**Submission from the Center for Reproductive Rights following the call for submissions by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on the right to sexual and reproductive health – challenges and opportunities during COVID-19**

**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 fulfill. 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 Center for Reproductive Rights (the Center) is pleased to provide this submission and attachments for the Report of the Special Rapporteur on the right to health on the right to sexual and reproductive health – challenges and opportunities during COVID-19.

This submission will focus on the impact of COVID-19 on the sexual and reproductive health and rights (SRHR) of women and girls. It examines access to sexual and reproductive health services as essential services in the context of the pandemic, including maternal health, access to abortion with no restrictions as to reason, as well as women and girls’ SRHR in humanitarian settings, also focusing on intersectional discrimination faced by marginalized populations.

1. **Background**

The UN Secretary General recognized that the pandemic has exacerbated existing human rights concerns such as limited access to SRHR and stressed the need to mitigate the impact of the crisis on women and girls access to these services.[[1]](#endnote-1) While seeking sexual and reproductive health services (SRHS) and information, women and girls are facing challenges and barriers that have been exacerbated by the pandemic, but also new ones that have been created,[[2]](#endnote-2) effectively limiting of eliminating women and girls’ access to life saving and essential health services. These barriers include waiting periods and abortion and parental consent for access to sexual and reproductive health information and services. In the current context, women and girls are more likely to continue facing challenges accessing quality reproductive health care especially in rural areas or marginalized communities.

1. **International Legal framework**

States have clear legal obligations under current human standards to ensure the respect, protection and fulfillment of SRHR and that the measures taken to address the COVID-19 pandemic do not directly or indirectly discriminate against women and girls.[[3]](#endnote-3)

**1) Access to sexual and reproductive health services in the context of COVID-19**

The UN General Secretary stated that “human rights are key in shaping the pandemic response”[[4]](#endnote-4) and stressed the need to continue delivering SRH services during the pandemic.[[5]](#endnote-5) WHO issued an operational guidance note for the COVID-19 context, in which it recommended that in the case of reduction in the availability of essential sexual and reproductive health services, digital health services and self-care interventions should be prioritized, which also includes *inter alia* ensuring access to contraception and abortion.[[6]](#endnote-6)

Human rights experts have also recalled states obligations[[7]](#endnote-7) to provide the full range of sexual and reproductive health information and services on a non-discriminatory basis,[[8]](#endnote-8) including access to contraception, quality and acceptable maternal health care, and safe and legal abortion, in line with international human rights standards.[[9]](#endnote-9) Human rights experts also stressed that the states response plans and measures to COVID-19 should not further exacerbate entrenched structural inequalities and inequities,[[10]](#endnote-10) adding that health emergencies often exacerbate pre-existing barriers such as social norms and gender-based discrimination, criminalization, and third-party authorization requirements.[[11]](#endnote-11)

The CEDAW Committee stressed that states must ensure access to contraceptive information and services as an essential measure[[12]](#endnote-12) and recalled the states their obligations to continue to provide sexual and reproductive health as essential services, including modern forms of contraception, safe abortion and post-abortion services to women and girls at all times, including though easy-to-access procedures, such as online prescriptions.[[13]](#endnote-13) Therefore, guaranteeing access to contraception can mitigate short-term demands on the healthcare system that would result from unplanned pregnancy.[[14]](#endnote-14)

**2) Access to abortion**

WHO has established access to legal and safe abortion services as essential services [[15]](#endnote-15) and treaty bodies indicated that restrictive laws on abortion violate a series of human rights, including the rights to health, life, privacy and the right to live a life free of discrimination based on gender or on gender stereotypes and the right to live a life free from cruel, inhuman and degrading treatment.[[16]](#endnote-16) The CEDAW Committee has established that the criminalization of abortion, the denial or delay of safe abortion and the post-abortion care and the forced continuation of a pregnancy are forms of discrimination and gender-based violence.[[17]](#endnote-17)

Treaty monitoring bodies have long recognized the connection between restrictive abortion laws, high rates of unsafe abortion, and maternal mortality.[[18]](#endnote-18) In General Comment No. 36 on the right to life, the Human Rights Committee has reaffirmed that states have a duty to ensure that women and girls do not have to undertake unsafe abortions as part of preventing foreseeable threats to the right to life and that 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 undertake unsafe abortions.[[19]](#endnote-19)

The provision of post-abortion care is a long standing human rights obligation and denying of abortion and post- abortion care can pose a risk to physical, mental, and emotional health and safety, risks that are heightened during a pandemic.

**3) Medication and self-managed abortion**

UN Treaty monitoring bodies, which monitor state compliance with UN human rights treaties and guide states on how states can meet their human rights obligation, have found that restrictive abortion laws violate a range of human rights, including the rights to health, life, privacy, to be free from gender discrimination or gender stereotyping, and to be free from ill-treatment.[[20]](#endnote-20) They have repeatedly recognized the connection between restrictive abortion laws, high rates of unsafe abortion and

maternal mortality.[[21]](#endnote-21)

The Committee on the Elimination of Discrimination Against Women has noted that it is a form of gender discrimination for a State party to “*refuse to provide legally for the performance of certain reproductive health services for women” or to punish women who seek those services*.[[22]](#endnote-22)’’

The treaty monitoring bodies recognize that abortion must be decriminalized, legalized at least on certain grounds, and services must be available, accessible, affordable, acceptable, and of good quality.[[23]](#endnote-23) The Human Rights Committee has said that States may not regulate abortion in a manner contrary to their duty to ensure that women and girls do not have to undertake unsafe abortions, that any restrictions must be non-discriminatory, and that States must provide safe, legal and effective access

to abortion, inter alia, “when carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering.[[24]](#endnote-24) The treaty monitoring bodies recommend that States should liberalize their abortion laws to improve access and remove legal, financial, and practical barriers that deny effective access by women and girls to safe and legal abortion, including medically unnecessary barriers to abortion and third-party authorization requirements.[[25]](#endnote-25)

States are required to eliminate laws and policies that undermine autonomy, integrity and right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health.[[26]](#endnote-26)

CEDAW described the prohibition of misoprostol in one state as “indicative of the ideological environment” and having a “retrogressive impact”, and urged the state to reintroduce it, in order to reduce women's maternal mortality and morbidity rates due to unsafe abortion.[[27]](#endnote-27)

Medical abortion has been addressed by the Committee on Economic, Social and Cultural Rights (CESCR), first indirectly through General Comment No. 14 which interprets and sets forth guidance on how to implement the right to health, which states that providing access to medicines on the WHO Model List of Essential Medicines is a core obligation of the right to enjoy the highest attainable standard of health.[[28]](#endnote-28) CESCR’s General Comment No. 22 on the right to sexual and reproductive health reinforced the obligation to ensure access to essential medicines, and specified access to “medicines for abortion.”[[29]](#endnote-29)

In 2020, CESCR’s General Comment No. 25 on science and economic social and cultural rights, the Committee said that States must ensure access to up-to-date scientific technologies necessary for women in relation to the right to sexual and reproductive health, in particular medication for abortion, on the basis of non-discrimination and equality.[[30]](#endnote-30)

The Special Rapporteur on the Right to Health has also expressed concern about legal restrictions that impede access to essential medicines, thereby limiting women’s accessibility to sexual and reproductive health.[[31]](#endnote-31)

No treaty monitoring body has yet addressed legal and policy barriers specific to self-managed abortion in detail, such as requirements that a health care professional be involved with an abortion and that an abortion must take place in a hospital or other specified health care facility.

UN experts expressed concern about the emergency orders and policies taken by the authorities addressing the COVID-19 crisis to restrict reproductive rights, by delaying or denying access to abortion, which exacerbates the existing barriers and generate regression in the access to legal abortion care.[[32]](#endnote-32) Similarly, the Working Group on discrimination against women and girls expressed concern about the increased restriction on the ability of women and girls to access essential sexual and reproductive health services,[[33]](#endnote-33) including due to new barriers to access to abortion services and recommended that “safe abortion and post abortion services […] must be ensured to women and girls at all times, through toll-free hotlines and easy-to-access procedures such as online prescriptions”.[[34]](#endnote-34)

The COVID-19 pandemic has further reduced access to abortion, with barriers increasing for a variety of reasons, including lack of service providers available, fear of going to health facilities, and due to anti-abortion governments excluding abortion from the list of essential services to be maintained during the pandemic. The WHO has recognized that women’s and girls’ access to essential health services, including sexual and reproductive health services, is likely to be affected by the restrictions on mobility and economic challenges faced due to the COVID-19 pandemic and response.[[35]](#endnote-35)

It has noted that such restrictions on access to services are a violation of human rights[[36]](#endnote-36) and has provided rights-based interim operational guidance on how States should maintain essential sexual and reproductive health services in the context of the pandemic, and recommended that[[37]](#endnote-37):

* When facility-based provision of sexual and reproductive health services is disrupted, prioritize digital or telemedicine health services, and self-managed interventions, while ensuring access to a trained provider if needed.
* Consider the option of using non-invasive medical methods for managing safe abortion and incomplete abortion and take steps to meet the anticipated increase in need for medical methods of abortion.

During the COVID-19 pandemic, some governments have relaxed regulations on medical abortion and facilitating access by telemedicine, measures which have been welcomed by human rights experts.[[38]](#endnote-38)

The COVID-19 pandemic has underscored the need for States to improve access to medical abortion and remove restrictions on telemedicine, as well as consider reforming legal frameworks relating to self-managed medical abortion. These measures would help ensure that all women and girls have their sexual and reproductive rights respected, protected, and fulfilled, by increasing access to safe and legal abortion. Human rights standards on abortion should evolve with the new realities shaped by the COVID-19 pandemic and should look at increasing access to abortion services for all pregnant persons, including by removing barriers to medical abortion, in line with WHO recommendations.

**4. Women and girls’ sexual and reproductive rights in humanitarian settings**

States have the duty to respect, protect and fulfill sexual and reproductive rights during humanitarian crises.[[39]](#endnote-39) The pandemic has exacerbated pre-existing patterns of discrimination and violence in humanitarian settings. In addition, it threatens to push fragile settings into new crises with already strained health systems and logistics networks, inadequate and overcrowded spaces and shelters, limited protections from gender-based violence and insufficient hygiene and sanitation facilities and supplies.[[40]](#endnote-40)

The Inter-Agency Working Group on Reproductive Health in Crises urged a rights-based approach to the incorporation of women and girls’ access to essential and rights-fulfilling sexual and reproductive health information and services SRHR during the COVID-19 response.[[41]](#endnote-41) The Working Group has developed a detailed set of policy recommendations on how this should be done.[[42]](#endnote-42)

The CEDAW Committee indicated that states “must adopt a rights-based approach and undertake a gender-conflict analysis to protect women and girls in humanitarian settings and conflict situations” and that “[t]hey must take remedial measures to reduce the risk of COVID-19 and counter disruptions of services to prevent avoidable maternal and child morbidity and mortality in humanitarian settings”.[[43]](#endnote-43)

**5) Marginalized populations**

Marginalized populations, including *inter* alia, racial, indigenous minorities and other ethnic communities, as well as migrant and rural women and women deprived of their liberty have long experienced the disproportionate impact of restricted access to comprehensive reproductive health care and the pandemic has exacerbated the existing inequities.[[44]](#endnote-44)

WHO emphasized the importance of addressing the particular needs of marginalized populations under Covid-19.[[45]](#endnote-45)

Human rights experts have called on governments to refrain from actions that might exacerbate existing inequalities; develop and intersectional response to the pandemic; address the specific needs of individuals facing multiple and intersecting forms of discrimination who may be disproportionately affected by the pandemic; and avoid potential inequity in pandemic-related health policies.[[46]](#endnote-46) The CEDAW Committee called on states to ensure that COVID-19 responses are gender-sensitive, intersectional and address the disproportionate impact of the pandemic on women’s health.[[47]](#endnote-47)

The Working Group on discrimination against women and girls called on states to take a gender-sensitive intersectional approach in the response to the pandemic, indicating that multiple and intersecting forms of discrimination interact to exacerbate structural inequalities and marginalize and disproportionately impact certain groups of women and girls.[[48]](#endnote-48) They reaffirmed that denying women access to information and services which only they require is inherently discriminatory and prevents women from exercising control over their own bodies and lives.[[49]](#endnote-49)

1. **Regional examples**
2. **Access to sexual and reproductive health information and services**

In the US, the situation of increasing rates of maternal mortality and morbidity and wide racial and ethnic disparities in maternal health outcomes, in which Black and indigenous women in the US were much more likely to die from pregnancy complications that white women were and where women of color suffered disproportionately high rates of maternal morbidity, was exacerbated by the pandemic (see: [Maternal Health & COVID-19 in the US fact sheet](https://reproductiverights.sharepoint.com/:w:/r/USPrograms/HumanRights/_layouts/15/guestaccess.aspx?email=PDaher%40reprorights.org&e=pE7shp&wdLOR=c0DCBF723-05A5-427E-A942-8943E150F04F&share=EZuo50XZjNxHpHy7kQpzr70B4p3AO_tUffpj25-lciVeZQ)). Reports indicate that COVID-19 has put further strain on the maternal health care system and is exacerbating the underlying maternal health crisis facing Black and Indigenous women.[[50]](#endnote-50) In the US, the pandemic has also provided an opportunity for some government officials to further their ideological opposition to abortion and restrict access to essential healthcare. In the days and weeks after the COVID-19 outbreak, government orders in a number of states forced clinics providing abortion care to turn away hundreds of patients, many of whom had no other option.[[51]](#endnote-51) These actions are part of an ongoing and long-standing effort by states to limit, and in many cases prohibit, abortion access in the US.

In South America, maternal healthcare has been de-prioritized due to the pandemic and it is predicted that there will be 28,000 maternal deaths in the region due to the reduction of maternal health services.[[52]](#endnote-52) Reports indicate that barriers to maternal healthcare have caused the 2020 maternal mortality rate to increase between 35% and 49% compared to 2019 in Chile, Mexico and Peru.[[53]](#endnote-53) On a positive note, Mexico’s Ministry of Health declared maternal health services as essential and implemented ambulatory or self-managed services and follow-up procedures provided and guided through telemedicine.[[54]](#endnote-54)

In South America, States’ measures in response to COVID-19 crisis have further curtailed access to access to abortion services.[[55]](#endnote-55) The lack of clear state policies and directives establishing abortion as an essential service and ensuring its availability and accessibility during the pandemic has led to de-prioritize its availability, and thus deny access to necessary care,[[56]](#endnote-56) with the exception of Colombia, where the Ministry of Health established that abortion was an essential service that could not be interrupted during the pandemic and that information about SRHS should be provided to patients at all time.[[57]](#endnote-57) In countries where abortion is still completely or partially criminalized, the persecution of women who have suffered obstetric emergencies or pregnancy complications has continued, even during the health emergency crisis.[[58]](#endnote-58) By denying access to time-sensitive abortion care, officials place the health and economic security of pregnant people and families at risk and exacerbate systemic inequities.Furthermore, restrictions on essential healthcare services such as abortion undermine public health efforts to respond to COVID-19.

In Nepal, The Center has urged the government to ensure, respect, protect, and fulfil their commitments to SRHR, and to create enabling environment for safe, quality, affordable and accessible services for women and girls, in a joint statement with the Reproductive Health Right Working Group (RHRWG). We jointly intervened when a Province Hospital due to the Covid-19 situation, decided to immediately stop the provision of maternal Health, abortion, contraception and other RH services. We also submitted a letter of objection together to the Province Government, hospital management and other relevant government offices, which subsequently led to that the hospital decided to resume all RH services immediately. The Center together with RHRWG produced a video to ensure access to SRH services on a regular basis even during COVID-19 pandemic. The video clip, including a message from the spokesperson of the Ministry of Health and Population, has been publicly shared as a message from the government in Nepal. Together with our local partners, we advocated with the government to ensure SRHR as basic and essential health services including developing a policy brief and issuing a joint statement through RHRWG’s network to highlight SRHR issues during the COVID-19 pandemic. This resulted in the Nepal government adoption of the interim guidelines for health service providers during the Covid-19 pandemic which recognized SRHR and safe abortion service as essential basic health services. It also resulted in the government’s provision of telemedicine and home visit services for SRH services including abortion, as well as the dispersal of medication abortion pills in pharmacies during the pandemic.

In the Philippines, The Center has provided technical support and resources to our partners including the Philippines Safe Abortion Advocacy Network (PINSAN) and the Commission on Human Rights, Commission on Women, and Department of Health (DOH), to ensure that comprehensive SRH services are recognized as essential health services in specific family planning guidelines from the DOH. In late March, the DOH issued a policy on the continuous provision of essential health services including SRH and FP services. Together with our local partners, we have held public events e.g. March 2021 and closed-door diplomatic briefings where we linked our ongoing decriminalization of abortion campaign to the increased risk of gender-based violence, child marriage, unwanted pregnancies, unsafe abortions, and maternal deaths that women and girls face as a result of the pandemic.

**In Pakistan,** he Center contributed to and co-signed a statement issued by the Pakistan Alliance on Post-Abortion Care (PAPAC) calling on the government and service providers to ensure availability of safe abortion services during the pandemic in Pakistan. The Center is working with its partner in Pakistan, the Collective for Social Science Research (CSSR), to document the impact of Covid-19 on the availability of SRH services in province of Sindh through rigorous research and data collection. The information collected so far has been summed up in a blog on CSSR's website and the final evidence-based report has been launched and presented in various fora including key findings on existing gaps and challenges, as well as recommendations and solutions to ensure access to essential SRH services in Pakistan in the context of COVID-19. The fact-finding report was published in November 2020. We collaborated with the Collective for Social Science Research to conduct a fact-finding on the impact of COVID-19 on the sexual and reproductive health and rights of women and girls in Sindh province, which includes Pakistan’s largest city of Karachi. The fact-finding was conducted from March to August 2020 and included tracking of media reports, key informant interviews, as well as a consultation with reproductive health experts. Our findings show that with the onset of the pandemic, the availability of reproductive health services, including contraception, safe abortion services and obstetric services in Sindh declined. Based on the recommendations in the report, the Sindh Health Minister committed to secure SRHR services and facilitate telehealth and helplines during the pandemic and beyond.

1. **Violence Against Women and Girls**

During the pandemic, violence against women and girls was exacerbated, resulting in rising domestic violence, rape, child and forced marriages and unplanned pregnancies. UNFPA estimates that, as a consequence of the pandemic, which disrupted contraceptive use for about 12 million women, approximately 1.4 million of unintended pregnancies took place during 2020 across low- and middle-income countries.[[59]](#endnote-59) In April 2020, UNFPA also warned that the pandemic will have a negative effect on preventable maternal deaths.[[60]](#endnote-60)

In the Machakos County in Kenya, approximately 4,000 adolescent schoolgirls became pregnant between February and June 2020 during the country’s lockdown and approximately 200 of the girls were 14 years or younger. In the Phalombe district in Malawi, over 5,000 adolescent girls became pregnant between January and May 2020.

In Nigeria, governors of the country’s 36 states resolved in June 2020 to declare a state of emergency over the high levels of sexual violence and brutal rape and killings of women and girls amidst a COVID-19 lockdown; and women and girls in the conflict-affected parts of the country, already exposed to increased risks of sexual violence, forced pregnancy and maternal morbidity have also experienced heightened violations. UNFPA has predicted that COVID-19 will result in at least 500,000 additional teenage pregnancies by 2021 throughout the LAC region,[[61]](#endnote-61) most of which will be product of rape.[[62]](#endnote-62) The alarming rise of sexual violence against girls, as well as the high incidence of teenage pregnancy and birth in girls were documented in Colombia, Ecuador, Guatemala, Nicaragua and Peru.[[63]](#endnote-63)

1. **SRHR in humanitarian settings**

In areas affected by armed conflict, the provision of sexual and reproductive health information and services has been further restricted, in particular in rural areas. In Colombia, outside the main cities, there was a decrease of almost 20% in the provision of abortion with respect to the previous year and, at the first level of healthcare, there was a considerable decrease of 76.2%, particularly in departments highly affected by armed conflict. In general, the quality, accessibility and availability of these services have been affected in places affected by humanitarian crises.[[64]](#endnote-64)

1. **Suggested recommendations**

* States should establish precise guidelines on the essential nature of sexual and reproductive health information and services, including on how to overcome existing barriers and new limitations. In this sense, states should address pre-existing barriers and legislative restrictions that limited access to comprehensive sexual and reproductive health services prior to COVID-19 and report on steps taken to this effect.
* States should ensure access to modern contraceptive, emergency contraceptives, maternal healthcare, and free and legal access to abortion, especially in rural, remote, or conflict-affected areas and ensure access to women and girls in vulnerable situations, including survivors of sexual violence, girls and adolescents, migrant women and women deprived of liberty, among others.
* States should ensure access available, acceptable, accessible and good quality sexual and reproductive health information and services.
* States should decriminalize abortion, guarantee access to abortion with no restriction as to reason and should guarantee access to medication abortion and remove restrictions on telemedicine and self-managed medication abortion.
* States should maintain comprehensive sexual and reproductive health information and services and center the health and rights of pregnant women and girls during and after the COVID-19 pandemic.

1. UNSDG, *COVID-19 and Human Rights: We are all in this together*, April 2020, <https://unsdg.un.org/resources/covid-19-and-human-rights-we-are-all-together>. [↑](#endnote-ref-1)
2. According to UNFPA, in Latin America and the Caribbean Region this crisis is having “a considerable impact on women’s access to healthcare and, in particular, to sexual and reproductive health services”. UNFPA, *COVID-19 Situation Report No.4*, Latin America and the Caribbean Region, Reporting period May 14 to June 2, [www.unfpa.org/sites/default/files/resource-pdf/LACRO\_COVID-19\_Regional\_Sitrep\_4\_June\_5.pdf](http://www.unfpa.org/sites/default/files/resource-pdf/LACRO_COVID-19_Regional_Sitrep_4_June_5.pdf). [↑](#endnote-ref-2)
3. CEDAW Committee, *Guidance Note on CEDAW and COVID-19*, April 2020, <https://www.ohchr.org/EN/HRBodies/Pages/COVID-19-and-TreatyBodies.aspx> [↑](#endnote-ref-3)
4. UNSDG, *Op cit.* note 1. [↑](#endnote-ref-4)
5. United Nations, *Shared Responsibility, Global Solidarity: responding to the socio-economic impacts of COVID-19*, March 2020, <https://unsdg.un.org/sites/default/files/2020-03/SG-Report-Socio-Economic-Impact-of-Covid19.pdf> [↑](#endnote-ref-5)
6. WHO, *Maintaining essential healthcare services: operations guidance for the COVID-19 context: interim guidance*, 1 June 2020, <https://apps.who.int/iris/handle/10665/332240> [↑](#endnote-ref-6)
7. Human Rights Committee, *Statement on derogations from the Covenant in connection with the COVID-19 pandemic*, U.N. Doc. CCPR/C/128/2, 24 April 2020; Committee on Economic, Social and Cultural Rights, *Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights*, U.N. Doc. CESCR E/C.12/2020/1 17 April 2020. [↑](#endnote-ref-7)
8. Treaty Bodies Chairs’ statement on COVID-19, *UN Human Rights Treaty Bodies call for human rights approach in fighting COVID-19*, 24 March 2020, [www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25742&LangID=E](http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25742&LangID=E) [↑](#endnote-ref-8)
9. CEDAW Committee, *op. cit.* note 3; Statement by the Working Group on discrimination against women and girls, *Responses to the COVID-19 pandemic must not discount women and girls*, 20 April 2020, [www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25808&LangID=E](http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25808&LangID=E); OHCHR Factsheet, *COVID-19 and Women’s Human Rights*, 15 April 2020, [www.ohchr.org/Documents/Issues/Women/COVID-19\_and\_Womens\_Human\_Rights.pdf](http://www.ohchr.org/Documents/Issues/Women/COVID-19_and_Womens_Human_Rights.pdf); Working Group on discrimination against women and girls, *United States: Authorities manipulating COVID-19 crisis to restrict access to abortion*, press-release 27 May 2020, statement endorsed by Danius Pūras, Special Rapporteur on the right to physical and mental health and Dubravka Šimonovic, Special Rapporteur on violence against women, its causes and consequences, [www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25907&LangID=E](http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25907&LangID=E); See also: WHO, *Addressing Human Rights as Key to the COVID-19 Response*, 21 April 2020, <https://apps.who.int/iris/rest/bitstreams/1275275/retrieve>. [↑](#endnote-ref-9)
10. Treaty Bodies Chairs’ statement on COVID-19, *UN Human Rights Treaty Bodies call for human rights approach in fighting COVID-19*, 24 March 2020, <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25742>. [↑](#endnote-ref-10)
11. OHCHR Factsheet, *op. cit.* note 9 [↑](#endnote-ref-11)
12. CESCR Committee, Gen. Comment No. 22, paras. 13, 28, 45, 57, 62; Human Rights Committee, Gen. Comment No. 36, at para. 8; CEDAW Committee, Gen. Recommendation No. 24, paras. 12(d), 17. [↑](#endnote-ref-12)
13. CEDAW Committee, *op. cit.* note 3. [↑](#endnote-ref-13)
14. CESCR Committee, General Recommendation No. 22, paras. 13, 28, 45, 57, 62; Human Rights Committee, Gen. Comment No. 36, para. 8; CEDAW Committee, Gen. Recommendation No. 24, paras. 12(d), 17. [↑](#endnote-ref-14)
15. WHO, [www.who.int/health-topics/abortion#tab=tab\_1](https://www.who.int/health-topics/abortion#tab=tab_1). [↑](#endnote-ref-15)
16. Human Rights Committee, Mellet v. Ireland, Communication No. 2324/2013, paras. 7.6, 7.7, 7.8, Doc. UN. CCPR/C/116/D/2324/2013, 2016, https://undocs.org/es/CCPR/C/116/D/2324/2013; Human Rights Committee, Whelan v. Ireland, Commcationn No. 2425/2014, paras. 7.7 - 7.9, 7.12, Doc. UN. CCPR/C/119/D/2425/2014, 2017, <https://undocs.org/CCPR/C/119/D/2425/2014>; Human Rights Committee, K.L. v. Peru, Communication No. 1153/2003, Doc. UN. CCPR/ C/85/- D/1153/2003, 2005, [www.undocs.org/CCPR/C/85/D/1153/2003](http://www.undocs.org/CCPR/C/85/D/1153/2003); CEDAW Committee, L.C. v. Peru, Commc’n No. 22/2009, para. 8.15, Doc. UN. CEDAW/C/50/D/22/2009, 2011, <https://www2.ohchr.org/english/law/docs/CEDAW-C-50-D-22-2009_en.pdf>; CESCR Committee, General Comment No. 22, para. 10; CEDAW Committee, Alyne da Silva Pimentel Teixeira v. Brazil, Communication No. 17/2008, Doc. UN. CEDAW/C/49/D/17/2008, 2011, <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2FC%2F49%2FD%2F17%2F2008&Lang=en>; CAT Committee, Concluding Observations : El Salvador, para. 23, Doc. UN, CAT/C/SLV/- CO/2, 2009, <https://undocs.org/CAT/C/SLV/CO/2>; CAT Committee, Concluding Observations: Nicaragua, para. 16, Doc. UN, CAT/C/NIC/CO/1, 2009, <https://undocs.org/CAT/C/NIC/CO/1>. [↑](#endnote-ref-16)
17. CEDAW Committee, General Recommendation No. 30: Women in conflict prevention, conflict, and post-conflict situations, (2013); CEDAW Committee, General Recommendation No. 24, paras. 11, 14. [↑](#endnote-ref-17)
18. CESCR Committee, Gen. Comment No. 22, paras. 10, 28; Human Rights Committee, Gen. Comment No. 36, para. 8. [↑](#endnote-ref-18)
19. Human Rights Committee, Gen. Comment No. 36, para. 8 [↑](#endnote-ref-19)
20. See, e.g., 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); CRC Committee, Gen. Comment No. 15 (on the right of the child to the enjoyment of the highest attainable standard of health), para. 70, U.N. Doc. CRC/C/GC/15 (2013 [↑](#endnote-ref-20)
21. CESCR Committee, Gen. Comment No. 22, paras. 10, 28, U.N. Doc. E/C.12/GC/22 (2016); Human Rights Committee, Gen. Comment No. 36, para. 8 U.N. Doc. CCPR/C/GC/36 (2018); See also, Human Rights Committee, Concluding Observations: Nigeria, para. 22, U.N. Doc. CCPR/C/NGA/CO/2 (2019).; CEDAW Committee, Concluding Observations: Paraguay, paras. 30, 31, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).; CEDAW Committee, Concluding Observations: 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); CEDAW Committee, Concluding Observations: Paraguay, para. 31(a), U.N. Doc. CEDAW/C/PRY/CO/6 (2011); CEDAW Committee, Concluding Observations: Chile, para. 20, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); CESCR Committee, Concluding Observations: Philippines, para. 31, U.N. Doc. E/C.12/PHL/CO/4 (2008). [↑](#endnote-ref-21)
22. CEDAW Committee, Gen. Recommendation No. 24: Article 12 of the Convention (Women and Health), (1999), para. 11 &14, U.N. Doc. A/54/38/Rev.1, chap. I. [↑](#endnote-ref-22)
23. CESCR Committee, Gen. Comment No. 22, paras. 11- 21 U.N. Doc. E/C.12/GC/22 (2016). [↑](#endnote-ref-23)
24. Human Rights Committee, Gen. Comment No. 36, para. 8 U.N. Doc. CCPR/C/GC/36 (2018). [↑](#endnote-ref-24)
25. Human Rights Committee, Gen. Comment No. 36 (The right to life) para. 8, U.N. Doc. CCPR/C/GC/36 (2018); Human Rights Committee, Gen. Comment No. 28 (The equality of rights between men and women), paras. 10-11, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000); CESCR Committee, Gen. Comment No. 22 (the right to sexual and reproductive health), paras. 28, 34, 40, 41, 45, 49(a), 49(e), 57, U.N. Doc. E/C.12/GC/22 (2016); CEDAW Committee, Gen. Recommendation No. 24 (women and health), para. 14, U.N. Doc. A/54/38/Rev.1 chap I (1999); CEDAW Committee, Gen. Recommendation No. 35 (gender-based violence against women, updating Gen. Recommendation No. 19), (2017), para. 29(c)(i), U.N. Doc. CEDAW/C/GC/35 (2017); CEDAW Committee, Gen. Recommendation No. 34 (the rights of rural women), para. 39(c), U.N. Doc. CEDAW/C/GC/34 (2016); CRC Committee, Gen. Comment No. 20 (the implementation of the rights of the child during adolescence), para. 60 U.N. Doc. CRC/C/GC/20 (2016); CRC Committee, Gen. Comment No. 15 (on the right of the child to the enjoyment of the highest attainable standard of health), paras. 31, 70, U.N. Doc. CRC/C/GC/15 (2013); Human Rights Committee, Concluding Observations: Angola, paras. 21-22, U.N. Doc. CCPR/C/AGO/CO/2 (2019); CESCR Committee, Concluding Observations: Cameroon, para. 59, U.N. Doc. E/C.12/CMR/CO/4 (2019); CEDAW Committee, Concluding Observations: Colombia, paras. 37-38, U.N. Doc. CEDAW/C/COL/CO/R.9 (2019); CRC Committee, Concluding Observations: Bahrain, para. 38, U.N. Doc. CRC/C/BHR/CO/4-6 (2019). [↑](#endnote-ref-25)
26. CESCR Committee, Gen. Comment. No. 22, para 34, U.N. Doc. E/C.12/GC/22 (2016); CESCR, Concluding Observations, Ecuador, para 52(f), U.N. Doc. E/C.12/ECU/CO/4 (2019). [↑](#endnote-ref-26)
27. DAW Committee, Philippines Inquiry Summary (Article 8 of Optional Protocol to Convention on the Elimination of All Forms of Discrimination against Women), paras. 9, 52(v), U.N. Doc. CEDAW/C/OP.8/PHL/1 (2014). [↑](#endnote-ref-27)
28. CESCR Committee , Gen. Comment No.14, The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000), reprinted in Compilation of Gen. Comments and Gen. Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003), para 43(d). [↑](#endnote-ref-28)
29. CESCR Committee, Gen. 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. 12, U.N. Doc. E/C.12/GC/22 (2016) [↑](#endnote-ref-29)
30. CESCR Committee, Gen. Comment No. 25 (2020) On science and economic, social, and cultural rights (article 15 (1) (b), (2), (3) and (4) of the International Covenant on Economic, Social and Cultural Rights, para. 33, U.N. Doc. E/C.12/GC/25. [↑](#endnote-ref-30)
31. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, on access to medicines. U.N. Doc. A/HRC/23/42, para. 45 (2013). [↑](#endnote-ref-31)
32. Working Group on discrimination against women and girls, *op. cit.* note 9. [↑](#endnote-ref-32)
33. *Ibid.* [↑](#endnote-ref-33)
34. *Ibid*. See also: OHCHR Factsheet, *op. cit,* note 9. [↑](#endnote-ref-34)
35. WORLD HEALTH ORGANIZATION (WHO), Addressing Human Rights as Key to the COVID-19 Response, (21 April 2020), available at https://www.who.int/publications-detail/addressing-human-rights-as-key-to-the-covid-19-response [↑](#endnote-ref-35)
36. Ibid, see also UNFPA. COVID-19 A gender lens, available at https://www.unfpa.org/resources/covid-19-gender-lens. [↑](#endnote-ref-36)
37. ORLD HEALTH ORGANIZATION (WHO), Maintaining essential health services: operational guidance for the COVID-19 context, available at https://apps.who.int/iris/rest/bitstreams/1279080/retrieve, see, in particular, section 2.1.4 SEXUAL AND REPRODUCTIVE HEALTH SERVICES, p. 29 [↑](#endnote-ref-37)
38. Center for Reproductive Rights, Access to Comprehensive Sexual and Reproductive Health Care in a Human Rights Imperative During the Covid-19 Pandemic (2020); WORLD HEALTH ORGANIZATION (WHO), Maintaining essential health services: operational guidance for the COVID-19 context, available at https://apps.who.int/iris/rest/bitstreams/1279080/retrieve, see in particular section 2.1.4 SEXUAL AND REPRODUCTIVE HEALTH SERVICES, p. 29 [↑](#endnote-ref-38)
39. CEDAW Committee, General Recommendation No. 30, para. 2.; Human Rights Committee, General Comment No. 36, paras. 2, 10, 64; CESCR Committee, General Comment No. 14, paras. 40, 65.; CESCR Committee, General Comment No. 3, para. 10.; Human Rights Committee, General Comment No. 31: The nature of the general legal obligation imposed on States parties to the Covenant, para. 11; Human Rights Committee, General Comment No. 29: States of emergency, para. 3; 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). [↑](#endnote-ref-39)
40. See <http://reproductiverights.org/wp-content/uploads/2020/12/Sexual-and-Reproductive-Rights-During-COVID-19-Response-and-Beyond.pdf> [↑](#endnote-ref-40)
41. Inter-Agency Working Group on Reproductive Health in Crises, May 2020, *COVID-19 Pandemic further threatens women and girls already at risk in humanitarian and fragile settings*, <https://cdn.iawg.rygn.io/documents/IAWG-COVID-ADVOCACY-STATEMENT.pdf?mtime=20200512014036&focal=none> [↑](#endnote-ref-41)
42. *Ibid*. [↑](#endnote-ref-42)
43. CEDAW Committee, *op. cit.* note 3. [↑](#endnote-ref-43)
44. Working Group of Experts on People of African Descent, *Statement on COVID-19: Racial equity and racial equality must guide State action*, 6 April 2020, <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25768>; Special Rapporteur on extreme poverty and human rights, *US COVID-19 strategy failing the poor, says UN expert*, April 16, 2020, <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25798&LangID=E>; Treaty Monitoring Bodies Chairs’ statement, *UN Human Rights Treaty Bodies call for human rights approach in fighting COVID-19*,<https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25742&LangID=E>; OHCHR Factsheet, *op. cit.* note 9; Compilation of Special Procedures’ statements, <https://www.ohchr.org/EN/HRBodies/SP/Pages/COVID-19-and-Special-Procedures.aspx>. [↑](#endnote-ref-44)
45. WHO, *Maintaining essential healthcare services: operations guidance for the COVID-19 context: interim guidance*, 1 June 2020, <https://apps.who.int/iris/handle/10665/332240>. [↑](#endnote-ref-45)
46. CESCR Committee, *Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights*, 17 April 2020, E/C.12/2020/1, para 15; CEDAW Committee, *op. cit.* note 3; Statement by the Working Group on discrimination against women and girls, *op. cit.* note 9; OHCHR Factsheet, *op. cit.* note 9. [↑](#endnote-ref-46)
47. CEDAW Committee, *op. cit.* note 3. [↑](#endnote-ref-47)
48. Working Group on discrimination against women and girls, *op. cit.* note 9. [↑](#endnote-ref-48)
49. *Ibid.* [↑](#endnote-ref-49)
50. See: Sandhya Raman, *COVID-19 amplifies racial disparities in maternal health*, Roll Call, May 14, 2020, <https://www.rollcall.com/2020/05/14/covid-19-amplifies-racial-disparities-in-maternal-health/>; Joia Crear-Perry, *Black Mamas Can Thrive During Childbirth, COVID-19 Or Not*, Essence, March 19, 2020, [https://www.essence.com/feature/ black-mamas-childbirth-covid-19-coronavirus/](https://www.essence.com/feature/black-mamas-childbirth-covid-19-coronavirus/); Claire Cleveland, *Coronavirus Is Stressing Pregnant Women And New Mothers Out. These Researchers Are Trying to Understand How to Help*, CPR News, May 23, 2020, <https://www.cpr.org/2020/05/23/coronavirus-is-stressing-pregnant-women-and-new-mothers-out-these-researchers-are-trying-to-understand-how-to-help/>; Nina Martin, *What Coronavirus Means for Pregnancy, and Other Things New and Expecting Mothers Should Know*, ProPublica, Mar. 19, 2020,<https://www.propublica.org/article/coronavirus-and-pregnancy-expecting-mothers-q-and-a>. [↑](#endnote-ref-50)
51. <https://reproductiverights.org/sites/default/files/documents/How%20State%20COVID-19%20Orders%20Can%20Impact%20Abortion%20Access.pdf> [↑](#endnote-ref-51)
52. UNDP & UNICEF, *Desafíos de la pandemia de COVID-19 en la salud de la mujer, de la niñez y de la adolescencia en América Latina y el Caribe*, September 28, 2020, [www.latinamerica.undp.org/content/rblac/es/home/library/crisis\_prevention\_and\_recovery/desafios-de-la-pandemia-de-covid-19-en-la-salud-de-la-mujer--de-.html](http://www.latinamerica.undp.org/content/rblac/es/home/library/crisis_prevention_and_recovery/desafios-de-la-pandemia-de-covid-19-en-la-salud-de-la-mujer--de-.html). [↑](#endnote-ref-52)
53. See: CLACAI, *La salud reproductiva es vital: Chile*, 2020, <https://saludreproductivavital.info/resultados/resultado-chile/>; El Economista, *Por COVID una de cada dos muertes maternas*, March 23, 2021, <https://www.eleconomista.com.mx/politica/Por-Covid-19-una-de-cada-dos-muertes-maternas-20210322-0144.html> and ; Swiss Info, *Perú retrocedió en 2020 ocho años en los niveles de mortalidad materna*, March 31, 2021, <https://www.swissinfo.ch/spa/per%C3%BA-maternidad_per%C3%BA-retrocedi%C3%B3-en-2020-ocho-a%C3%B1os-en-los-niveles-de-mortalidad-materna/46496276>. [↑](#endnote-ref-53)
54. Health Secretary of Mexico, *Lineamiento para la prevención y mitigación de COVID-19 en la atención del embarazo, parto, puerperio y de la persona recién nacida*, April 10, 2020, <https://www.gob.mx/cms/uploads/attachment/file/546239/Lineamiento_prevencion_y_mitigacion_de_COVID-19_en_el_embarazo_CNEGSR__1_.pdf> [↑](#endnote-ref-54)
55. In Chile and Mexico the requests for legal abortion decreased between 21% and 66% due to the mobility restrictions, confinement measures and fear of contagion of COVID-19 at the medical facility. In Ecuador, Guatemala, Colombia and some provinces of Argentina, the lack of clear information on how and where access these services, their inaccessibility in rural areas and unnecessary delays from providers have limited its access. See: CLACAI, *op. cit.* note 36; Expansión Política, *En tiempos de COVID-19, se pierden servicios de Interrupción Legal de Embarazos*, December 22, 2020, <https://politica.expansion.mx/mexico/2020/12/22/en-tiempos-de-covid-19-se-pierden-servicios-de-interrupcion-legal-de-embarazos>; Surkuna, Movimiento de Mujeres de El Oro, Fundación Lunita Lunera y Fundación Mujer & Mujer, *Encuesta virtual: Acceso y Atención en Servicios de Salud Sexual y Salud Reproductiva durante la pandemia por COVID-19 en Ecuador*, p. 1 y 5, <https://libreseinformadas.org/wp-content/uploads/2020/09/resultados_monitoreo_de_servicios_de_salud_sexual_y_salud_reproductiva_compressed.pdf>; United Nations, Guatemala*. Guatemala:**COVID-19. Informe de Situación No. 4*, April 30, 2020, <https://reliefweb.int/sites/reliefweb.int/files/resources/GT%20Informe%20de%20Situacio%CC%81n%20No.%204%20EHP-OCR%20COVID19%2020200429%20FINAL%202.pdf>; Mesa por la Vida y la Salud de las Mujeres and El Espectador, *Los dilemas alrededor del aborto en Colombia durante la pandemia*, April 21, 2020, <https://www.elespectador.com/coronavirus/los-dilemas-alrededor-del-aborto-en-colombia-durante-la-pandemia-articulo-915825> and; La Izquierda Diario. *¿Por qué es importante el aborto legal en medio del COVID-19?*, April 10, 2020, <http://www.laizquierdadiario.com/Por-que-es-importante-el-aborto-legal-en-medio-del-COVID-19> [↑](#endnote-ref-55)
56. This has been documented in Brazil, Costa Rica, Ecuador and Mexico. See: Human Rights Watch. *Penurias de una niña de 10 años para acceder al aborto legal en Brasil*, August 21, 2020, <https://www.hrw.org/es/news/2020/08/21/penurias-de-una-nina-de-10-anos-para-acceder-al-aborto-legal-en-brasil> and; NVI, *Niegan aborto seguro en el Hospital Civil de Oaxaca*, August 17, 2020, <https://www.nvinoticias.com/nota/156683/niegan-embarazo-seguro-en-el-hospital-civil-de-oaxaca>. [↑](#endnote-ref-56)
57. Ministry of Health of Colombia, *Plan de acción para la prestación de servicios de salud durante las etapas de contención y mitigación de la pandemia por SARS-CoV-2 (COVID-19)*, March 30, 2020, <https://www.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n%20No.%20536%20de%202020.pdf> [↑](#endnote-ref-57)
58. El Comercio. 2020. *Mujer es procesada por 'aborto consentido; la denuncia salió de un hospital*,<https://www.elcomercio.com/actualidad/mujer-procesada-aborto-denuncia-bolivar.html>; La Prensa. *Detienen a madre acusada de matar a su recién nacido,* May 19 2020, <https://www.laprensa.hn/sucesos/1380838-410/honduras-detenida-aborto-santa-rosa-de-copan-policia-nacional>; La Prensa. *Detienen a mujer por presunto aborto en Talanga, Francisco Morazán,* May 17 2020,  
    <https://www.laprensa.hn/sucesos/1380378-410/talanga-francisco-morazan-aborto-cinthia-flores-policia-nacional> and; El Norte, *Aumentan denuncias de aborto*, November 16, 2020, [www.elnorte.com/aplicacioneslibre/preacceso/articulo/default.aspx?\_\_rval=1&urlredirect=https://www.elnorte.com/aumentan-denuncias-de-aborto/ar2071577?referer=--7d616165662f3a3a6262623b727a7a7279703b767a783a--](http://www.elnorte.com/aplicacioneslibre/preacceso/articulo/default.aspx?__rval=1&urlredirect=https://www.elnorte.com/aumentan-denuncias-de-aborto/ar2071577?referer=--7d616165662f3a3a6262623b727a7a7279703b767a783a--) [↑](#endnote-ref-58)
59. UNFPA, *Impact of COVID-19 on Family Planning: What we know one year into the pandemic*, 11 March 2021, [www.unfpa.org/sites/default/files/resource-pdf/COVID\_Impact\_FP\_V5.pdf](http://www.unfpa.org/sites/default/files/resource-pdf/COVID_Impact_FP_V5.pdf). [↑](#endnote-ref-59)
60. UNFPA, *Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage*, 27 April 2020, [www.unfpa.org/sites/default/files/resource-pdf/COVID-19\_impact\_brief\_for\_UNFPA\_24\_April\_2020\_1.pdf](http://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf). [↑](#endnote-ref-60)
61. See : UNFPA, *Datos de América Latina y el Caribe sobre el impacto de la Covid-19 en la salud sexual y reproductiva de adolescentes y mujeres en América Latina y el Caribe*. Semana Andina 2020, September 21 de 2020, <https://colombia.unfpa.org/sites/default/files/pub-pdf/infografia-3-semana_andina.pdf>; [↑](#endnote-ref-61)
62. According to MESCEVI, "any pregnancy in a girl under 14 years of age should be considered non-consensual and, therefore, the product of sexual violence” Follow-up Mechanism of the Convention of Belém do Pará (MESCEVI), *Hemispheric Report on Sexual Violence and Child Pregnancy in the States Parties to the Convention of Belém do Pará*, Approved by the MESCEVIby the Committee of Experts of the MESCEVI at its Thirteenth Meeting, on October 13, 2016 in Mexico City, Mexico, para 9 <https://www.oas.org/en/mesecvi/docs/MESECVI-EmbarazoInfantil-ES.pdf> [↑](#endnote-ref-62)
63. See: Primicias, *Embarazo adolescente creció en los meses más duros de la pandemia*, November 21, 2020, <https://www.primicias.ec/noticias/sociedad/embarazo-adolescente-crecio-meses-pandemia/>; OSAR, *Monitoreo de embarazos en adolescentes al 20 de mayo 2020*, <https://osarguatemala.org/monitoreo-de-embarazos-en-adolescentes-entre-10-y-19-anos-al-20-de-mayo-2020/>; Prensa Libre, *Guatemala registra casi dos mil embarazos en niñas de 10 a 14 años en este 2020*, June 10, 2020, <https://www.prensalibre.com/guatemala/comunitario/guatemala-registra-casi-dos-mil-embarazos-en-ninas-de-10-a-14-anos-en-este-2020/> and; Report of civil society organizations for the regional thematic hearing regional, *Sexual violence forced pregnancies and access to health services in the context of the COVID-19 pandemic*, held on October 8, 2020 during the 177th regular session of the IACHR, <https://www.ninasnomadres.org/alza-la-voz/wp-content/uploads/2021/03/Informe-NNM-CIDH.pdf> [↑](#endnote-ref-63)
64. Information collected by the Center for Reproductive Rights with our partner Mesa por la Vida y la Salud de las Mujeres. Clacai. Monitoreo De Políticas De Salud Reproductiva En El Marco De Las Respuesta Al Brote De Covid-19 Y Acciones De Incidencia A Nivel Nacional Para Fortalecer El Acceso A Servicios Esenciales De Salud Reproductiva A Nivel Nacional (Colombia), <https://saludreproductivavital.info/wp-content/uploads/2020/12/COLOMBIA.-MONITOREO-DE-POLITICAS-DE-SALUD-REPRODUCTIVA_02.pdf> [↑](#endnote-ref-64)