**The Center for Reproductive Rights (the Center)—an international nonprofit 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.**

We are pleased to present this submission to the Special Rapporteur on violence against women, its causes and consequences, for her report on obligations of States to criminalize rape as a grave and systematic human rights violation and a form of gender-based violence against women. The Center urges that the report of the Special Rapporteur include sexual and reproductive rights as an integral part of state obligations to address rape and other forms of sexual and gender-based violence. As recognized by WHO, ‘sexual violence has a profound impact on physical and mental health. As well as causing physical injury, it is associated with an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences.’[[1]](#endnote-1)

An effective approach to the criminalization of rape requires the need to address legal, policy and practice barriers that hinder the realization of sexual and reproductive health and rights for survivors of rape and other gender-based violence.

This submission will look briefly at the legal frameworks on rape as a human rights violation and a form of gender-based violence against women. It will then look more deeply into the issue of state obligations to ensure access to the range of sexual and reproductive health information and services for victims and survivors of rape and sexual and gender-based violence. The submission will then look more closely at the issue of rape and conflict-related sexual violence and provision of sexual and reproductive health information and services in humanitarian settings and study the issue of accountability in these settings for violations. 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.

1. **Legal Framework: rape as a human rights violation and a form of gender-based violence against women and provision of sexual and reproductive health information and services**
	1. **Rape and sexual violence as a human rights violation and a form of gender-based violence against women**

The Committee on the Elimination of Discrimination Against Women (CEDAW Committee) has stated in its General Recommendation 35 on gender-based violence against women that ‘*the opinio juris and State practice suggest that the prohibition of gender-based violence against women has evolved into a principle of customary international law[[2]](#endnote-2)*’ thereby strengthening the legal obligation of States to prohibit and criminalize it as a grave human rights violation.

The Committee emphasizes the pervasiveness of gender-based violence against women, and highlights that inadequate, non-existent and/or poorly implemented legislative frameworks, misuse of tradition, culture, religion or fundamentalist ideologies, and significant reductions in public spending, often as part of “austerity measures” following economic and financial crises, further weaken the state responses and lead to a culture of impunity.[[3]](#endnote-3)

The CEDAW Committee has also states that ‘*gender-based violence against women, may amount to torture or cruel, inhuman or degrading treatment in certain circumstances, including in cases of rape, domestic violence or harmful practices, among others*’, and that in some cases, some forms of gender-based violence against women may also constitute international crimes.[[4]](#endnote-4)

The CEDAW Committee has highlighted that States have a legal obligation to ensure that sexual assault, including rape is characterized as a crime against women’s right to personal security and their physical, sexual and psychological integrity. The Committee has also emphasized that States need to base the definition of sexual crimes, including marital and acquaintance/date rape, on lack of freely given consent, and that this definition should take into account coercive circumstances. States also have the obligation to ensure that limitations, where they exist, should prioritize the interests of the victims/survivors and give consideration to circumstances hindering their capacity to report the violence suffered to competent services/authorities.[[5]](#endnote-5)

Crucially, the CEDAW Committee recognizes that violations of sexual and reproductive health and rights such as forced sterilizations, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, also constitute forms of gender-based violence and may amount to torture or cruel, inhuman or degrading treatment.[[6]](#endnote-6)

The Human Rights Council, in its resolution on ‘*Accelerating efforts to eliminate all forms of violence against women: preventing and responding to rape and other forms of sexual violence*’[[7]](#endnote-7) has also recognized that sexual violence and rape disproportionately affect women and girls, occur in all spheres of society, in public and private life, in peace time, during periods of civil unrest or political transition, and in conflict and post-conflict situations.[[8]](#endnote-8) The resolution, while failing to clearly articulate rape and sexual violence as human rights violations, calls upon States, inter alia, *to ensure that all forms of rape and sexual violence are criminalized in national law and to take appropriate legislative and policy steps to ensure the prompt and adequate investigation, prosecution and accountability of perpetrators, including by strengthening the capacity of the criminal justice system.[[9]](#endnote-9)* The resolution also urges *States to ensure that national laws and policies are in compliance with their international human rights obligations and are non-discriminatory by, inter alia, permitting prosecution of marital rape and repealing provisions that require corroboration of testimony, enable perpetrators of rape to escape prosecution and punishment by marrying their victim, and subject victims of sexual violence to prosecution for moral crimes or defamation*.[[10]](#endnote-10)

The resolution also crucially underscores ‘*the importance for States to address all health consequences, including physical, mental and sexual and reproductive health consequences, of rape and other forms of sexual violence against women and girls by providing accessible health-care services that are responsive to trauma and include affordable, safe and effective treatment’*.[[11]](#endnote-11)

This recognition that rape and sexual violence have consequences on women’s and girl’s sexual and reproductive health and rights, from which derive an obligation for States to provide sexual and reproductive health information and services, is core to ensure victims’ and survivors’ access to reparations and justice.

However, despite these legal obligations, restrictive legal frameworks on SRHR prevent women and girls victims and survivors to access rehabilitation services and reparations.

* 1. **Impact of restrictive legal frameworks on SRHR of victims and survivors of rape and sexual violence**

Survivors of rape need access to a comprehensive range of sexual and reproductive health services, including abortion and emergency contraception. Access to such services should be available free from discrimination, coercion and violence. Addressing the underlying social determinants of health is also central to effectively addressing rape and other forms of violence against women as well as creating an environment where women have access to the full range of sexual and reproductive health services.

* + 1. **Impact of Restrictive Abortion Laws**

Treaty monitoring bodies have long recognized the connection between restrictive abortion laws, high rates of unsafe abortion and maternal mortality[[12]](#endnote-12), 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.[[13]](#endnote-13)

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.

Systemic sexual violence paired with minimal access to sexual and reproductive health services means that women and girls in Latin America and the Caribbean 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[[14]](#endnote-14). The Center for Reproductive Rights has brought forward cases before the United Nations Human Rights Committee (“the Committee”). [These cases](https://reproductiverights.org/sites/default/files/documents/20190523-GLP-LAC-ElGolpe-FS-A4.pdf) 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.

According to the The World Health Organization (WHO), ‘20 or 30 others experience acute or chronic morbidity, often with permanent sequelae that undermine their normal functioning’.[[15]](#endnote-15)

WHO has also made the link between unsafe abortion and maternal morbidity, highlighting that women 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)*
* *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.’[[16]](#endnote-16)*

In General Comment (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. Accordingly States must not impose criminal sanctions against women and girls undergoing abortion or against medical service providers assisting them in doing so, and at a minimum “*must provide access to 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 is not viable*”[[17]](#endnote-17). This formulation 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.

Treaty monitoring bodies have found that States should eliminate punitive measures for women who undergo abortions and for health care providers who deliver abortion services,[[18]](#endnote-18) provide post-abortion care to women and adolescents, regardless of whether or not abortion is legal,[[19]](#endnote-19), address the socio-economic needs of women seeking abortion services[[20]](#endnote-20) 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.[[21]](#endnote-21)

* + 1. **Access to emergency contraception**

Treaty monitoring bodies have paid particular attention to the issue of access to emergency contraception, which prevents pregnancy following unprotected sexual intercourse. Emergency contraception should be available without a prescription,[[22]](#endnote-22) should be free for victims of violence including adolescents,[[23]](#endnote-23) and special measures should be taken to ensure that it is available to women in conflict and post-conflict zones.[[24]](#endnote-24) Failure to ensure legal and accessible emergency contraception for women who are victims of rape or sexual abuse can result in physical and mental suffering that may amount to ill-treatment.[[25]](#endnote-25)

* + 1. **Stigma and Discrimination and the Realization of SRHR**

Stigma and stereotypes permeate laws on rape and its enforcement, they also are prevalent in the laws concerning the provision of sexual and reproductive health services, obstructing access to services for survivors of rape. Several of the treaty monitoring bodies, and CEDAW in particular, have regularly called on States to work to eradicate gender stereotypes, noting that patriarchal attitudes, cultural stigma, gender stereotypes about women as mothers and caregivers, prejudices about sexual and reproductive health services, and taboos about sexuality outside of marriage all contribute to the lack of access to reproductive health information, good and services[[26]](#endnote-26). In General Comment No. 22 the CESCR Committee called on States to eliminate discriminatory stereotypes, assumptions and norms concerning sexuality and reproduction that underlie restrictive laws and undermine the realization of sexual and reproductive health .[[27]](#endnote-27)

The treaty monitoring bodies have noted that denial of access to abortion may be based on gender stereotypes about the traditional roles of women primarily as mothers and caregivers, which may also constitute or exacerbate gender discrimination and undermine gender equality[[28]](#endnote-28). They have also expressed concern about situations where abortion is legal but stigmatized, which may lead women to resort to unsafe and clandestine abortions[[29]](#endnote-29) and lead to a higher rate of morbidities.

The Special Rapporteur on Violence Against Women, its causes and consequences (SRVAW) also emphasizes the role of gender stereotypes in preventing women and girls from accessing sexual and reproductive health information and services free of discrimination, coercion and violence: ‘*Harmful gender stereotypes in reproductive health context on women’s decision-making competence, women’s natural role in society and motherhood limit women’s autonomy and agency. These stereotypes arise from strong religious, social and cultural beliefs and ideas about sexuality, pregnancy and motherhood.*’[[30]](#endnote-30)

The rights to equality and non-discrimination are fundamental tenets of international human rights law. Gender equality includes the right to de-facto or substantive equality,[[31]](#endnote-31) and realizing substantive gender equality requires addressing the historical roots of gender discrimination, gender stereotypes, and traditional understandings of gender roles that perpetuate discrimination and inequality.[[32]](#endnote-32)

The CESCR Committee has stated that realizing women’s rights and gender equality requires reforming the discriminatory laws, policies and practices, and removing all barriers that interfere with women’s access to comprehensive sexual and reproductive health services, goods, education and information.[[33]](#endnote-33) Both CEDAW and CESCR have suggested that States must adopt temporary special measures to eliminate conditions and combat gender-based stereotypes and attitudes that perpetuate inequalities and discrimination, in order to enable all individuals and groups to enjoy sexual and reproductive health on a basis of equality.[[34]](#endnote-34)

* + 1. **Addressing social and other determinants of health**

Addressing underlying and social determinants of health and general conditions in society that affect the enjoyment of the right to life with dignity can contribute positively to the realization of substantive gender equality and to reproductive rights, and gender based violence, and mitigate the compounded effects of restrictive legislative frameworks, discrimination and gender stereotypes.

* Social determinants of health refer to the conditions in which people are born, grow, live, work and age, which are shaped by unequal power structures and resource distribution at the local, national and global levels, and include poverty and income inequality, systemic discrimination, and marginalization based on prohibited grounds of discrimination.[[35]](#endnote-35)
* Underlying determinants of sexual and reproductive health include access to housing, safe drinking water, and effective sanitation systems, access to justice, and freedom from violence and other rights violations, among other factors.[[36]](#endnote-36)

These determinants impact the choices and meaningful agency that individuals can exercise with respect to their sexual and reproductive health, thus States must address them in laws, institutional arrangements and social practices in order to ensure that they do not prevent individuals from effectively enjoying their reproductive rights in practice[[37]](#endnote-37).

In General Comment No. 36 the Human Rights Committee expressed the view that the duty to protect life also implies that States should take appropriate measures to address the general conditions in society that may prevent individuals from enjoying their right to life with dignity.[[38]](#endnote-38)

This obligation includes ensuring access to essential goods and services, including, inter alia, health-care, and developing campaigns for raising awareness of gender-based violence and harmful practices.

1. **Conflict related sexual violence and rape and access to SRH information and services for women and girls in humanitarian settings**
	1. **International legal framework under International Human Rights Law (IHL)**

Human rights law and international humanitarian law are complementary and mutually reinforcing, and States must therefore respect, protect, and fulfill SRHR during conflict and humanitarian emergencies, including ensuring access to services for women and girls who are survivors of gender-based violence.[[39]](#endnote-39) The treaty monitoring bodies have developed extensive guidance for States which reinforce and complement State’s humanitarian legal obligations.

In conflict-affected settings, the 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,[[40]](#endnote-40)
* 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[[41]](#endnote-41).

The CEDAW and CESCR Committees 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[[42]](#endnote-42).

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-based approach to SRHR in humanitarian settings requires, *inter alia*:[[43]](#endnote-43)

* Ensuring available, accessible, adequate, and quality services without discrimination;
* 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), exploitation, and forced marriage.[[44]](#endnote-44) 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*.”[[45]](#endnote-45)

International human rights bodies, including the CEDAW, CESCR and Human Rights Committees have affirmed that fundamental human rights obligations, continue to apply even in humanitarian settings.[[46]](#endnote-46) Although international human rights law permits states to derogate from certain civil and political rights in some humanitarian settings and to limit certain obligations with respect to economic, social, and cultural rights depending on resource availability,[[47]](#endnote-47) human rights treaty bodies have emphasized that such derogations are subject to strict conditions and that certain minimum core obligations are non-derogable. [[48]](#endnote-48) Even where derogations are permitted, the measures taken cannot involve discrimination based solely on prohibited grounds, including sex.[[49]](#endnote-49) Moreover, within the context of humanitarian settings, human rights bodies hold that the right to equality and non-discrimination applies.[[50]](#endnote-50) 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.[[51]](#endnote-51) 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.”[[52]](#endnote-52) 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.”[[53]](#endnote-53)

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.[[54]](#endnote-54) 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.[[55]](#endnote-55)

Treaty Monitoring Bodies have also reiterated that international humanitarian law and international human rights law are complementary and mutually reinforcing.[[56]](#endnote-56)

* 1. **International legal framework under International Humanitarian Law (IHL)**

While IHRL and IHL are complementary bodies of international law, IHL also includes protections related to sexual and reproductive health.

Non-discrimination is a core principle of IHL, which prohibits adverse distinction based on sex, among other grounds.[[57]](#endnote-57) As one commentator notes, “[t]his is a prohibition on discrimination and not on differentiation,”[[58]](#endnote-58) as IHL also provides for specific protections for women and imposes obligations on parties to an armed conflict to respect women’s specific needs.[[59]](#endnote-59) Current interpretation of these needs encompasses protection from sexual violence as well as the need to ensure that women in conflict receive medical treatment and adequate health services, including counseling.[[60]](#endnote-60)

The 2016 commentary of the International Committee of the Red Cross (ICRC) notes that this care 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.”[[61]](#endnote-61) Moreover, 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.[[62]](#endnote-62) IHL establishes an affirmative duty to provide medical care for the wounded.[[63]](#endnote-63)Additional Protocol I includes in its 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.”[[64]](#endnote-64) Victims of sexual violence, including rape, also fall within the protections provided for the wounded and sick in armed conflict situations.[[65]](#endnote-65)

As such, at minimum, IHL establishes an obligation to provide medical care and attention to pregnant women and victims of sexual violence. The ICRC notes that this is an obligation of means, meaning that parties must make “best efforts” to fulfill it, including by permitting humanitarian organizations to assist.[[66]](#endnote-66) With regard to the treatment of the sick and wounded, the prohibition on adverse distinction has been interpreted to permit distinction only on the basis of medical need.[[67]](#endnote-67) The ICRC describes this IHL principle as similar to the human rights principle of non-discrimination,[[68]](#endnote-68) suggesting that human rights law can provide additional guidance as to how this principle should be interpreted with respect to the medical treatment of women in conflict.

IHL also requires civilians and individuals no longer participating in hostilities (persons hors de combat), including the sick and wounded, to be treated humanely in all circumstances.[[69]](#endnote-69) Although humane treatment is not defined in the Geneva Conventions, Common Article 3, which constitutes the minimum yardstick of treatment during armed conflict, specifically prohibits acts of torture and cruel treatment as well as humiliating and degrading treatment.[[70]](#endnote-70)

Rape and sexual violence are prohibited and constitute “violence to life and person” or “outrages upon personal dignity” or both and violate the fundamental guarantees of IHL to humane treatment.[[71]](#endnote-71) In describing the current interpretation of humane treatment, the ICRC explains that “the detailed rules found in international humanitarian law and human rights law give expression to the meaning of ‘humane treatment.’”[[72]](#endnote-72) The 2016 commentary notes that “[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.”[[73]](#endnote-73) For fundamental IHL guarantees, including humane treatment, human rights law and the interpretation of human rights bodies can clarify analogous IHL principles.[[74]](#endnote-74) As such, interpretation and guidance from human rights bodies regarding torture and cruel, inhuman, or degrading treatment can help define the contours of humane treatment.[[75]](#endnote-75)

* 1. **Accountability for sexual and gender-based violence (SGBV) and to SRHR**

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

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[[76]](#endnote-76) 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.[[77]](#endnote-77) 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[[78]](#endnote-78) and ensuring access to healthcare that is safe and responds to the needs of survivors of sexual violence.[[79]](#endnote-79)

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.[[80]](#endnote-80)

Principles and 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.[[81]](#endnote-81) Aid efforts guided by the principles of non-discrimination and equality, moreover, prioritize the needs of marginalized or vulnerable groups or individuals.[[82]](#endnote-82) 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.[[83]](#endnote-83)

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.[[84]](#endnote-84) 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,”[[85]](#endnote-85) which the UN Security Council also has affirmed in the context of humanitarian aid programs.[[86]](#endnote-86) 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*.”[[87]](#endnote-87) 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.[[88]](#endnote-88)

A human rights-based 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.[[89]](#endnote-89)

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.[[90]](#endnote-90) 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.[[91]](#endnote-91)

**The provision of sexual and reproductive health information and services free from discrimination, coercion and violence, 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.[[92]](#endnote-92) Examples of social accountability include “community-based oversight of finances and quality of care at points of service provision, including ‘community scorecards.’”[[93]](#endnote-93)

1. **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](https://reproductiverights.org/sites/default/files/documents/Breaking-Ground-2020.pdf.), 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.

The [Office of the High Commissioner for Human Rights](https://www.ohchr.org/EN/NewsEvents/Pages/COVID19Guidance.aspx), many [UN independent human rights experts](https://www.ohchr.org/EN/HRBodies/SP/Pages/COVID-19-and-Special-Procedures.aspx) (the “special procedures”), and [the World Health Organization](https://www.who.int/publications-detail/addressing-human-rights-as-key-to-the-covid-19-response) 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.

[UN special procedures](https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25808&LangID=E.), and [the World Health Organization](https://www.who.int/news-room/detail/30-03-2020-who-releases-guidelines-to-help-countries-maintain-essential-health-services-during-the-covid-19-pandemic) 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](https://www.ohchr.org/Documents/HRBodies/CEDAW/Statements/CEDAW_Guidance_note_COVID-19.docx) 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:

[TheCommittee on the Elimination of Discrimination Against Women has called on governments](https://www.ohchr.org/Documents/HRBodies/CEDAW/Statements/CEDAW_Guidance_note_COVID-19.docx) 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](https://www.un.org/sites/un2.un.org/files/un_policy_brief_on_human_rights_and_covid_23_april_2020.pdf) 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 World Health Organization has recognized](https://www.who.int/publications-detail/addressing-human-rights-as-key-to-the-covid-19-response) 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](https://reproductiverights.org/sites/default/files/documents/Breaking-Ground-2020.pdf) have repeatedly and consistently [affirmed](https://reproductiverights.org/sites/default/files/documents/Breaking-Ground-2020.pdf) that access to abortion care is a human right.[The World Health Organization](https://www.who.int/hac/events/drm_fact_sheet_sexual_and_reproductive_health.pdf) and the [Inter-Agency Working Group on Reproductive Health in Crises](https://iawg.net/resources/safe-abortion-care-in-the-minimum-initial-service-package-misp-for-sexual-and-reproductive-health-in-humanitarian-settings) (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.

In order to sustain accessibility to abortion care during the COVID-19 pandemic, [regional human rights experts have recommended](https://reliefweb.int/sites/reliefweb.int/files/resources/Regional%20Operative%20Guidance-SRMNCAH%20services_final_170420..pdf) that governments should ensure uninterrupted supplies for all essential sexual and reproductive health services.

In order to further improve access to abortion care, IAWG hasnoted that governments should [ensure support for self-management of medical abortion](https://cdn.iawg.rygn.io/documents/IAWG-Full-Programmatic-Guidelines.pdf?mtime=20200410142450&focal=none#asset:30551) care for up until 12 weeks of pregnancy and that remote approaches can be considered for counseling 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](https://apps.who.int/iris/bitstream/handle/10665/325771/WHO-MVP-EMP-IAU-2019.06-eng.pdf?ua=1), 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 barriersin 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.

1. **Regional Examples – See Annex I and II**
2. **Recommendations**
	1. We respectfully recommend that the report highlights legal obligations of States to provide sexual and reproductive health information and services free of coercion, discrimination, and violence, including in humanitarian settings and in the context of the COVID-19 pandemic.
	2. We also recommend that the Special Rapporteur highlights the harmful impact of restrictive abortion laws and restrictive legal frameworks pertaining to SRHR on 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.
	3. We further recommend that the Special Rapporteur highlights the lifting of barriers with regards to access to abortion in certain countries as a policy recognition of how unnecessary they are and urges States to States to guarantee access to safe and legal abortion on request.

**Annex I**

**Honduras**

For women and girls, Honduras is one of the most dangerous countries in the world to live in. The country presents particularly high rates of sexual violence[[94]](#endnote-94). In 2017 there were 2,854 criminal complaints of sexual crimes against women, from which 83% were perpetrated against girls and adolescents[[95]](#endnote-95). Throughout all of 2019, violence against women in Honduras continued this alarming pattern. The *Office of the Special Prosecution for Women* reported that during the first semester of 2019 there were more than 2,500 complaints of violence against women, mostly regarding domestic and sexual violence, which amounts to 13.6 complaints received daily[[96]](#endnote-96). These official figures are nonetheless an underrepresentation of the reality of cases as women do not tend to file criminal complaints for fear of retaliation[[97]](#endnote-97). Moreover, the rates of impunity are very high as most of the reported cases of sexual violence are not prosecuted, leaving these crimes unpunished and thus perpetuating and normalizing the cycle violence against women[[98]](#endnote-98).

To this already distressing situation faced by women and girls in Honduras, we must add Honduras’ regressive policies regarding reproductive health, particularly the absolute lack of access to reproductive health care, including to the emergency contraceptive pill, even in cases of sexual assault. In fact, beyond Honduras’ total criminalization of abortion without exceptions, since 2009 Honduras also prohibits the use, distribution, and sale of emergency contraception pills (EPCs), including for women and girls who are victims of sexual violence. Taken together, it means that Honduras maintains the strictest ban on emergency contraception in the world[[99]](#endnote-99)**.** Specifically regarding girls and adolescents, Honduras not only does not protect them from acts of sexual violence[[100]](#endnote-100), but also force them to enter undesired maternities.[[101]](#endnote-101) Just between 2015 and 2017 the public hospitals registered 2,426 births to girls aged 10 to 14 years old and 66,481 births of girls and adolescents between 10 and 18 years old[[102]](#endnote-102).

**Nicaragua**

In Nicaragua, judicial responses to sexual violence has been very deficient. According to statistics from the Institute of Legal Medicine, in 2012, a total of 5,977 forensic reports were produced on sexual violence, amounting to a rate of 98 incidents per 100,000 residents. Of the reports, 51% (3,020) were for sexual violence against children under the age of 13, with 82% of this group being girls.[[103]](#endnote-103) In 2017, records show that 1,589 girls under the age of 12 were examined for evidence of sexual violence, or 41% of all women examined for evidence of sexual violence.[[104]](#endnote-104) However, it can be inferred that the numbers are much worse, as many women and girls are afraid to file complaints because, in approximately 90% of cases, the assailant is a relative or acquaintance,[[105]](#endnote-105) or because services are inaccessible and the victims face stigma.[[106]](#endnote-106) Moreover, since 2012, a *Model for Providing Comprehensive Care to Women Victims of Gender-Based Violence*[[107]](#endnote-107)is in place. Its objective is “to contribute to effective access to justice for women, girls, boys, and adolescents to be able to restore their right to live with dignity and free from violence;” however, impunity remains high for these crimes. Only around 10% of the assailants reported have been criminally prosecuted.[[108]](#endnote-108) Additionally, the model does not outline specific actions, although it does recognize that girls, boys, and adolescents require differential care.

If these figures are alarming, the situation of sexual and reproductive health for children and adolescents is critical. Nicaragua has the highest proportion of births to girls under the age of 18 in Latin America (28.1%).[[109]](#endnote-109) Between 2000 and 2010, pregnancies of girls between the ages of 10 and 14 increased by 47%.[[110]](#endnote-110) Between 2010 and 2015, an average of 1,500 girls between the ages of 9 and 14 were impregnated per year, accounting for 5% of all births. A third of these girls (34.6%) were impregnated by a man between the ages of 20 and 24, while 20% were impregnated by a man over the age of 25. **The healthcare provided to girls who are victims of sexual violence, pregnant girls, and girls who are mothers is inadequate and deficient**. Since 2007, abortion has been fully criminalized abortion, by a new Criminal Code[[111]](#endnote-111) that replaced the 1974 provisions [[112]](#endnote-112) that enabled girls who were victims of sex crimes to terminate their pregnancies based on the high risk to their life and health. Complications during the delivery continue to be three times more frequent in girls under the age of 14 compared to other women,[[113]](#endnote-113) and the risk of dying is four times greater.[[114]](#endnote-114)

In this context, it is a serious problem that access to information is not enough to prevent sexual violence against and pregnancies of girls under the age of 14. One clear example of this is that the right to access to secular, scientific, and good-quality sex education is only recognized starting in the fifth grade of elementary school.[[115]](#endnote-115) That is, girls are not given information enabling them to identify sexual violence or care pathways.[[116]](#endnote-116)

**ISSUE III**

The following information seeks to highlight the main impacts that the COVID-19 pandemic has had on women and girls’ rights, in the Latin American region, with particular focus on the increase of sexual violence, the barriers on access to sexual and reproductive health services, and the criminalization of women for reproductive-health related matters during the period of mandatory quarantine and social distancing.

1. **Increase of sexual violence rates during the public health emergency**
* In so far as the home can be the most dangerous place for women[[117]](#endnote-117), the COVID-19 pandemic has caused women to be locked up with their abusers and therefore confinement increases the risk of violence against women as the length of co-habitation increases[[118]](#endnote-118). With respect to girls and adolescents, confinement generates an increase in sexual violence against them[[119]](#endnote-119). **UN Women** has characterized this as the shadow pandemic[[120]](#endnote-120).
* This has been a particular worrisome problem in the **Latin American region**[[121]](#endnote-121), especially in: **Bolivia, Chile, Colombia, Ecuador, Honduras, México, Nicaragua, Perú**.
1. **Lack of access to contraceptives (including emergency contraceptive pill)**
* According to the Inter-American Commission of Women (CIM for its Spanish acronym), “[i]n Latin America and the Caribbean, an estimated 18 million additional women will lose their access to modern contraceptives, given the current context of the COVID-19 pandemic”[[122]](#endnote-122).
* Indeed, in LAC, the COVID-19 pandemic has been greatly affected access to contraceptives in two essential ways:
1. there has be a worrisome shortage of stock of contraceptives, which means their availability is highly reduced, particularly so in rural, disadvantageous, and impoverished areas; and
2. there has been great disinformation regarding the essential character of this *service* during the pandemic and where and how can women access this, which leads to uncertainty and further creates barriers.
* We have been able to see this particularly in:
* **Honduras**: our partners (*Centro de Derechos de Mujeres*) have reported that they are facing major disruption in contraceptive supply chains. In detail, the *Grupo Estratégico por las PAE*, found that from a survey of 11 local Health Offices, two (2) did not had supply of any type of contraceptive methods, three (3) of them had no availability of condoms, six (6) of them had condom’s shortage (provision for only one month), and none had oral or contraceptive implants available[[123]](#endnote-123).
* **Ecuador**: our partners (*Fundación Desafío* and *CEPAM-Guayaquil*) reported stock-outs of contraceptives and lack of access to information in relation to the availability of contraceptives.
* **Chile**: civil society organizations and our partners (*Humanas*) reported that the information regarding contraception methods and its distribution is not clear[[124]](#endnote-124).
* **Peru:** our partners (*Promsex*) have reported a lack of access and continuity of contraceptive methods and ECPs.
* **Guatemala:** our partners (*Mujeres Transformando el Mundo*) informed that health services unrelated to COVID have been delayed. This caused obstacles for women to access to emergencies kits for survivors of sexual violence.
1. **Lack of access to abortion services**
* In a region where access to abortion is already very restrictive, the COVID pandemic and the national quarantine measures have **further curtailed, limited, and imposed barriers for accessing this service.** The lack of clear State policies and measures guaranteeing the availability and accessibility of abortion services during the pandemic, has led many healthcare providers to prejudicially consider abortion not to be an essential health service and deny the service.
* We have seen this problem in:
* **Brazil,** where the main hospital that provided legal abortion in Sao Paulo, *Hospital Pérola Byington*, suspended access to abortion **services** during the pandemic[[125]](#endnote-125). Recently, it has been reported that the service has been reestablished, after the Public Ministry and the Public Defense Office intervened,[[126]](#endnote-126) however civil society organizations continue to report uncertainty as to the availability of the service.
* **Ecuador,** where our partners (Surkuna) reported that women are being denied abortion services and that three women have almost died as they have been denied healthcare services when they arrived at the hospital with obstetric emergencies or complications.
* **Chile**, where there are reports of shortages in the supply of Misoprostol and Mifepristone (specifically in San José Hospital, one of the largest public hospitals in Santiago[[127]](#endnote-127). Furthermore, our partners (Humanas) informed that there is a lack of information of where to access this services and that abortion centers are closed.
* **Colombia,** where civil organizations reported that healthcare providers have delayed abortion services disregarding government guidelines[[128]](#endnote-128). As well, there are reports of obstacles for requesting abortion services[[129]](#endnote-129).
* **Costa Rica,** where our partners (ACCEDER) have received reports of women whose request for an abortion has been denied.
* **Argentina**, where, even though at the national level and in the province of Buenos Aires abortion services have been deemed essential, other provinces have not implemented or addressed specific procedures for the compliance to the national recommendations[[130]](#endnote-130).
1. **Lack of access or deficient maternal healthcare**
* In LAC, maternal healthcare has been de-prioritized due to the COVID pandemic, limiting prenatal, delivery and postnatal care and exposing women to the risk of contagion. The CIM has reported that “[a]s part of the general measures to limit contact, several countries have prohibited the entry of midwives, partners and other family members during childbirth/postpartum, which leaves women in a situation of isolation. Other women are opting for home births, but not necessarily with the appropriate conditions to face them”[[131]](#endnote-131).
* We have seen this in:
* **Chile**, where midwives’ associations have reported that the official guidelines and protocols for healthcare during COVID-19 ignore maternal healthcare. Especially, they reported that those guidelines do not address the possibility for home visits to provide prenatal and birth care services[[132]](#endnote-132).
* **Peru**, where public hospitals have implemented procedures, intended to prevent COVID-19 transmission, that subdue women to the burden of giving birth alone[[133]](#endnote-133). As well, it has been reported that prenatal and postnatal controls have been limited[[134]](#endnote-134). Finally, our partners (Promsex) have reported that due to the lack of maternal healthcare measures, pregnant women are exposed to the risk of contagion particularly because there is no other option to access to sexual and reproductive health than going to public hospitals (where the risk of infection is higher).
* **Honduras**, where our partners (CDM) reported that the access to prenatal care have been denied, even in high-risk pregnancies.
1. **Criminalization of women for reproductive health related complications**
* In LAC countries, were abortion is still totally or partially criminalized, the prosecution of women who suffered obstetric emergencies or pregnancies complications has continued even in the emergency context. This has led to the denial of health treatment and the increase of morbidity rate.
* In **Ecuador**, there are reports that a woman was **accused and prosecuted for the crime of abortion** when she arrived at the Hospital with hemorrhages[[135]](#endnote-135).
1. **Particular vulnerabilities of certain categories of women**
* In the region, women who are deprived of liberty and women who are health workers have been uniquely impacted by COVID by being exposed to the virus and not being guaranteed their basic necessities[[136]](#endnote-136).
* In **Ecuador**, our partners (Surkuna) have reported that women who are medical professionals and are pregnant are not allowed to stop working, despite of their vulnerability and the State obligation to guarantee their fundamental rights[[137]](#endnote-137).
* In **El Salvador,** women who have been arbitrary imprisoned are facing shortenings in their basic hygiene commodities[[138]](#endnote-138) and are exposed to a higher risk of contagion due to prison overcrowding.

Annex II

**Regional example - Kenya: JMM’s Story**

In Kenya, abortion is allowed only when the life and health of the pregnant woman or adolescent is at risk or in when a trained medical professional believes the situation to be an emergency. Due to intense stigma and shame surrounding abortion, women are forced to seek clandestine care from untrained health providers. Approximately a quarter of the estimated 465,000 illegal abortions that women seek out in Kenya each year result in severe complications and hospitalizations. Thousands of women and girls are injured for life—or do not survive. [[139]](#endnote-139)

When she was just 14, JMM was coerced into a sexual relationship with an older man in her village and later discovered that she was pregnant. Abortion is stigmatized in Kenya and Wanjiku found herself in a desperate situation.

Like many other women and girls who find themselves in this position, JMM sought abortion care from an unqualified provider. She became ill almost immediately after the procedure and required immediate medical attention. Instead, she had to visit multiple hospitals that could not provide the necessary services. When she finally did find a qualified facility, she was neglected, abused, and forced to sleep on a mattress on the dirty hospital floor during her stay.

In 2015, the Center for Reproductive Rights filed a petition to hold the government accountable for its failure to respect, protect and fulfill JMM’s rights.[[140]](#endnote-140) The petition challenges the lack of guidelines on abortion that can guide health care providers in cases such as JMM’s. The petition further challenges the government’s directive banning health providers from participating in any abortion training thus limiting their ability to respond in cases where abortion is necessary of where post abortion care is required.  By withdrawing the Standards and Guidelines for reducing morbidity and mortality from unsafe abortions in Kenya, prohibiting trainings on safe abortion care, and banning Medabon, a safe and effective method of medication abortion, the Kenyan government violated JMM’s life.

Over time, JMM suffered from a slew of severe health complications that could have been prevented had she received timely care after the botched procedure. Ultimately, this delay in care led to her premature death in 2018.

On June 2019, a five-judge bench of the High Court of Kenya delivered a groundbreaking judgement which found that by withdrawing the Standards and Guidelines and the training curriculum and by banning the use of Medabon, the Ministry of Health violated and or threatened the rights of women and adolescent girls of reproductive age to: the highest attainable standard of health, to non-discrimination, to information, consumer rights, and to benefit from scientific progress and that the government of Kenya should compensate JMM’s mother for the physical, psychological, emotional and mental anguish, stress, pain, suffering and death of JMM occasioned by the violation of JMM’s constitutional rights.[[141]](#endnote-141)

1. <https://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf> [↑](#endnote-ref-1)
2. Committee on the Elimination of Discriminationagainst WomenGeneral recommendationNo. 35 on gender-based violence against women,updating general recommendationNo. 19, July 14th 2017, U.N. doc CEDAW/C/GC/35, para. 2 [hereinafter CEDAW General Recommendation 35] [↑](#endnote-ref-2)
3. CEDAW General Recommendation 35, para. 6-7 [↑](#endnote-ref-3)
4. Ibid:, para. 16 [↑](#endnote-ref-4)
5. Ibid.; para. 33 [↑](#endnote-ref-5)
6. Ibid.; para. 18 [↑](#endnote-ref-6)
7. A/HRC/RES/23/25 [↑](#endnote-ref-7)
8. Idem [↑](#endnote-ref-8)
9. Ibid; OP. 7 [↑](#endnote-ref-9)
10. Ibid; OP.8 [↑](#endnote-ref-10)
11. Ibid; OP.10 [↑](#endnote-ref-11)
12. 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); [↑](#endnote-ref-12)
13. 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) [↑](#endnote-ref-13)
14. 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 [↑](#endnote-ref-14)
15. Ashford L. Hidden suffering: disabilities from pregnancy and childbirth in less developed countries. Population Reference Bureau; 2002. Available from: <http://www.prb.org/pdf/hiddensufferingeng.pdf> [accessed 24 June 2013]; Reichenheim ME, Zylbersztajn F, Moraes CL, Lobato G. Severe acute obstetric morbidity (near-miss): a review of the relative use of its diagnostic indicators. Arch Gynecol Obstet 2009; 280: 337-43 <http://dx.doi.org/10.1007/s00404-008-0891-1> pmid: [19112576](http://www.ncbi.nlm.nih.gov/sites/entrez?cmd=Retrieve&db=PubMed&list_uids=19112576&dopt=Abstract). [↑](#endnote-ref-15)
16. WHO, ‘Preventing Unsafe Abortion’, available at <https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion> [↑](#endnote-ref-16)
17. Human Rights Committee, *Gen. Comment No. 36,* para. 8 [↑](#endnote-ref-17)
18. 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). [↑](#endnote-ref-18)
19. 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) [↑](#endnote-ref-19)
20. 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, [↑](#endnote-ref-20)
21. CRC Committee, *Gen. Comment No. 20*, para. 39. [↑](#endnote-ref-21)
22. CEDAW Committee, *Concluding Observations: Hungary*, para 31(b), U.N. Doc CEDAW/C/HUN/CO/7-8 (2013). [↑](#endnote-ref-22)
23. CRC Committee, *Gen. Comment No. 15,* para 70; CRC Committee, *Gen. Comment No.* 20 para 59; CEDAW Committee General Recommendation No. 35, para 40(c); CESCR Committee, General Comment No. 22, para 13, 45, 57; CEDAW Committee, *Concluding Observations: Peru*, paras. 35-36,U.N. Doc. CEDAW/C/PER/CO/7-8 (2014); CRC Committee, *Concluding Observations: Costa Rica*, paras. 63-64, U.N. Doc. CRC/C/CRI/CO/4 (2011). [↑](#endnote-ref-23)
24. CEDAW Committee, *Gen. Recommendation No. 30,* para 52(c); CEDAW Committee, *Concluding Observations: Central African Republic*, paras. 39-40, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014). [↑](#endnote-ref-24)
25. CEDAW Committee, *Gen. Recommendation No. 35*, paras. 18, 40(c); CAT Committee, *Concluding Observations: Greece*, paras. 24, 25,U.N. Doc. CAT/C/GRC/7 (2019) [↑](#endnote-ref-25)
26. CEDAW Committee, *Gen. Recommendation No. 35*, at paras. 26(c), 37(a), 38(a); CESCR Committee, *General Comment No. 22*, paras. 27, 35; CESCR Committee, *General Comment No. 16*, para. 5; CRC Committee, *Gen. Comment No. 20,* para. 28*;* CRC Committee, *Gen. Comment No. 15,* para. 9; Human Rights Committee, *Gen. Comment No.28,* para 5; CEDAW Committee, *Concluding Observations: Iraq,* paras. 42-43, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); *Bangladesh*, para. 35 (b), U.N. Doc. CEDAW/C/BGD/CO/8 (2016). [↑](#endnote-ref-26)
27. CESCR Committee, *General Comment No. 22*, paras. 27, 35, 36 [↑](#endnote-ref-27)
28. CEDAW Committee, Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol, U.N. Doc. CEDAW/C/OP.8/GBR/1, paras. 73, 74; CEDAW Committee, Summary of the inquiry concerning the Philippines under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women CEDAW/C/OP.8/PHL/1 (2014) para. 43; 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, *Gen. Comment No.* 22, paras. 27, 31, 55.

In *L.C v Peru*, the CEDAW Committee addressed stereotyped roles of women and considered that decisions regarding health-care were influenced by the stereotype that protection of the foetus should prevail over the health of the pregnant woman, thereby violating the State’s obligation to take measures to achieve the elimination of practices based on stereotyped roles for women. In *Mellet v Ireland*, some members of the Human Rights Committee considered that the legislative framework, which prohibited abortion except where the life of the pregnant woman is at risk, was based on a sexist stereotype limiting women to a reproductive role as mothers, and infringed rights to self-determination and to gender equality; *Mellet v Ireland, Annex I,* individual opinion of Yadh Ben Achour (concurring), para. 4, Annex II individual opinion of Sarah Cleveland (concurring), paras. 14, 15; see also Annex IV individual opinion of Víctor Rodríguez Rescia and Olivier de Frouville and Fabián Salvioli (concurring), paras. 10, 11 [↑](#endnote-ref-28)
29. CEDAW Committee, *Concluding Observations: Hungary,* para. 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); Human Rights Committee, *Gen. Comment No. 36,* para. 8; [↑](#endnote-ref-29)
30. Rebecca J. Cook and Simone Cusack, Gender Stereotyping: Transnational Legal Perspectives (Philadelphia, University of Pennsylvania Press, 2010), p. 34; The Special Rapporteur on Violence Against Women, Its Causes and Consequences, ‘A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence’ (U.N. Doc A/74/137) paras. 42 à 48 [↑](#endnote-ref-30)
31. Human Rights Committee, General Comment No. 28: Equality of Rights between Men and Women, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000); Human Rights Committee, General Comment No. 18: Non-discrimination, UN Doc HRI/GEN/1/Rev.1 at 26 (1994); CESCR Committee, General Comment No. 16: The Equal Rights of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights, UN Doc E/C.12/2005/4 (2005); CESCR Committee, General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights, UN Doc E/C.12/GC/20 (2009); CEDAW Committee, General Recommendation No. 25: Article 4, Paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on Temporary Special Measures, UN Doc A/59/38 (2004) [↑](#endnote-ref-31)
32. CESCR Committee*, Gen. Comment No. 22*, 1, para. 27 [↑](#endnote-ref-32)
33. CESCR Committee*, Gen. Comment No. 22*, paras. 22 – 28; CESCR Committee*, Gen. Comment No. 16*, para. 29. [↑](#endnote-ref-33)
34. CEDAW Committee, *Gen. Recommendation No. 25,* paras. 7, 8; CESCR Committee*, Gen. Comment No. 22*, paras. 35, 36. [↑](#endnote-ref-34)
35. CESCR Committee*, Gen. Comment No. 22,* para 8 [↑](#endnote-ref-35)
36. *Ibid.,* para 7 [↑](#endnote-ref-36)
37. *Ibid.,* para 8 [↑](#endnote-ref-37)
38. Human Rights Committee, *General Comment No. 36*, para 26 [↑](#endnote-ref-38)
39. 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 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 [↑](#endnote-ref-39)
40. CEDAW Committee, Gen. Recommendation No. 30, para.52(c) [↑](#endnote-ref-40)
41. *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 [↑](#endnote-ref-41)
42. CESCR Czech, Slovakia, CEDAW Lithuania, CERD [↑](#endnote-ref-42)
43. CEDAW Committee, *Gen. Recommendation No. 30*; CEDAW Committee, *Gen. Recommendation No. 33*, [↑](#endnote-ref-43)
44. 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. [↑](#endnote-ref-44)
45. 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. [↑](#endnote-ref-45)
46. 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) [hereinafter 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.”) [↑](#endnote-ref-46)
47. 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) [hereinafter 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 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) [hereinafter CRC]; CRPD, art. 4(2); *see also* CESCR Committee, *General Comment No. 3*,para. 9. [↑](#endnote-ref-47)
48. 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). [↑](#endnote-ref-48)
49. Human Rights Committee, *Gen. Comment No. 29*, para. 8. [↑](#endnote-ref-49)
50. *See generally* Breaking Ground 2018 [↑](#endnote-ref-50)
51. 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) [hereinafter 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.”). [↑](#endnote-ref-51)
52. CEDAW Committee, *Gen. Recommendation No. 30*, para. 2. [↑](#endnote-ref-52)
53. CEDAW Committee, *Gen. Recommendation No. 28*, para. 11. [↑](#endnote-ref-53)
54. 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) [hereinafter CEDAW Committee, *Gen. Recommendation No. 30*]; *see also* CAT Committee, *Concluding Observations: Iraq*, para. 13, U.N. Doc. CAT/C/IRQ/CO/1 (2015). [↑](#endnote-ref-54)
55. CEDAW Committee, *Gen. Recommendation No. 30*, para. 57. [↑](#endnote-ref-55)
56. Human Rights Committee General Comment 36 para. 64, CEDAW Committee General Recommendation 30 paras. 9, 12 and 19 [↑](#endnote-ref-56)
57. ICRC, 2016 Commentary on the First Geneva Convention,art. 12, para. 1392; Id. art. 3, para. 578; Jean S. Pictet et al., Commentary: I Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, art. 12 (1952) [hereinafter Pictet Commentary, Vol. I]. See also ICRC, Customary IHL Database, Rule 88, https://www.icrc.org/customary-ihl/eng/docs/v1\_rul\_rule88 (last visited May 31, 2017); Jelena Pejic, Non-discrimination and armed conflict, 841 International Review of the Red Cross (2001), https://www.icrc.org/eng/ resources/documents/article/other/57jqzq.htm. [↑](#endnote-ref-57)
58. Charlotte Lindsey, Women Facing War, at 20 [↑](#endnote-ref-58)
59. Geneva Convention I, art. 12; Geneva Convention II, art. 12; Geneva Convention III, art. 14; Geneva Convention IV, art. 27 (discussing protection of women “against any attack on their honor,” women as the “object of special respect,” and the obligation to protect women “in particular against rape, forced prostitution and any other form of indecent assault”); Additional Protocol I, art. 76(1). ICRC, 2016 Commentary on the First Geneva Convention, art. 12, paras. 1426-37; Id., art. 3, para. 578; Pictet Commentary, Vol. I, art. 12. See also ICRC, Customary IHL Database, Rule 134, https://www.icrc.org/customary-ihl/eng/docs/ v1\_rul\_rule134 (last visited May 31, 2017) (collecting evidence of this rule from both IAC and NIAC) [↑](#endnote-ref-59)
60. ICRC, 2016 Commentary on the First Geneva Convention, art. 3, paras. 696-707; ICRC, Customary IHL Database, Rule 134, https://www.icrc. org/customary-ihl/eng/docs/v1\_rul\_rule134 (last visited May 31, 2017). [↑](#endnote-ref-60)
61. ICRC, 2016 Commentary on the First Geneva Convention, art. 12, paras. 1429-30 (emphasis added). [↑](#endnote-ref-61)
62. 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). [↑](#endnote-ref-62)
63. 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) [↑](#endnote-ref-63)
64. Additional Protocol I, art. 8(a) [↑](#endnote-ref-64)
65. See, e.g., Bellal, Who is Wounded and Sick?, in The 1949 Geneva Conventions: A Commentary 762-64 (Clapham, Gaeta, Sassòli, eds.) (2015) (noting that “rape victims can be qualified as ‘wounded and sick’ within the meaning of the Geneva Conventions”); Stéphane Kolanowski, Protection of Women under International Humanitarian Law, Report of ICRC-EUISS Colloquium on Women and War 21 (Sept. 30, 2014), available at https://www.icrc.org/en/ download/file/8598/icrc\_report\_women\_and\_war.pdf [↑](#endnote-ref-65)
66. ICRC, 2016 Commentary on the First Geneva Convention, art. 12, para. 1379; ICRC, Customary IHL Database, Rule 110, https://www.icrc. org/customary-ihl/eng/docs/v1\_rul\_rule110 (last visited May 31, 2017). [↑](#endnote-ref-66)
67. ICRC, 2016 Commentary on the First Geneva Convention, art. 12, paras. 1392-96 (2016); ICRC, Customary IHL Database, Rule 88, https://www.icrc.org/customary-ihl/eng/docs/v1\_rul\_rule88 (last visited May 31, 2017); Rule 110, https://www.icrc.org/customary-ihl/eng/docs/ v1\_rul\_rule110 (last visited May 31, 2017). [↑](#endnote-ref-67)
68. ICRC, 2016 Commentary on the First Geneva Convention, art. 3, para. 578, n. 339 (“In permitting and in fact requiring distinction that is not adverse but favourable to the persons concerned, so that they fully benefit from humane treatment, humanitarian law is not dissimilar to human rights law in its approach to non-discrimination.”); see also Gabor Rona and Robert McGuire, The Principle of Non-Discrimination, para. 7, in The 1949 Geneva Conventions: A Commentary (Clapham, Gaeta, Sassòli, eds.) (2015). [↑](#endnote-ref-68)
69. Common Article 3. See also Geneva Convention I, art. 12; Geneva Convention II, art. 12; Geneva Convention III, art. 13; Geneva Convention IV, arts. 5 and 27; Additional Protocol I, art. 75(1); Additional Protocol II, art. 4(1). Persons hors de combat include “(a) anyone who is in the power of an adverse party; (b) anyone who is defenceless because of unconsciousness, shipwreck, wounds or sickness; or (c) anyone who clearly expresses an intention to surrender; provided he or she abstains from any hostile act and does not attempt to escape.” ICRC, Customary IHL Database, Rule 47, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1\_rul\_rule47 (last visited May 31, 2017). IHL also includes explicit obligations to treat prisoners of war humanely. ICRC, Customary IHL Database, Rule 87, https://www. icrc.org/customary-ihl/eng/docs/v1\_rul\_rule87 (last visited May 31, 2017). In general, IHL guarantees women the same protection as men regardless of status, but provides women with some specific protections in recognition of their specific needs. ICRC, Customary IHL Database, Rule 134, https://www.icrc.org/customary-ihl/eng/docs/v1\_rul\_rule134 (last visited May 31, 2017). [↑](#endnote-ref-69)
70. Common Article 3. See also ICRC, 2016 Commentary on the First Geneva Convention, art. 3, paras. 202-08; Pictet Commentary, Vol. I, art. 3 (noting that the listing in Common Article 3 was intended to be flexible and not restrictive); Jean S. Pictet et al., Commenatary: IV Geneva Convention Relative to the Protection of Civilian Persons in Time of War, art. 3 (1958); ICRC, Customary IHL Database, Rule 87, https://www. icrc.org/customary-ihl/eng/docs/v1\_rul\_rule87 (last visited May 31, 2017). [↑](#endnote-ref-70)
71. Additional Protocol I, art. 75 (prohibiting “humiliating and degrading treatment, enforced prostitution and any form of indecent assault”); Additional Protocol II, art. 4 (including rape as an outrage upon personal dignity); ICRC, Customary IHL Database, Rule 93, https://www.icrc.org/ customary-ihl/eng/docs/v1\_rul\_rule93 (last visited May 31, 2017). [↑](#endnote-ref-71)
72. ICRC, Customary IHL Database, Rule 87, https://www.icrc.org/customaryihl/eng/docs/v1\_rul\_rule87 (last visited May 31, 2017) [↑](#endnote-ref-72)
73. ICRC, 2016 Commentary on the First Geneva Convention, art. 3, para. 203 [↑](#endnote-ref-73)
74. 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). [↑](#endnote-ref-74)
75. 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). [↑](#endnote-ref-75)
76. 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. [↑](#endnote-ref-76)
77. Id; [↑](#endnote-ref-77)
78. 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.”) [↑](#endnote-ref-78)
79. 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.”) [↑](#endnote-ref-79)
80. *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]. [↑](#endnote-ref-80)
81. *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 “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]. [↑](#endnote-ref-81)
82. *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>. [↑](#endnote-ref-82)
83. *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”). [↑](#endnote-ref-83)
84. *See* Human Rights Based Approach to Development; UNFPA, The Human Rights-Based Approach, [↑](#endnote-ref-84)
85. *ICPD Programme of Action*,para. 7.7. [↑](#endnote-ref-85)
86. S.C. Res. 1889 [on women and peace and security], para. 1, U.N. Doc. S/RES/1889 (Oct. 5, 2009). [↑](#endnote-ref-86)
87. SR Health Report (2013), para. 12. [↑](#endnote-ref-87)
88. *Id.*, para. 12. [↑](#endnote-ref-88)
89. *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. [↑](#endnote-ref-89)
90. UNGA Res. 60/147,para. 3(b). [↑](#endnote-ref-90)
91. 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). [↑](#endnote-ref-91)
92. 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) [↑](#endnote-ref-92)
93. *Id.*, para. 74; *see also* *Social Accountability*, CARE International, [http://governance.care2share.wikispaces.net/Social+Accountability](http://governance.care2share.wikispaces.net/Social%2BAccountability) (last visited June 12, 2017). [↑](#endnote-ref-93)
94. *See for instance*, IACHR, Country Reports, Honduras 2019, par. 233; and Asociadas por lo Justo, Centro de Derechos de Mujeres, and Centro de Estudios de la Mujer Honduras, *Informe de Organizaciones Feministas de Honduras: Situación de la Violencia contra las Mujeres en Honduras* (2014), pg. 3 available at: <https://www.justassociates.org/sites/justassociates.org/files/informe-violencia-mujeres-honduras-relatoraonu-junio2014_0.pdf>; [↑](#endnote-ref-94)
95. Instituto Universitario en Democracia, Paz y Seguridad de la Universidad Nacional Autónoma de Honduras (UNAH-IUDPAS) & Ministerio Público de Honduras, *Boletín nacional enero – diciembre 2017,* “*Delitos sexuales y lesiones”* pág. 9 (2018),

<https://iudpas.unah.edu.hn/observatorio-de-la-violencia/boletines-del-observatorio-2/boletines-nacionales/> [↑](#endnote-ref-95)
96. El Heraldo, “Preocupante aumento de la violencia contra las mujeres Honduras”, July 9, 2019, available at: <https://www.elheraldo.hn/pais/1300410-466/preocupante-aumento-de-la-violencia-contra-las-mujeres-en-honduras>; Tiempo Digital, “Incremento de violencia contra la mujer pone en alerta al país”, July 11, 2019, available at: <https://tiempo.hn/incremento-de-violencia-contra-la-mujer-pone-en-alerta-al-pais1/>. [↑](#endnote-ref-96)
97. IACHR, Country Reports, Honduras 2019, par. 233. Available at: <https://www.oas.org/es/cidh/informes/pdfs/Honduras2019.pdf> [↑](#endnote-ref-97)
98. IACHR, Country Reports, Honduras 2019, par. 255; See also, Centro de Derechos de Mujeres, CDM  *Observatorio de Derechos Humanos de las Mujeres* (July, 2015), the rate of impunity between 2010 and 2014 was of 94%, pg. 9, available at: <http://derechosdelamujer.org/wp-content/uploads/2016/02/Observatorio-Violencia-sexual.pdf>. [↑](#endnote-ref-98)
99. Jodi Jacobson, *Honduran Supreme Court Upholds Most Sweeping Ban on Emergency Contraception Anywhere, RH Reality Check* (Feb. 14, 2012), *available at* <http://rhrealitycheck.org/article/2012/02/14/honduran-supreme-court-upholds-complete-ban-on-emergency-contraception-0/> . [↑](#endnote-ref-99)
100. Under the current Honduran legislation a pregnancy of a girl 14 and under would imply that a sexual violation occurred. Criminal Code, art. 140, numeral 1. [↑](#endnote-ref-100)
101. Report prepared by the Special Rapporteur on the right to health, UN Doc. A/66/254 at para 27. [↑](#endnote-ref-101)
102. Somos muchas, por la vida y la libertad de las Mujeres; Abogados sin Fronteras Canadá, *Informe alternativo de seguimiento ante el Comité de Derechos Humanos por Observaciones Finales al Estado de Honduras,* Sep. 14, 2018 https://www.asfcanada.ca/site/assets/files/7187/informe\_alternativo\_cdm-asfc\_para\_el\_comite\_de\_dd\_hh\_\_de\_la\_onu\_sobre\_honduras\_17\_09\_2018.pdf [↑](#endnote-ref-102)
103. Coordinating Federation of Nicaraguan NGOs that Work on Childhood and Adolescence (CODENI), Sexual Violence. Available at <http://www.codeni.org.ni/proteccion-especial/violencia-intrafamiliar/violencia-sexual/> [↑](#endnote-ref-103)
104. Institute of Legal Medicine, 2017 Annual Report, available at: <https://www.poderjudicial.gob.ni/pjupload/iml/pdf/Anuario_2017.pdf> [↑](#endnote-ref-104)
105. Idem [↑](#endnote-ref-105)
106. Amnesty International, Hear their voices and take action, 2011, available at <http://www.movimientoautonomodemujeres.org/archivos/92.pdf> [↑](#endnote-ref-106)
107. Judicial Branch, Republic of Nicaragua, Model for Providing Comprehensive Care to Women Victims of Gender-based Violence, available at: <https://www.poderjudicial.gob.ni/genero/pdf/MAI2012.pdf>. [↑](#endnote-ref-107)
108. Stolen Lives and Periodismo Humano. Impunidad para la violencia sexual infantil en Nicaragua. Available at: <http://periodismohumano.com/sociedad/infancia/impunidad-para-la-violencia-sexual-infantil-en-nicaragua.html> [↑](#endnote-ref-108)
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