

Submission to the United Nations Working Group on Discrimination Against Women and Girls concerning womens’ and girls’ sexual and reproductive health in situations of crisis

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**About the Submitting Organization**

The Global Justice Center (GJC) is an international human rights organization, with consultative status to the United Nations, dedicated to advancing gender equality through the rule of law. We combine advocacy with legal analysis to ensure equal protection of the law for women and girls.

Since 2005, GJC has challenged discriminatory political and legal systems that fail to enforce human rights or ensure equal protection for women and girls. A major component of this work is ensuring the protection of, and access to, sexual and reproductive health and rights. For the past decade, GJC has worked to protect these rights to ensure access to essential reproductive services. GJC’s Abortion Access in Conflict program aims to ensure that victims of rape in armed conflict are provided access to abortion as a matter of right to comprehensive and non-discriminatory medical care under international humanitarian law (IHL). GJC’s Sexual and Gender-based Violence program focuses on dismantling the patriarchal norms embedded in many legal systems and ensuring a gender inclusive and rights-based approach to justice and accountability. This submission will focus on both of these programs, specifically touching on the need for humanitarian aid donors to comply with international law, the international legal violations of US foreign aid policy, and accountability for sexual and gender-based violence in Burma.

**Concept/definition of crisis**

1. **Please provide information on the legal and policy framework used by your State to manage situations of crisis and on how the concept of “crisis” has been defined or framed.**

*Concerning legal frameworks used during armed conflict:* Internationally, there are several overlapping legal frameworks that apply in the crisis situation of armed conflict, including domestic laws, international human rights, and international humanitarian law (“IHL”). In armed conflict, IHL is the *lex specialis*,[[1]](#footnote-1) meaning that because it is the law designed to regulate conduct relating to hostitlities, its rules concerning protected categories of individuals in armed conflict displace directly conflicting provisions of other legal regimes.[[2]](#footnote-2)

Under the 1949 Geneva Conventions and their Additional Protocols (comprising the main corpus of IHL) pregnant people in armed conflict are considered “wounded and sick.”[[3]](#footnote-3) As such, they are entitled to receive comprehensive, non-discriminatory medical treatment based solely on their medical condition. In all cases, medical treatment should be as favorable to women as that granted to men.[[4]](#footnote-4) The right does not mean that medical treatment for each sex must be identical. Instead, medical outcomes for the sexes must be the same and can be achieved through differential treatment.[[5]](#footnote-5) Whereas one sex requires surgery as a medical treatment for their condition, another sex requires the option of abortion.

In addition to encompassing abortion services as non-discriminatory and necessary medical care, IHL also protects the procedure via its guarantee of humane treatment and the right to be free from treatment that is cruel and inhuman. The denial of abortion services has been explicitly determined to cause serious mental and physical suffering constituting torture and other cruel, inhuman and degrading treatment in certain contexts.[[6]](#footnote-6)

International human rights law is complimentary to IHL and applies in a broader range of crisis situations, such as natural disasters and migration, as well as during times of peace. Denial of abortion in certain circumstances can violate international human rights, including the right to life, freedom from torture and other cruel, inhuman, and degrading treatment, and non-discrimination. Domestic laws and policies are expected to comport with the State’s international human rights obligations.

Domestic law applies in all situations, including crises. However, where there is armed conflict, national legislation is legally displaced by IHL insofar as it contradicts IHL as the *lex specialis*. This is why, as a general rule, soldiers cannot be prosecuted for their licit acts of war, such as killing enemy soldiers during battle. The International Committee of the Red Cross’s Professional Standards for Protection Work calls for protection actors to “be prepared to point out that domestic law cannot be used as an excuse for non-compliance with international obligations.”[[7]](#footnote-7)

Thus and importantly, international donors contributing humanitiaran aid to situation of armed conflict cannot discharge their obligations under IHL by deferring to domestic legislation.

1. **Please list the type of situations that would fit the concept of “crisis” in your State and indicate what situations are excluded.**

*Concerning international humanitarian aid donor governments and entities:* Armed conflict, natural disasters, and forced displacement are routinely considered “crises” for the purposes of aid strategies.[[8]](#footnote-8) As discussed above, despite the humanitarian strategies for grouping these together, armed conflict gives rise to specific legal obligations under IHL that should be included in donor policies. Notably, excluded from most donor policies, are crises such as transitional and post-conflict situations, discrimination, and post-colonization situations. Some of these, particularly post-conflict situations and generalized poverty may be addressed through country’s development aid strategies rather than their humanitarian aid policies.

1. **What institutional mechanisms are in place for managing a crisis and how are priorities determined?**

**Challenges and good practices**

1. **Please highlight any challenges faced in the provision of SRH services and good practices in ensuring women’s and girls’ SRHR in situations of crisis, including, for example, measures concerning timely access to the the following types of services and aspects of care:**
2. **Access to non-biased and scientifically accurate information about sexual and reproductive health matters and services;**

*Concerning US policy restricting information in crisis contexts:* In January 2017, US President Donald Trump signed a presidential memorandum reinstating the Mexico City Policy, better known as the Global Gag Rule (GGR).[[9]](#footnote-9) The policy applies to US global health assistance and prohibits non-US NGOs from providing abortion services or engaging in abortion-related speech with funds from any source, including other donors, and thusly restricts a wide variety of speech about abortion, including information and certain types of research.[[10]](#footnote-10) As a result, non-US NGOs receiving US global health assistance cannot provide pregnant people with information on the full range of SRH services available to them nor can they refer patients to providers that are not subject to US restrictions. These restrictions violate providers’ rights to free speech and association and create barriers to pregnant peoples’ access to information.[[11]](#footnote-11)

1. **Access to medical professionals and health service providers, including traditional birth attendants, with adequate provision for their training and safety including personal protective equipment;**
2. **Access to essential medicines as prescribed by the WHO, equipment and technologies essential for the quality provision of sexual and reproductive health services;**
3. **Prevention of HIV transmission, post-exposure prophylaxis and treatment for HIV/AIDS as well as the prevention and treatment of sexually transmissible infections;**
4. **Pregnancy-related health services, including pre- and post-natal care, assistance during child-birth, and emergency obstetric care;**
5. **The full range of modern contraceptive information and services, including emergency contraception, as well as family planning information and services related to the number, timing and spacing of pregnancies and infertility treatments;**
6. **Safe abortion services including surgical and non-surgical methods of termination of pregnancy and humane post-abortion care, regardless of the legal status of abortion;**

*Concerning US policy restricting the provision of abortion services and information in crisis contexts:* Since 1973, the United States has enforced abortion restrictions on all of its foreign aid. Originating from the Helms Amendment to the Foreign Assistance Act, the US categorically prevents its funds from being used to provide abortion services, to discuss abortion as an option, or even discuss the need for safe abortion services in fact-finding reports.[[12]](#footnote-12) The Helms Amendment is currently implemented without exceptions for rape, life endangerment, or incest. Furthermore, while the Leahy Amendment does permit counselling and information about all pregnancy options, in line with *local* law, studies have shown that the amendment is ill-understood and little utilised.[[13]](#footnote-13) Today, the situation is made worse by President Trump’s reinstatement of the Global Gag Rule, now termed “Protective Life in Global Health Assistance,” which nearly fully censors the abortion-related activity of any non-US recipient of US global health assistance, with narrow exceptions in cases of rape, incest and life endangerment.[[14]](#footnote-14)

Such policies not only actively stifle abortion-related care, they also create a chilling environment around SRH, such that many recipients of US aid refuse to engage even in permitted activities.[[15]](#footnote-15) Since the US is the largest bilateral provider of humanitarian aid, US policy sets the tone on abortion in the majority of humanitarian settings. Furthermore, for those organisations that are already reluctant to include abortion within their work, these restrictions are a convenient excuse for not including abortion in their SRH packages.

While certain other donors are less restrictive, either expressly or implicitly permiting their funds to be used for abortion services, few if any require their grantees provide the option of abortion or establish reporting requirements on their provision. Donor policies often use a needs-based model—administering medical care to meet patients’ needs without regard to the legal framework. Particularly in light of global assaults on reproductive health, it is essential that these needs are bolstered by the strong rights-based protections embedded in IHL and international human rights.

*Concerning access to SRHR services, and specifically abortion services, in armed conflict contexts:* Survivors of armed conflict face a high risk of unwanted pregnancy due to exposure to frequent, forced, and unprotected sex, and a lack of access to contraception.[[16]](#footnote-16) Nearly half of women who become pregnant from sexual violence seek or undergo termination of their pregnancy, often using medications or herbs obtained outside the formal healthcare sector.[[17]](#footnote-17) Unsafe abortion is a major factor in maternal morbidity and mortality. Ten percent of maternal deaths globally are the result of unsafe abortion[[18]](#footnote-18); 97% of those are in the developing world.[[19]](#footnote-19) Indeed, the provision of safe abortion care is still missing or largely ignored by humanitarian health actors.[[20]](#footnote-20) Case-studies in Mali, Lebanon, Burkina Faso, the Democratic Republic of the Congo, and South Sudan all highlight the unavailability of abortion in crisis situations.[[21]](#footnote-21) Several studies have found a reluctance or resistance among reproductive health care workers to providing abortion services.[[22]](#footnote-22) For example, an analysis of the Médecins Sans Frontières’ experience in implementing safe abortion care determined that the main challenge was actually internal resistance amongst staff.[[23]](#footnote-23) Humanitarian aid providers are often unsure of what is permitted by laws and policy and erring on the side of caution—rather than on the side of patients’ rights—makes it easier to dismiss services such as safe abortion which carry stigma and are viewed as controversial.[[24]](#footnote-24) In humanitarian aid communications on the Commission website[[25]](#footnote-25) stigmatic language when referring to abortion can be found as well, such as in reports addressing neonatal mortality.

1. **Treatment for pregnancy-related morbidities such as obstetric fistula and uterine prolapse, among others;**
2. **Screenings and treatment for reproductive cancers;**
3. **Menstrual hygiene products, menstrual pain management and menstrual regulation;**
4. **Prevention, investigation and punishment of all forms of gender-based violence, and access to timely and comprehensive medical interventions, mental health care, and psychosocial support for victims and survivors;**

*Concerning global initiatives towards prevention, investigation and punishment of gender-based conflicts in situations of armed conflict:* Despite increased international political focus on gender-based violence, international organizations and other stakeholders have shown unwillingness to recognize gender-based violence and other forms of discrimination as indicating factors of mass atrocities. Early warning assessments and risk factors for mass atrocity crimes overwhelmingly exclude gender-specific experiences.[[26]](#footnote-26) After the occurrence of mass atrocities, investigations and prosecutions, often limited resources and expertise, tend to focus on cases that are perceived as “winnable.” As a result, the jurisprudence of mass atrocitiy crimes includes few cases at the international level that address gender-based violence.

*Concerning domestic initiatives towards prevention, investigation and punishment of gender-based conflicts in situations of armed conflict:* At the domestic level, inadequacies in national legislation fail to criminalize certain forms of sexual and gender-based violence or to provide adequate remedies. For example, the Burma’s penal code was adopted in 1861 and continues to apply outdated definitions of rape, vague conceptions of forced sterilization and abortion, and overly restrictive abortion policies.[[27]](#footnote-27) The law also fails to account for the range of services necessary for survivors of violence against women. While a new draft Prevention of Violence against Women Law is under consideration, it does not sufficiently address these barriers to prevention, investigation, punishment, and remedies for survivors.[[28]](#footnote-28)

1. **Measures to prevent and prohibit practices such as female genital mutilation and child, early and forced marriage;**
2. **Legal and policy safeguards against abuses and delays in the provision of SRH services for example in relation to confidentiality, referrals, informed consent, conscientious objection, and third party consent requirements;**
3. **The affordability of SRH services especially for those in situations of vulnerability; and**
4. **Other pertinent information that may affect the availability accessibility, affordability, acceptability and quality of SRH services and information.**

**Experiences of crisis**

1. **Please list the situations of crisis experienced by your State in the last five years.**

*Concerning the ongoing crisis in northern Rakhine State, Burma:* Starting in October 2016 and then again in August 2017, Burma’s security forces engaged in what it called “clearance operations” against the Rohingya, an ethno-religious minority in Burma’s Rakhine State. The operations were characterized by brutal violence and serious human rights violations on a mass scale. Survivors report indiscriminate killings, rape and sexual violence, arbitrary detention, torture, beatings, and forced displacement. According to the UN Human Rights Council-mandated Independent International Fact-Finding Mission on Myanmar (FFM), the treatment of the Rohingya population during the “clearance operations” amounts to genocide, crimes against humanity, and war crimes.[[29]](#footnote-29) These mass atrocity crimes build upon years of discriminatory laws and practices that deny the Rohingya citizenship rights, restrict movement and access to healthcare, and limit marriage and the family planning. The clearance operations have created a crisis of mass displacement.

Ethnic minority groups throughout Burma are also affected by discrimination and repression at the hands of the Burmese government as well as long-standing conflicts between the military and various ethnic armed groups. The “civilian” government established in 2011 serves as a façade of democracy while the military continues to retain full control.[[30]](#footnote-30) Brutal oppression, often including sexual and gender-based violence, are met with impunity.

1. **What was the impact of those crises on women and girls? Please provide information in particular on the following aspects:**
2. **Which groups of women and girls were most affected and how, taking into account different factors, such as age, geographic location (including urban and rural areas), ethnic and social origin, disability, marital status, migratory status, citizenship status or other status?**

*Concerning the ongoing crisis in northern Rakhine State, Burma:* Burmese ethnic women’s organizations have found time and again that widespread sexual violence is part of a deliberate and systematic pattern of targeting women and girls in their communities.[[31]](#footnote-31) Indeed, the FFM found that sexual and gender-based violence was a “hallmark of the Tatmadaw’s operations against ethnic minorities in Kachin, Shan and Rakhine states” and that “[t]hese violations, for most part perpetrated against ethnic women and girls, were used with the intent to intimidate, terrorise and punish the civilian population and as a tactic of war.”[[32]](#footnote-32)

During the operations against the Rohingya in particular, Burma’s military perpetrated different types of violence against women and based on their age and ability. Specifically, Rohingya women and girls of reproductive age were targeted for brutal rape, gang rape and sexual violence. Amidst massive and multifarious operations which included a litany of international crimes and human rights abuses, Burma’s military demonstrated a clear pattern of targeting unmarried Rohingya women or girls between the ages of 13 and 25 for rape and sexual violence.

1. **What was the impact on their SRHR? Were any specific risk factors and needs identified? Do you have data and/or qualitative information disaggregated by the factors listed under question 6(a)? If not, please explain why.**

*Concerning the ongoing crisis in northern Rakhine State, Burma:* The systemic and widespread perpetration of sexual violence, including mass, gang, and public rape, led to a heightened probability of unwanted pregnancies. Survivors also suffered injuries and genital mutilation that increased the risk of maternal mortality and morbidity. The forced displacement of survivors further exacerbated these risks by forcing them to endure further physical and psychological trauma fleeing their homes. This along with restrictive abortion laws and discriminatory restrictions on movement and access to health care prevented pregnant people from accessing SRH services in the immediate aftermath of their attacks.

Moreover, these attacks were carried out in the context of a “situation of severe, systemic and institutionalised oppression from birth to death” and that “their extreme vulnerability is a consequence of State policies and practices implemented over decades, steadily marginalising the Rohingya and eroding their enjoyment of human rights.”[[33]](#footnote-33) Many of these practices existed before the 2016 and 2017 operations, although some such as movement restrictions (and their consequences for healthcare access) have since been tightened.

In 2015 concerns that Rohingya would soon be outnumbering Burma’s “native” groups led to a package of laws ostensibly designed to “protect race and religion,” but which instead limited the Rohingya’s freedom to marry and have families of the size and timing of their choosing.[[34]](#footnote-34) Politicians have publicly stated that these laws are intended to control the Rohingya population,[[35]](#footnote-35) and their existence sheds light on prevailing stereotypes, including that Rohingya are polygamous and have a high birth rate, and that Buddhist women need protection from conversion to Islam and marriage to Muslims.[[36]](#footnote-36) For example, the Population Control Health-care Law provides for local officials to “organize” couples to practice 36-month birth spacing.[[37]](#footnote-37) While neutral on its face, the law is motivated by a belief that Muslims have too many children and therefore contribute to “overpopulation” and constitute a “threat” to the national character and identity of Burma.[[38]](#footnote-38)

1. **What were the main obstacles encountered by the State, if any, in identifying and addressing the impact of the crisis on women’s and girls’ SRHR?**
2. **What measures were adopted during and after the crisis to ensure women and girls’ access to sexual and reproductive health services? Please indicate which SRHR services are recognized as essential services in the health policy or laws of your State and are funded through the health system. What steps were taken to ensure the continuity of services and access during the crisis?**

*Concerning the ongoing crisis in northern Rakhine State, Burma:* Burma has a very restrictive law against abortion. Bangladesh, where an estimated 750,000 Rohingya fled in response to the so-called “clearance operations”, also prohibits abortion. However, following its war for independendence in 1971, Bangladesh temporarily waived the ban on abortions and—though unable to formally lift the ban in Parliament—allowed “menstrual regulation” to remove of the contents of the uterus before a positive pregnancy test.[[39]](#footnote-39) Billed as a backup form of contraception, the practice paved the way for international NGOs to quickly deploy emergency contraception and abortion in certain cases to assist Rohingya refugees.

1. **What other protocols or systems were put in place to prevent adverse reproductive and sexual health outcomes due to the common risks triggered by crisis including, for example, gender-based violence and child marriage? Were any special measures adopted for specific groups of women and girls?**
2. **Were women’s rights organizations[[40]](#footnote-40) involved in the needs and impact assessments and the recovery policies? If not, please indicate why.**
3. **Which actors or institutions played a role in the provision of emergency responses? Please describe their role and explain what roles were played, if any, by national women’s rights or human rights mechanisms, or other similar bodies as well as civil society organisations.**
4. **How were the emergency responses funded and to what extent did they rely on foreign aid or assistance, if any? Please also indicate how in your State adequate financing of women’s sexual and reproductive health is ensured more generally on an ongoing basis.**
5. **What obstacles have civil society organisations encountered in their efforts to deliver sexual and reproductive services?**
6. **Could you identify any lessons learned? Please indicate if and how these lessons have been applied in preparedness strategies or in subsequent situations of crisis.**
7. **If your State has humanitarian aid programmes, please indicate whether SRHR are explicitly covered in the humanitarian aid strategy and how priorities on SRHR are set.**
8. **Please indicate the main challenges, if any, encountered by women and girls to access justice and obtain reparations for violations of their SRHR, including any procedural barriers, and the types of assistance available to access legal and other remedies. Please also indicate the groups of women and girls most affected. Where applicable, please indicate the role played by a national truth and reconciliation commission (or a similar body) in ensuring the recognition of human rights violations in relation to women’s and girls’ SRHR and reparations.**
1. The *lex specialis* principle is a legal concept through which the special law takes precedence over the general law. [↑](#footnote-ref-1)
2. *See* Akila Radhakrishnan, Elena Sarver & Grant Shubin, *Protecting safe abortion in humanitarian settings: overcoming legal and policy barriers*, 25 Reprod. Health Matters 40 (2017). [↑](#footnote-ref-2)
3. International Committee of the Red Cross. Commentary of 2016 on convention (I) for the amelioration of the condition of the wounded and sick armed forces in the field (Geneva, 12 August 1949). 2016. [↑](#footnote-ref-3)
4. International Committee of the Red Cross. Commentary of 1960 on Convention (III) relative to the Treatment of Prisoners of War (Geneva, 12 August 1949) art. 14. 1960. [↑](#footnote-ref-4)
5. UN Human Rights Council. Rep., of the special rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, U.N. Doc. A/HRC/31/57 (2016). [↑](#footnote-ref-5)
6. UN Committee on the Elimination of Discrimination against Women, General Recommendation 30 on women in conflict prevention, conflict and post-conflict situations, U.N. Doc. CEDAW/C/GC/30. para. 52(c) (2013). [↑](#footnote-ref-6)
7. UN Security Council. Report of the Secretary-General on women peace and security, U.N. Doc. S/2013/525. para. 72(a) (2013). [↑](#footnote-ref-7)
8. *See, e.g.*, Ministry for Europe and Foreign Affairs, France’s humanitarian strategy (2018-2022), *available at:* <https://www.diplomatie.gouv.fr/IMG/pdf/strategie_humanitaire_2018-_eng_cle4c3b27-3.pdf>; Ministry for Foreign Affairs of Finland, Finland’s Humanitarian Policy, *available at:* <https://um.fi/documents/35732/48132/finlands_humanitarian_policy>. [↑](#footnote-ref-8)
9. Mexico City Policy, 82 FR 8495 (2017). [↑](#footnote-ref-9)
10. *Id.*  [↑](#footnote-ref-10)
11. Global Justice Center and CHANGE, “Censorship Exported: The Impact of Trump’s Global Gag Rule

on the Freedom of Speech and Association” (Jan. 2019), https://globaljusticecenter.net/files/Censorship\_Exported\_Impact\_of\_Trumps\_GGR.pdf [↑](#footnote-ref-11)
12. International Committee of the Red Cross, Professional standards for protection work. 2013. p. 63–64. [↑](#footnote-ref-12)
13. Kallas K, Radhakrishnan A., If these walls could talk, they would be censored, Reproductive laws for the 21st Century (2012). [↑](#footnote-ref-13)
14. Ipas and Ibis, U.S. Funding for Abortion, How the Helms and Hyde amendments harm women and providers (2015) p. 7. [↑](#footnote-ref-14)
15. Kallas K, Radhakrishnan A., If these walls could talk, they would be censored, Reproductive laws for the 21st Century (2012); The White House Office of the Press Secretary, Presidential memorandum regarding the Mexico City policy (2017). [↑](#footnote-ref-15)
16. Oladeji, O., et al, Sexual Violence–Related Pregnancy Among Internally Displaced Women in an Internally Displaced Persons Camp in Northeast Nigeria, Journal of Interpersonal Violence, 1-13, (2018) doi:10.1177/0886260518792252. [↑](#footnote-ref-16)
17. Rouhani, S. et al, A Quantitative Assessment of Termination of Sexual Violence-Related Pregnancies in Eastern Democratic Republic of Congo, Conflict and Health, 10(1), 1-9 (2016) doi:10.1186/s13031-016-0073-x. [↑](#footnote-ref-17)
18. Special tabulations of data from Say et al., Global causes of maternal death: a WHO systematic analysis, *Lancet Global Health,*2014, 2(6):e323–e333, [http://dx.doi.org/10.1016/S2214-109X(14)70227-X](http://dx.doi.org/10.1016/S2214-109X%2814%2970227-X). [↑](#footnote-ref-18)
19. Singh, S. et al, Abortion Worldwide: Uneven Progress and Uneven Access, Guttmacher Institute (2017), <https://www.guttmacher.org/report/abortion-worldwide-2017>. [↑](#footnote-ref-19)
20. Casey, S. E., et al, Progress and Gaps in Reproductive Health Services in Three Humanitarian Settings: Mixed-Methods Case Studies. Conflict and Health, 9(Suppl 1), 1- 13, (2015), doi:10.1186/1752-1505-9-S1-S3; Scott, R. et al, Setting the Research Agenda for Induced Abortion in Africa and Asia. International Journal of Gynecology & Obstetrics, 142(2), (2018) 241-247. doi:10.1002/ijgo.12525. [↑](#footnote-ref-20)
21. Reese Masterson, A., et al, Assessment of Reproductive Health and Violence against Women among Displaced Syrians in Lebanon, BMC Women’s Health; London, 14, 1-8 (2014) doi:http://dx.doi.org.proxy.bib.uottawa.ca/10.1186/1472-6874-14-25; Tunçalp, O., et al, Conflict, Displacement and Sexual and Reproductive Health Services in Mali: Analysis of 2013 Health Resources Availability Mapping System (HeRAMS) Survey, Conflict and Health, 9(1), 1-9 (2015) doi:10.1186/s13031-015-0051-8; Casey, S. E., et al, Progress and Gaps in Reproductive Health Services in Three Humanitarian Settings: Mixed-Methods Case Studies, Conflict and Health, 9(Suppl 1), 1- 13 (2015) doi:10.1186/1752-1505-9-S1-S3. [↑](#footnote-ref-21)
22. Schulte-Hillen, C. et al, Why Médecins Sans Frontières (MSF) Provides Safe Abortion Care and What That Involves. Conflict and Health, 10(1), 1-4 (2016) doi:10.1186/s13031-016- 0086-5; Burkhardt, G., et al, Sexual Violence-Related Pregnancies in Eastern Democratic Republic of Congo: A Qualitative Analysis of Access to Pregnancy Termination Services. Conflict and Health, 10(1), 1-9 (2016) doi:10.1186/s13031-016-0097-2; Casey, S. E., et al, Use of Facility Assessment Data to Improve Reproductive Health Service Delivery in the Democratic Republic of the Congo, Conflict and Health, 3(1), 1- 12 (2009) doi:10.1186/1752-1505-3-12; Onyango, M.A, & Heidari, S., Care with Dignity in Humanitarian Crises: Ensuring Sexual and Reproductive Health and Rights of Displaced Populations. Reproductive Health Matters, 25( 51), 1–6 (2017) doi:10.1080/09688080.2017.1411093. [↑](#footnote-ref-22)
23. Schulte-Hillen, C. et al, Why Médecins Sans Frontières (MSF) Provides Safe Abortion Care and What That Involves. Conflict and Health, 10(1), 1-4 (2016) doi:10.1186/s13031-016- 0086-5. [↑](#footnote-ref-23)
24. McGinn, T., & Casey, S.E., Why Don’t Humanitarian Organizations Provide Safe Abortion Services? Conflict and Health, 10(1), 1-7 (2016) doi:10.1186/s13031-016-0075-8. [↑](#footnote-ref-24)
25. DG Echo website, accessed May-June 2020. [↑](#footnote-ref-25)
26. UN, “Framework of Analysis for Atrocity Crimes,” 2014; US Holocaust Memorial Museum, “Preventing Genocide: A Blueprint for US Policy Makers,” 2008. [↑](#footnote-ref-26)
27. Global Justice Center, *Myanmar’s Proposed Prevention Of Violence Against Women Law A Failure to Meet International Human Rights Standards* (July 2020), <https://globaljusticecenter.net/files/20200710_MyanmarPOVAWlawAnalysis.pdf>. [↑](#footnote-ref-27)
28. *Id.* [↑](#footnote-ref-28)
29. Human Rights Council, Rep. of the independent international fact-finding mission on Myanmar, 39th Sess., Sept. 10-28. 2018, U.N. Doc. A/HRC/39/64 (2018). [↑](#footnote-ref-29)
30. Global Justice Center, *Structural Barriers to Accountability for Human Rights Abuses in Burma* (Oct. 2018), <https://globaljusticecenter.net/files/Structural-Barriers---Burma.pdf>. [↑](#footnote-ref-30)
31. Shan Women’s Action Network, *License to Rape* (2002); Women’s League of Burma, *Same Impunity, Same Patterns* (2014). [↑](#footnote-ref-31)
32. UN Independent International Fact-Finding Mission on Myanmar, Report on sexual and gender-based violence in Myanmar and the gendered impact of its ethnic conflicts para. 2, 22 August 2020. [↑](#footnote-ref-32)
33. Report of the detailed findings of the Independent International Fact-Finding Mission on Myanmar, U.N. Doc. A/HRC/39/CRP.2, 17 Sept. 2018, para. 458. [↑](#footnote-ref-33)
34. Report of the detailed findings of the Independent International Fact-Finding Mission on Myanmar, U.N. Doc. A/HRC/39/CRP.2, 17 Sept. 2018, para. 1409. For a brief description of the Religious Conversion Law (2015), Population Control Health-care Law (2015), Buddhist Women’s Special Marriage Law (2015), and Monogamy Law (2015), see UN Doc. A/HRC/31/71, Annex; see also ALTSEAN Burma, “Rohingya Targeted by Ethnic Cleansing in Arakan/ Rakhine State,” at 15. [↑](#footnote-ref-34)
35. Fortify Rights, “Policies of Persecution,” at 26-27, 34. Reports indicate that this policy was sporadically and inconsistently enforced. See, e.g., U.S. Dep’t of State, “Country Reports for Human Rights Practices in 2017: Burma,” at 33. [↑](#footnote-ref-35)
36. *See* Report of the detailed findings of the Independent International Fact-Finding Mission on Myanmar, U.N. Doc. A/HRC/39/CRP.2, 17 Sept. 2018, para. 600. [↑](#footnote-ref-36)
37. UN Human Rights Council, Report of the Special Rapporteur on the situation of human rights in Myanmar, U.N. Doc. A/HRC/31/71, list of legislation provided in Annex, Mar. 18, 2016. [↑](#footnote-ref-37)
38. Krithika Varagur, “The Muslim Overpopulation Myth that Just Won’t Die,” Atlantic, Nov. 14, 2017); Hannah Beech, “Across Myanmar, Denial of Ethnic Cleansing and Loathing of Rohingya,” N.Y. Times, Oct. 24, 2017; UN Secretary-General, “Report on the Situation of Human Rights in Myanmar,” para. 20, UN Doc. A/71/308, Aug. 5, 2016 (noting only a “marginal increase” in proportions of Christians and Muslims in Myanmar compared with 1983); UN Doc. S/2018/250, para. 55. See also section above on “Marriage and Family Planning.” These beliefs are compounded by the lack of accurate census data and consistent birth registration of Rohingya in Myanmar. Amnesty Int’l, “Caged Without a Roof,” at 37. [↑](#footnote-ref-38)
39. Patrick Adams, *How Bangladesh Made Abortion Safer*, New York Times (Dec. 28, 2018). [↑](#footnote-ref-39)
40. The expression women’s rights organizations should be understood as encompassing organizations of women of different ages, backgrounds and identities. [↑](#footnote-ref-40)