CENTER for REPRODUCTIVE RIGHTS

Submission from the Center for Reproductive Rights following the call for submissions of the Committee on the Elimination of Racial Discrimination (CERD Committee) for the Day of General Discussion on "racial discrimination and the right to health" (30 June 2022)

The Center for Reproductive Rights (the Center)—an international non-profit legal advocacy organization headquartered in New York City, with regional offices in Nairobi, Bogotá, Geneva, and Washington, D.C. and a staff of approximately 200 diverse professionals in 14 countries—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; the right to bodily autonomy and to informed consent to treatment; and preventing and addressing sexual violence. During this time, the Center has conducted advocacy to support norm development at the U.N., including with the treaty monitoring bodies in the development of General Recommendations and Comments.

The Center is pleased to provide this submission for the day of general discussion on "racial discrimination and the right to health." This submission will focus on systemic racial and intersectional discrimination in the context of the right to sexual and reproductive health.

I. Introduction

Women, girls and other persons who can get pregnant who are protected by the Convention on the Elimination of All Forms of Racial Discrimination (the Convention) face discrimination, acts of violence and violations of their sexual and reproductive rights. Systemic or structural racism and racial discrimination also impact the rights of groups protected under the Convention, undermining their access to social and other determinants of health and further infringing on their ability to realize the right to sexual and reproductive health, among other human rights. These women and girls also confront intersectional discrimination, such that subgroups of women experience sexual and reproductive rights violations in disproportionate and distinct ways. Guaranteeing the right to health under the Convention requires that states take measures to address intersectional discrimination and systemic racism, generally, as well in the context of sexual and reproductive health.

The Center submits this information with the understanding, affirmed by this Committee in numerous General Recommendations, that the Convention provides protection from discrimination to a range of individuals.[1] Through General Recommendations, this Committee has affirmed that discrimination based on caste[2] and against indigenous peoples,[3] Roma,[4] people of African descent,[5] migrants, refugees, asylum-seekers, undocumented non-citizens and "persons who cannot establish the nationality of the State on whose territory they live,"[6] among others, falls under the scope of the Convention.

II. Intersectional Discrimination and Sexual and Reproductive Health (Question 12)

Treaty monitoring bodies and human rights experts have recognized that an intersectional analysis of discrimination based on gender and other relevant grounds (including race, descent, national or social origin, indigenous origin or identity, refugee, migrant and asylum status, age, disability, sexual orientation, gender identity, political or other opinion, religion, poverty, among others) is essential to effectively protect,

promote and fulfil the sexual and reproductive rights of women and girls and other persons who can get pregnant. All women, and subgroups of women, cannot be treated homogenously in response to rights violations, as they do not experience rights violations in the same way.[7] Moreover, the principle of universality, fundamental to human rights law, demands that intersectional discrimination be addressed. The right to be free from discrimination cannot be realized until intersectional discrimination is made visible and specific measures are taken to prevent, prohibit and remedy this type of discrimination.

Intersectional discrimination, a term coined by Professor Kimberlé Williams Crenshaw,[8] recognizes the "multidimensionality" of individuals' experiences of discrimination and does not treat different prohibited grounds of discrimination "as mutually exclusive categories of experience and analysis."[9] Instead, as the Committee on the Rights of Persons with Disabilities (CRPD Committee) has explained: "Intersectional discrimination refers to a situation where several grounds operate and interact with each other at the same time in such a way that they are inseparable."[10] These inseparable prohibited grounds of discrimination function together to produce a distinct disadvantage.

For example, Romani women have been involuntarily sterilized not only because they are women or because they are Roma, but because they are Romani women. These two identities/characteristics—being a women and being Roma—function together to create a distinct form of discrimination that combines both racism and sexism and that is based on negative stereotypes about Romani women's sexuality and fertility, among other harmful notions.[11] Notably, the CRPD Committee has observed that harmful intersectional stereotyping, such as that based on gender and disability, can lead to structural or systemic discrimination, "inextricably linked to a lack of policies, regulation and service provision specifically for women with disabilities."[12]

As the CRPD Committee has noted in its General Comment 3 on women and girls with disabilities, intersectional discrimination—including against "indigenous women; refugee, migrant, asylum seeker and internally displaced women; . . . and women from different ethnic, religious and racial backgrounds"[13]—requires a particularized and targeted response:

> Intersectional discrimination recognizes that individuals do not experience discrimination as members of a homogenous group but rather, as individuals with multidimensional layers of identities, statuses and life circumstances. It means acknowledging the lived realities and experiences of heightened disadvantage of individuals caused by multiple and intersecting forms of discrimination, **which requires targeted measures with respect to disaggregated data collection, consultation, policymaking, enforceability of non-discrimination and provision of effective remedies**.[14]

Although U.N. treaty monitoring bodies and Special Procedures often equate or link intersectional discrimination with multiple discrimination, they are conceptually distinct. Multiple discrimination refers to discrimination on "two or several grounds, in the sense that discrimination is compounded or aggravated,"[15] with each type of discrimination operating *separately*.

In the context of sexual and reproductive health and rights, as with other rights, an intersectional analysis of discrimination based on gender and race and other possible grounds is imperative both for successfully identifying and understanding the structural or root causes of a violation and for determining appropriate and effective remedies to achieve non-discrimination and equality. The failure to recognize intersectional discrimination serves only to perpetuate that situation of discrimination.[16] As Crenshaw explains in the context of Black women: "Because the intersectional experience is greater than the sum of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated."[17]

The Need to Advance Treaty Monitoring Body Standards on Intersectional Discrimination

Although this and other treaty monitoring bodies have consistently recognized the harms of multiple and intersectional discrimination, most treaty monitoring bodies have yet to develop a clear and robust intersectional analysis in their views in individual complaints, concluding observations or general recommendations/comments relating to sexual and reproductive health. In particular, treaty monitoring bodies have fallen short of clearly and comprehensively articulating state responsibilities in the context of intersectional discrimination.

For example, the Committee on Economic, Social and Cultural Rights (CESCR Committee) has recognized intersectional discrimination as a distinct form of discrimination[18] and has explicitly underscored the need for measures to address intersectional discrimination in the context of sexual and reproductive health;[19] however, the Committee has not articulated robust state obligations or recommendations in this regard.

Although the Committee on the Elimination of Discrimination against Women (CEDAW Committee) has clarified certain state obligations, its intersectional analysis remains underdeveloped. In its general recommendation on core obligations, the CEDAW Committee notes that "[i]ntersectionality is a basic concept for understanding the scope of the general obligations of States parties" to eliminate discrimination. It further calls upon states to "legally recognize such intersecting forms of discrimination and their compounded negative impact on the women concerned and prohibit them . . . [and] to adopt and pursue policies and programmes designed to eliminate such occurrences, including, where appropriate, temporary special measures . . . ."[20] The Committee has clarified that specific temporary special measures may be required to address multiple and intersecting forms of discrimination against women, including on "grounds such as race, ethnic . . . identity, . . . caste or other factors."[21] The CEDAW Committee has also consistently acknowledged the impact of intersectional discrimination on women and girls,[22] including rural women,[23] migrant women,[24] women in conflict,[25] and women refugees and asylum-seekers,[26] among others.

Nonetheless, the Committee has not always applied a robust intersectional analysis to state obligations concerning the right to health. For example, in *Alyne da Silva Pimentel v. Brazil*, the CEDAW Committee found Brazil responsible for discrimination against Alyne, an Afro-Brazilian women who died following pregnancy and post-natal complications, "not only on the basis of her sex, but also on the basis of her status as a woman of African descent and her socio-economic background."[27] Yet the Committee's general recommendations to Brazil failed to address the intersection of racial and sex-based discrimination that led to Alyne's death, making no mention of the state party's obligation to address racial discrimination against women of African descent in the provision of maternal health care.[28]

In *A.S. v. Hungary*, the CEDAW Committee found that the sterilization of A.S., a Romani woman, without her full and informed consent was a violation of her rights under the Convention.[29] This decision was groundbreaking in many ways; however, it failed to acknowledge the deeply entrenched intersectional discrimination that has been a root cause of the practice of forced and coercive sterilization of Romani women. A.S.'s intersectional identity was critical for both understanding the violation and crafting an appropriate remedy, yet the Committee focused exclusively on a single, gender-based ground of discrimination in finding a violation and issuing its recommendations to the state party.

This Committee has drawn particular attention to the gender-related dimensions of racial discrimination, "recognizing that some forms of racial discrimination have a unique and specific impact on women, [and committing] in its work to take into account gender factors or issues which may be interlinked with racial discrimination."[30] In this context, the CERD Committee has specifically highlighted sexual and reproductive rights violations, including "sexual violence committed against women members of particular racial or ethnic groups in detention or during armed conflict; the coerced sterilization of indigenous women."[31] The Committee has also called attention to multiple discrimination against women members of descent-based communities,[32] female non-citizens,[33] Romani women,[34] and women and girls of African descent.[35]

This Committee has further addressed intersectional discrimination in its concluding observations.[36] However, the CERD Committee has not yet articulated clear state obligations or recommendations to specifically address the intersectional discrimination experienced by women and girls in the context of their right to health, including sexual and reproductive health. This general recommendation on the right to health represents a critical opportunity for the Committee to lead on these issues and articulate robust state obligations to prevent, combat and redress intersectional discrimination in the context of the right to health.

The Committee's inclusion of intersectional discrimination standards in this general recommendation would not only provide critical guidance to states on their obligations under the Convention, but also inform states' efforts to realize the 2030 Agenda for Sustainable Development, which is designed to "leave no one behind" and, as such, is grounded in human rights principles. Treaty monitoring bodies have recognized that realizing the Sustainable Development Goals, such as those regarding health (Goal 3), gender equality (Goal 5) and discrimination against women and girls (Targets 5.1 and 10.3) requires inclusive, intersectional approaches, including targeted measures for disadvantaged groups of women.[37]

III. International Legal Framework: Sexual and Reproductive Health and Rights and Substantive Equality (Questions 5, 9, 11, 12)

States have clear legal obligations to ensure the respect, protection and fulfillment of sexual and reproductive rights without discrimination. In General Comment No. 22, the CESCR Committee reiterated states' obligation "to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to ensure the full realization of the right to sexual and reproductive health."[38] The CESCR Committee described the right to sexual and reproductive health as covering a range of freedoms and entitlements, including "the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health."[39] The CESCR Committee also recognized that individuals belonging to particular groups, including indigenous or ethnic minorities, may be disproportionately affected by intersectional discrimination in the context of sexual and reproductive health, requiring special measures to guarantee substantive equality.[40]

States' obligations must be implemented in a way that ensures that all sexual and reproductive health information and services are available, accessible, acceptable, and of good quality.[41] Acceptability requires that facilities, goods, information and services are respectful of medical ethics and culturally appropriate.[42] The core obligation to ensure the satisfaction of minimum essential levels of the right to sexual and reproductive health includes the duty of states, "guided by . . . the most current international guidelines established by United Nations agencies, in particular WHO," to:[43]

- Repeal or eliminate laws, policies and practices that criminalize, obstruct, or undermine an individual's or a particular group's access to sexual and reproductive health facilities, services, goods, and information.
- Guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services, goods, and facilities, in particular for women and disadvantaged groups.
- Ensure all individuals and groups have access to comprehensive education and information on sexual and reproductive health, and ensure that it is non- discriminatory, non-biased, evidence-based, and takes into account the evolving capacities of children and adolescents.
- Ensure access to effective and transparent remedies and redress for violations of the right to sexual and reproductive health.

As recognized by the CESCR Committee, the right to sexual and reproductive health is indivisible from and interdependent with other rights.[44] It extends beyond sexual and reproductive health care and services to include the underlying and **social determinants of sexual and reproductive health**.[45] These underlying determinants include "access to safe and potable water, adequate sanitation, adequate food and nutrition, adequate housing, safe and healthy working conditions and environment, health-related education and information, and effective protection from all forms of violence, torture and discrimination,"[46] among others.

The CESCR Committee has further underscored the role of **systemic or structural discrimination** in infringing on the right to sexual and reproductive health, stating:

> In all countries, patterns of sexual and reproductive health generally reflect social inequalities in society and unequal distribution of power based on gender, ethnic origin, age, disability and other factors. Poverty, income inequality, systemic discrimination and marginalization . . . are all social determinants of sexual and reproductive health, which also have an impact on the enjoyment of an array of other rights . . . . **Therefore, to realize the right to sexual and reproductive health, States parties must address the social determinants as manifested in laws, institutional arrangements and social practices that prevent individuals from effectively enjoying in practice their sexual and reproductive health.**[47]

The Special Rapporteur on racism, racial discrimination, xenophobia and related intolerance has noted that

> structural discrimination can be the result of past historical injustices perpetrated against specific groups of individuals. Long after that formalized racial discrimination was dismantled, the inequalities that were created continued to have a disadvantage or disproportionate effect on the human rights of individuals of specific ethnic and racial groups. Indigenous peoples, Roma, members of communities based on caste or analogous systems of inherited status, ethnic minorities and people of African descent remain particularly affected by this historical legacy, notably in the areas of health . . .," among other areas.[48]

This Committee acknowledged this reality in a statement on COVID-19, noting that the unequal distribution of COVID-19 vaccines "replicates slavery and colonial-era racial hierarchies . . . which further deepens structural inequalities affecting vulnerable groups protected under the Convention."[49]

Substantive Equality and Gender Stereotypes (Question 11)

Treaty monitoring bodies have long recognized the need to use a substantive equality approach to ensure gender equality and address structural discrimination in the context of reproductive rights. They have called on states to ensure positive reproductive health outcomes, such as fulfilling unmet need for modern contraceptives, lowering rates of maternal mortality, including by ensuring access to abortion, and reducing rates of adolescent pregnancy.[50] They have repeatedly condemned laws that restrict or prohibit health services primarily or exclusively needed by women on the basis that they violate the rights to equality and non-discrimination.[51] The CEDAW Committee has stated that "it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."[52]

Several of the treaty monitoring bodies have regularly called on states to work to eradicate gender stereotypes that underlie restrictive laws and undermine the realization of sexual and reproductive health, noting that patriarchal attitudes, cultural stigma, and 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, goods and services.[53]

To achieve substantive equality, states must reform discriminatory laws, policies, and practices; remove all barriers that interfere with women's access to comprehensive sexual and reproductive health services, goods, education, and information;[54] and implement temporary special measures.[55] These measures should:

- Address discriminatory power structures.[56]
- Recognize that women and men experience different kinds of rights violations due to discriminatory social and cultural norms, including in the context of health,[57] and that, women may also face multiple and intersectional discrimination, based on multiple grounds, including race, disability, age or other statuses.[58]
- Ensure equality of results.[59]

IV. The Impact of Systemic Racism and Intersectional Discrimination on Sexual and Reproductive Health and Rights (Questions 15, 16)

Although this submission focuses on four key sexual and reproductive rights issues, it is critical to contextualize these rights violations as forming part of a wider set of discriminatory laws, policies, and practices faced by women, girls and other persons who can get pregnant. These abuses occur as part of a continuum of discrimination and violence against women in society in all areas of economic, social and cultural rights, including housing and employment, but also in civil and political rights, such as in the exercise of freedom of expression or association. Women, girls and other persons who can get pregnant also experience this discrimination and abuse when seeking other forms of sexual and reproductive health care, including fertility treatments, contraception, or in other sexual and reproductive health contexts—and it is often targeted against individuals with intersectional identities.

Abortion

Globally, restrictive abortion laws and policies and other barriers to abortion care have served to push abortion underground, increase rates of unsafe abortion, and delay access to essential and time-sensitive health care. These laws and polices disproportionately harm low-income communities and communities facing intersectional discrimination and exacerbate social inequality.

In the United States, for example, abortion bans and restrictions are escalating,[60] disproportionately impacting Black, Indigenous, and other people of color (BIPOC) experiencing intersectional discrimination.[61] Abortion bans and medically unnecessary restrictions deprive, delay, demean, stigmatize, and misinform people seeking abortion care while increasing health risks for patients. These bans and restrictions also extend a violent legacy of state control over the reproductive lives of BIPOC, in violation of their rights to autonomy, privacy, life, health, equality, and non-discrimination.[62]

The United States Supreme Court recently overturned nearly 50 years of precedent protecting the constitutional right to choose to terminate a pregnancy before viability.[63] BIPOC and people working to make ends meet are, and will continue to be, particularly devastated and disadvantaged by this decision, given that they already face significant barriers to accessing health care due to systemic racism, implicit biases, and other forms of discrimination.[64]

The U.S. state of Texas recently enacted Senate Bill 8 ("S.B. 8"), which bans abortion as early as six weeks of pregnancy and authorizes private individuals to enforce the law by filing lawsuits to obtain civil penalties from people who provide abortion care or assist others in obtaining abortion care. The law has eliminated almost all abortion access in the state and effectively makes abortion care unavailable beginning at this early stage of pregnancy to anyone who cannot afford to travel out of state.[65] Black, Indigenous, and Latina women in Texas, who already face substantial barriers to accessing reproductive health care because of systemic racism,[66] are particularly impacted.[67] Black women and birthing people will disproportionately suffer the gravest consequences of forced pregnancy under S.B. 8 in light of the maternal mortality crisis in Texas and the significantly higher rates of maternal mortality and morbidity Black women and birthing people experience compared to white women in the state.[68] Already this year, at least twelve other states have enacted, introduced or noticed their intention to introduce laws copying Texas S.B. 8. Idaho and Oklahoma have enacted such bans.

Human Rights Standards

Treaty monitoring bodies have long recognized the connection between restrictive abortion laws, high rates of unsafe abortion, and maternal mortality[69] 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.[70] In General Comment No. 36 on the right to life, the Human Rights Committee has specified that states should not regulate pregnancy or abortion in ways that force women and girls to resort to unsafe abortions, and they should revise their abortion laws accordingly,

including by refraining from introducing new barriers to abortion (non-retrogression principle).[71] 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.[72]

Treaty monitoring bodies recommend that states should decriminalize abortion[73] and liberalize their abortion laws to improve access; they should also remove legal, financial, and practical barriers that deny effective access by women and girls to safe and legal abortion,[74] including medically unnecessary barriers to abortion and third-party authorization requirements.[75]

In outlining states' core obligations to ensure the satisfaction of minimum essential levels of the right to sexual and reproductive health, the CESCR Committee notes that states "should be guided by . . . the most current international guidelines established by United Nations agencies, in particular WHO.[76] In its most recent Abortion Care Guideline, the World Health Organization (WHO) recommends the full decriminalization of abortion[77] and against laws and other regulations that restrict abortion by grounds. The WHO recommends that abortion be available on the request of the woman, girl or other pregnant person.[78] It further recommends against gestational age limits,[79] mandatory waiting periods for abortion[80] and third-party authorization.[81]

The WHO's Abortion Care Guideline provides public health evidence to support its law and policy recommendations and consistently refers to discrimination, including based on race and ethnicity, as playing a part in hindering access to abortion services.[82] For example, the WHO found that evidence showed that third-party authorization requirements delayed access to abortion for minors, with a disproportionate impact on "minors from ethnic minorities or of lower socioeconomic status."[83]

Maternal Health and Obstetric Violence

Women experience a wide range of rights violations when seeking maternal health care. In 2014 in a statement on disrespect and abuse during facility-based childbirth, the WHO noted that "a growing body of research on women's experiences during pregnancy, and particularly childbirth, paints a disturbing picture," and condemned "outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay."[84]

Discrimination in these contexts is often aimed at women with intersectional identities, including those of African descent or from ethnic minorities, refugees, migrants and women of lower socioeconomic status. For example, in some settings, migrant and refugee women may be "expected to pay higher rates for services or to pay bribes" to receive care.[85] Particularly harmful restrictions and obstacles confront undocumented migrant women in Europe, as legal and policy exclusions or financial and practical barriers severely curtail these women's ability to access affordable maternal health care throughout pregnancy.[86] And in a number of central and eastern European countries, Romani women have faced ethnic segregation and racial discrimination, harassment and abuse in reproductive health care settings including obstetric care.[87]

In the U.S., Black and Indigenous women face a maternal health crisis, with significantly higher rates of maternal mortality[88] and pregnancy complications[89] than white women. In hospital settings, where most Black women in the United States give birth, racism and sexism facilitate mistreatment and abuse.[90] In addition, pregnant people across the U.S. have been subjected to criminal prosecution or other punitive legal systems because of their pregnancy or an outcome of their pregnancy.[91] This punishment disproportionately affects BIPOC and immigrant women, especially those living in poverty. As medical and public health experts have cautioned,[92] the threat of criminal or civil punishment harms the health of

pregnant people by eroding trust in the medical system and deterring them from care when they most need it. This only compounds the existing health risks faced by Black and Indigenous birthing people.[93]

In Peru, indigenous women have historically experienced serious violations of their sexual and reproductive rights, including being subjected to obstetric violence during childbirth. For example, when Eulogia,[94] a *campesino* woman descendant from the original Quechua people of Peru, went into labor, instead of respecting her decision to have a homebirth (as she had done with her other five children), she was forced by local health authorities to go to a health center, under the threat of both a monetary fine and the withholding of the birth certificate of her child. Once at the health center, Eulogia was not provided with assistance in her language, Quechua, and was violently and physically forced by a nurse to give birth in a horizontal position against her ancestral customs. During this struggle, her son, Sergio, was born and his head hit the ground. In the immediate aftermath, Eulogia was not only denied information regarding her son's health status but was also forced to shower with cold water against her own will and against her people's cosmovision that considers cold water as a wound to the body that has just given birth. As a result of the injury Sergio suffered at birth, he had multiple severe health problems and ultimately died at the age of 12.[95]

Eulogia's case reveals a system of institutionalized gender-based violence that perpetuates discriminatory stereotypes against indigenous peoples—in particular, indigenous women, and *campesino*, Quechua-speaking and poor women. Fueled by negative stereotypes about indigenous customs regarding pregnancy, childbirth and postpartum as "backward" and "ignorant,"[96] this violence also illustrates the impact of intersectional discrimination on the provision of care during childbirth.[97]

In Pakistan, there are vast disparities in maternal mortality rates between ethnic groups. While the overall maternal mortality rate in Pakistan is 189 deaths per 100,000 live births, the province of Balouchistan, which is predominantly inhabited by members of the Balouch ethnic group, has a maternal mortality rate of 317 per 100,000 live births.[98] The significantly higher maternal mortality rates within this historically discriminated-against ethnic group reflects the lack of investment in affordable obstetric care services in the geographical areas where they are predominantly based.

Human Rights Standards

Treaty monitoring bodies have developed strong human rights standards on women's right to maternal health care, framing 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.[99] In General Recommendation No. 24, the CEDAW Committee recommended that states "require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice."[100]

States must guarantee all women available, accessible, acceptable, and good quality maternal health services.[101] Treaty monitoring bodies have further found that social and other determinants of health must be addressed in order for women to be able to seek and access the maternal health services they need.[102] In General Comment No. 36, the Human Rights Committee affirmed that preventable maternal deaths are a violation of the right to life and recommended that states develop strategic plans and campaigns for improving access to treatments designed to reduce maternal mortality, as part of advancing the enjoyment of the right to life.[103] Treaty monitoring bodies have also specifically recognized that intersectional discrimination can hinder women's access to maternal health services and have recommended that states put a particular focus on the maternal health needs of women who face discrimination in health care access, including adolescents, poor women, minority women, rural women, migrant women, and women with disabilities. This requires the collection of disaggregated data on maternal mortality.[104]

In the first decision by a treaty monitoring body on maternal mortality, *Alyne da Silva Pimentel v. Brazil*, the CEDAW Committee found that Brazil had discriminated against Alyne, an Afro-Brazilian woman who died

from obstetric complications after being denied quality maternal health care in both private and public health care facilities. The Committee recognized that Alyne experienced discrimination on the basis of her sex, her status as a woman of African descent and her socioeconomic background.[105] However, the CEDAW Committee's general recommendations to Brazil failed to address the State's obligation to specifically prohibit and prevent the intersectional discrimination, based on race and sex, that contributed to Alyne's death.[106]

Forced and Coercive Sterilization

The forced or coercive sterilization of women is a global phenomenon that disproportionately impacts certain subgroups of women, including indigenous peoples[107] and ethnic or racial minorities. As the 2014 U.N. interagency statement on forced sterilization underscores, "these discriminatory practices are often founded on wrongful stereotyping based on gender, race and ethnicity."[108]

Health care providers may sterilize women without their informed consent because of harmful and discriminatory beliefs that they are not "worthy" of procreation, they are incapable of making responsible decisions regarding contraception, they are not fit to be "good mothers," or that their offspring are not desirable.[109] This is particularly the case in instances in which harmful gender stereotypes intersect with stereotypes about race, ethnicity, indigeneity, socioeconomic status, migrant status, health status, disability or any other status.

Although the widespread and systematic practice of forced and coercive sterilization of Romani women in some central and eastern European countries is a well-documented past practice[110] and has been the subject of repeated condemnation, accountability has been limited. A small number of individual women have obtained compensation following arduous litigation over many years; however, most Romani women who were forcibly sterilized have been unable to obtain redress.[111]

In the United States, there is a long history of state-sponsored programs to forcibly sterilize Black, Indigenous and other women of color and immigrant women.[112] Immigrant rights organizations recently documented accounts of medical neglect and non-consensual hysterectomies being performed on immigrant women in a detention facility in the state of Georgia.[113]

Likewise, in India, several documented instances of state-sponsored forced sterilization over the years have highlighted unsanitary and abusive practices in sterilization camps, particularly in areas dominated by tribal and indigenous communities.[114] This is despite progressive decisions by the courts holding the State accountable and directing the discontinuation of such camps.[115] For certain 'particularly vulnerable tribal groups' in the state of Chhattisgarh, on the other hand, family planning services were completely prohibited until recently as a blanket response to *concerns* over their fertility rates and without addressing chronic poverty and malnourishment as amongst key root causes for negative health outcomes.[116]

Human Rights Standards

Human rights bodies and experts, including this Committee, have long recognized that forced or coerced sterilization violates a range of human rights, including the right to be free from torture and other ill-treatment, and have repeatedly emphasized the need to obtain informed consent for such procedures.[117]

This Committee has noted that "certain forms of racial discrimination may be directed towards women specifically because of their gender, such as . . . the coerced sterilization of indigenous women."[118]

The CEDAW Committee has identified forced sterilization as a form of gender-based violence[119] and has called for complaints about forced sterilization to be duly investigated and for the provision of remedies and redress that are "adequate, effective, promptly granted, holistic and proportionate to the gravity of the harm suffered."[120]

Sexual and Reproductive Health in Conflict and Humanitarian Settings

This Committee and the CEDAW Committee have recognized that women experience intersectional discrimination and violence, especially sexual violence,[121] in conflict and post-conflict settings, and that these violations disproportionately impact women and girls from particular racial or ethnic groups,[122] as well as "internally displaced and refugee women; women's human rights defenders; women belonging to diverse caste, ethnic, national, religious or other minorities or identities who are often attacked as symbolic representatives of their community."[123]

Conflict also disrupts access to health services, including essential sexual and reproductive health services,[124] leaving women and girls "at a greater risk of unplanned pregnancy, severe sexual and reproductive injuries and contracting sexually transmitted infections, including HIV and AIDS, as a result of conflict-related sexual violence."[125] This lack of access to essential health care has a disproportionate impact on people who are already under-served due to racism and other forms of discrimination in the health care system, aggravating their exposure to discrimination and gender-based violence.[126] The Special Rapporteur on the right to health has noted that "[w]omen often experience higher incidence of poor health outcomes in conflict . . . [and] are more likely to turn to unsafe abortion services when facing an unplanned pregnancy."[127]

In 2017, Myanmar security forces committed widespread sexual violence against Rohingya Muslims in Myanmar's Rakhine state as part of its ethnic cleansing campaign.[128] Killings, rapes, arbitrary arrests, and mass arsons of homes by Myanmar security forces caused an estimated 750,000 Rohingya refugees to cross the border into Cox's Bazar, Bangladesh, where Rohingya women faced an acute need for sexual and reproductive health services.[129] Access to emergency obstetric care and contraception in refugee camps was limited, exposing women and girls to risk of maternal mortality and unwanted pregnancies.[130] During the Covid-19 pandemic, access to crucial sexual and reproductive health services in refugee camps was further disrupted.[131]

OHCHR and the Working Group on Discrimination Against Women and Girls have recognized promising practices for realizing a "circle of accountability" for sexual and reproductive health and rights in humanitarian settings.[132] For example, in a northern Ugandan refugee settlement, community models have been implemented to collect, review, monitor, and ultimately remedy sexual and reproductive health-related complaints and violations to ensure equal access to comprehensive, quality, and lifesaving sexual and reproductive health services and information, without discrimination.[133]

Human Rights Standards

Human rights law and international humanitarian law are complementary and mutually reinforcing, and states must therefore respect, protect, and fulfill sexual and reproductive health and rights during conflict and humanitarian emergencies, including by ensuring access to services for women and girls who are survivors of gender-based violence.[134] Treaty monitoring bodies have developed extensive guidance for states that reinforce and complement state's humanitarian legal obligations.

In conflict-affected settings, the CEDAW Committee has called on states to:

- Ensure access to maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission, and emergency obstetric care.[135]
- Give priority to the provision of sexual and reproductive health services, including safe abortion services, noting with concern the effects of armed conflict on sexual and reproductive health and maternal mortality.[136]
- "Address the specific risks and particular needs of different groups of internally displaced and refugee women, subjected to multiple and intersecting forms of discrimination, including women with disabilities, older women, girls, widows, women who head households, pregnant women, women living with HIV/AIDS, rural women, indigenous women, women belonging to ethnic, national, sexual or religious minorities, and women human rights defenders."[137]

V. Monitoring and Accountability to Address Discrimination (Question 35)

Human rights obligations include ensuring accountability for sexual and reproductive rights violations, which, in turn, helps guide states in meeting their human rights commitments and provides an opportunity to improve laws, policies and practices.[138] Financial and budgetary allocation is critical to the realization of rights[139] and ensuring accountability.

A human rights-based approach also requires establishing accountability mechanisms to ensure redress for survivors of mistreatment and violence, including financial compensation, acknowledgement of wrongdoing and a formal apology, and guarantees of non-repetition.[140] Institutional and health system accountability requires that complaint procedures be instituted in all health care facilities, including appeals procedures, and that states routinely undertake maternal death reviews or audits.[141] States must strengthen health systems by using both quantitative and qualitative indicators to monitor health outcomes, including the collection of disaggregated data and qualitative experiences of women receiving reproductive health care, particularly women belonging to groups that have historically experienced racism and other forms of discrimination in the health care system, including indigenous women, women of African descent, Dalit women, Romani women, and refugee and migrant women, among others.

In all efforts at prevention, monitoring and redress, states and health care facilities must ensure that women—including women who have experienced multiple, intersecting forms of discrimination—are active and informed participants in accounting for their experiences and redesigning systems to ensure accountability.[142]

VI. ANNEX: Recommendations

We respectfully suggest that the Committee's General Recommendation on racial discrimination and the right to health include clear and specific language and recommendations that:

Sexual and Reproductive Health

- Affirm, in line with other treaty monitoring bodies, that the right to health includes the right to sexual and reproductive health. And that:
    - States have an obligation to guarantee access to comprehensive sexual and reproductive health services, including maternal health care, abortion services, infertility care, access to contraceptives and care for survivors of sexual violence, including in humanitarian settings, without discrimination, coercion or violence.
    - States must also guarantee the underlying determinants of sexual and reproductive health, including the right to health information and to comprehensive sexuality education, including for adolescents.
    - The right to health encompasses the right to free and fully informed consent to treatment.
    - The right to health, including sexual and reproductive health, requires that States take measures to address structural and intersectional discrimination. This requires the adoption of special measures.

Structural Discrimination

- Affirm, in line with the CESCR Committee and other treaty monitoring bodies, that the right to health, including sexual and reproductive health, requires States to take affirmative measures to address structural discrimination.
    - Systemic or structural racism and discrimination continue to create inequalities that disadvantage and impact the human rights of groups protected under the Convention, infringing on their ability to realize their right to sexual and reproductive health. Discriminatory sexual and reproductive health policies and practices, in turn, further deepen existing structural inequalities.[143] States must recognize and take affirmative measures to address this dynamic in guaranteeing the right to sexual and reproductive health.

- Specifically, this requires that health policies "appropriately address the needs of disadvantaged and marginalized groups"[144] and that states take "affirmative measures to eradicate legal, procedural, practical and social barriers to the enjoyment of the right to sexual and reproductive health."[145]

Intersectional Discrimination

- Recognize that women with intersecting identities—including racial or ethnic minorities, Romani, indigenous, refugee or migrant women, women with disabilities, living in rural areas or socioeconomically disadvantaged or in adolescence—suffer disproportionately and in cumulative ways the consequences of discrimination.
- Provide a clear and comprehensive definition of intersectional discrimination, as distinct from multiple discrimination. Clarify standards and state obligations with respect to intersectional discrimination and the right to sexual and reproductive health and note that they may require special measures. These obligations include:
  - The adoption of legislation and polices targeted at addressing the prejudices and discriminatory stereotypes upon which various forms of intersectional discrimination are based. States must legally recognize and prohibit intersectional discrimination.
  - Disaggregated data collection. States must compile data, disaggregated by dimensions of inequality, such as sex, gender, race, ethnicity, caste, ability, age, immigration status, nationality, geography and wealth, on the accessibility, availability and quality of sexual and reproductive health services, including in humanitarian settings. Ensure that data collection respects privacy in accordance with international standards of data protection and is done in a sensitive manner and in close consultation with the affected groups.
  - The commitment of resources to address the intersecting forms of discrimination that contribute to reproductive health disparities and the specific risks faced by indigenous, ethnic and other minority, migrant, refugee and displaced women and girls and persons who can get pregnant, among others.
  - Consultation with and the active participation of people from impacted communities, including indigenous and ethnic and racial minority and refugee women and girls and other persons who can get pregnant, in the development of culturally sensitive laws, policies and programs, including the creation of monitoring and accountability mechanisms.
  - Targeted monitoring and accountability measures, including the provision of effective remedies that explicitly recognize and address intersectional discrimination in the context of sexual and reproductive health.
- Explicitly require states to periodically report on the intersectional discrimination and stereotyping experienced by subgroups of women that undermine the realization of the right to sexual and reproductive health. Grounds of discrimination may include discrimination based on gender and ethnic, indigenous, national or social origin, race, refugee, migrant or asylum status; as well as other possible grounds, including age, disability, sexual orientation, gender identity, political or other opinion and religion, among others. This list is non-exhaustive.

Abortion

- Affirm, in line with other treaty monitoring bodies and the WHO's 2022 Abortion Care Guideline (noting that the CESCR Committee has required states to be guided by the "most current international guidelines" from the WHO[146]), that states have an obligation to decriminalize abortion and call on states to guarantee access to abortion without restrictions as to reason, emphasizing how all restrictions on access to abortion disproportionately impact individuals facing racial and intersectional discrimination.
- Recommend that states record and monitor health outcomes related to abortion laws and policies and report them to the Committee in their periodic reports.

Maternal Health

- Call on states to take targeted steps to reduce maternal mortality and morbidity rates and to address any persistent racial, ethnic or other intersectional discrimination in maternal health care and maternal health outcomes and prohibit practices of segregation. Require states to include disaggregated data on maternal mortality in their periodic reports.

Forced and Coercive Sterilization

- Affirm that forced or coercive sterilization is a violation of the right to health, among other rights, and recognize that this practice disproportionately impacts women facing racial and intersectional discrimination, including Romani women and indigenous women. Call upon states to guarantee accountability for these violations, including establishing effective reparations mechanisms, and underscore their obligation to ensure the active participation of survivors in the creation of accountability and monitoring mechanisms.

Humanitarian Settings

- Affirm the sexual and reproductive health rights of women and girls and other persons who can get pregnant as essential in conflict and post-conflict settings. Note the disproportionate impact of conflict, and the corresponding lack of access to sexual and reproductive health services, on women facing intersectional discrimination.

Monitoring and Accountability

- Clarify that state obligations on the right to health require monitoring and accountability measures for sexual and reproductive health violations, including measures specifically targeting intersectional discrimination. States must:
    - Strengthen mechanisms for reporting, monitoring and evaluation of sexual and reproductive health care in public and private healthcare facilities. This requires systematic tracking and evaluation.
    - Create and strengthen and fund accountability mechanisms to foster the accountability of multiple actors at various levels, within health care settings as well as within the justice system, including, but not limited to, mechanisms of professional accountability; institutional accountability; health system accountability; private actor accountability; and donor accountability.
    - Guarantee full and fair investigations into allegations of sexual and reproductive rights violations.
    - Ensure that victims of rights violations are provided targeted remedies, which acknowledge and address any intersectional discrimination, that may take the form of restitution, compensation, satisfaction or guarantees of non-repetition, by both state and non-state actors.
    - Adopt an intercultural and participatory approach to sexual and reproductive health to ensure that indigenous and ethnic and other minority women and girls are actively involved in shaping and implementing the sexual and reproductive health programs offered to them, including through their own institutions and communities, and are represented in the health care workforce and among health care decision-makers.

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ENDNOTES

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[2] CERD Committee, *Gen. Recommendation No. 29*, Preamble.
[3] CERD Committee, *Gen. Recommendation No. 23*, para. 1 (The CERD "Committee has consistently affirmed that discrimination against indigenous peoples falls under the scope of the Convention and that all appropriate means must be taken to combat and eliminate such discrimination."); *see also* CERD Committee, *Gen. Recommendation No. 24*, para. 1.
[4] CERD Committee, *Gen. Recommendation No. 27*.
[5] CERD Committee, *Gen. Recommendation No. 34*.
[6] CERD Committee, *Gen. Recommendation No. 30*.
[7] *See, e.g.,* Special Rapporteur on violence against women, its causes and consequences, *Multiple and intersecting forms of discrimination and violence against women*, para. 101, U.N. Doc. A/HRC/17/26 (2011) (noting that: "In meeting their international legal obligations, States must bear in mind that discrimination affects women in different ways depending on how they are positioned within the social, economic and cultural hierarchies that prohibit or further compromise certain women's ability to enjoy universal human rights. This approach also reveals critical aspects of intra-gender discrimination and inequality, which up until now have been invisible in efforts to treat all women homogenously in the responses to violence.")
[8] Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, University of Chicago Legal Forum, Vol. 1989: Iss.1, Article 8 (1989), available at https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf.
[9] *Id.* at 139.
[10] CRPD Committee, *Gen. Comment No. 3*, para. 4(c).
[11] Zampas C, Lamačková A. *Forced and coerced sterilization of women in Europe.* International Journal of Gynecology and Obstetrics, 2011, 114:163–166.
[12] CRPD Committee, *Gen. Comment No. 3*, para. 17(e).
[13] *Id.* at para. 5.
[14] *Id.* at para. 16 (emphasis added).
[15] *Id.* at para. 4(c).
[16] Special Rapporteur on violence against women, its causes and consequences, *Multiple and intersecting forms of discrimination and violence against women*, paras. 42-43, 49, U.N. Doc. A/HRC/17/26 (2011).
[17] Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, University of Chicago Legal Forum, Vol. 1989: Iss.1, Article 8, p. 140 (1989).
[18] CESCR Committee, *Gen. Comment No. 20*, para. 27.
[19] CESCR Committee, *Gen. Comment No. 22*, paras. 30-32. The CESCR Committee has stated that: "Measures to guarantee non-discrimination and substantive equality should be cognizant of and seek to overcome the often exacerbated impact that intersectional discrimination has on the realization of the right to sexual and reproductive health." *Id.* at para. 30.
[20] CEDAW Committee, *Gen. Recommendation No. 28*, para. 18. *See also* CEDAW Committee, *Gen. Recommendation No. 25*, para. 28 ("States parties should explain the reasons for choosing one type of measure over another. The justification for applying such measures should include a description of the actual life situation of women, including the conditions and influences which shape their lives and opportunities — or that of a specific group of women, suffering from multiple forms of discrimination — and whose position the State party intends to improve in an accelerated manner with the application of such temporary special measures. At the same time, the relationship between such measures and general measures and efforts to improve the position of women should be clarified.").
[21] CEDAW Committee, *Gen. Recommendation No. 25*, para. 12.
[22] See, for example, CEDAW Committee and CRC Committee, *Joint Gen. Recommendation/Gen. Comment. No. 31 of the CEDAW Committee and No. 18 of the CRC Committee*, paras. 5, 14, 15, 54, U.N. Doc. CEDAW/C/GC/31-CRC/C/GC/18 (2014).
[23] CEDAW Committee, *Gen. Recommendation No. 34*, paras. 14-15.
[24] CEDAW Committee, *Gen. Recommendation No. 26*, para. 6.
[25] CEDAW Committee, *Gen. Recommendation No. 30*, paras. 7, 57.
[26] CEDAW Committee, *Gen. Recommendation No. 32*, para. 16.
[27] Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, para. 7.7, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).
[28] *Id.* para 8.
[29] A.S. v. Hungary, CEDAW Committee, Commc'n No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).
[30] CERD Committee, *Gen. Recommendation No. 25*, para. 3.
[31] *Id.* at para. 2.
[32] CERD Committee, *Gen. Recommendation No. 29*, section 2.
[33] CERD Committee, *Gen. Recommendation No. 30*, para. 8.
[34] CERD Committee, *Gen. Recommendation No. 27*, paras. 6, 22, 34.
[35] CERD Committee, *Gen. Recommendation No. 34*, paras. 22-24, 26.
[36] See, for example, CERD Committee, *Concluding Observations: Slovakia*, paras. 23-24, U.N. Doc. CERD/C/SVK/CO/11-12 (2018) (expressing serious concerns to Slovakia over the discriminatory treatment and segregation of Romani women and girls in health care facilities and the reports about "verbal and physical violence faced by Roma women when accessing sexual and reproductive health services" and recommending the adoption by the state of a number of measures to address these concerns); CERD Committee, *Concluding Observations: United States*, para. 15, U.N. Doc. CERD/C/USA/CO/7-9 (2014); CERD Committee, *Concluding*

Observations: United States, para. 32, U.N. Doc. CERD/C/USA/CO/6 (2008) (expressing concern to the United States about the persistence of racial disparities in sexual and reproductive health, noting the high maternal mortality rates among Black women).
[37] *See, for example,* CEDAW Committee, *Guidance Note on CEDAW and COVID-19*, para. 7, https://www.ohchr.org/Documents/HRBodies/CEDAW/Statements/CEDAW_Guidance_note_COVID-19.docx; CESCR Committee, *The Pledge to "Leave No One Behind": The International Covenant on Economic, Social and Cultural Rights and the 2030 Agenda for Sustainable Development*, para. 7, U.N. Doc. E/C.12/2019/1 (2019).
[38] CESCR Committee, *Gen. Comment No. 22,* para. 45. See also CESCR Committee, *Gen. Comment No. 14*, para. 8.
[39] CESCR Committee, *Gen. Comment No. 22*, para. 5.
[40] *Id.* paras. 5, 10, 30 (noting that these were individuals belonging to "...groups including but not limited to poor women, persons with disabilities, migrants, indigenous or other ethnic minorities, adolescents, lesbian, gay, bisexual, transgender and intersex persons, and people living with HIV/AIDS").
[41] CESCR Committee, *Gen. Comment No. 22,* paras. 12-21; CESCR Committee, *Gen. Comment No. 14*, para. 12.
[42] CESCR Committee, *Gen. Comment No. 14*, paras. 12(c), 27; CESCR Committee, *Gen. Comment No. 22*, para. 20.
[43] CESCR Committee, *Gen. Comment No. 22*, para. 49.
[44] *Id.* at para. 10.
[45] *Id.* at paras. 7-8.
[46] *Id.* at para. 7.
[47] *Id.* at para. 8 (emphasis added).
[48] Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance, *Interim Report: Issues of Concern for the Mandate*, para. 11, U.N. Doc. A/66/313 (2011).
[49] CERD Committee, *Statement 2 (2022): Statement on the lack of equitable and non-discriminatory access to COVID-19 vaccines*, p.2 (2022).
[50] CEDAW Committee, *Gen. Recommendation No. 24*, para. 21; CESCR Committee, *Gen. Comment No. 16*, para. 29; Human Rights Committee, *Gen. Comment No. 36*, para 8. *See also,* Human Rights Committee, *Concluding Observations: Rwanda*, U.N. Doc. CCPR/C/RWA/CO/4 (2016); CEDAW Committee, *Concluding Observations: Argentina,* paras. 34-35, U.N. Doc. CEDAW/C/ARG/CO/7 (2016); CEDAW Committee, *Concluding Observations: Thailand,* para. 39, U.N. Doc. CEDAW/C/THA/CO/6-7 (2017); CEDAW Committee, *Concluding Observations: Congo*, para. 36(f), U.N. Doc. CEDAW/C/COG/CO/6 (2012); CRC Committee, *Concluding Observations: Central African Republic*, para. 55, U.N. Doc. CRC/C/CAF/CO/2 (2017); CEDAW Committee, *Concluding Observations: Nigeria*, paras. 37-38, U.N. Doc. CEDAW/C/NGA/CO/7-8 (2017); CESCR Committee, *Concluding Observations: Namibia*, para. 65(a), U.N. Doc. E/C.12/NAM/CO/1 (2016).
[51] CESCR Committee*, Gen. Comment No. 22*, paras. 22-28; CRC Committee, *Gen. Comment No. 20,* para. 59; 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).
[52] CEDAW Committee, *Gen. Recommendation No. 33,* paras. 47, 51(l); CEDAW Committee, *Gen. Recommendation No. 24*, para. 11.
[53] CEDAW Committee, *Gen. Recommendation No. 35*, paras. 26(c), 37(a), 38(a); CESCR Committee*, Gen. Comment No. 22*, paras. 27, 35-36; CESCR Committee, *Gen. Comment No. 16,* para. 5; CRC Committee, *Gen. Comment No. 20*, para. 28*;* CRC Committee, *Gen. Comment No. 15*, para. 9; Human Rights Committee, *Gen. Comment No. 28*, para. 5; Human Rights Committee, *Gen. Comment No. 36*, para. 8; CRPD Committee, *Gen. Comment No. 3*, paras. 38-40, 62(b)(ii); CEDAW Committee, *Concluding Observations: Iraq,* paras. 42-43, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); CEDAW Committee, *Concluding Observations: Bangladesh*, para. 35 (b), U.N. Doc. CEDAW/C/BGD/CO/8 (2016).
[54] CESCR Committee*, Gen. Comment No. 22*, paras. 22-28; CESCR Committee, *Gen. Comment No. 16,* para. 29.

[56] CEDAW Committee, *Gen. Recommendation No. 25*, para. 9; CESCR Committee, *Gen. Comment No. 20*, paras. 8, 9, 39.
[57] CRC Committee, *General Comment No. 15*, para. 9.
[58] CRPD Committee, *General Comment No. 6*, paras. 19 and 21; CEDAW Committee, *Gen. Recommendation No. 25*, para. 12; CEDAW Committee, *Gen. Recommendation No. 28*, para. 18; CESCR Committee, *Gen. Comment No. 20*, para. 17; Human Rights Committee, *Gen. Comment No. 28*, para. 30; CRPD Committee, *General Comment No. 3*, paras. 3, 4, 38.
[59] CEDAW Committee, *Gen. Recommendation No. 25*, paras. 8-10; CESCR Committee, *Gen. Comment No. 3*, para. 10; Human Rights Committee, *Gen. Comment No. 28*, para. 3; CEDAW Committee, *Gen. Recommendation No. 28*, para. 20.
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[87] *See, e.g.*, Center for Reproductive Rights & Poradňa pre občianske a ľudské práva (Center for Civil and Human Rights), VAKERAS ZORALES – SPEAKING OUT: ROMA WOMEN'S EXPERIENCES IN REPRODUCTIVE HEALTH CARE IN SLOVAKIA (2017), *available at* https://reproductiverights.org/wp-content/uploads/2021/03/GLP-SlovakiaRomaReport-Final-Print.pdf; European Roma Rights Centre (ERRC) v. Bulgaria, Complaint No. 151/2017, European Committee of Social Rights; ERRC, *Romani woman harassed by racist hospital staff during childbirth wins case*, Jan. 18, 2017, http://www.errc.org/press-releases/romani-woman-harassed-by-racist-hospital-staff-during-childbirth-wins-case (last visited May 22, 2019); Carmen Gheorghe & Cristina Mocanu, *Challenging intersectionality: Roma women's voices and experiences: Experiences of discrimination of Roma women in housing, education, health and employment - Comparative research on multiple discrimination in Finland, Italy and Romania* (2021), E-Romnja Association for Promoting Roma Women's Rights, Romni Onlus, Helsinki Deaconess Institute Foundation, Center for Not-for-profit Law, http://e-romnja.ro/wp-content/uploads/2021/04/Research-Intersect-Voices-.pdf.

[88] Emily Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016*, CDC (Sept. 6, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm; Emily Peterson et al., *Morbidity and Mortality Weekly Report, Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*, CDC (May 10, 2019), https://pubmed.ncbi.nlm.nih.gov/31071074/.

[89] Andrea Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010*, AJOG (Dec. 2, 2013), https://www.ajog.org/article/S0002-9378(13)02153-4/fulltext.

[90] Center for Reproductive Rights & Black Mamas Matter Alliance, *Submission to the UN Special Rapporteur on Violence against Women* (May 17, 2019), https://www.reproductiverights.org/sites/default/files/2019-07/SR%20VAW%20joint%20submission_CRR%2BBMMA_May%202019_FINAL.pdf.

[91] *See e.g.*, Lynn Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y, & L. 299 (Apr. 2013), https://read.dukeupress.edu/jhppl/article/38/2/299/13533/Arrests-of-and-Forced-Interventions-on-Pregnant; If/When/How: Lawyering for Reproductive Justice, *Roe's Unfinished Promise: Decriminalizing Abortion Once and For All* (2019), https://www.ifwhenhow.org/resources/roes-unfinished-promise-2019-update/; Wendy Bach, *Prosecuting Poverty, Criminalizing Care*, 60 WM. & MARY L. REV. 809 (2019), https://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=3789&context=wmlr.

[92] *See e.g.*, ACOG, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period: Statement of Policy* (2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period.

[93] *For more on these issues, see* Center for Reproductive Rights and partner reproductive rights and justice organizations' submission: *Suggested List of Themes to the Country Rapporteur and Task Force on the United States for the 106th Session of the Committee on the Elimination of Racial Discrimination, April 11-29, 2022*, available at https://tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/USA/INT_CERD_NGO_USA_48581_E.pdf.

[94] Eulogia and her son Sergio's case are currently before the Inter-American Commission on Human Rights' merits stage. The Admissibility Report was issued on April 4, 2014. See, Admissibility Report, No. 35/14, Petition No. 1334-09, April 4, 2014, OEA/Ser.L/V/II.150, http://www.oas.org/es/cidh/decisiones/2014/PEAD1334-09ES.pdf.

[95] PROMSEX. *Eulogia, Hechos del Caso*, https://incidenciainternacional.promsex.org/2020/06/23/eulogia/.

[96] Center for Reproductive Rights and PROMSEX, *Case of Eulogia Guzmán and her son Sergio v. Perú*, p.4 (2022).

[97] Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018) (noting, "The care provided to indigenous people who are often at the lower ends of social and economic hierarchies tends to be non-evidence-based, risky and even harmful . . . It is also often rife with cultural bias and insensitivity, making the experience of childbirth physically and emotionally traumatic by forcing indigenous women who are used to delivering in squatting or other positions to deliver lying down, not allowing companionship, or insisting on unauthorised discharge of the placenta, which can carry deep cultural and spiritual significance.").

[98] National Institute of Population Studies, *Pakistan Maternal Mortality Survey* (2019).

[99] 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, U.N.T.S. 13 (*entered into force* Sept. 3, 1981).

[100] CEDAW Committee, *Gen. Recommendation No. 24*, para. 31(e).

[101] CESCR Committee, *Gen. Comment No. 14*, para. 12; CEDAW Committee, *Gen. Recommendation No. 24*, paras. 26, 27; CESCR Committee, *Gen. Comment No. 22*, para. 45.

[102] CESCR Committee, *Gen. Comment No. 22*, paras.7-8; Human Rights Committee, *Gen. Comment No. 36*, para. 26; CESCR Committee, *Gen. Comment No. 14*, paras. 4, 10 – 12; CRC Committee, *Gen. Comment No. 20*, para.57; CRC Committee, *Gen. Comment No. 15*, paras. 5, 13, 17.

[103] Human Rights Committee, *Gen. Comment No. 36*, para. 26. *See also* Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Reducing maternal mortality: the contribution of the right to health*, paras. 31-36, U.N. Doc. A/61/338 (2006).

[104] CESCR Committee, *Gen. Comment No. 14,* para. 20; CESCR Committee, *Gen. Comment No. 20*, para. 20; CEDAW Committee, *Gen. Recommendation No. 9*; CRC Committee, *General Comment No. 5*, para. 45; CRC Committee, *Gen. Comment No. 20*, para. 37(c); CEDAW Committee, *Concluding Observations: Romania*, paras. 40-41, U.N. Doc. CEDAW/C/ROU/CO/7-8 (2017); CEDAW Committee, *Concluding Observations: Lesotho*, paras. 32-33, U.N. Doc. CEDAW/C/LSO/ CO/1-4/Add.1 (2013). *See also* 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*, paras. 43-44, 81(t), U.N. Doc. A/74/137 (2019) (The Special Rapporteur on violence against women has also recognized the "aggravating negative impact" of intersectional discrimination in maternal health care, noting, among other examples, the discriminatory practice of segregating women within maternal health facilities based on race or ethnicity, and stating that "appropriate legal and policy responses are needed in this regard."); Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Reducing maternal mortality: the contribution of the right to health*, para. 17(c), U.N. Doc. A/61/338 (2006) (…this entails

services that are "sensitive to gender and to the rights and cultures of minorities and indigenous peoples" and "may require addressing discriminatory laws, polices, practices and gender inequalities that prevent women and adolescents from seeking good quality services.").

[105] Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, para. 7.7, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).

[106] *Id.* para 8.

[107] See, for example, María Mamérita Mestanza Chávez v. Peru. Petition 12.191, Report No. 71/03. Friendly settlement of 22 October. Washington, DC, InterAmerican Commission on Human Rights, 2003; WHO, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement*, p.5 (2014).

[108] WHO, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement*, p.4 (2014).

[109] OHCHR, *Background paper on the role of the judiciary in addressing the harmful gender stereotypes related to sexual and reproductive health and rights* (2016); WHO, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement* (2014); 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*, para. 21, UN. Doc. A/74/137 (2019). Under these circumstances, health care providers substitute their own views and beliefs about their patient's procreation, rather than securing the patient's informed consent to the procedure. The UN Special Rapporteur on torture has noted the paternalistic assumptions underlying this practice: "the administration of non-consensual medication or involuntary sterilization is often claimed as being a necessary treatment for the so-called best interest of the person concerned." He references the International Federation of Gynecology and Obstetrics ethical guidelines, which note that "sterilization for the prevention of future pregnancy cannot be ethically justified on grounds of medical emergency. Even if a future pregnancy may endanger a woman's life or health, she must be given the time she needs to consider her choice. Her informed decision must be respected, even if it is considered liable to be harmful to her health." Juan Méndez, *Report of the UN Special Rapporteur on torture and other cruel, inhuman and degrading treatment,* paras. 32-33, U.N. Doc. A/HRC/22/53 (2013); see also WHO, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement* (2014).

[110] *See, e.g*, Open Society Foundations, ON THE MARGINS: ROMA AND PUBLIC SERVICES IN SLOVAKIA, (2001), pp. 62-70; Center for Reproductive Rights & Poradňa pre občianske a ľudské práva, BODY AND SOUL, FORCED STERILIZATION AND OTHER ASSAULTS ON ROMA REPRODUCTIVE FREEDOM (2003).

[111] *See, e.g.*, Human Rights Committee, *Concluding Observations: Slovakia*, paras. 26-27, U.N. Doc CCPR/C/SVK/CO/4 (2016). *See also* ERRC, COERCIVE AND CRUEL: STERILISATION AND ITS CONSEQUENCES FOR ROMANI WOMEN IN THE CZECH REPUBLIC (1966-2016) (2016), *available at* http://www.errc.org/uploads/upload_en/file/coercive-and- cruel-28-november-2016.pdf; Center for Reproductive Rights & Poradňa pre občianske a ľudské práva, VAKERAS ZORALES – SPEAKING OUT: ROMA WOMEN'S EXPERIENCES IN REPRODUCTIVE HEALTH CARE IN SLOVAKIA (2017), https://www.reproductiverights.org/sites/crr.civicactions.net/files/webform/GLP- SlovakiaRomaReport-Final-Print.pdf; *How to apply for compensation for illegally performed sterilization in the Czech Republic* (21 Dec. 2021), http://www.romea.cz/en/news/czech/how-to-apply-for-compensation-for-illegally-performed-sterilization-in-the-czech-republic; Poradňa pre občianske a ľudské práva (Center for Civil and Human Rights), *As the Slovak Government apologises for forcible sterilisations of Romani women today, the next step must be compensating them* (24 Nov. 2021), https://poradna-prava.sk/en/news/as-the-slovak-government-apologises-for-forcible-sterilisations-of-romani-women-today-the-next-step-must-be-compensating-them/; *The Slovak president Zuzana Čaputová supports compensation of forcibly sterilized Romani women* (3 May 2022), https://poradna-prava.sk/en/news/the-slovak-president-zuzana-caputova-supports-compensation-of-forcibly-sterilized-romani-women/

[112] Lisa Ko, Unwanted Sterilization and Eugenics Programs, PBS (Jan. 29, 2016), https://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states/; Deirdre Owens & Sharla Fett, Black Maternal and Infant Health: Historical Legacies of Slavery, AJPH (Oct. 2019), https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305243.

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[114] SAMA Resource Group for Women, Jan Swasthya Abhiyan, National Alliance for Maternal Health & Human Rights, Camps of Wrongs: The Mourning Afterwards| A fact-finding on sterilization deaths in Bilaspur (2014), https://samawomenshealth.files.wordpress.com/2014/12/camp-of-wrongs-the-mourning-afterwards.pdf; Human Rights Law Network, Mistreatment and Coercion: Unethical Sterilization in India (2018), https://slic.org.in/uploads/2018/10/Mistreatment-and-Coercion-Unethical-Sterilization-in-India-3.pdf; See also recent news reportage e.g., *Mass Sterilisation Camps Violate Norms and Fail Women's Health Needs In Chhattisgarh* (2021), https://behanbox.com/2021/09/28/mass-sterilisation-camps-violate-norms-and-fail-womens-health-needs-in-chhattisgarh/.

[115] See e.g., *Ramakant Rai v. Union of India,* (2009) 16 SCC 565 and *Devika Biswas v. Union of India & Ors*., (2016) 10 SCC 733, cited in Center for Reproductive Rights, *Securing Reproductive Justice in India: A Casebook* (2020)*, https://reproductiverights.org/wp-content/uploads/2020/12/SecuringReproductiveJusticeIndia-Full.pdf*.

[116] See Sulakshana Nandi et al, Denying access of Particularly Vulnerable Tribal Groups to contraceptive services, *Reproductive Health Matters*, vol. 26, no. 54, 2018, pp. 84–97.

[117] *See, e.g.*, A.S. v. Hungary, CEDAW Committee, Commc'n No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (2006); Human Rights Committee, *Concluding Observations: Czech Republic*, para. 10, U.N. Doc. CCPR/C/CZE/CO/2 (2007); Human Rights Committee, *Concluding Observations: Slovakia*, para. 12, U.N. Doc. CCPR/CO/78/SVK (2003); Human Rights Committee, *Concluding Observations: Peru*, para. 21, U.N. Doc. CCPR/CO/70/PER (2000); CEDAW Committee, *Concluding Observations: Czech Republic*, paras. 23-24, U.N. Doc. CEDAW/C/CZE/CO/3 (2006); CEDAW Committee, *Concluding Observations*: *Hungary*, paras. 8-9, U.N. Doc. CEDAW/C/HUN/CO/6

(2007); CEDAW Committee, *Concluding Observations*: *Peru*, paras. 484-485, U.N. Doc. A/57/38, Supp. No. 38 (2002); CAT Committee, *Concluding Observations: Czech Republic*, paras. 5(k), 6(n), U.N. Doc. CAT/C/CR/32/2 (2004); CAT Committee, *Concluding Observations: Peru*, para. 23, U.N. Doc. CAT/C/PER/CO/4 (2006); CAT Committee, *Concluding Observations: Peru*, para. 19, U.N. Doc. CAT/C/ PER/CO/5-6 (2013); CAT Committee, *Concluding Observations: Czech Republic,* para. 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012); Committee on the Elimination of Racial Discrimination (CERD Committee), *Concluding Observations: Czech Republic*, para. 14, U.N. Doc. CERD/C/CZE/CO/7 (2007); CERD Committee, *Concluding Observations: Slovakia*, para. 12, U.N. Doc. CERD/C/65/CO/7 (2004); CRPD Committee, *Gen. Comment No. 3,* paras. 44, 63(a); CRPD Committee, *Gen. Comment No. 1,* para. 35; CESCR Committee*, Gen. Comment No. 22*, para. 57; CEDAW Committee, *Gen. Recommendation No. 24,* para. 22; *See also,* CEDAW Committee, *Gen. Recommendation No. 35*, para. 18; Human Rights Committee, *Gen. Comment No. 28*, para. 20.

[118] CERD Committee, *Gen. Recommendation No. 25*, para. 2.

[119] CEDAW Committee, *Gen. Recommendation No. 35*, para. 18.

[120] CEDAW Committee, *Gen. Recommendation No. 33*, para. 19(d); CEDAW Committee, *Concluding Observations: Slovakia*, para. 33(d), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); CEDAW Committee, *Concluding Observations: Barbados*, paras. 41-42, U.N. Doc. CEDAW/C/BRB/CO/5-8 (2017).

[121] Women and girls in conflict are also subjected to a range of other sexual and reproductive rights violations, from "forced marriage, forced prostitution and forced impregnation to forced termination of pregnancy and sterilization." CEDAW Committee, *Gen. Recommendation No. 30*, para. 34.

[122] CERD Committee, *Gen. Recommendation No. 25*, para. 2. *See also* Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *The right to health in conflict situations*, para. 49, U.N. Doc. A/68/297 (2013) ("the use of gender-based violence as a strategy of conflict has been well documented. Such violence can include incestuous rape and public rape, rape as a deliberate vector of HIV, camps specifically designed for forced impregnation of women, and premeditated rape as a tool of political repression. Women and girls are common targets of sexual violence . . . [and] armed groups may also specifically target sex workers, sexual and ethnic minorities and other communities as a tool for "social cleansing" of "undesirable elements".").

[123] CEDAW Committee, *Gen. Recommendation No. 30*, para. 36. See also Special Rapporteur on the situation of human rights defenders, *Human rights defenders operating in conflict and post-conflict situations*, para. 28, U.N. Doc. A/HRC/43/51 (2019).

[124] States fail to prioritize sexual and reproductive health services in their responses to conflict, as they "are typically not considered essential or urgent." U.N. Working Group on discrimination against women and girls, *Women's and girls' sexual and reproductive health rights in crisis*, para. 33, U.N. Doc. A/HRC/47/38 (2021).

[125] CEDAW Committee, *Gen. Recommendation No. 30*, para. 50.

[126] The failure to prioritize sexual and reproductive health services in conflict situations leaves migrant, refugee and internally displaced women without critical support and health care. As the Working Group on Discrimination against Women and Girls has found: "In some destination countries, migrant women have been put in detention centres, denied basic reproductive health goods and services and subjected to non-consensual and medically unnecessary reproductive health procedures." U.N. Working Group on discrimination against women and girls, *Women's and girls' sexual and reproductive health rights in crisis*, paras. 60-61, U.N. Doc. A/HRC/47/38 (2021).

[127] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *The right to health in conflict situations*, para. 43, U.N. Doc. A/68/297 (2013).

[128] United Nations Security Council, Report of the Secretary General on Conflict-Related Sexual Violence, para. 55, S/2018/250, (23 March 2018).

[129] INTER AGENCY WORKING GROUP, WOMEN AND GIRLS CRITICALLY UNDERSERVED IN ROHINGYA REFUGEE RESPONSE (2018), *available at* https://reliefweb.int/sites/reliefweb.int/files/resources/IAWG%20Statement%20on%20Rohingya%20Humanitarian%20Response.pdf .

[130] *Id.*

[131] Saferworld, Doing right by women and girls in Cox's Bazaar (2019).

[132] U.N. Office of the High Commissioner for Human Rights (OHCHR), *Comprehensive approach to promoting, protecting and respecting women's and girls' full enjoyment of human rights in humanitarian situations*, U.N. Doc. A/HRC/49/37 (2022); see also U.N. Working Group on discrimination against women and girls, *Women's and girls' sexual and reproductive health rights in crisis*, para. 37, U.N. Doc. A/HRC/47/38 (2021).

[133] Center for Reproductive Rights, *Implementing rights-based accountability for sexual and reproductive health and rights in humanitarian settings: Good-practice case study from Adjumani district*, northern Uganda (2022), *available at* https://reproductiverights.org/wp-content/uploads/2022/05/Implementing-rights-based-accountability-for-SRHR-in-humanitarian-settings.pdf.

[134] CEDAW Committee, *Gen. Recommendation No. 30,* para. 2; CRC Committee, *Gen. Comment No. 20,* para. 79; CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, para. 10(d), U.N. Doc. CEDAW/C/COD/CO/8 (2019); Human Rights Committee, *Gen. Comment No. 36,* paras. 2, 10, 64; CESCR Committee, *Gen. Comment No. 14,* paras. 40, 65; CESCR Committee, *Gen. Comment No. 3,* para. 10.; Human Rights Committee, *General Comment No. 31*, para. 11; Human Rights Committee, *General Comment No. 29*, para. 3; Legality of the Threat or Use of Nuclear Weapons, Advisory Opinion, 1996 I.C.J., para. 22 (July 8); Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory, Advisory Opinion, 2004 I.C.J., para. 106 (July 9); Armed Activities on the Territory of the Congo (Democratic Republic of the Congo v. Uganda), Judgment, 2005 I.C.J., para. 216 (Dec. 19); Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, art. 11, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611, (*entered into force* May 3, 2008); Convention on the Rights of the Child, *adopted* Nov. 20, 1989, arts.22, 38, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Jan. 3, 1976); CRC Committee, *Gen. Comment No. 20,* paras. 79, 80; CESCR Committee*, Gen. Comment No. 22*, paras. 30, 31.

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

[136] CEDAW Committee, *Gen. Recommendation No. 30;* CEDAW Committee, *Concluding Observations: Central African Republic*, para. 40(b), U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014). *See also,* CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, paras. 35-36, U.N. Doc. CEDAW/C/COD/CO/5 (2006).
[137] CEDAW Committee, *Gen. Recommendation No. 30*, para. 57(b).
[138] Cottingham, Jane, et. al., *Using human rights for sexual and reproductive health: improving legal and regulatory frameworks*. Bulletin of the World Health Organization 2010; 88:551-555.
[139] *See, for example*, CESCR Committee, *Gen. Comment No. 22*, paras. 33, 45, 49(b).
[140] 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 (2012) (Remedies may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. Remedies may be administrative, but appeal to judicial review from administrative proceedings will often be appropriate. Remedies may also be provided through a national human rights institution. In all cases, remedies should be accessible, affordable, timely and effective, which will require adequate funding, capacity and mandates... To ensure the effective use of remedies, the State must systematically raise awareness about the applicability of claims relating to women's sexual and reproductive health rights among lawyers, judges and the public, and provide adequate funding for accountability mechanisms*).*
[141] *Id.*
[142] *Id.* at pgs. 11-14.
[143] This Committee acknowledged this reality in the context of health most recently in a statement on COVID-19, noting that the unequal distribution of COVID-19 vaccines "replicates slavery and colonial-era racial hierarchies; and which further deepens structural inequalities affecting vulnerable groups protected under the Convention." CERD Committee, *Statement 2 (2022): Statement on the lack of equitable and non-discriminatory access to COVID-19 vaccines*, p.2 (2022).
[144] CESCR Committee, *Gen. Comment No. 22*, para. 61.
[145] *Id.* at para. 63 (emphasis added).
[146] *Id.* at para. 49.