the individuals and communities most directly affected.

A human rights-compliant approach to SRHR in humanitarian settings requires, *inter alia*:[5]

- Ensuring available, accessible, adequate, and quality services without discrimination, violence or coercion;
- Ensuring those who seek services are able to make informed and autonomous decisions, without spousal, parental, or third-party consent;
- Establishing systems for maintaining privacy and confidentiality; and
- Access to justice and effective remedies when individual rights are violated.

In humanitarian, and conflict-affected settings in particular, the breakdown of state infrastructure and disruption in access to basic services can lead to traditional accountability mechanisms being inaccessible or unavailable. These include access to domestic courts or tribunals, administrative processes within health systems such as maternal death surveillance response, and social accountability processes that prioritize community participation in decision-making and budgeting processes that prioritize women's and girls' rights. The breakdown of state infrastructure exacerbates pre-existing systemic inequalities and patterns of discrimination that negatively affect women and girls. Indeed, in humanitarian settings women and girls may face discrimination due to their legal status, and are at an increased risk of being subject to discrimination and other human rights violations when seeking health care, such as sexual and gender-based violence (SGBV),

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Committee, *Gen. Comment No. 36*, para. 64; Human Rights Committee, *General Comment No. 31: The nature of the general legal obligation imposed on States parties to the Covenant*, (80th Sess., 2004), para. 11, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004); Human Rights Committee, *General Comment No. 29: States of emergency (Article 4)*, (72nd Sess., 2001), para. 3, U.N. Doc. CCPR/C/21/Rev.1/Add.11 (2001); Legality of the Threat or Use of Nuclear Weapons, Advisory Opinion, 1996 I.C.J., para. 22 (July 8); Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory, Advisory Opinion, 2004 I.C.J., para. 106 (July 9); Armed Activities on the Territory of the Congo (Democratic Republic of the Congo v. Uganda), Judgment, 2005 I.C.J., para. 216 (Dec. 19); CRPD Article 11, CRC Article 22, 38; CRC Committee Gen. Comment No. 20 paras. 79, 80; CESCR Committee, *Gen. Comment No. 22*, paras. 30, 31

[2] CEDAW Committee, Gen. Recommendation No. 30, para.52(c)

[3] *Ibid*; CEDAW Committee, Concluding Observations: Central African Republic, para. 40(b), U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014); see also CEDAW Committee, Concluding Observations: Democratic Republic of the Congo, paras. 35-36, U.N. Doc. CEDAW/C/COD/CO/5 (2006

[4] CESCR Czech, Slovakia, CEDAW Lithuania, CERD

[5] CEDAW Committee, *Gen. Recommendation No. 30*; CEDAW Committee, *Gen. Recommendation No. 33*,

exploitation, and forced marriage.[6] As the Center called for in its 2017 briefing paper, Ensuring Sexual and Reproductive Health and Rights of Women and Girls Affected by Conflict, "*ensuring the provision of sexual and reproductive health information and services and accountability for sexual violence in these settings is central not only to an effective humanitarian response but also to fulfilling fundamental human rights and humanitarian law obligations*."[7]

The U.N. Working Group on Discrimination Against Women and Girls has recognised the power structures that govern the lives of women and girls and that humanitarian and conflict situations only exacerbate the existing crisis they experience:[8]

'Gender inequality, manifesting in systemic disadvantages for women throughout their life cycle and gender-based violence, is viewed by many women around the world as a crisis in itself, one that has been normalized by centuries of patriarchal, colonial and racialized legal and policy frameworks and institutions and deepened by the non-implementation of legal protections and political commitments. Many crises experienced individually by women and girls, such as unplanned pregnancy and sexual violence, infringe on their dignity, restrict their freedoms and are tied to their sexual and reproductive status. They are linked to structural discrimination and fostered by the patriarchal oppression, pervasive gender stereotypes, stigma and taboos that drive gender inequality. Such crises are not officially recognized and continue to be ignored, notwithstanding their systemic nature and the grave consequences for women and girls.'

Human Rights, including SRHR, apply in all settings and at all times, including in humanitarian settings and including during armed conflict.

This has long been articulated by international human rights bodies, including the CEDAW, CESCR and Human Rights Committees. [9] Although international human rights law permits states to derogate from certain civil and political rights and to limit certain obligations with respect to economic, social, and cultural rights depending on resource availability,[10] human rights treaty bodies have emphasized that such derogations are

[6] International Committee of the Red Cross (ICRC), Women and War (June 2015), available at https://www.icrc.org/en/publication/0944-women-and-war; U.N. Secretary-General, Rep. of the Secretary-General on women, peace and security, paras. 5-7, U.N. Doc. S/2002/1154 (Oct. 16, 2002); Therese McGinn & Sara E. Casey, Why don't humanitarian organizations provide safe abortion services?, 10:8 CONFLICT AND HEALTH (March 2016), available at https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-016-0075-8.

[7] CENTER FOR REPRODUCTIVE RIGHTS, ENSURING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF WOMEN AND GIRLS AFFECTED BY CONFLICT 6 (2017), available at https://www.reproductiverights.org/document/briefingpaper-ensuring-sexual-and-reproductive-health-and-rights.

[8] Working Group on Discrimination Against Women and Girls, April 2021 report on Discrimination Against Women and Girls in Crisis, para. 12, U.N. Doc A/HRC/47/38 available at https://www.ohchr.org/EN/Issues/Women/WGWomen/Pages/SexualReproductiveHealthRights.aspx

[9] CEDAW Committee, General Recommendation 30, para. 4, Human Rights Committee, General Comment 36, para. 64; Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health (Art.12), para. 47, U.N. Doc. E/C.12/2000/4 (2000) [CESCR, Gen. Comment No. 14] (confirms that "if resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above… a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations … which are non-derogable.")

[10] Human Rights Committee, *General Comment No. 29: States of Emergency (Article 4)*, para. 1, U.N. Doc. CCPR/C/21/Rev.1/Add.11 (2001) [Human Rights Committee, *Gen. Comment No. 29*]; OHCHR, INTERNATIONAL LEGAL PROTECTION OF HUMAN RIGHTS IN ARMED CONFLICT 10 (2011), *available at* http://www.ohchr.org/Documents/Publications/HR_in_armed_conflict.pdf. State obligations with respect to economic, social, and cultural rights, including the right to health, are subject to progressive realization, though states are obligated to take steps to the maximum of available resources to fully realize these rights. ICESCR, art. 2(1); Convention on the Rights

subject to strict conditions and that certain minimum core obligations are non-derogable. [11] Even where derogations are permitted, the measures taken cannot involve discrimination based solely on prohibited grounds, including sex.[12] In its General Recommendation No. 28, the CEDAW Committee affirmed that, even during disasters and public emergencies, women's rights are not suspended, and states must continue to respect, protect, and fulfill women's right to equality, which includes their reproductive rights.[13] The CEDAW Committee has found that *"[p]rotecting women's human rights at all times, advancing substantive gender equality before, during, and after conflict, and ensuring that women's diverse experiences are fully integrated into all . . . reconstruction processes are important objectives of the Convention*."[14] The CEDAW Committee has noted that, instead of suspending rights protections, states should "adopt strategies and take measures addressed to the particular needs of women in . . . states of emergency."[15] Disappointingly, of the countries providing their 2020 review of the implementation of the Beijing Declaration and Platform for Action, only 20 per cent of them indicated that they had provided women and girls, including refugees, in humanitarian settings with access to sexual and reproductive health services.[16]

In its General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, the CEDAW Committee urges states to prevent, investigate, and punish all forms of gender-based violence and to ensure survivors' access to justice, comprehensive medical treatment, and psychosocial support.[17] The Committee also specifically calls on states to safeguard refugees and internally displaced persons (IDPs) from child, early, and forced marriage, to provide them with immediate access to medical services, and to create accountability mechanisms for gender-based violence in all displacement settings.[18]

Treaty Monitoring Bodies have also reiterated that international humanitarian law and international human rights law are complementary and mutually reinforcing.[19]

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of the Child, *adopted* Nov. 20, 1989, art. 4, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989), (*entered into force* Sept. 2, 1990) [CRC]; CRPD, art. 4(2); *see also* CESCR Committee, *General Comment No. 3*, para. 9.

[11] States cannot derogate from certain *jus cogens* norms, such as the prohibitions on torture, genocide, and slavery, even during situations of armed conflict. *See* Human Rights Committee, *Gen. Comment No. 29*, para. 7. Minimum core obligations with respect to economic, social, and cultural rights are not subject to resource availability and are non-derogable. *See C*ESCR Committee, *Gen. Comment No. 14*, para 47; CESCR Committee, *General Comment No. 15: The right to water (arts. 11 and 12 of the International Covenant on Economic, Social and Cultural Rights)*, at 13, para. 40, U.N. Doc. E/C.12/2002/11 (2003); *see also* OHCHR, PROTECTION OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS IN CONFLICT, REPORT OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS 4-5 (2015), *available at* http://www.ohchr.org/Documents/Issues/ESCR/E-2015-59.pdf. At the regional level, the African Charter of Human and Peoples' Rights does not permit any grounds for derogation. *See* African Charter for Human and Peoples' Rights, *adopted* June 27, 1981, art. 25, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) (Banjul Charter).

[12] Human Rights Committee, *Gen. Comment No. 29*, para. 8.

[13] States' obligations under the treaty "do not cease in periods of armed conflict or in states of emergency resulting from political events or natural disasters." The CEDAW Committee explained that these situations "have a deep impact on and broad consequences for the equal enjoyment and exercise by women of their fundamental rights" and called upon states to pursue strategies and measures aimed at addressing the particular needs of women during such states of emergency. CEDAW Committee, *General Recommendation No. 28 on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, at 3, para. 11, U.N. Doc. CEDAW/C/GC/28 (2010) [CEDAW Committee, *Gen. Recommendation No. 28*]. *See also* CEDAW Committee, *Gen. Recommendation No. 30*, para. 2 ("The Committee reiterates that States parties' obligations continue to apply during conflict or states of emergency without discrimination between citizens and non-citizens within their territory or effective control, even if not situated within the territory of the State party.").

[14] CEDAW Committee, *Gen. Recommendation No. 30*, para. 2.

[15] CEDAW Committee, *Gen. Recommendation No. 28*, para. 11.

[16] See para 250, https://undocs.org/E/CN.6/2020/3

[17] CEDAW Committee, *General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations*, para. 38(e), U.N. Doc. CEDAW/C/GC/30 (2013) [CEDAW Committee, *Gen. Recommendation No. 30*]; *see also* CAT Committee, *Concluding Observations: Iraq*, para. 13, U.N. Doc. CAT/C/IRQ/CO/1 (2015).

[18] CEDAW Committee, *Gen. Recommendation No. 30*, para. 57.

[19] Human Rights Committee General Comment 36 para. 64, CEDAW Committee General Recommendation 30 paras. 9, 12 and 19

Recent UN Mission reports illustrate on the importance of the provision of sexual and reproductive health goods and services in humanitarian settings, emphasizes that States are accountable for fulfilling their obligations for ensuring access to sexual and reproductive health services in different humanitarian contexts.

The 2020 report of the UN Mission in South Sudan and the Office of the High Commissioner for Human Rights report, Access to Health for Survivors of Conflict-Related Sexual Violence in South Sudan, found that there was on average one health facility per 10,000 people in South Sudan, and many did not have enough qualified personnel to treat the survivors of sexual violence[20]. The report recommended that the government substantially increase funding for the public health sector, strengthening the capabilities of facilities and health workers, and improving access to sexual and reproductive care[21].The report, which covered human rights as a component of a peace mission, was ground-breaking as it went beyond a focus on criminal accountability for perpetrators and covered the steps needed to comprehensively and sustainably deliver quality sexual and reproductive health services, as a step towards ensuring accountability for survivors of sexual violence, and could be a model for other situations[22].

In 2019 the Independent International Fact-Finding Mission on Myanmar documented sexual and gender-based violence against a backdrop of wide-ranging gender inequality and denial of reproductive health care. In Venezuela, OHCHR reported on limited access to sexual and reproductive health goods and services, with zero contraceptives available in several cities, alongside severe restrictions on abortion, with an estimated 1 in 5 maternal deaths linked to unsafe abortions.

The right to bodily autonomy and sexual and reproductive health and rights (SRHR), including access to contraception and safe abortion services, must be upheld regardless of people's location or status e.g. if the women or girl is a refugee, asylum seeker or migrant. For instance, making safe and effective contraceptive methods easily accessible results in fewer sexually transmitted infections, fewer unintended pregnancies, fewer women and girls dying and becoming disabled due to pregnancy and childbirth – including from unsafe abortions. As recommended by UN Working groups there must be a greater urgency to take 'preventative actions' by States prioritising and implementing effective preventive measures and policy responses which for example include decriminalising abortion services and expanding access to medical abortion and post abortion care and specifically during a crisis removing legal barriers.[23]

Lack of access to sexual reproductive health (SRH) information and services is compounded for women and girls in humanitarian crisis, migrant, or refugee situations where lack of sensitization to their rights, and the politicization of SRHR issues, act to legitimize an inadequate government and donor response. However, it is important to recognize that violations of refugee and migrant women's SRHR often occur in the context of, and in correlation to, pre-existing gender-based inequality and violence.[24]

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[20] A/HRC/43/56 - Report of the Commission on Human Rights in South Sudan – Infographic - 20 February 2020; Report of the Commission on Human Rights in South Sudan, A/HRC/40/69

[21] Access to Health for Survivors of Conflict-Related Sexual Violence in South Sudan (May 2020) https://www.ohchr.org/Documents/Countries/SS/access_to_health_for_survivors_of_conflict-related_sexual_violence_in_south_sudan.pdf

[22] https://unmiss.unmissions.org/survivors-sexual-violence-south-sudan-struggle-access-health-care

[23] See para 77 (b) https://www.ohchr.org/EN/Issues/Women/WGWomen/Pages/SexualReproductiveHealthRights.aspx

[24] Sexual and reproductive health and rights of refugee and migrant women: gynecologists' and obstetricians' Responsibilities https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1002/ijgo.13111

Through OB-GYN member societies, FIGO has helped to effect change at national and local levels to improve access to SRH information and services – FIGO has seen the positive impact such programmes bring to the lives of millions of people. A huge proportion of maternal deaths and disabilities could be prevented through ensuring universal access to SRH services, alongside the integration of reproductive health into national strategies and programs, as required by Sustainable Development Goal 3.7 aims to ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. A denial of SRHR, which includes access to family planning and safe abortion services, directly reflects gender inequalities (SDG 5) and the lack of prioritisation in resources and investment for the human rights of women and girls.

Successful SRHR services require funding and infrastructure that is context specific, using local knowledge and local partners reaching women and girls at every point of service care. At a time when pressure is exceptional – not least due to the COVID-19 pandemic – any reductions in donor country funding commitments for SRHR services will have a large impact on health and care systems that are already overburdened and understaffed.[25]

SRHR are fundamental to women and girls achieving their right to live with human dignity and in the exercise of their right to their bodily autonomy – the ability for women and girls to choose if and when they have children is central to their right to equality, as well as to reducing poverty and achieving sustainable development.

II) Accountability for sexual and gender-based violence (SGBV) and to SRHR

In addition to the legal obligations detailed above, human rights and humanitarian principles[26] are critical to ensuring that humanitarian funding, programs, and policies are driven by, benefiting, and accountable to the individuals most directly affected by them.

Despite these obligations, there is a frequent absence of accountability, including remedy and redress, for human rights violations and violations of IHL in conflict settings. This accountability deficit has been for instance recognized within the Women, Peace and Security (WPS) agenda in its resolution 2242. To date, the WPS agenda has disproportionately focused on the criminal responsibility of perpetrators of sexual and gender-based violence and has not centred the experiences and voices of women and girls primarily affected. In addition, women human rights defenders (WHRDs) (includes health care providers) working to protect SRHR, are viewed as a threat to oppressive patriarchal structures and religious and traditional 'norms', are targeted (along, at times with their families) and subjected to intimidation harassment and violence in the most extreme cases killings and retaliation because of their efforts to ensure the realization of women and girls sexual and reproductive health rights, in the overwhelming majority of cases perpetrators are never held accountable and access to justice is denied the WHRDs and their families/communities.

Obligations to respect, protect, and fulfil sexual and reproductive health and rights in particular receive inadequate attention and access to robust accountability mechanisms or effective remedies remains relatively

[25] FIGO calls for reinstatement of funding for UNFPA following cuts to UK Government's overseas aid budget

[26] The seven humanitarian principles are Humanity, impartiality, neutrality, independence, voluntary service, unity and universality - https://www.icrc.org/sites/default/files/topic/file_plus_list/4046-the_fundamental_principles_of_the_international_red_cross_and_red_crescent_movement.pdf

uncommon. Meaningful accountability will include at least the following components: responsibility, answerability, non-repetition and enforceability[27]. Accountability can take many forms. It compasses multiple, participatory and transparent forms of monitoring, review and oversight, including administrative, social, political, legal and accountability of diverse humanitarian actors.

There is a global consensus that there is a need to bridge the humanitarian and development nexus: this can't be done without emphasizing the centrality of human rights in these conversations. Human rights are the glue holding the humanitarian and development streams of work together and the precondition to preventing violations from happening in the first place: accountability is central to this conversation.

Humanitarian principles of humanity, neutrality, impartiality and independence are key to ensure that humanitarian action's main objective remains to protect life and health and ensure respect for human beings[28] and is carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no adverse distinction on the basis of nationality, race, gender, religious belief, class or political opinion.[29] Sphere Handbook Protection Principles also include protection of affected populations' sexual and reproductive health and rights, calling for guaranteeing access to healthcare and family planning that prevents excessive maternal and newborn morbidity and mortality[30] and ensuring access to healthcare that is safe and responds to the needs of survivors of sexual violence.[31]

Human rights principles of equality and non-discrimination, participation, transparency, and accountability are foundational to IHRL and are necessary to guide and inform all aspects of humanitarian service provision to ensure that it reflects and meets the needs of the individuals and communities most directly affected.[32]

These principles and the rights to non-discrimination and equality are central to ensuring that humanitarian programs and policies recognize and address the root causes of sexual violence and SRHR violations in humanitarian settings to better prevent and eradicate these practices.[33] Aid efforts guided by the principles of

27 See for more information, OHCHR & Centre for Economic, Social and Cultural Rights, Who will be accountable? (HR/PUB/13/1/Add.1), summary available at: https://www.ohchr.org/Documents/Publications/WhoWillBeAccountable_summary_en.pdf ; An effective remedy must also include gender-transformative, victim/survivor-centered and comprehensive reparations; A/60/147 (2005)

28 The Fundamental Principles were proclaimed by the 20th International Conference of the Red Cross, Vienna, 1965. The revised text is contained in the Statutes of the International Red Cross and Red Crescent Movement, adopted by the 25th International Conference of the Red Cross, Geneva in 1986, see preamble; see also endorsement in United Nations General Assembly Res. 46/182, Strengthening of the coordination of humanitarian emergency assistance of the United Nations, A/RES/46/182 (19 December 1991) para. 2.

29 Id;

30 Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, 2018 Edition, sexual and reproductive health standard 2.3.1, (Key actions include "… clean and safe delivery, essential newborn care, and emergency obstetric and newborn care services are available at all times; provide all visibly pregnant women with clean delivery packages when access to skilled health providers and healthcare facilities cannot be guaranteed; consult the community to understand local preferences, practices and attitudes towards contraception; make a range of long-acting reversible and short-acting contraceptive methods available at healthcare facilities based on demand, in a private and confidential setting.")

31 Id., sexual and reproductive health standard 2.3.2, (Key actions include "identify a lead organisation to coordinate a multi-sectoral approach to reduce the risk of sexual violence, ensure referrals and provide holistic support to survivors; inform the community of available services and the importance of seeking immediate medical care following sexual violence; establish safe spaces in healthcare facilities to receive survivors of sexual violence and to provide clinical care and referral; make clinical care and referral to other supportive services available for survivors of sexual violence.")

32 *See* The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies, HRBA PORTAL (March 2005), http://hrbaportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies [hereinafter Human Rights Based Approach to Development].

33 *Cf.* OHCHR, PRINCIPLES AND GUIDELINES FOR A HUMAN RIGHTS APPROACH TO POVERTY REDUCTION STRATEGIES, para. 21, U.N. Doc. HR/PUB/06/12 (2006) (noting, in the poverty reduction context, that an approach based on these principles shifts focus from

non-discrimination and equality, moreover, prioritize the needs of marginalized or vulnerable groups or individuals.[34] To ensure that programs are accessible to the most vulnerable requires agencies and donors to monitor and collect data disaggregated on a number of different grounds, including, but not limited to, gender, age, ethnicity, religion, and geographic location.[35]

Meaningful participation of women and girls in humanitarian settings, particularly those from vulnerable or marginalized groups, is a key priority in all stages of humanitarian response, from the development to the implementation, monitoring, and evaluation of service policies and programs. A human-rights based approach recognizes the agency of affected individuals to participate in, shape, and make decisions regarding programs and policies that are intended to be for their benefit.[36] As part of the International Conference on Population and Development, states acknowledged that reproductive health programming "must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of service,"[37] which the UN Security Council also has affirmed in the context of humanitarian aid programs.[38] As noted by the Special Rapporteur on Health, "[*i]nvolvement in decision-making processes empowers affected communities and ensures ownership of decisions and resources, which leads to sustainable systems and, potentially, the resolution of conflicts*."[39] Effective and meaningful participation, in turn, rests on the ability of affected individuals to have access to reliable SRHR-related information as well as transparency regarding humanitarian funding decisions and structures.[40]

A human rights-compliant approach also prioritizes a broad and robust understanding of accountability to ensure that policymakers, decision-makers, and others who have an impact on affected individuals and communities are held responsible for their actions and decisions and that individuals whose rights have been violated have access to remedies.

Effective accountability mechanisms require participation and transparency as well as the ability to confer meaningful and effective remedies to victims of violations on a basis of non-discrimination.[41]

"narrow economic issues towards a broader strategy that also addresses the socio-cultural and political-legal institutions which sustain the structures of discrimination"); *see also* UNFPA, The Human Rights-Based Approach, http://www.unfpa.org/human-rights-based-approach (last visited June 9, 2017) [hereinafter UNFPA, The Human Rights-Based Approach].

[34] *See* Human Rights Based Approach to Development; Lena Kähler, Marie Villumsen, Mads Holst Jensen, and Pia Falk Paarup, *AAAQ & Sexual and Reproductive Health and Rights: International Indicators for Availability, Accessibility, Acceptability, and Quality*, THE DANISH INSTITUTE FOR HUMAN RIGHTS 24-25 (2017), *available at* https://www.humanrights.dk/sites/humanrights.dk/files/media/dokumenter/nyheder/aaaq-srhr_issue_paper_dihr_2017_standard.pdf.

[35] *See, e.g.*, OHCHR, A HUMAN RIGHTS-BASED APPROACH TO DATA: LEAVING NO ONE BEHIND IN THE 2030 DEVELOPMENT AGENDA 6-7 (Feb. 19, 2016), http://www.ohchr.org/Documents/Issues/HRIndicators/GuidanceNoteonApproachtoData.pdf; UNIVERSITY OF ESSEX HUMAN RIGHTS CENTRE CLINIC AND THE EUROPEAN ROMA RIGHTS CENTRE, DISAGGREGATED DATA AND HUMAN RIGHTS: LAW, POLICY AND PRACTICE 7 (Oct. 2013), *available at* https://www.essex.ac.uk/hrc/careers/clinic/documents/disaggregated-data-and-human-rights-law-policy-and-practice.pdf; *see also* CESCR, *Gen. Comment No. 22*, para. 15 (noting that "health facilities, goods, information and services related to sexual and reproductive health care should be accessible to all individuals and groups without discrimination and free from barriers").

[36] *See* Human Rights Based Approach to Development; UNFPA, The Human Rights-Based Approach,

[37] *ICPD Programme of Action*, para. 7.7.

[38] S.C. Res. 1889 [on women and peace and security], para. 1, U.N. Doc. S/RES/1889 (Oct. 5, 2009).

[39] SR Health Report (2013), para. 12.

[40] *Id.*, para. 12.

[41] *See generally* United Nations General Assembly Res. 60/147, *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*, A/RES/60/147 (21 March 2006) [hereinafter UNGA Res. 60/147]; *see also* SR Health Report (2013), , paras. 61-67.

International human rights and political bodies have recognized that accountability requires prompt investigation into violations and punishment of perpetrators as well as legal and policy shifts in order to prevent future violations.[42] Remedies, moreover, must aim to restore the rights of victims of violations and must include adequate, effective, transformative and prompt reparation, forms of which include restitution, compensation, rehabilitation (e.g. medical or psychological services), satisfaction, and guarantees of non-repetition.[43] **The provision of sexual and reproductive health information and services, as medical services, therefore constitutes an integral part of reparations under international humanitarian law.**

As OHCHR has noted in its technical guidance on maternal mortality, human rights accountability entails multiple forms of monitoring, review, and oversight, including administrative, social, political and legal, and accountability for multiple actors within the system[44], all of them necessary to create a 'circle of accountability' around women and girls in crisis settings, circles that would truly reflect their experiences and demands. Examples of social accountability include "community-based oversight of finances and quality of care at points of service provision, including 'community scorecards."[45]

III) International legal framework under International Humanitarian Law (IHL)

IHL is applicable only in times of armed conflict, including both international armed conflict and non-international armed conflict. IHL binds all parties to an armed conflict, including non-state armed groups.[46]

[42] UNGA Res. 60/147,para. 3(b).

[43] Restitution aims to restore the victim to her original situation before the violation and includes restoration of enjoyment of human rights, return to one's place of residence, or return of property. Compensation is required as appropriate and proportional to the gravity of the violation and the circumstances of each case. Rehabilitation includes medical and psychological care as well as legal and social services. Satisfaction aims to ensure the cessation of continuing violations and includes verification and public disclosure of facts. Guarantees of non-repetition aim to prevent future violations and include structural and systemic changes, such as legal reform and education. *Id.* paras. 19-23. *See also* Human Rights Committee, *Gen. Comment No. 31*, para. 16; CAT Committee, *General Comment No. 3: Implementation of article 14 by States parties*, para. 2, U.N. Doc. CAT/C/GC/3 (2012); CEDAW Committee, *General Recommendation No. 33 on women's access to justice*, para. 19(f), U.N. Doc. CEDAW/C/GC/33 (2015).

[44] OHCHR, *Technical guidance on the application of a human-rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, paras. 74-75, U.N. Doc. A/HRC/21/22 (July 2, 2012) and see also OHCHR *Follow-up on the application of the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity*, paras 38 and 62 j), U.N. Doc. A/HRC/39/6 (June 29, 2018)

[45] *Id.*, para. 74; *see also Social Accountability*, CARE INTERNATIONAL, http://governance.care2share.wikispaces.net/Social+Accountability (last visited June 12, 2017).

[46] '… Under Article 3 common to the Geneva Conventions of 12 August 1949, non-international armed conflicts are armed conflicts in which one or more non-State armed groups are involved. Depending on the situation, hostilities may occur between governmental armed forces and non-State armed groups or between such groups only. … Non-governmental groups involved in the conflict must be considered as "parties to the conflict", meaning that they possess organized armed forces. This means for example that these forces have to be under a certain command structure and have the capacity to sustain military operations. Additional Protocol II to the Geneva Convention of 12 August 1949 develops and supplements common Article 3 without modifying its existing conditions of application, by introducing a requirement of territorial control. It provides that non-governmental parties must exercise such territorial control "as to enable them to carry out sustained and concerted military operations and to implement this Protocol". Additional Protocol II expressly applies only to armed conflicts between State armed forces and dissident armed forces or other

IHL allows for no derogation or reservation.[47] In addition, many, but not all, of the customary international law rules, including those rules related to fundamental guarantees, apply to both international armed conflict (IAC) and non-international armed conflict (NIAC) and hence, non-state armed groups.[48]

IHL grants women the same protection as men, regardless if they are combatants, fighters, civilians or hors de combat. Recognizing their specific needs and vulnerabilities they face in conflict, however, IHL affords women additional specific protections and rights.[49] IHL contains important standards with regard to obligations regarding treatment of women civilians. medical treatment as well as the treatment of civilian women, and particularly pregnant women.

Customary IHL Rule 134 related to NIAC, for example, refers to specific aspects of this rule that would apply to women and girls, such as ' by requiring respect for the person and honour of each, prohibiting violence to life, health and physical and mental well-being, prohibiting outrages upon personal dignity, including humiliating and degrading treatment, rape, enforced prostitution and any form of indecent assault, and requiring the separation of women and men in detention' (see also section below on sexual violence). [50]

Rule 134 also requires that the specific protection, health and assistance needs of women affected by armed conflict must be respected and references IHRL standards to support this.[51] The ICRC has interpreted this norm as encompassing "medical, psychological and social assistance", including trauma treatment and counselling.[52] The breadth of this responsibility is also recognised in the ICRC Commentary (2016), which notes that the special protection and care afforded to women must take into account "the distinct set of needs of and particular physical and psychological risks facing women, including those arising from social structures" and requires "equal respect, protection and care based on all the needs of women" .[53] For example, the Geneva Conventions and Additional Protocol I require that parties to an armed conflict treat pregnant women and nursing mothers with particular care, including with respect to medical assistance.[54] IHL establishes an affirmative duty to provide medical care for the wounded.[55]Additional Protocol I includes in its

organised armed groups. Contrary to common Article 3, the Protocol does not apply to armed conflicts occurring only between non-State armed groups.' from ICRC Case Book : https://casebook.icrc.org/glossary/non-international-armed-conflict
See also, (1) Customary IHL Rules, Chapter 32 (page 299); (2) *Prosecutor v Sam Hinga Norman* (Case No. SCSL-2004-14-AR72(E)) Decision on Preliminary Motion Based on Lack of Jurisdiction (Child Recruitment), Decision of 31 May 2004, at para 22, in which the Appeals Chamber of the Sierra Leone Special Court held that: *"it is well settled that all parties to an armed conflict, whether states or non-state actors, are bound by international humanitarian law, even though only states may become parties to international treaties."* https://sierralii.org/sl/judgment/special-court/2004/18; (3) Updated European Union Guidelines on promoting compliance with international humanitarian law (IHL) (2009/C/303/06) 15 December 2009. https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52009XG1215(01)&from=EN

[47] ICRC, Customary International Law Database, Introduction to Fundamental Guarantees, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_intofugu

[48] See Rules 87-105, Rules on Fundamental Guarantees https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_cha_chapter32

[49] ICRC ICHL, Rule 134, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_cha_chapter39_rule134

[50] ICRC Customary IHL Rule 134

[51] ICRC, CIHL Rule 134

[52] ICRC, 2016 commentary art. 12, paras. 1429-30

[53] ICRC, 2016 commentary art. 12, paras. 1429-30

[54] Geneva Convention I, art. 12; Additional Protocol I, art. 8(a); ICRC, 2016 Commentary on the First Geneva Convention, art. 12, paras. 1432 (2016); ICRC, Customary IHL Database, Rule 134, https://www.icrc. org/customary-ihl/eng/docs/v1_rul_rule134 (last visited May 31, 2017) (citing to CEDAW report).

[55] ICRC, 2016 Commentary on the First Geneva Convention, art. 12, para. 1365; Pictet Commentary, Vol. I, art. 12; ICRC, Customary IHL Database, Rule 110, https://www.icrc.org/customary-ihl/eng/ docs/v1_rul_rule110 (last visited May 31, 2017)

definition of the wounded and sick "*maternity cases" and "other persons who may be in need of immediate medical assistance or care, such as… expectant mothers*."[56]

Customary IHL prohibits sexual violence against any person, regardless of sex, applicable in both IAC and NIAC, and are also applicable to non-state actors. [57] The range of prohibited actions include rape and enforced prostitution, sexual slavery, forced pregnancy, forced sterilisation, forced public nudity or stripping, mutilation of sexual organs, forced marriage, forced inspections for virginity, sexual exploitation (such as obtaining sexual services in return for food or protection), forced abortions and sex trafficking.[58] The ICRC Commentary (2016) further notes that "there is a growing acknowledgement that women, men, girls and boys are affected by armed conflict in different ways" and "[s]ensitivity to the individual's inherent status, capacities and needs, including how these differ among men and women due to social, economic, cultural and political structures in society, contributes to the understanding of humane treatment under common Article 3".[59]

The complementary and mutually reinforcing protection of International Human Rights Law and IHL has been expressly recognized by international and regional courts and tribunals.[60] ICRC's customary IHL Study notes that human rights law instruments, documents and case law support, strengthen and clarify analogous principles of international humanitarian law.[61] For example, fundamental guarantees, including humane treatment, and non-discrimination, human rights law and the interpretation of human rights bodies can clarify analogous IHL principles.[62] As such, interpretation and guidance from human rights bodies regarding non discrimination against women and torture and cruel, inhuman, or degrading treatment can help define the contours of IHL .[63]

[56] Additional Protocol I, art. 8(a)

[57] ICRC CIHL Database Rule 93 ; see also Protocl I (Art. 75 (2)(b) and Protocol II Article 4 (2)(e)- https://ihl-databases.icrc.org/customary-ihl/eng/print/v1_rul_rule93

[58] ICRC Commentary Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Geneva, 12 August 1949.**Commentary of 2016 Article 3 : Conflicts not of an international character**, available at https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?key=rape&action=openDocument&documentId=59F6CDFA490736C1C1257F7D004BA0EC

[59] ICRC CIHL, Rule 134 ; ICRC, 2016 Commentary, article 12, paras 1429-30.

[60] ICRC, Humanitarian Law, HR Law and Refugee Law—the Three Pillars, https://www.icrc.org/en/doc/resources/documents/statement/6t7g86.htm; OHCHR Report on HR in Conflict, , p. 118; Committee on the Elimination of Discrimination Against Women, General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, paras. 19-20, U.N. Doc. CEDAW/C/GC/30 (2013)..

[61] Customary International Humanitarian Law, part V, chapter 32 (SEE IF UPDATE); See also generally, Vienna Convention on the Law of Treaties, Article 31 (3) (c), in the interpretation of a treaty 'there shall be taken into account…any relevant rules of international law applicable tin the relations between the parties.'

[62] ICRC, Customary IHL Database, Introduction to Fundamental Guarantees, https://www.icrc.org/customary-ihl/eng/docs/v1_rul_intofugu (last visited May 31, 2017); ICRC, Customary IHL Database, Rule 87, https://www.icrc. org/customary-ihl/eng/docs/v1_rul_rule87 (last visited May 31, 2017).

[63] See ICRC, 2016 Commentary on the First Geneva Convention, art. 3 (citing to human rights bodies and standards to interpret the scope of humane treatment); International Criminal Tribunal for the Former Yugoslavia (ICTY), Prosecutor v. Furundzija, Case No. IT-95-17/1 (Trial Chamber), 10 December 1998, para. 159 (citing to the Convention Against Torture to interpret the definition of torture under IHL); see also Cordula Droege, 'In truth the leitmotiv': the prohibition of torture and other forms of ill-treatment in international humanitarian law, 89 Int'l Rev. of the Red Cross 515, 517 (2007), https://www.icrc.org/eng/assets/files/other/irrc-867-droege.pdf (noting that "the notions of ill-treatment are so similar" in IHL and IHRL "that the interpretation of one body of law influences the other and vice versa"). Cf. Manfred Nowak and Ralph Janik, Torture, Cruel, Inhuman, or Degrading Treatment or Punishment, in The 1949 Geneva Conventions: A Commentary 320 (Clapham, Gaeta, Sassòli, eds.) (2015) (describing the different types of ill-treatment under IHRL, IHL, and ICL and noting that there are some differences in the definition and interpretation of these terms among different bodies and courts).

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IV) Humanitarian settings: the impact of restrictive abortion laws

Treaty monitoring bodies and the World Health Organisation (WHO) have long recognized the connection between restrictive abortion laws, high rates of unsafe abortion and maternal mortality[64], and found that restrictive abortion laws violate a range of human rights, including the rights to health, life, privacy, freedom from gender discrimination or gender stereotyping, and freedom from ill-treatment.[65]

Exception-based legal frameworks on abortion also hinder and do not guarantee women and girls' access to abortion services, including for survivors of rape and sexual violence. To ensure access free of discrimination, coercion and violence, States should guarantee access to abortion on request and strongly regulate health care providers enacting 'refusal of care based on conscience or religion' which in practice consequents unjustified refusal of essential time-sensitive healthcare.[66]

For instance, in Latin America and the Caribbean, systemic sexual violence paired with minimal access to sexual and reproductive health services means that women and girls are frequently forced to carry unwanted pregnancies to term. This has a negative impact on girls' mental, physical, and social health and leaves them vulnerable to higher risks of maternal mortality, anxiety, depression, post-traumatic stress disorder, and suicide[67]. The Center for Reproductive Rights has brought forward cases before the United Nations Human Rights Committee ("the Committee"). These cases are emblematic of a regional pattern of sexual and reproductive rights violations against girls and the lack of judicial recourse for victims of sexual abuse. Our petitioners' stories are uniquely their own because every instance of sexual violence is personal, but the violence, trauma, and human rights abuses they have experienced are not unique. Further, FIGO's scientific evidence has been used in strategic litigation to ensure accountability for the denial of abortion services.[68]

WHO has also made the link between unsafe abortion and maternal morbidity, highlighting that women and girls can face a range of harms and complications that affect their quality of life and well-being following unsafe abortion procedures: '*the major life-threatening complications resulting from the least safe abortions are haemorrhage, infection, and injury to the genital tract and internal organs. Unsafe abortions when performed under least safe conditions can lead to complications such as:*

- *incomplete abortion (failure to remove or expel all of the pregnancy tissue from the uterus)*
- *haemorrhage (heavy bleeding)*

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[64] CESCR Committee, *Gen. Comment No. 22*, paras. 10, 28*;* Human Rights Committee, *Gen. Comment No. 36*, para. 8; *See, e.g.*, Human Rights Committee, *Concluding Observations: Nigeria*, para. 22, U.N. Doc. CCPR/C/NGA/CO/R.2 (2019) CEDAW Committee, *Concluding Observations: Paraguay*, paras. 30, 31, U.N. Doc. CEDAW/C/PRY/CO/6 (2011); *Sierra Leone*, para. 32(d), U.N. Doc. CEDAW/C/SLE/CO/6 (2014)*;* CESCR Committee, *Concluding Observations: Argentina*, para 55, 56, U.N. Doc E/C.12/ARG/CO/4 (2018);

[65] Mellet v. Ireland, Human Rights Committee, Commc'n No. 2324/2013, paras. 7.6, 7.7, 7.8, U.N. Doc. CCPR/C/116/2324/2013 (2016); Whelan v. Ireland, Human Rights Committee, Commc'n No. 2425/2014, paras. 7.7 - 7.9, 7.12, U.N. doc. CCPR/C/119/D/2425/2014 (2017); K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011). CESCR Committee, *General Comment No. 22*, para. 10; CEDAW Communication No. 17/2008, Alyne da Silva Pimentel v. Brazil; CAT Committee, *Concluding Observations: El Salvador*, para. 23, U.N. Doc. CAT/C/SLV/CO/2 (2009); CAT Committee, *Concluding Observations*: Nicaragua, para 16, UN Doc. CAT/C/NIC/CO/1 (2009)

[66] For further info, see http://www.redaas.org.ar/objecion-de-conciencia-mapa

[67] Pan American Health Organization (PaHO) etal., accelerating Progress toward the reduction of adolescent Pregnancy in Latin America and the Caribbean, 15 (2017), available athttp://iris.paho.org/xmlui/bitstream/handle/123456789/34493/9789275119761-eng.pdf?sequence=1&isAllowed=y&ua=1; p.24

[68] Eg see ref R.R versus Poland: https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22001-104911%22]}

- *infection*
- *uterine perforation (caused when the uterus is pierced by a sharp object)*
- *damage to the genital tract and internal organs by inserting dangerous objects such as sticks, knitting needles, or broken glass into the vagina or anus.*[69]*'*

In General Comment 36 on the right to life, the Human Rights Committee highlights states' obligations in relation to preventing maternal mortality resulting from restrictive abortion laws, such as obligations to decriminalize abortion as well as to protect against the mental and physical health risks associated with unsafe abortion by ensuring access to all, 'especially boys and girls, to quality and evidence-based information and education about sexual and reproductive health and to a wide range of affordable contraceptive methods, and prevent the stigmatization of women and girls seeking abortion [and/or healthcare providers delivering such services].'.[70] It notes that the regulation of abortion[71]

must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant. Thus, restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering which violates article 7, discriminate against them or arbitrarily interfere with their privacy. States parties must provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl is at risk, or where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or where the pregnancy is not viable. ***In addition, States parties may not regulate pregnancy or abortion in all other cases in a manner that runs contrary to their duty to ensure that women and girls do not have to resort to unsafe abortions, and they should revise their abortion laws accordingly*** *(emphasis added).*[72]

The formulation above allows for a broad interpretation of the minimum grounds under which abortion should be made legal and also calls on states to take affirmative steps to provide access to abortion and could include any law or regulation which does not allow abortion on request and which poses barriers to safe abortion in other ways. Due to the deplorable conditions, dangers, and violence that persons face in many humanitarian settings,[73] any pregnancy in such a setting could lead to such pain or suffering for an individual that a denial of a request for an abortion could to amount to cruel, inhuman, and degrading treatment and, given the lack of available SRH services in such settings, could also jeopardize the right to life, in violation of human rights obligations.[74] The CEDAW Committee sets forth an approach which supports this. In its General Recommendation 30, it calls for States parties to ensure access to "safe abortion services," in the context of conflict,[75] without conditioning such services on a minimum grounds-based approach, (e.g., life, health, rape

[69] See https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion
[70] *Human Rights Committee General Comment 36, para. 8.*
[71] *Id., para. 8.*
[72] *Id., para. 8.*
[73] *John Zarocostas, Humanitarian crises: needs grow as health funding falls, The Lancet (2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30153-7/fulltext; The Lancet, Humanitarian Crises in a global pandemic (2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31749-9/fulltext?rss=yes.*
[74] *See also* CEDAW Committee, *Gen. Recommendation No. 30, supra* note 30, para. 52(c) (implicitly recognizing this by acknowledging states' obligation to provide safe abortion services, without referring to any grounds for abortion) ; A. RADHAKRISHNAN, *Protecting safe abortion, supra note 28.*
[75] CEDAW Committee, *Gen. Recommendation No. 30,* para. 52(c).

or severe fetal impairment), and like all human rights standards, never limits obligations under abortion to only circumstances in which abortion services are legal.

Treaty monitoring bodies have also found that States should eliminate punitive measures for women and girls who undergo abortions and for health care providers who deliver abortion services,[76] provide post-abortion care to women and adolescents, regardless of whether or not abortion is legal,[77], address the socio-economic needs of women and girls seeking abortion services[78] and consider establishing a legal presumption stating that adolescents are competent to seek and have access to sexual and reproductive health commodities and services, including abortion.[79]

Access to safe abortion is time-sensitive essential health care. However abortion is often the only health service to be governed by criminal law rather than regulated in the same way as any other healthcare procedure.

Restrictive ground-based abortion laws even in 'peaceful' settings discriminate which woman or girl could *potentially* be *eligible* for a legal abortion. Criminalising abortion laws create a chilling effect which both inhibits persons to seek abortion and health-care providers (HCP) to provide safe abortion services. In addition, the criminal law stigmatizes abortion, in contravention of international human rights obligations.[80]

Humanitarian settings further compound women and girls, often already, limited access to comprehensive SRH services, including safe abortion services. Consequently, humanitarian settings increase the risk of women and girls to unsafe abortions due to reduced access to SRH services and supplies as a consequence of the collapse, weakening or disruption of the health system and the provision of health care. During humanitarian crises, patterns of discrimination and sexual violence against women and girls are aggravated, resulting in an increased risk of unwanted pregnancies and unsafe abortions.[81]

It is estimated that 25.1 million unsafe abortions occurred worldwide each year during 2010 - 2014, with 24.3 million (97%) of these in developing countries. The proportion of unsafe abortions was significantly higher in developing countries than that in developed countries (49.5% vs.12.5%). When grouped by the legal status of abortion, the proportion of unsafe abortions was significantly higher in countries with highly restrictive abortion laws than in those with less restrictive laws.[82] For example: the risk of dying from an unsafe abortion is highest in Africa - over 75% of all abortions in sub-Saharan Africa are unsafe due to restrictive abortion laws.[83]

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[76] Human Rights Committee, *Gen. Comment No. 36*, para. 8; CEDAW Committee, *Gen. Recommendation No. 24*, para. 14; CRC Committee, *Concluding Observations: Nicaragua*, para. 59, U.N. Doc. CRC/C/NIC/CO/4 (2010); CAT Committee, *Concluding Observations: Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009); CESCR Committee: Concluding Observations: Pakistan, paras. 77, 78, U.N. Doc. CESCR/C/PAK/CO/1 (2017).

[77] CRC Committee, *General Comment No. 15*, para 70; Human Rights Committee, *Gen. Comment No. 36*, para 8; CESCR Committee, *Gen. Comment No. 22*, para 28; CEDAW Committee, *Gen. Comment No. 35*, para 18; CAT Committee, *Concluding Observations: Poland*, para 34(e), U.N. Doc. CAT/C/CO/POL/7 (2019)

[78] Mellet v. Ireland, Human Rights Committee, Communication No. 2324/2013, para. 7.11, U.N. Doc. CCPR/C/116/D/2324/2013 (2016). Whelan v. Ireland, Human Rights Committee, Commc'n No. 2425/2014,

[79] CRC Committee, *Gen. Comment No. 20*, para. 39.

[80] Human Rights Committee, General Comment 36 para. 8

[81] A qualitative study on health care providers' experiences of providing comprehensive abortion care in Cox's Bazar, Bangladesh https://conflictandhealth.biomedcentral.com/track/pdf/10.1186/s13031-021-00338-9.pdf

[82] Best Practice & Research Clinical Obstetrics and Gynaecology: Preventing unsafe abortion: Achievements and
The FIGO Initiative for the Prevention of Unsafe
https://reader.elsevier.com/reader/sd/pii/S1521693419300793?token=81BE6F91D537563040F822E61736D270EC55B26B68424B942AE8A86DE3FE0AF91E9BFCDC3684A8A4F225CA3B7E2C09A8&originRegion=eu-west-1&originCreation=20210519150900

[83] Abortion-related near-miss morbidity and mortality in 43 health facilities with differences in readiness to provide abortion care in Uganda https://gh.bmj.com/content/6/2/e003274

Limited access to safe abortions is due to the perceptions that 'there is no need', 'abortion is too complicated to provide in crises', 'abortion is illegal' and 'donors do not fund abortion services'. Further, a lack of training of HCPs, a lack of knowledge about the legal status of abortion in the specific context and humanitarian actors and the unregulation of 'Conscientious objection' of HCPs which is nurtured by HCPs negative attitudes toward abortion constitute additional barriers to safe abortion services in humanitarian settings[84]. Research and trainings programmes (such as Values, Clarification and Attitude Transformation) in low- and middle-income countries (LMIC) have demonstrated that HCPs play an important role in the provision of comprehensive abortion care and that their personal perception of abortion and attitudes toward women and girls seeking abortion-related care can act as both a facilitator and a barrier in service provision.[85]

V) Country examples

- *Cox's Bazar, Bangladesh- barriers to access to safe abortion and contraception* [86]

Since August 2017, more than 745,000 Rohingya refugees have fled Myanmar due to ongoing persecution and escalating violence, joining the estimated 200,000 Rohingyas already residing in Cox's Bazar district in Bangladesh. Home now to over 900,000 Rohingya refugees Cox's Bazar is the world's most densely populated refugee settlement. Rohingya women and girls currently living in the refugee settlement have been exposed to sexual violence. The United Nation's (UN) independent fact-finding mission in Myanmar[87] reports large-scale incidences of rape and other forms of sexual violence by the Myanmar military, targeting Rohingya women and girls. In addition, following displacement, Rohingya women and girls continue to face different forms of sexual- and gender-based violence, which might further increase the risk of unintended pregnancies and unsafe abortions.

A qualitative study on health care providers' experiences of providing comprehensive abortion care in Cox's Bazar, Bangladesh found the following key barriers[88]

[84] A qualitative study on health care providers' experiences of providing comprehensive abortion care in Cox's Bazar, Bangladesh https://conflictandhealth.biomedcentral.com/track/pdf/10.1186/s13031-021-00338-9.pdf
[85] Ibid.
[86] A qualitative study on health care providers' experiences of providing comprehensive abortion care in Cox's Bazar, Bangladesh https://conflictandhealth.biomedcentral.com/track/pdf/10.1186/s13031-021-00338-9.pdf
[87] Report of the independent international fact-finding mission on Myanmarhttps://www.ohchr.org/Documents/HRBodies/HRCouncil/FFM-Myanmar/A_HRC_39_64.pdf
[88] A qualitative study on health care providers' experiences of providing comprehensive abortion care in Cox's Bazar, Bangladesh https://conflictandhealth.biomedcentral.com/track/pdf/10.1186/s13031-021-00338-9.pdf

Table 3 Barriers and facilitators in the provision of CAC

Category	Barriers	Facilitators
Organisation, collaboration and policies influencing the provision of CAC	• Mexico City Policy • FP policy • Lack of space to provide services • Lack of accessibility and availability of IUD and implant • MR medication sold at local shops	• MR policy • UNFPA's leadership • Good collaboration among differ stakeholders • Supportive work environment • Availability of commodities and equipment
Influence of confidence, competence and pride on HCPs' provision of CAC	• Lack of knowledge on the abortion law • Varying knowledge on the MR policy	• HCPs confidence • Training of HCPs • Provider–client communication • HCPs taking pride in their work
Influence of HCPs' understanding of Rohingya women's needs on CAC provision	• HCPs' condescending attitudes and preconceived ideas • HCPs' strategies for increasing acceptance • Requiring husbands' permission	• HCPs' strategies for increasing acceptance

**CAC – comprehensive abortion care, FP – family planning, MR – menstrual regulation*

The study concluded that the availability and accessibility of comprehensive abortion care was limited by unfavourable abortion policies, a lack of privacy, a lack of knowledge of abortion laws and policies, health care providers' personal beliefs and a lack of cultural safety. To ensure the accessibility and availability of quality services, a comprehensive approach to sexual and reproductive health and rights is needed. Organisations must ensure that health care providers have knowledge of abortion policies and the ability to provide quality care that is woman-centred and non-judgmental.

- *Colombia - SRHR of Venezuelan refugees*

Colombia has received approximately 1.2 million refugees since 2017, driven by the political and economic crisis in Venezuela. The healthcare needs of women in refugee and migrant populations are huge, and since March 2017, approximately 60,000 pregnant women from Venezuela have given birth in Colombia. There is an increase in cases of extreme maternal morbidity (four-fold), increase in cases of low birth weight infants and perinatal deaths (two-fold) and an increase in cases of gestational syphilis (almost five-fold comparing January 2018 and January 2019)[89].

Women from Venezuela living in Colombia require: access to sexual and reproductive health care services to close the unmet need for modern contraceptive methods and limit unwanted or adolescent pregnancy; safe abortion and post-abortion services; protection from sexual exploitation and integrated care for sexual and gender-based violence; maternal health, antenatal care and hospital-based deliveries overseen by skilled health personnel; neonatal health care; reproductive morbidity and cancer screening, as well as midlife needs. These must be provided at primary health care level for refugees at a wider scale.

FIGO welcomed the Constitutional Court of Colombia's ruling that the healthcare system continue to provide care for Venezuelan citizens no matter their immigration status.

[89] FIGO Statement on Health of Refugees and Migrants in Colombia

- *Lebanon – Syrian refugees, especially those with inter-sectional identities, have less access to primary healthcare serves than Lebanese population*[90]

Lebanon is hosting 1.5 million Syrian refugees, 75% percent of whom are women and children. According to the UN High Commissioner for Refugees (UNHCR), Syrian refugees have less access to primary healthcare services than the Lebanese population. Among Syrian refugees, the individuals most at risk of discrimination are survivors of gender-based violence (GBV) individuals with disabilities, unmarried women and girls, LGBTQI persons. Although 80% of the cost of primary health care is covered by the UNHCR, use is dwindling due to collateral medical costs and humiliation experienced during clinical visits.[91] A recent study found that Syrian refugees report lack of dignity as a main barrier to their use of healthcare services; experienced mainly in the form of long waiting times, attitudes of the medical personnel ("naming and shaming"), and the high cost of services refugees.[92] Embedding the right to human dignity in the delivery of healthcare is fundamental, and governments, donors and NGOs must ensure greater accountability when health care providers and health care systems deny the right to healthcare of vulnerable and marginalised populations.

- *Sexual Violence in Conflict*

Rape is used as a weapon of war. For example, in the Democratic Republic of Congo an estimated 400 000 women are raped each year.[93] But international rescue initiatives do not always prioritise the particular needs of women and girls who are survivors and victims of war. While standards of care such as the WHO Technical Guidance 'Improving the health care of pregnant refugee and migrant women and newborn children' exist to guide response, as well as the Inter-Agency Minimum Initial Service Package (MISP) for sexual and reproductive health, the later – MISP does not yet include abortion services, even for survivors of rape.[94]

Impact of COVID-19 pandemic on sexual and gender-based violence and access to sexual and reproductive health information and services

The COVID-19 pandemic is pushing healthcare systems to their limits and compelling governments and healthcare institutions to make difficult and increasingly urgent decisions about how to deliver care while also curbing virus transmission. Human rights experts have made clear that, in the midst of the crisis, sexual and reproductive health services remain essential, and government responses to the pandemic must respect individuals' human rights, including the rights to life, health, sexual and reproductive health, privacy, bodily integrity, equality and non-discrimination, and freedom from cruel, inhuman, and degrading treatment. Moreover, human rights experts have stressed that governments must ensure that responses do not exacerbate existing and entrenched structural inequalities and inequities.

[90] Sexual and reproductive health and rights of refugee and migrant women: gynecologists' and obstetricians' Responsibilities https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1002/ijgo.13111
[91] Ibid.
[92] Baroud M, Mouheildine O. Healthcare needs and barriers of persons with disabilities: An exploratory study among Syrian refugees, Palestine Refugees from Syria, and Lebanese. Beirut: The Issam Fares Institute for Public Policy and International Affairs (AUB Policy Institute), American University of Beirut; 2018. https ://www.aub.edu.lb/ifi/Docum ents/ publications/research_reports/2018-2019/20181 004_healthcare_needs_persons_with_disa ilities.pdf.
[93] Bress J, Kashemwa G, Amisi C, Armas J, McWhorter C, Ruel T, et al. Delivering integrated care after sexual violence in the Democratic Republic of the Congo. BMJ Global Health. 2019;4:e001120. https://gh.bmj.com/content/bmjgh/4/1/e001120.full.pdf
[94] A qualitative study on health care providers' experiences of providing comprehensive abortion care in Cox's Bazar, Bangladesh https://conflictandhealth.biomedcentral.com/track/pdf/10.1186/s13031-021-00338-9.pdf

CENTER *for* REPRODUCTIVE RIGHTS

FIGO International Federation of Gynecology and Obstetrics
the Global Voice for Women's Health

The Office of the High Commissioner for Human Rights, many UN independent human rights experts (the "special procedures"), and the World Health Organization have affirmed that human rights must guide the public health response to COVID-19. Such responses should ensure that any emergency measures — including states of emergency — are legal, proportionate, necessary and non-discriminatory, have a specific focus and duration, and take the least intrusive approach possible to protect public health, human rights, and the rule of law. Human rights-based responses to the crisis must be inclusive, equitable and universal, to ensure that no one is left behind. Some countries however are instrumentalizing the COVID-19 crisis to roll back on human rights in general and on sexual and reproductive rights in particular. For instance, the U.S., in USAID's recent letter to the UN Secretary General Antonio Guterres contesting, have contested the classification of abortion as an essential health service within the UN Global Humanitarian Response Plan for COVID-19.

UN special procedures, and the World Health Organization have reiterated that sexual and reproductive health care is essential health care that governments must prioritize and include as part of their COVID-19 responses. Essential sexual and reproductive health services include confidential access to contraception, safe abortion and post-abortion services, maternity care, and easy-to-access procedures such as online prescriptions, if necessary free of charge.

International experts have provided guidance on how governments should ensure timely, uninterrupted access to the full range of essential sexual and reproductive health care during the COVID-19 pandemic:

The Committee on the Elimination of Discrimination Against Women has called on governments to ensure that COVID-19 responses are gender-sensitive, intersectional, and address the disproportionate impact of the pandemic on women's health. The Committee has urged governments to ensure uninterrupted access to gender-sensitive essential health services, such as pre and post-natal care, termination of pregnancy, and the availability of contraceptives. The Committee has noted that guaranteeing uninterrupted access requires governments to ensure there is no disruption in the supply chain of sexual and reproductive health commodities, including production, shipping, and distribution.

The Office of the High Commissioner for Human Rights (OHCHR) and many special procedures have further recommended that governments mitigate the impact of the COVID-19 crisis on women and girls' access to sexual and reproductive health and rights and ensure their full and equal representation in all decision-making on short-term mitigation and long-term recovery.

The WHO has recognized that increased restrictions on mobility affecting access to essential health services, including sexual and reproductive health, violate human rights and has recommended that governments consider and address such impacts when responding to COVID-19.

The UN human rights treaty bodies have repeatedly and consistently affirmed that access to abortion care is a human right. The WHO and the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) have made clear that, even in emergencies, abortion care is essential for preventing maternal mortality and morbidity and protecting the right to life with dignity, and thus should remain available.

With regards to the provision of sexual and reproductive health information and services in humanitarian settings in the context of the pandemic, the Center led within the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) the drafting of an Advocacy Brief that went through field and clinical validation processes by frontline health care workers, civil society, clinicians and epidemiologists.

Some key highlights of the brief include:

- Access to safe abortion and post abortion care are listed as essential health services along with contraception, intrapartum care for all births, emergency obstetric and newborn care, clinical care for rape survivors, and prevention and treatment for HIV and other sexually-transmitted infections.
- The technical guidance for health care workers articulates that risks of adverse outcomes from medical complications related to sexual and reproductive health outweigh the potential risks of COVID-19 transmission at health facilities.
- The framing continues to articulate SHR services in the context of an effective public health response as well as a rights-fulfilling response.

In order to sustain accessibility to abortion care during the COVID-19 pandemic, regional human rights experts have recommended that governments should ensure uninterrupted supplies for all essential sexual and reproductive health services.

WHO has stated that a barrier to access to safe abortion is the lack of trained providers. It is estimated that the global deficit of skilled health-care providers will reach 12.9 million by 2035. Such shortages are especially critical in low-income countries and all the more so in countries experiencing humanitarian crisis. Time-sensitive essential health care such as abortion-related care provision is often limited to specialist doctors with overly burdensome processes for women/girls to access a safe abortion (e.g. multiple doctor sign-off/approval exacerbated further in a context of health care provider shortages). WHO has reported that task-sharing among health care providers would better effectively utilise practitioners, midwives, nurses and auxiliaries in many settings, which would positively strengthen access and the availability of SRHR services, includes safe abortion care, that women and girls require.[95]

Further, in order to further improve access to abortion care, IAWG has noted that governments should ensure support for self-management of medical abortion care for up until 12 weeks of pregnancy and that remote approaches can be considered for counselling on self- management. Relatedly, the World Health Organization recommends that governments should ensure the availability of all essential medicines covered under the WHO Model List of Essential Medicines, which includes the active drugs for medication abortion, misoprostol and mifepristone.

It is worth mentioning that a small number of countries have taken steps to address barriers in access to abortion, thereby highlighting how unnecessary these barriers are. For example, France, Ireland, and parts of the UK have adopted temporary measures to secure access to abortion care during the pandemic, including by legalizing teleconsultations and use of early medical abortion at home. However, in some of these countries these measures are considered inadequate for meeting the needs of individuals seeking care and advocates are asking governments to adopt additional measures to extend time periods and broaden grounds for abortion.

[95] Health worker roles in providing safe abortion care and post-abortion contraception P3

pps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=8054A67F779D04E79DAF57ECAC3BCFE0?sequence=1

FIGO's OB-GYN member society - Acta Obstetricia et Gynecologica Scandinavica conducted a global survey on 'How the coronavirus disease 2019 pandemic is impacting the sexual and reproductive health and rights and response'[96] its core findings from 51 participants representing 29 countries revealed:

- 86% reported that access to contraceptive services was less or much less because of COVID-19, corresponding figures for surgical and medical abortion were 62% and 46%.
- The increased risk of gender-based and sexual violence was assessed as moderate or severe by 79%. Among countries with mildly restrictive abortion policies, 69% had implemented changes to facilitate access to abortion during the pandemic, compared with none among countries with severe restrictions, 87.5% compared with 46% had implemented changes to facilitate access to contraception.
- The content analysis showed that (a) prioritizations in health service delivery at the expense of SRHR, (b) lack of political will, (c) the detrimental effect of lockdown, and (d) the suspension of sexual education, were threats to SRHR access (theme 1). Requirements to mitigate these threats (theme 2) were (a) political will and support of universal access to SRH services, (b) the sensitization of providers, (c) free public transport, and (d) physical protective equipment. A contrasting third theme was the state of exception of the COVID-19 pandemic as a window of opportunity to push forward women's health and rights (see FIGO's statement: FIGO endorses the permanent adoption of telemedicine abortion services ref. recommendations per COVID opportunities)
- Respondents called primarily for increased government response, will, and accountability for universal access to abortion and contraceptive services. The policy changes that were called for were the provision of outpatient abortion services, allowance for home medical abortion, increased gestational age limits, increased sexual education at schools, and the facilitation of abortion and contraceptive services through telemedicine. '*Thinking about innovative measures in dealing with current status, such as remote approaches (telephone, digital applications, SMS text messaging, voice calls, interactive voice response) whenever applicable'. (Iraq response)*
- The need for providers to become sensitized to women's needs and rights was also a recurring topic. '*Clinical providers should be trained in unconscious bias and non-judgemental engagement with clients and ensuring consumer choices in contraception*'. (Lebanon response)

UNFPA analysed data for 115 low- and middle-income countries in January 2021[97] and estimates that:

- An estimated 12 million women may have been unable to access family planning services as a result of the COVID-19 pandemic, with disruption of supplies and services lasting an average of 3.6 months. This number could be as high as 23 million on the higher end of projections, or as low as 4 million at the lower end of projections.
- As a result of these disruptions, as many as 1.4 million unintended pregnancies may have occurred before women were able to resume use of family planning services. This number could be as high as

[96] How the coronavirus disease 2019 pandemic is impacting sexual and reproductive health and rights and response: Results from a global survey of providers, researchers, and policy-makers https://obgyn.onlinelibrary.wiley.com/doi/10.1111/aogs.14043
[97] UNFPA - Impact of COVID-19 on Family Planning: What we know one year into the pandemic, 11 March 2021 https://www.unfpa.org/sites/default/files/resource-pdf/COVID_Impact_FP_V5.pdf

2.7 million at the higher end of projections, or as low as 500,000 at the lower end of projections.

- **Center's Country briefs**

  - Colombia – Please see submission attached herewith
  - Nigeria – Please see the Center's and LEDAP's report on the Conflict in Northeast Nigeria
  - Center's and CARE's joint pilot project in Uganda[98] – Please see presentation attached herewith. In northern Uganda, the Center for Reproductive Rights and CARE International have undertaken a project on rights-based accountability for violations of the sexual and reproductive health and rights of refugee and host community women and girls. The project builds the capacity of community representatives to integrate rights-based approaches to service provision and establishes a mechanism for collection, review, and response to community-led monitoring of SRH outcomes and service users' SRHR-related complaints and feedback when services are lacking respect for human rights. To ensure accountability, the mechanism is supported by an independent third party, with authority to review and provide reasoning for decisions taken and ensure access to an effective remedy when rights are not respected. The project highlights the importance of working directly with duty-bearers and rights-holders in the development of accountability mechanisms.

- **Recommendations**

  - We respectfully recommend that the report highlights the following:

    - legal obligations of States to provide sexual and reproductive health information and services free of coercion, discrimination, and violence and within a human rights-based approach including in humanitarian settings and in the context of the COVID-19 pandemic.[99]

    - the harmful impact of restrictive abortion laws and restrictive legal frameworks pertaining to SRHR on all persons who seek abortions, including victims and survivors of rape and sexual and gender-based violence, including in humanitarian settings and in the context of the COVID-19 pandemic, and urges States to guarantee access to safe and legal abortion on request which must include stronger regulation of refusal of care based on conscience or religion exercised by healthcare providers.

    - fleshes out the importance of rights-based accountability for all persons, including women and girls in humanitarian settings.

    - recognizes the obligations non-state actors have in respecting, protecting and fulfilling human rights, including SRHR and access to SRH services in humanitarian settings, including during armed conflict.

[98] See https://reproductiverights.org/story/center-launches-new-program-protect-refugee-rights-uganda
[99] Also see Recommendations part in A/HRC/47/38, paras. 76-80

- emphasizes the applicability of human rights in the range of humanitarian settings, including during armed conflict, and ensure the human rights protections and humanitarian principles underpin all interventions aimed at women and girls.
- recognizes the mutually reinforcing and complimentary nature of IHRL and IHL.