

Submission from the Center for Reproductive Rights following the call for submissions for the the follow-up report on the application of the technical guidance on the application of a human rights-based approach (HRBA) to reduce preventable maternal mortality and morbidity

The Center for Reproductive Rights (the Center)—an international nonprofit legal advocacy organization headquartered in New York City, with regional offices in Nairobi, Bogotá, Kathmandu, 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 provide this submission for the follow-up report on the application of the technical guidance on the application of a HRBA to reduce preventable maternal mortality and morbidity.

This submission will give an overview of the legal framework pertaining to the right to maternal health and will look more closely at the impact of restrictive legal frameworks and associated stigma and discrimination based on gender and disability on sexual and reproductive health and rights and on maternal morbidity.¹ Specifically, it will look at the impact of restrictive abortion laws on unsafe abortion rates and concomitant morbidities. It will then look at the linkages between maternal morbidity and humanitarian settings and will make recommendations to States and key stakeholders to ensure the respect, protection and fulfillment of women and girls’ right to sexual and reproductive health.

I. Legal framework

• **Maternal health**

Treaty monitoring bodies have developed strong human rights standards on women’s right to maternal health care, rooting this right within the rights to life, health, equality and non-discrimination, and freedom from ill-treatment.

The right to maternal health care encompasses a woman’s right to the full range of services in connection with pregnancy and the postnatal period and the ability to access these services free from discrimination, coercion, and violence.²

Furthermore, treaty monitoring bodies have found that social and other determinants of health must be addressed in order for women to be able to effectively seek and access the maternal health services they need.³

Finally, women must be able to exercise reproductive and bodily autonomy in determining the number and spacing of their children, have adequate information about maternal health care, and be empowered to utilize maternal health services.

Treaty monitoring bodies and Special Rapporteurs have grounded the right to maternal health in the following human rights:

- **Right to life:** States must take positive measures to protect individuals from arbitrary and preventable loss of life and address direct threats to enjoying a life with dignity, including preventable maternal death. Human Rights Committee General Comment No. 36 on the right to life affirms that preventable maternal deaths are a violation of the right to life and that States should develop strategic plans “for improving access to medical examinations and treatments designed to reduce maternal and infant mortality.”⁴ The Committee on the Elimination of all Forms of Discrimination Against Women

(CEDAW Committee)⁵ and the Committee on the Rights of the Child (CRC Committee)⁶ also interpret the right to life to include State obligations to prevent and address maternal mortality.

- **Right to health:** In accordance with article 12.1 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), States parties recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and article 12.2 illustrates “steps to be taken by the States Parties ... to achieve the full realization of this right”.⁷ Maternal health is grounded in the right to health; and the Committee on Economic, Social and Cultural Rights (CESCR Committee) indicates that States’ obligations to guarantee maternal health care is comparable to a core obligation under this right to health.⁸
- **Availability, Accessibility, Acceptability, and Quality⁹:** States must ensure adequate pre and postnatal care, skilled birth attendants, and emergency obstetric services if needed.¹⁰ Facilities should be accessible in law and in fact, thus: physically accessible, affordable, and adequate information available. States should guarantee that hospitals stock sufficient supplies, medicines, established referral systems for obstetric emergencies, and that health workers have adequate training on quality maternal health services.¹¹ Under ICESCR, States have a core obligation to ensure that commodities on the World Health Organization’s (WHO) Model List of Essential Medicines are provided.¹² This includes medicines for the prevention and treatment of pre-eclampsia and eclampsia, post-partum hemorrhage, and maternal sepsis, as well as for the provision of safe abortion and management of incomplete abortion.¹³
- **Right to equality and non-discrimination¹⁴:** The treaty monitoring bodies recognize that failure to provide women with quality maternal health services violates the rights to equality and non-discrimination, because these are services that only women need to meet their specific health needs.¹⁵ They have also specifically recognized that intersectional discrimination can hinder women’s access to reproductive health services, and recommended that States put a particular focus on the maternal health needs of marginalized groups of women: adolescents, women living with HIV, poor women, minority women, rural women, and women with disabilities.¹⁶
- **Right to freedom from cruel, inhuman, and degrading treatment:** The Committee against Torture (CAT Committee) has expressed concern about high maternal mortality rates, particularly those resulting from unsafe abortion, demonstrating that preventable maternal deaths may violate protections against the right to freedom from cruel, inhuman, and degrading treatment.¹⁷ The CAT Committee and CEDAW Committee have raised concerns about maltreatment of women seeking maternal health care and abuse in maternal health facilities that can amount to ill-treatment. For example, the shackling of women detainees during labor and delivery¹⁸ and post-delivery detainment of pregnant women who are unable to pay their medical bills.¹⁹ In her last report to the United Nations General Assembly (UNGA)²⁰, the Special Rapporteur on Violence Against Women examines the linkages between mistreatment of women in childbirth and torture, inhuman, cruel or degrading treatment (TCIDT) and has stated that mistreatment and violence against women during childbirth are widespread and systematic human rights violations and that “*States are responsible for addressing violations by health institutions, whether committed by public sector employees or by private contractors working on behalf of the State. States also have an obligation to uphold their human rights obligations, including those under the Convention on the Elimination of Discrimination against Women and the UN Declaration on the Elimination of Violence against Women, which calls on them to pursue by all appropriate means and without delay, a policy of eliminating discrimination and gender-based violence against women, including in the field of health.*”²¹ States also have the obligation to address the drivers of such practices.²²

- **Impact of restrictive legal frameworks on SRHR and maternal morbidity**

- **Impact of Restrictive Abortion Laws on Maternal Morbidity**

Treaty monitoring bodies have long recognized the connection between restrictive abortion laws, high rates of unsafe abortion and maternal mortality²³, 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.²⁴

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’.²⁵

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.*²⁶

Moreover, the CEDAW Committee has found that criminalization of abortion, denial or delay of safe abortion and post-abortion care, and forced continuation of pregnancy, are forms of gender discrimination and gender-based violence.²⁷

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*”²⁸. 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,²⁹ provide post-abortion care to women and adolescents, regardless of whether or not abortion is legal,³⁰ address the socio-economic needs of women seeking abortion services³¹ 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.³²

- **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.³³

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.³⁴ 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 or 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.³⁵

- **Stigma and Discrimination and the Realization of SRHR**

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 services³⁶. 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.³⁷

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 equality³⁸. They have also

expressed concern about situations where abortion is legal but stigmatized, which may lead women to resort to unsafe and clandestine abortions³⁹ 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.’⁴⁰

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,⁴¹ 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.⁴²

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.⁴³ 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.⁴⁴

- **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 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.⁴⁵
- 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.⁴⁶

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 practice⁴⁷.

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.⁴⁸

This obligation includes ensuring access to essential goods and services, including health-care, and developing campaigns for raising awareness of gender-based violence and harmful practices, and for improving access to medical examinations and treatments designed to reduce maternal and infant mortality and morbidity.

- **Addressing Obstetric Fistula in Pakistan: The Story of Kiran Sohail**

Pakistan has a high maternal mortality ratio (178 deaths per 100,000 live births)⁴⁹ in large part due to the neglect of women during pregnancy and childbirth, especially of low-income women who are unable to afford high quality reproductive health care, as well as negligence on the part of health care providers. Poor quality of services leads not only to maternal deaths but also maternal morbidities such as obstetric fistula that lead to unbearable pain and suffering. Hundreds of women in Pakistan develop obstetric fistula every year due to absence of antenatal care as well as prolonged obstructed labor in the absence of a skilled medical attendant.⁵⁰ Maternal health experts also report that many women in Pakistan develop iatrogenic fistula due to negligence by doctors while performing cesarean section surgery.⁵¹ Women who develop obstetric fistula are forced to live with this condition for many years due to the non-availability of affordable fistula repair surgery. The neglect of women persists due to weak monitoring and regulation of doctors and health professionals.

In her early 20s, Kiran Sohail, a resident of Karachi, gave birth to her first child. Shortly after the delivery, Kiran developed the symptoms of obstetric fistula, a debilitating, preventable pregnancy-related injury that plunged her into almost a decade of unbearable suffering and isolation.

Obstetric fistula—most often caused by prolonged, obstructed labor that is not addressed by prompt obstetric care—occurs when a hole opens between the birth canal and the bladder, causing the constant, uncontrollable leaking of urine and/or feces. With the proper treatment, the devastating condition can be quickly repaired. However, Kiran did not receive this treatment as she was unable to afford it.

Like thousands of victims of obstetric fistula, Kiran experienced intense social stigma and shame and was forced to live in extreme discomfort, making it nearly impossible for her to perform daily tasks or leave her home. Many of those afflicted with the condition are abused, shunned and even abandoned by their families, communities, and spouses.

Before finding a qualified provider at a charitable hospital who was able to perform the surgery to repair the fistula free of cost, Kiran sought treatment for *eight years*, but was repeatedly told by doctors at private and government health facilities that they lacked the training to provide treatment.

The Center for Reproductive Rights, together with the South Asia Reproductive Justice and Accountability Initiative (SARJAI), filed a petition in the High Court of Sindh, Karachi, demanding that the government ensure affordable access to, and information about, treatment for obstetric fistula in every district in the province of Sindh.⁵²

Following this petition, the Court has passed a number of significant interim orders. The court ordered funds to be allocated for fistula repair training programs as well as treatment and rehabilitation services for patients. The Sindh Maternal, Newborn and Child Health Programme also began talks with petitioners to allocate appropriate funds to build fistula repair centers in the province.⁵³

This case was the first in Pakistan seeking recognition of the widespread incidence of obstetric fistula as a violation of women's fundamental rights to dignity and life. The Sindh High Court subsequently ordered the government to implement measures to provide access to obstetric fistula care in the province of Sindh, including the creation of fistula repair centers and the recruitment of qualified gynecologists to government hospitals.⁵⁴

II. Maternal Morbidity and SRHR in Humanitarian Settings

While there continues to be a need for more reliable data on maternal mortality in humanitarian settings, there is little doubt that conflict exacerbates maternal mortality and morbidity.⁵⁵

In 2015, a United Nations (UN) inter-agency report found that in countries designated as fragile states, which include conflict-affected settings, the estimated lifetime risk of maternal mortality is 1 in 54, as compared to 1 in 180 global lifetime risk.⁵⁶

Moreover, maternal mortality ratios (MMRs) in countries affected by conflict remain high and have been shown to increase during periods of conflict. The Central African Republic has an MMR of 882 per 100,000 live births, which reflects improvement over the past 15 years but a slight increase since the start of the most recent period of unrest in 2013.⁵⁷ Similarly, Syria's MMR has increased from 49 to 68 per 100,000 live births since the start of the conflict in 2011.⁵⁸

Studies have found that MMRs among refugees receiving humanitarian aid tend to be lower than among the host population or country of origin, but that delays in seeking and receiving care are among the most significant factors in maternal deaths⁵⁹ – factors that are likely exacerbated for asylum seekers in transit.⁶⁰ A recent study conducted among Syrian refugee women in Lebanon found that many women experienced or perceived challenges in accessing reproductive health services, primarily due to costs, distance or transport to facilities, or fear of mistreatment, with more than 35% reporting problems during pregnancy or complications during labor, delivery, or abortion.⁶¹

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. 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.⁶² 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.”⁶³

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.⁶⁴ 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,⁶⁵ human rights treaty bodies have emphasized that such derogations are subject to strict conditions and that certain minimum core obligations are non-derogable.⁶⁶ Even where derogations are permitted, the measures taken cannot involve discrimination based solely on prohibited grounds, including sex.⁶⁷

a. International legal framework under International Human Rights Law (IHRL)

With the prevalence of sexual violence in humanitarian settings, human rights bodies increasingly have provided recommendations regarding gender-based violence experienced by women and girls, explaining that the right to be free from gender-based violence still applies in humanitarian settings.

Treaty Monitoring Bodies have also reiterated that international humanitarian law and international human rights law are complementary and mutually reinforcing.⁶⁸

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.⁶⁹ 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.⁷⁰

Moreover, within the context of humanitarian settings, human rights bodies hold that the right to equality and non-discrimination applies.⁷¹ 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.⁷² 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."⁷³ 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."⁷⁴

b. 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, including maternal health care.

Non-discrimination is a core principle of IHL, which prohibits adverse distinction based on sex, among other grounds.⁷⁵ As one commentator notes, "[t]his is a prohibition on discrimination and not on differentiation,"⁷⁶ as IHL also provides for specific protections for women and imposes obligations on parties to an armed conflict to respect women's specific needs.⁷⁷ 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.⁷⁸

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."⁷⁹ 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.⁸⁰ IHL establishes an affirmative duty to provide medical care for the wounded.⁸¹ 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."⁸² Victims of sexual violence, including rape, also fall within the protections provided for the wounded and sick in armed conflict situations.⁸³

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.⁸⁴ 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.⁸⁵ The ICRC describes this IHL principle as similar to the human rights principle of non-discrimination,⁸⁶ 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.⁸⁷ 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.⁸⁸

While rape and sexual violence are not explicitly prohibited under Common Article 3, other provisions in the Geneva Conventions and the Additional Protocols, as well as customary IHL, make clear that these acts 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.⁸⁹ 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.’”⁹⁰ 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.”⁹¹ For fundamental IHL guarantees, including humane treatment, human rights law and the interpretation of human rights bodies can clarify analogous IHL principles.⁹² 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.⁹³

c. 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 beings⁹⁴ 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.⁹⁵ 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 mortality⁹⁶ and ensuring access to healthcare that is safe and responds to the needs of survivors of sexual violence.⁹⁷

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.⁹⁸

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.⁹⁹ Aid efforts guided by the principles of non-discrimination and equality, moreover, prioritize the needs of marginalized or vulnerable groups or individuals.¹⁰⁰ 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.¹⁰¹

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.¹⁰² 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,”¹⁰³ which the UN Security Council also has affirmed in the context of humanitarian aid programs.¹⁰⁴ 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.”¹⁰⁵ 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.¹⁰⁶

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.¹⁰⁷ 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.¹⁰⁸ Remedies, moreover, must aim to restore the rights of victims of violations and must include adequate, effective, and prompt reparation, forms of which include restitution, compensation, rehabilitation (e.g. medical or psychological services), satisfaction, and guarantees of non-repetition.¹⁰⁹ 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.¹¹⁰ Examples of social accountability include “community-based oversight of finances and quality of care at points of service provision, including ‘community scorecards.’”¹¹¹

d. Regional Examples: Nigeria and Myanmar

• Nigeria

Ongoing human rights fact-finding being conducted by the Center in north-eastern Nigeria is documenting the impacts of the longstanding Boko Haram conflict on SRHR and accountability for rights violations. Preliminary findings reveal a severe lack of availability and prioritization of SRH services for internally displaced persons (IDPs), and women and girls specifically.¹¹² These findings corroborate the UN Special Rapporteurs’ joint-visit report on Nigeria which observed internally displaced women and girls experiencing “limited access to services, including . . . sexual and reproductive health services. Internally displaced persons have also reported lack of proper care for pregnant women and lack of medical attention for nursing mothers.”¹¹³ The African Commission on Human and Peoples’ Rights has raised concerns about the staggering maternal mortality levels, particularly in north-eastern Nigeria, and has urged the government to take action.¹¹⁴ National legal accountability requires Nigeria to address preventable maternal mortality by strengthening national and subnational health systems and eliminating discriminatory laws and practices that negatively affect IDPs’ ability to seek health care.¹¹⁵ Ensuring accountability in the planning and budgeting of health services undertaken at varying levels of government, and in some cases non-state actor service providers, should reflect transparency, monitoring, and oversight on the expenditure and adequate allocation of funds for SRH services.¹¹⁶

The Report of the United Nations High Commissioner for Human Rights on *violations and abuses committed by Boko Haram and the impact on human rights in the countries affected* reveal women and girls being subject to widespread SGBV and “severe forms of abuse, including sexual slavery, sexual violence, forced marriages, forced pregnancies and forced conversions.”¹¹⁷ In 2015 more than 200 Nigerian women and girls were reported to have been pregnant as a result of serial rape or forced marriage when rescued by the Nigerian Army from Boko Haram. None of the girls were offered access to safe abortion, leading some of them to seek illegal and unsafe abortions.¹¹⁸ The Center’s fact-finding work in north-eastern Nigeria further documents a recognition that the provision and allocation of funds for SRH services were not prioritized in the response. Our preliminary findings suggest that “state actors have yet to be held accountable, despite allegations and evidence of exploitative sexual encounters between affected populations (including minors) and some members of the military.”¹¹⁹ There is also evidence of a broader lack of accountability for violations committed by non-state actors, for example sexual violence perpetrated against internally displaced women by fellow IDPs, or exploitation by camp management. Though some formal accountability mechanisms such as camp mobile courts were available for women and girls, the experiences documented in our fact-finding indicate a fear of stigma and reprisal for seeking SRH services or justice.¹²⁰ OHCHR reporting further confirms that “owing to stigma, cultural and religious norms and deeply entrenched gender stereotypes, most victims have been reluctant to speak about sexual violence they have endured” and “pregnant women and women who gave birth while in captivity, or shortly after rescue, are particularly stigmatized, together with their children.”¹²¹

- **Myanmar**

Since August 25, 2017, killings, rapes, arbitrary arrests, and mass arsons of homes by Myanmar security forces have caused an estimated 750,000 Rohingya from Myanmar’s Rakhine state, of which 60% are women and girls, to cross the border into Cox’s Bazar, Bangladesh.¹²² Displaced Rohingya women have limited access to crucial sexual and reproductive health services, including availability of life-saving emergency obstetric care,¹²³ access to voluntary contraception and availability of a range of good quality contraceptives¹²⁴, and access to menstrual regulation which can be performed in Bangladesh within twelve weeks of a woman’s last menstrual period without confirmation of pregnancy.¹²⁵ Within Myanmar, both before and during the military operation, the Rohingya population faced severe discrimination and serious barriers to accessing health care.¹²⁶ Indeed, the Myanmar government is reported to have denied access to medical care and blocked humanitarian aid to the internally displaced Rohingya population, including sexual and reproductive health care.¹²⁷ As a result, Rohingya women face an acute risk of maternal mortality and morbidity while internally displaced and as refugees, and the need for services is compounded by the large-scale sexual violence that Rohingya women and girls face. Ensuring accountability for the provision of health services for Rohingya women and girls must take a transnational approach to ensure that sexual and reproductive health and rights are respected, protected, and fulfilled at the site of conflict in Myanmar, as well as in the refugee camps.¹²⁸

The Independent International Fact-Finding Mission on Myanmar concluded in its September 2018 report to the United Nations Human Rights Council that clear patterns of systematic and targeted human rights violations were committed by the Tatmadaw against the Rohingya in Rakhine State. Violations include “rape and sexual violence as part of a deliberate strategy to intimidate, terrorise or punish a civilian population, and are used as a tactic of war” and the report documents that “hundreds, possibly thousands, of Rohingya women and girls were brutally raped, including in public mass gang rapes.”¹²⁹ In refugee camps, Rohingya women and girls remain at risk for SGBV as a result of child, early, and forced marriage and trafficking, and overcrowding resulting in security concerns.¹³⁰ Given the reporting barriers and stigma associated with reporting experiences of SGBV to both health and protection agencies, the number of reported cases are likely to be underestimates.¹³¹ The treaty bodies have found

that the denial of safe abortion care to survivors of rape in armed conflict violates the rights to health and privacy and could amount to a violation of the prohibition on ill-treatment.¹³² While abortion is illegal in Bangladesh except where undertaken to save the life of a pregnant woman¹³³, the law does provide for menstrual regulation within the first twelve weeks of pregnancy.¹³⁴ However, the service is only accessible within ten camp facilities and remains inadequate to meet the needs of women who present with pregnancies as a result of rape.¹³⁵ Non-derogable minimum core obligations related to SRH require states to take steps to prevent unsafe abortion and to provide post-abortion care and counseling; they also require states to “repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access by individuals or a particular group to sexual and reproductive health facilities, services, goods and information.”¹³⁶

The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) reports that despite immense need, post-rape care, including emergency contraception, safe abortion, and counselling services, remain inadequate, non-comprehensive, and of inconsistent quality in the Cox’s Bazar refugee camps, and that many settlement areas still lack basic clinical management for survivors of sexual violence required by the Minimum Initial Service Package (MISP).¹³⁷ Per the MISP, clinical services for survivors of sexual violence include a list of emergency contraceptives, post-exposure prophylaxis (PEP), pregnancy testing, as well as referral mechanisms.¹³⁸ However, referrals for care that is unavailable or cannot be provided in the camps remains a significant challenge, especially given the restrictions placed on the movements of the Rohingya.¹³⁹

In the Center’s letter to the CEDAW Committee on the situation of Rohingya women and girls from northern Rakhine state of Myanmar, guaranteeing varying forms of accountability for this population was essential. We called on the CEDAW Committee to recommend to the Government of Myanmar to immediately investigate, prosecute, and punish perpetrators of violence against the Rohingya population, including sexual violence against women and girls, and ensure the participation of Rohingya women and girls in any accountability process.¹⁴⁰ Furthermore, for the Rohingya women and girls displaced into refugee camps in Bangladesh, we requested that the Committee recommend that the Government of Bangladesh, relevant UN agencies, and humanitarian organizations work together to ensure that Rohingya women and girls have access to quality SRH services, and that their perspectives are taken into account in the process of developing and implementing programs, including SRH services.

III. Recommendations

The Center respectfully requests that the upcoming OHCHR report on PMMM will highlight the following recommendations:

- Highlight the negative impact of restrictive legislative frameworks on women and girls’ SRHR and on maternal morbidity rates.
- Call on States to liberalize their legislative frameworks in accordance with international human rights law and standards.
- Call on States and other relevant actors to give renewed emphasis to maternal mortality and morbidity initiatives in their development partnerships and international assistance and cooperation arrangements, including by strengthening technical cooperation to address maternal mortality and morbidity, including through the transfer of expertise,

technology and scientific data and exchanging good practices with developing countries, while honouring existing commitments, and to integrate a human rights-based perspective into such initiatives, addressing the impact that discrimination against women and girls has on maternal mortality and morbidity.

- Call on States to strengthen their statistical capacity and to promote reliable transparent, collaborative and disaggregated data collection on the availability, accessibility, acceptability and quality of sexual and reproductive health-care services for all women and girls.
- Call for a broad and robust understanding of rights-based accountability to ensure that the full range of involved actors are held responsible and answerable for their actions and decisions, and that rights holders have access to reparations, remedies, and guarantees of non-recurrence that are enforceable if their rights are violated. This requires accountability mechanisms that are participative, transparent, and confer prompt, meaningful, and effective remedies to victims and survivors of violations.¹⁴¹
- Call for a circle of accountability to be created around women and girls in humanitarian settings, enabling their lived experiences and their full, equal, effective and meaningful participation in all areas that affect them, including the provision of SRH information and services, to inform and improve legislative frameworks and global standards and policies. This circle of accountability, as conceptualized by OHCHR, would include unpacking legal, financial and social systems of accountability, as well as using data, monitoring and evaluation as accountability tools, all the while centralizing human rights standards in devising these systems.
- Hold states accountable for all respective legal obligations to respect, protect, and fulfill women and girls' rights throughout humanitarian response, including states hosting refugees and displaced populations and donor states under international human rights law, international humanitarian law, international refugee law, and international criminal law.

We are grateful for this opportunity to input in this report. Should the Office need any additional information, please do not hesitate to reach out to Christina Zampas, Associate Director for Global Advocacy, at czampas@reprorights.org and Paola Salwan Daher, Senior Global Advocacy Advisor, at pdaher@reprorights.org.

¹ This submission understands 'maternal morbidity' as 'any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman's wellbeing', as per WHO's Working Group on Maternal Morbidity (WGMM)'s definition, available [here](#).

- ² Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 12, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1980), U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].
- ³ See, e.g., Committee on the Elimination of Discrimination against Women (CEDAW Committee) & Committee on the Rights of the Child (CRC Committee), *Joint General Recommendation No. 31 & General Comment No. 18: On harmful practices* (2014), at 18, paras. 68-69, U.N. Doc. CEDAW/C/GC/31-CRC/C/GC/18 (2014) [hereinafter CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18*]. See also CRC Committee, *Concluding Observations: Mongolia*, para. 51(a), U.N. Doc. CRC/C/MNG/CO/3-4 (2010); Committee on Economic, Social and Cultural Rights (CESCR Committee), *Concluding Observations: Australia*, para. 28, U.N. Doc. E/C.12/AUS/CO/4 (2009).
- ⁴ Human Rights Committee, *General Comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life* (2018), at 7, para. 26, U.N. Doc. CCPR/C/GC/36 (2018) [hereinafter Human Rights Committee, *Gen. Comment No. 36*].
- ⁵ CEDAW Committee, *Report of the Committee on the Elimination of Discrimination against Women*, (20th Sess., 1999), at 52, para. 56, U.N. Doc. A/54/38/Rev.1 (1999) (“[T]he Committee notes that the level of maternal mortality due to clandestine abortions may indicate that the Government does not fully implement its obligations to respect the right to life of its women citizens.”).
- ⁶ CRC Committee, *Concluding Observations: Democratic Republic of Congo*, paras. 33-34, U.N. Doc. CRC/C/COD/CO/2 (2009).
- ⁷ International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 12, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR].
- ⁸ CESCR Committee, *General Comment No. 14 (2000): The right to the highest attainable standard of health (Art. 12)* (22nd Sess., 2000), at 5, para. 14, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR Committee, *Gen. Comment No. 14*]; CESCR Committee, *General Comment No. 22 (2016): On the right to sexual and reproductive health (Art. 12)*, (2016), at 12, para. 49, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter CESCR Committee, *Gen. Comment No. 22*]. See also Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*, para. 30-31, U.N. Doc. A/59/422 (Oct. 8, 2004) (by Paul Hunt).
- ⁹ CESCR Committee, *Gen. Comment No. 22*, paras. 12-21.
- ¹⁰ CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, (20th Sess., 1999), para. 11, U.N. Doc. A/54/38/Rev.1, chap. I (1999) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]; CESCR Committee, *Gen. Comment No. 14*, para. 12.
- ¹¹ CESCR Committee, *Concluding Observations: Brazil*, para. 28, U.N. Doc. E/C.12/BRA/CO/2 (2009); CRC Committee, *Concluding Observations: Uzbekistan*, para. 25, U.N. Doc. CRC/C/UZB/CO/3-4 (2013); CRC Committee, *Concluding Observations: Marshall Islands*, para. 52(g), U.N. Doc. CRC/C/MHL/CO/2 (2007); CRC Committee, *Concluding Observations: The Congo*, para. 59, U.N. Doc. CRC/C/COG/CO/2-4 (2014); CRC Committee, *Concluding Observations: Turkmenistan*, para. 52, U.N. Doc. CRC/C/TKM/CO/1 (2006); Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc’n No. 17/2008, para. 8(2)(b), U.N. Doc. CEDAW/C/49/D/17/2008 (2011). See also CEDAW Committee, *Concluding Observations: Kenya*, para. 38(b), U.N. Doc. CEDAW/C/KEN/CO/7 (2011).
- ¹² CESCR Committee, *Gen. Comment No. 22*, para. 49 g)
- ¹³ World Health Organization (WHO), Model List of Essential Medicines, 21st List, 2019, available under <https://apps.who.int/iris/bitstream/handle/10665/325771/WHO-MVP-EMP-IAU-2019.06-eng.pdf?ua=1>, sections 5 and 22.3 (Last checked 02/04/2020)
- ¹⁴ CESCR Committee, *Gen. Comment No. 22*, paras. 22-24, 30-32.
- ¹⁵ CESCR Committee, *Gen. Comment No. 14*, para. 43(d).
- ¹⁶ See, e.g., CEDAW COMMITTEE, CONCLUDING OBSERVATIONS: THAILAND, PARAS. 42-43, U.N. DOC. CEDAW/C/THA/CO/6-7 (2017); LESOTHO, PARAS. 32-33, U.N. DOC. CEDAW/C/LSO/CO/1-4 (2011), See also Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc’n No. 17/2008, paras. 7.6-7.7, U.N. Doc. CEDAW/C/49/D/17/2008 (2011), See also CESCR Committee, General Comment 22, para.16
- ¹⁷ Committee Against Torture (CAT Committee), *Concluding Observations: Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); CAT Committee, *Concluding Observations: Peru*, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013).
- ¹⁸ CAT Committee, *Concluding Observations: United States of America*, para. 33, U.N. Doc. CAT/C/USA/CO/2 (2006).
- ¹⁹ CAT Committee, *Concluding Observations: Kenya*, para. 27, U.N. Doc. CAT/C/KEN/CO/2 (2013).
- ²⁰ 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)
- ²¹ OHCHR, October 7th 2019, Press Release, ‘Widespread violence and mistreatment of women in childbirth are human rights violations that must end, says UN expert’ available at <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25111&LangID=E>
- ²² Idem; at <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25111&LangID=E>
- ²³ 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);

²⁴ *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)

²⁵ 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.

²⁶ WHO, 'Preventing Unsafe Abortion', available at <https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion>

²⁷ CEDAW Committee, *Gen. Recommendation No. 35*, para. 18; CEDAW Committee, *Gen. Recommendation No. 24*, paras. 11, 14.

²⁸ Human Rights Committee, *Gen. Comment No. 36*, para. 8

²⁹ 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).

³⁰ 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)

³¹ *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,

³² CRC Committee, *Gen. Comment No. 20*, para. 39.

³³ Ziraba AK, Izugbara C, Levandowski BA, et al. Unsafe abortion in Kenya: a cross-sectional study of abortion complication severity and associated factors. *BMC Pregnancy Childbirth*. 2015;15:34. Published 2015 Feb 15. doi:10.1186/s12884-015-0459-6

³⁴ Fact Sheet: Enforcing Kenya's obligation to provide legal abortion services, **FIDA KENYA & 3 OTHERS Vs. ATTORNEY GENERAL & 2 OTHERS CONSTITUTIONAL PETITION NO 266 OF 2015**, September 10th 2019 available at <https://reproductiverights.org/document/fact-sheet-enforcing-kenyas-obligation-provide-legal-abortion-services>

³⁵ Republic of Kenya, High Court of Kenya at Nairobi Constitutional and human rights division, Petition no 266 of 2015, Federation of women lawyers (FIDA Kenya) and 3 others vs AG and 2 others, Judgment-Petition No. 266 of 2015, paras. 379 and 411

³⁶ 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, *General 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).

³⁷ CESCR Committee, *General Comment No. 22*, paras. 27, 35, 36

³⁸ 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

³⁹ 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;

⁴⁰ 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

⁴¹ 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)

⁴² CESCR Committee, *Gen. Comment No. 22*, 1, para. 27

⁴³ CESCR Committee, *Gen. Comment No. 22*, paras. 22 – 28; CESCR Committee, *Gen. Comment No. 16*, para. 29.

⁴⁴ CEDAW Committee, *Gen. Recommendation No. 25*, paras. 7, 8; CESCR Committee, *Gen. Comment No. 22*, paras. 35, 36.

⁴⁵ CESCR Committee, *Gen. Comment No. 22*, para 8

⁴⁶ *Ibid.*, para 7

⁴⁷ *Ibid.*, para 8

⁴⁸ Human Rights Committee, *General Comment No. 36*, para 26

⁴⁹ UNICEF, **MATERNAL AND NEWBORN HEALTH DISPARITIES: PAKISTAN** (2017) available at https://data.unicef.org/wp-content/uploads/country_profiles/Pakistan/country%20profile_PAK.pdf.

⁵⁰ *Experts Call for Efforts to Prevent, Treat Obstetric Fistula*, DAWN NEWS, Sept. 29, 2017, <https://www.dawn.com/news/1360683>.

⁵¹ *Victims of Obstetric Fistula Continue to Suffer in Silence*, THE NEWS INTERNATIONAL, May 24, 2018, <https://www.thenews.com.pk/print/320649-victims-of-obstetric-fistula-continue-to-suffer-in-silence>.

⁵² Center for Reproductive Rights, *Pakistani High Court Calls for Response to Allegations Women Are Denied Maternal Health Services*, September 1st 2019, available at https://reproductiverights.org/press-room/pakistani-high-court-calls-for-response-to-allegations-women-are-denied-maternal-health-services?_ga=2.20615736.189778644.1580897369-2075782051.1571836963

⁵³ Pakistan Court Orders Implementation of Measures to Address Obstetric Fistula, February 27th 2019, available at <https://reproductiverights.org/press-room/pakistan-court-orders-implementation-measures-address-obstetric-fistula>

⁵⁴ *Id.*;

⁵⁵ *See, e.g.*, Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, *Rep. of the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*, para. 43, U.N. Doc. A/68/297 (Aug. 9, 2013) (by Anand Grover); Therese McGinn, Sara Casey, Susan Purdin, & Mendy Marsh, *Reproductive Health for conflict-affected people: Policies, research and programmes* 45 OVERSEAS DEVELOPMENT INSTITUTE HUMANITARIAN PRACTICE NETWORK 10-11 (Apr. 2004); *see also* Kayla McGowan, *Closing the Gaps of Maternal Health in Conflict and Crises*, MATERNAL HEALTH TASK FORCE BLOG (Dec. 15, 2016), <https://www.mhtf.org/2016/12/15/closingthe-gaps-of-maternal-health-in-conflict-and-crisis/>.

⁵⁶ WHO, UNICEF, UNFPA, WORLD BANK GROUP, & THE UNITED NATIONS POPULATION DIVISION, TRENDS IN MATERNAL MORTALITY: 1990 TO 2015, 15, 26 (2012), available at http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf.

⁵⁷ WHO, UNICEF, UNFPA, World Bank Group, & the United Nations Population Division, Trends in Maternal Mortality: 1990 to 2015, *Maternal Mortality Ratio (model estimate, per 100,000 live births): Central African Republic* (2015), available at <http://data.worldbank.org/indicator/SH.STA.MMRT?locations=CF> (last visited May 21, 2019).

⁵⁸ WHO, UNICEF, UNFPA, World Bank Group, & the United Nations Population Division, Trends in Maternal Mortality: 1990 to 2015, *Maternal Mortality Ratio (model estimate, per 100,000 live births): Syrian Arab Republic* (2015), available at <http://data.worldbank.org/indicator/SH.STA.MMRT?locations=SY> (last visited May 21, 2019).

⁵⁹ Michelle Hynes, Ouahiba Sakani, Paul Spiegel, & Nadine Cornier, *A Study of Refugee Maternal Mortality in 10 Countries, 2008-2010*, 38:4 INTERNATIONAL PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 205, 210 (Dec. 2012) (noting that these ratios may be lower for a number of reasons, including as a result of targeted humanitarian care, but that these findings “should be interpreted with caution” as maternal deaths were likely underreported).

⁶⁰ Moreover, studies noting the correlation between maternal stress, pregnancy-related complications, and fetal development suggest longer-term, intergenerational effects of conflict and displacement. *See, e.g.*, Delan Devakumar, Marion Birch, David Osrin, Egbert Sondorp, & Jonathan CK Wells, *The intergenerational effects of war on the health of children* (Apr. 2014), 12:57 BMC MEDICINE, available at <https://bmcmmedicine.biomedcentral.com/articles/10.1186/1741-7015-12-57>; E.J.H Mulder et al., *Prenatal*

maternal stress: effects on pregnancy and the (unborn) child (June 2002), 70 EARLY HUMAN DEVELOPMENT 3; Lucy Ward, *Mother's stress harms foetus, research shows*, THE GUARDIAN (May 31, 2007), <https://www.theguardian.com/science/2007/may/31/childrenservices.medicineandhealth>.

⁶¹ Amelia Reese Masterson, Jinan Usta, Jhumka Gupta, & Adrienne S. Ettinger, *Assessment of reproductive health and violence against women among displaced Syrians in Lebanon* (2014), 14:25 BMC WOMEN'S HEALTH 4, available at <http://bmcmwomenshealth.biomedcentral.com/articles/10.1186/1472-6874-14-25>.

⁶² 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>.

⁶³ 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>.

⁶⁴ 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.")

⁶⁵ 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.

⁶⁶ 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 CESCR 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).

⁶⁷ Human Rights Committee, *Gen. Comment No. 29*, para. 8.

⁶⁸ Human Rights Committee *General Comment 36* para. 64, CEDAW Committee *General Recommendation 30* paras. 9, 12 and 19

⁶⁹ 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).

⁷⁰ CEDAW Committee, *Gen. Recommendation No. 30*, para. 57.

⁷¹ See generally BREAKING GROUND 2018

⁷² 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.")

⁷³ CEDAW Committee, *Gen. Recommendation No. 30*, para. 2.

⁷⁴ CEDAW Committee, *Gen. Recommendation No. 28*, para. 11.

⁷⁵ 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>.

⁷⁶ Charlotte Lindsey, *Women Facing War*, at 20

⁷⁷ 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)

⁷⁸ 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).

⁷⁹ ICRC, 2016 Commentary on the First Geneva Convention, art. 12, paras. 1429-30 (emphasis added).

⁸⁰ 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).

⁸¹ 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)

⁸² Additional Protocol I, art. 8(a)

⁸³ 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

⁸⁴ 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).

⁸⁵ 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).

⁸⁶ 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).

⁸⁷ 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).

⁸⁸ 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., *Commentary: 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).

⁸⁹ 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).

⁹⁰ ICRC, Customary IHL Database, Rule 87, https://www.icrc.org/customaryihl/eng/docs/v1_rul_rule87 (last visited May 31, 2017)

⁹¹ ICRC, 2016 Commentary on the First Geneva Convention, art. 3, para. 203

⁹² 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).

⁹³ 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 Droegel, ‘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).

⁹⁴ 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.

⁹⁵ *Id.*;

⁹⁶ 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.”)

⁹⁷ *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.”)

⁹⁸ 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*].

⁹⁹ 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*].

¹⁰⁰ 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_dhr_2017_standard.pdf.

¹⁰¹ 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”).

¹⁰² See *Human Rights Based Approach to Development*; *UNFPA, The Human Rights-Based Approach*.

¹⁰³ *ICPD Programme of Action*, para. 7.7.

¹⁰⁴ S.C. Res. 1889 [on women and peace and security], para. 1, U.N. Doc. S/RES/1889 (Oct. 5, 2009).

¹⁰⁵ SR Health Report (2013), para. 12.

¹⁰⁶ *Id.*, para. 12.

¹⁰⁷ 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.

¹⁰⁸ UNGA Res. 60/147, para. 3(b).

¹⁰⁹ 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).

¹¹⁰ 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)

¹¹¹ *Id.*, para. 74; see also *Social Accountability*, CARE INTERNATIONAL, <http://governance.care2share.wikispaces.net/Social+Accountability> (last visited June 12, 2017).

¹¹² Onyema Afulukwe & Meera Shah, *Sexual and Reproductive Health and Rights Violations in the Conflict in North-East Nigeria* (under review, forthcoming 2019) (on file with the Center for Reproductive Rights).

¹¹³ Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, on the sale of children, child prostitution and child pornography and on contemporary forms of slavery, including its causes and consequences, *Rep. of the Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, on the sale of children, child prostitution and child pornography and on contemporary forms of slavery, including its causes and consequences on their joint visit to Nigeria*, para. 69, U.N. Doc. A/HRC/32/32/Add.2 (June 15, 2016).

¹¹⁴ African Commission on Human and Peoples' Rights, *Concluding Observations and Recommendations on the Third Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2005 – 2008)*, (44th Ordinary Sess.) (2008).

¹¹⁵ Onyema Afulukwe & Meera Shah, *Sexual and Reproductive Health and Rights Violations in the Conflict in North-East Nigeria* (under review, forthcoming 2019) (on file with the Center for Reproductive Rights).

¹¹⁶ Office of the United Nations High Commissioner for Human Rights (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*, U.N. Doc. A/HRC/21/22 (July 2, 2012).

¹¹⁷ U.N. Human Rights Council, *Report of the Working Group on the universal period review (Mongolia)*, para. 38, U.N. Doc. A/HRC/30/6.

¹¹⁸ Laura Bassett, *Instruments of Oppression*, HUFFINGTON POST (2015), available at <http://highline.huffingtonpost.com/articles/en/kenya-abortion/>.

¹¹⁹ Onyema Afulukwe & Meera Shah, *Sexual and Reproductive Health and Rights Violations in the Conflict in North-East Nigeria* (under review, forthcoming 2019) (on file with the Center for Reproductive Rights).

¹²⁰ *Id.*

¹²¹ OHCHR, *Violations and abuses committed by Boko Haram and the impact on human rights in the countries affected: Rep. of the United Nations High Commissioner for Human Rights*, (30th Sess., 2015), para. 43, U.N. Doc. A/HRC/30/67 (2015).

¹²² Special Rapporteur on the situation of human rights in Myanmar, *Rep. of the Special Rapporteur on the situation of human rights in Myanmar* (advance unedited version), (40th Sess., 2019), U.N. Doc. A/HRC/40/68 (Mar. 5, 2019); U.N. Human Rights Council, *Report of the independent fact-finding mission on Myanmar*, (39th Sess., 2018), U.N. Doc. A/HRC/39/64 (Sept. 12, 2018). See also Inter-Agency Working Group on Reproductive Health in Crises (IAWG), *Women and Girls Critically Underserved in the Rohingya Humanitarian Response* (Feb. 22, 2018), available at <https://reliefweb.int/sites/reliefweb.int/files/resources/IAWG%20Statement%20on%20Rohingya%20Humanitarian%20Response.pdf> [hereinafter IAWG, *Rohingya Humanitarian Response*].

¹²³ IAWG, *Rohingya Humanitarian Response*,

¹²⁴ *Id.*

¹²⁵ BANGLADESH FAMILY PLANNING DEPARTMENT, MINISTRY OF HEALTH, NATIONAL MENSTRUAL REGULATION SERVICES GUIDELINES (2013); Susheela Singh et al., *The Incidence of Menstrual Regulation Procedures and Abortion in Bangladesh 2014*, 43 INTERNATIONAL PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 1 (2017).

¹²⁶ Office of the Spokesperson of the United Nations Secretary-General, *Highlights of the Noon Briefing by Farhan Haq, Deputy Spokesman for Secretary-General António Guterres* (May 1, 2018), available at <https://www.un.org/sg/en/content/highlight/2018-05-01.html>; ASIAN-PACIFIC RESOURCE AND RESEARCH CENTRE FOR WOMEN (ARROW), *MYANMAR/BURMA: BREAKING BARRIERS, ADVOCATING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS 21-23*, (2016).

¹²⁷ IAWG, *Rohingya Humanitarian Response*

¹²⁸ Letter from the Center for Reproductive Rights to CEDAW Committee, *Re: Supplementary information on situation of Rohingya women and girls from northern Rakhine state of Myanmar for review by the Committee on Elimination of Discrimination against Women* (May 27, 2018), available at https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/MMR/INT_CEDAW_NGO_MMR_33504_E.pdf.

¹²⁹ U.N. Human Rights Council, *Myanmar: UN Fact-Finding Mission releases its full account of massive violations by military in Rakhine, Kachin and Shan States*, (Sept. 18, 2018), available at <https://www.ohchr.org/EN/HRBodies/HRC/Pages/NewsDetail.aspx?NewsID=23575&LangID=E>

¹³⁰ United Nations Population Fund (UNFPA), *As Rohingya Refugee Crisis Escalates, Women Emerge as Front-line Responders*, UNFPA, Dec. 6, 2017, available at <https://www.unfpa.org/news/rohingya-refugee-crisis-escalates-women-emerge-front-line-responders>.

¹³¹ IAWG, *Rohingya Humanitarian Response*,

¹³² CEDAW Committee, *Gen. Recommendation No. 30*, para. 57.

32 *Id.* para. 52(c); CEDAW Committee, *Concluding Observations: Syria*, para. 40, U.N. Doc. CEDAW/C/SYR/CO/2 (2014); CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, para. 32(e), U.N. Doc. CEDAW/C/COD/CO/6-7 (2013); Human Rights Committee, *Concluding Observations: Democratic Republic of the Congo*, paras. 13-14, U.N. Doc. CCPR/C/COD/CO/3 (2006).

¹³³ The Penal Code of 1860 (Act No. XLV of 1860), secs. 312-316 (1860) (Bangl.).

¹³⁴ BANGLADESH FAMILY PLANNING DEPARTMENT, MINISTRY OF HEALTH, NATIONAL GUIDELINES ON MENSTRUAL REGULATION (2013).

¹³⁵ IAWG, *Rohingya Humanitarian Response*, (Note that this figure is accurate up to the date of the IAWG statement, Feb. 22, 2018).

¹³⁶ CESCR, *Gen. Comment No. 22*, para. 49.

¹³⁷ IAWG, *Rohingya Humanitarian Response*; U.N. Secretary-General, *Conflict-related sexual violence*, para. 98(d); Center for Reproductive Rights et al., *NGO Statement Concerning Sexual and Reproductive Rights of Rohingya Women and Girls Displaced Due to Conflict in advance of the UN Security Council's Mission to Myanmar, Bangladesh* (Apr. 26, 2018), available at <https://www.womensrefugeecommission.org/images/zdocs/NGO-Statement-on-SRHR-of-Rohingya-Women.pdf>.

¹³⁸ IAWG, *Minimum Initial Service Package* (2011), available at <http://iawg.net/minimum-initial-service-package/>.

¹³⁹ UNFPA, MYANMAR: ANNUAL REPORT 2017, 11 (2017) available at <https://myanmar.unfpa.org/en/publications/unfpa-myanmar-annual-report-2017-0>.

¹⁴⁰ Letter from the Center for Reproductive Rights to CEDAW Committee,

¹⁴¹ 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 (Mar. 21, 2006); CEDAW Committee, *Gen. Recommendation No. 30*, paras. 13-18 (recommendations are in paras. 17-18).