**Submission from the Center for Reproductive Rights following the call for written submissions related to the Day of General Discussion organized by the Committee on the Rights of Persons with Disabilities regarding article 11 of the Convention**

**28 February 2023**

**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 fulfil. Since its inception 30 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 (SRH) 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 the Committee on the Rights of Persons with Disabilities will hold in March 2023 and support the Committee in elaborating a general comment on persons with disabilities in situations of risk and humanitarian emergencies. This submission will focus on the State party’s obligations for Sexual and Reproductive Health and Rights (SRHR) in Humanitarian Settings pursuant to article 11 of the Convention on the Rights of Persons with Disabilities.

1. **Introduction**

This submission is based in the consideration that humanitarian[[1]](#endnote-1) and risk situations exacerbate pre-existing and create new patterns and systems of discrimination and inequalities, and further undermine access to health services and information, disrupt protection systems, resulting in a disproportionately negative impact on the enjoyment of human rights by women and girls[[2]](#endnote-2) and other persons of diverse sexual orientations, gender identities and expressions, and sex characteristics (SOGIESC) with disabilities. It specifically refers to the multiple and intersecting forms of discrimination which create additional barriers to access sexual and reproductive health services and information.

A General comment on Art. 11 on the CRPD Convention is an opportunity to fill the lack of comprehensive and robust standards and guidance on the SRHR of women and girls with disabilities in risk and humanitarian settings and guide the development of standards from a human rights based approach. International human rights law needs to address the intersectional discrimination faced by women and girls with disabilities[[3]](#endnote-3) and to establish clear and positive legal obligations for States to identify and remedy its root causes. The Committee on the Rights of Persons with Disabilities (CRPD Committee), as the body which monitors implementation of the Convention on the Rights of Persons with Disabilities (CRPD Convention) by the States parties, has thus the unique opportunity to guide these efforts in a very critical moment considering the increase of humanitarian situations and protracted crisis around the world[[4]](#endnote-4) and the number of persons with disabilities impacted by these situations. The Committee has also an opportunity to weigh in from a disabilities rights perspective within the broader debate on women and girls in humanitarian settings.[[5]](#endnote-5)

Importantly, in 2020, the Human Rights Council adopted by consensus its first resolution on the rights of women and girls in humanitarian settings.[[6]](#endnote-6) This resolution was adopted within a broader framework of growing momentum and political will around the issue of accountability for women’s and girls’ human rights in humanitarian settings. This resolution built on previous efforts by the Council to give attention to this issue as a human rights concern.[[7]](#endnote-7) Similarly, human rights investigations established by the Human Rights Council have also adopted a gender-responsive and survivor-centred approach to address the impact of violations suffered by women and girls.[[8]](#endnote-8)

1. *Relevant figures on Women and Girls with Disabilities in Humanitarian Settings*

Women and girls with disabilities account for nearly one-fifth of all women and girls worldwide.[[9]](#endnote-9) And of the 235 million people who needed humanitarian protection and assistance as of 2021, 35 million were persons with disabilities.[[10]](#endnote-10) This marks an alarming increase of 40 per cent over the previous year.[[11]](#endnote-11) Similarly, in 2019, the United Nations Population Fund (UNFPA) estimated that 35 million women and girls of reproductive age required humanitarian assistance for reasons related to conflict and natural disasters.[[12]](#endnote-12) It is also worth noting that in countries designated as fragile states, the estimated lifetime risk of maternal mortality is 1 in 54, compared to a worldwide risk of 1 in 180; notably, 66% of the globe’s maternal deaths occur in fragile settings, totalling more than 500 deaths each day.[[13]](#endnote-13)

1. *Lack of Access to Sexual and Reproductive Health Information and Services in Humanitarian Settings*

Persons with disabilities are among the most marginalized groups when it comes to sexual and reproductive health information and services.[[14]](#endnote-14) They often cannot obtain the most basic information while they usually have greater and more distinct needs for SRH education and care than persons without disabilities due to their increased vulnerability to abuse.[[15]](#endnote-15) They are three times more likely to be victims of physical and sexual abuse and rape.[[16]](#endnote-16) They have often been denied the right to establish relationships and to decide whether, when, and with whom to have a family. Many have been subjected to forced sterilizations, forced abortions, or forced marriages. They are more likely to experience physical, emotional, and sexual abuse and other forms of gender-based violence. They are more likely to become infected with HIV and other sexually transmitted infections (STIs).[[17]](#endnote-17) Furthermore, assumptions by medical staff that women and girls with disabilities need only disability-related services[[18]](#endnote-18), inaccessible buildings and equipment, lack of information in accessible formats, or lack of transportation increase their marginalization.[[19]](#endnote-19)

In humanitarian and risk situations, loss of community support and protection mechanisms puts women and girls with disabilities at an increased risk of gender-based violence, particularly to those with intellectual and psychosocial disabilities.[[20]](#endnote-20) The lack of access to education deprives them of access to informal information networks on safety, gender-based violence, and relationships,[[21]](#endnote-21) making them less likely to tell others about or seek assistance for instances of violence and abuse.[[22]](#endnote-22)

1. *Multiple and intersecting forms of discrimination*

The CRPD Convention has been critical in the recognition of the intersections between discrimination based on disability and on other grounds such as, *inter alia*, gender, age, sexual orientation, gender identity and sex characteristics.[[23]](#endnote-23) Across the Convention there is consistent emphasis on the need to incorporate a gender sensitive perspective into its implementation.[[24]](#endnote-24) In its General Comment no. 3 the CRPD Committee expressly states that harmful intersectional stereotyping, such as those based on gender and disability, can lead to structural or systemic discrimination that are intrinsically linked to a lack of adequate law enforcement and programs.[[25]](#endnote-25) It has also highlighted that intersectional discrimination including against “indigenous women; refugees, migrant, asylum seekers and internally displaced women; and women from different ethnic, religious and racial backgrounds”[[26]](#endnote-26) requires a particularized and targeted response.[[27]](#endnote-27)

Similarly, the Committee on Economic, Social and Cultural Rights’ (CESCR Committee) General Comment no. 22 also provides a comprehensive explanation of non-discrimination, including multiple and intersecting grounds of discrimination, in relation to the sexual and reproductive health and rights.[[28]](#endnote-28) It notes that individuals belonging to particular groups may be disproportionately affected by intersectional discrimination in the context of sexual and reproductive health.[[29]](#endnote-29) The Committee on the Elimination of Racial Discrimination (CERD Committee) and the Committee on the Elimination of Discrimination against Women (CEDAW Committee) have recognized that women experience intersectional discrimination and violence, especially sexual violence[[30]](#endnote-30) in conflict and post-conflict settings, and that these violations disproportionately impact women and girls from particular racial or ethnic groups.[[31]](#endnote-31)

In the context of sexual and reproductive health and rights, as with other rights, an intersectional analysis of discrimination based on disability, gender, 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 to perpetuate and further entrench that experience of discrimination.[[32]](#endnote-32)

1. **Normative Content** 
   1. **International Human Rights Law**

International human rights law (IHRL), continues to apply during humanitarian and risk situations, including during armed conflict[[33]](#endnote-33) and provides the most robust standards on SRHR than any other body of international law. These standards are complementary to those in international humanitarian and criminal law and can and should be used as interpretative tool for gaps in other branches of international law.[[34]](#endnote-34)

While IHRL allows for limitations on some rights during emergencies. However, any derogation has limitations and cannot be used as an ongoing excuse to fail to implement human rights obligations in emergencies. There are clear and narrow criteria controlling the scope and the circumstances under which derogability may be permissible to derogate from the implementation of human rights, such as the principle of proportionality.[[35]](#endnote-35) In addition, limitations must not be discriminatory, which includes discrimination against persons with disabilities.[[36]](#endnote-36) Similarly, there are non-derogable rights that do not allow for any limitations or derogations under any circumstances, including in emergencies, humanitarian and risk contexts, or even during armed conflict. The Human Rights Committee’s General Comment 29 notes that State parties may under no circumstances invoke article 4 of the International Covenant on Civil and Political Rights in a way that would result in the derogation of a non-derogable right or as justification for violating humanitarian law, peremptory norms of international law, or international criminal law (ICL).[[37]](#endnote-37)

There are two non-derogable rights in United Nations (UN) treaties bodies that are particularly important in the context of SRHR: the right to life and the prohibition of torture and other cruel, inhuman, or degrading treatment or punishment.[[38]](#endnote-38)

1. *The Right to Life*

The Human Rights Committee’s General Comment no. 36 regarding State’s obligations to protect the right to life, includes prevention of maternal mortality[[39]](#endnote-39) including requiring that States ensure access to abortion.[[40]](#endnote-40) Further, the Human Rights Committee notes that the duty to protect life 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,[[41]](#endnote-41) e.g., ensuring access to essential goods and services, including health care, developing campaigns for raising awareness of gender-based violence and harmful practices, and improving access to medical examinations and treatments designed to reduce maternal and infant mortality.[[42]](#endnote-42) These actions need to also take into account the intersectional needs of women and girls with disabilities to protect their lives in humanitarian and risk situations.

1. *The Right to Be Free from Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment*

As the Committee against Torture (CAT Committee) has repeatedly stated, the right to be free from torture and cruel, inhuman, and degrading treatment (TCIDT) carries with it non-derogable State obligations to prevent, punish, and redress violations of this right. The CAT, Human Rights and CEDAW Committees have found that denying or delaying safe abortion or post-abortion care may amount to TCIDT.[[43]](#endnote-43) For example, the Committee against Torture has expressed concern that complete bans on abortion may constitute torture or ill-treatment and has specifically refer to the World Health Organization’s abortion care guideline.[[44]](#endnote-44)

Under IHRL, States bear responsibility for acts of torture or ill-treatment committed also by non-State or private actors as part of their due diligence obligations.[[45]](#endnote-45) Furthermore, States’ obligations to prevent, punish, and redress torture and ill-treatment apply also to “contexts of custody or control, for example, […] hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled […] and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm.”[[46]](#endnote-46) This protection extends to both public and private educational settings, for example, where girls are subjected to sexual violence at the hands of teachers and administrators who exercise control and authority over them.[[47]](#endnote-47) It also includes the specific vulnerabilities involving “reproductive decisions, and violence by private actors in communities and homes,”[[48]](#endnote-48) The violation of these legal provisions occur “on the basis of their actual or perceived non-conformity with socially determined gender roles.”[[49]](#endnote-49) A clear example of this is the ill-treatment of women who seek post-abortion care, which is often a form of punishment for noncompliance with their traditional role as child-bearers.[[50]](#endnote-50)

Regarding consent and bodily and reproductive autonomy, treaty monitoring bodies recognize that States must guarantee women the right to be free from violence when seeking maternal health services. Women seeking health care may experience abuse and mistreatment at the hands of health care personnel, who hold clear positions of authority and often exercise significant control over women in these contexts. These abuses are often exacerbated when the health services they seek, such as abortion, are highly stigmatized.[[51]](#endnote-51)

Treaty monitoring bodies have recognized that women are denied reproductive and bodily autonomy when they are subjected to violence or coercion, including TCIDT, which may include:

1. **Denial of and forced reproductive health procedures,** including forced or coerced sterilization, forced or coerced abortion, and mandatory testing for pregnancy or sexually transmitted diseases, all of which violate women’s rights to health-related decision-making and informed consent.[[52]](#endnote-52)

Coercive sterilization is a grave human rights violation that is frequently targeted at women and girls facing intersectional discrimination, such as women and girls with disabilities, HIV positive, and indigenous women and girls.[[53]](#endnote-53) Experts recognize that the permanent deprivation of one’s reproductive capacity and bodily autonomy without informed consent generally results in psychological trauma, including depression and grief.[[54]](#endnote-54)

The CRPD has confirmed that any medical procedure or intervention performed without free and informed consent, including procedures and interventions related to contraception and abortion may be considered as cruel, inhuman or degrading treatment or punishment and as breaching a number of international human rights treaties.[[55]](#endnote-55) Other UN treaty monitoring bodies have also stated that coercive sterilization violates the right to be free from torture and CIDT[[56]](#endnote-56) as well as women’s rights to informed consent and dignity.[[57]](#endnote-57) They have repeatedly emphasized the need to obtain informed consent for sterilization procedures.[[58]](#endnote-58)

Similarly, Special Procedures have asserted that forced sterilization is a method of medical control that violates women’s physical integrity and security that constitutes violence against women.[[59]](#endnote-59) The Special Rapporteur on Torture has emphasized that forced abortions and sterilization of women with disabilities may constitute torture or CIDT when they are conducted with the legal consent of the person’s guardian but against the disabled woman’s will.[[60]](#endnote-60) The Special Rapporteur has also asserted that “forced abortions or sterilizations carried out by State officials in accordance with coercive family planning laws or policies may amount to torture[….].”[[61]](#endnote-61)

In addition to such coercive procedures, women and girls seeking reproductive health care services may experience denial of care due to discrimination, stigma, and negative gender stereotypes. The UN Special Rapporteur on Torture has noted that “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” under paternalistic assumptions.[[62]](#endnote-62) In many instances, for example, abortion and post-abortion medical care are necessary to safeguard women’s and girls’ lives and health. But all too often, women and girls are denied access to these medical services due to restrictive laws and policies or health care personnel’s decision not to provide legal services because of their own objections or discriminatory attitudes toward the woman seeking services.

**ii. Restrictive abortion laws,** human rights bodies have recognized that, denial of a service may violate the right to be free from torture or CIDT. International and regional human rights bodies have long recognized that restrictive abortion laws violate women’s human rights, including their right to be free from TCIDT, and States have an obligation to liberalize restrictive laws.[[63]](#endnote-63) In every single abortion related case before the Human Rights Committee, it found a violation of article 7 of the Convention.[[64]](#endnote-64) In addition, they have affirmed that in cases where abortion is legal, abortion services need to be safe and available, accessible, acceptable and of good quality.[[65]](#endnote-65) However, women are often denied access to abortion arguably with the discriminatory and improper purpose of discouraging them from terminating a pregnancy. This denial can cause tremendous pain and suffering and have long-lasting consequences for women’s health and lives.

**iii. Harmful traditional practices**, constitute a form of gender-based violence against women and girls that may amount to torture or cruel, inhumane or degrading treatment.[[66]](#endnote-66) Such practices are deeply rooted in discrimination on the basis of sex, gender, age and disability and have serious implications for reproductive and bodily autonomy.[[67]](#endnote-67) Specifically, child, early, and forced marriages can increase levels of violence and limit women’s opportunities for decision-making, particularly when it comes to sexuality and reproduction.[[68]](#endnote-68) Child, early, and forced marriage is often accompanied by early and frequent pregnancy and childbirth, which also results in increased maternal mortality rates.[[69]](#endnote-69) This practice triggers a continuum of human rights violations that continue throughout a girl’s life.

The treaty monitoring bodies are also concerned with the high prevalence of female genital mutilation (FGM).[[70]](#endnote-70) They have noted that there is no medical reason for FGM and explain that the practice can cause immediate and long-term health consequences, including shock, severe pain, infections, complications during childbirth, and other long-term gynecological problems.[[71]](#endnote-71) States must take immediate measures to address these harmful traditional practices by, *inter alia*,sharply reducing child and early marriage[[72]](#endnote-72) and providing immediate support services, including medical, psychological, and legal services, to women and girls who have undergone FGM.[[73]](#endnote-73)

**iv. Violence against women and girls in childbirth,** treaty monitoring bodies have recognized that the disrespect and abuse women face in maternal health facilities can amount to ill-treatment, including when women are detained and abused post-delivery for the inability to pay their maternal health care bills[[74]](#endnote-74) and when incarcerated women are shackled to beds during labor and delivery.[[75]](#endnote-75)

Additionally, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has noted that “[i]n many States women seeking maternal health care face a high risk of ill-treatment, particularly immediately before and after childbirth. Abuses range from extended delays in the provision of medical care, such as stitching after delivery to the absence of anaesthesia. Such mistreatment is often motivated by stereotypes regarding women’s childbearing roles and inflicts physical and psychological suffering that can amount to ill-treatment*.*”[[76]](#endnote-76) In addition, persons with disabilities are very often perceived as asexual or sexually inactive and their desires to become parents as well as their sexual and reproductive rights are frequently ignored.[[77]](#endnote-77) The CEDAW Committee has also expressed concern that women are often not consulted during delivery and are subjected to overly medicalized births. It has called for safeguards to ensure that overly medical procedures during childbirth, such as caesarean sections, only be carried out when necessary and with the patient’s informed consent.[[78]](#endnote-78)

1. *Economic Social and Cultural Rights*

Under IHRL, the concept of progressive realization to the maximum extent of States’ available resources[[79]](#endnote-79) is restricted by the obligation of “taking steps” toward the realization of rights and respect of non-retrogression.[[80]](#endnote-80) Measures adopted by States during risk and humanitarian situations, such as the diversion of financial and human resources away from sexual and reproductive health care and the imposition of restrictions on services, amount in practice to a retrogression incompatible with States’ human rights obligations.[[81]](#endnote-81)

States must respect core obligations ensuring non-discrimination[[82]](#endnote-82) and the satisfaction of minimum essential levels of rights, including the right to SHRH.[[83]](#endnote-83) The core obligation to ensure the satisfaction of minimum essential levels of SRHR includes the duties to guarantee universal and equitable access to affordable, acceptable, and quality SHRH services, goods, and facilities, particularly for women and disadvantaged and marginalized groups; ensure that all individuals and groups have access to comprehensive education and information on SHRH; and that such services are non-discriminatory, non-biased, evidence based, and cognizant of the evolving capacities of children and adolescents.[[84]](#endnote-84) There are further legal and policy duties such as the repealing or elimination of laws, policies, and practices that criminalize, obstruct, or undermine an individual’s or group’s access to SRH facilities, services, goods, and information, and to ensure access to effective and transparent remedies and redress for violations of the right to SRH.[[85]](#endnote-85)

Notably, in outlining states’ core obligations of the right to sexual and reproductive health, the CESCR Committee notes that States should be guided by the current international guidelines established by UN agencies, in particular the World Health Organization (WHO).[[86]](#endnote-86) The WHO, in its most recent Abortion Care Guideline recommends the full decriminalization of abortion[[87]](#endnote-87) and against laws and other regulations that restrict abortion. It recommends that abortion be available on the request of the woman, girl or other pregnant person.[[88]](#endnote-88) It further recommends against gestational age limits,[[89]](#endnote-89) mandatory waiting periods for abortion[[90]](#endnote-90) and third-party authorization.[[91]](#endnote-91) The WHO’s Abortion Care Guideline provides public health evidence to support its law and policy recommendations and consistently refers to discrimination, as reflected in the evidence-base, as playing a part in hindering access to abortion services.[[92]](#endnote-92) Furthermore, WHO has specifically reiterated that especially in times of crisis States should eliminate legal and administrative barriers to SRH services states including abortion.[[93]](#endnote-93)

1. *Discrimination against women and girls in conflict and post-conflict situations and access to reparations*

CEDAW general recommendation no.30 has come to address the rights of women and girls during armed conflict covering a wider spectrum of SHR beyond the protection against SGBV.[[94]](#endnote-94) It specifically urges States to “adopt strategies and take measures addressed to the particular needs of women in states of emergency” rather than suspending rights protections.[[95]](#endnote-95) In particular, CEDAW Committee calls States to prioritize the provision of sexual and reproductive health services, including safe abortion services, noting with concern the effects of conflict on SRHR and maternal mortality.[[96]](#endnote-96)

The CEDAW Committee specifically refers to the obligation to ensure the provision of adequate and comprehensive reparations, and address all gender-based violations, including sexual and reproductive rights violations.[[97]](#endnote-97) States parties to the Convention must also ensure redress for the acts of private individuals or entities, as part of their due diligence obligation.[[98]](#endnote-98) Application and enforcement of human rights standards within humanitarian settings and programs help strengthen accountability for access to SRH services.[[99]](#endnote-99)Accountability for SRHR violations requires the provision of reparations.[[100]](#endnote-100) Reparations must be timely, effective, transformative and address root causes of violations including, among other things, guarantees of non-recurrence and rehabilitation such as the removal of “specific barriers women and girls may face in seeking justice by establishing confidential and non-biased processes to receive and address complaints and make meaningful changes to services.”[[101]](#endnote-101)

1. **International Humanitarian Law (IHL)**

IHL requires parties to armed conflicts to afford special respect and protection to persons with disabilities and help ensure their inclusion.[[102]](#endnote-102)A number of weapons-related treaties prohibit the use of particular weapons aiming to prevent certain disabilities from occurring. These treaty provisions also seek to ensure that victims receive appropriate assistance.[[103]](#endnote-103) In addition to IHL, IHRL – particularly the CRPD Convention and its Optional Protocol – contains important protections. For example, the CRPD Convention recognizes States Parties’ obligations under, IHL and IHRL to ensure the protection and safety of persons with disabilities in humanitarian and situations, including armed conflict, humanitarian emergencies and natural disasters.[[104]](#endnote-104)

The general safeguards provided by the principle of humane treatment and the prohibition of adverse distinction under IHL guide States obligations on SRHR, especially in relation to the protection of women’s health, the prohibition of sexual violence and access to abortion. These specific provisions must be read in light of IHRL obligations on TCIDT and non discrimination to ensure effective and comprehensive protection of SRHR of women and girls with disabilities in humanitarian and risk situations. States have an obligation to adopt and apply domestic measures to implement IHL, including with respect to persons with disabilities in both wartime and peacetime. Some of these measures may require new legislation or regulations to be adopted, educational or assistance programmes, recruitment or training of personnel, or the introduction of new planning and administrative procedures. [[105]](#endnote-105)

1. *Adverse distinction*

Under IHL, parties to a conflict must treat all civilians and persons who are *hors de combat* without “adverse distinction.”[[106]](#endnote-106) The International Committee of the Red Cross (ICRC) describes IHL’s approach to the prohibition of adverse distinction as similar to IHRL’s approach to the prohibition of discrimination.[[107]](#endnote-107) This requires taking all feasible measures to remove and prevent the raising of any barriers that persons might face in gaining access to services or protection provided under IHL on par with other civilians and persons *hors de combat*.[[108]](#endnote-108) The general protections afforded to ‘adverse’ means differences in, or preferential treatment based on a person’s specific needs, including in relation to disabilities[[109]](#endnote-109).

Internally displaced persons (IDPs) with disabilities are also entitled to special respect and protection. The United Nations Guiding Principles recognize that certain IDPs “shall be entitled to protection and assistance required by their condition and to treatment which takes into account their special needs”.[[110]](#endnote-110) They are also entitled to receive “to the fullest extent practicable and with the least possible delay” medical care and attention “without distinction on any grounds other than medical ones”.[[111]](#endnote-111)

The prohibition of adverse distinction is found throughout the Geneva Conventions, and State practice establishes this rule as a norm of customary international law applicable in both international and non-international armed conflicts.[[112]](#endnote-112)In the context of services, including health services, IHL requires services meets a person’s specific needs.[[113]](#endnote-113) Importantly, the ICRC’s 2016 Commentary notes that “sex is traditionally recognized as justifying, and in fact requiring, differential treatment.”[[114]](#endnote-114) Grounds for non-adverse distinction could also be found in an awareness of how the social, economic, cultural or political context in a society forms roles or patterns with specific statuses, needs and capacities that differ among men and women of different ages and backgrounds. Thus, taking such considerations into account is no violation of the prohibition of adverse distinction, but rather contributes to the realization of humane treatment.[[115]](#endnote-115)

1. *Humane Treatment*

Under IHL,humane treatment requires that non-combatants, be treated with respect for their person and honour.[[116]](#endnote-116) Persons with disabilities benefit from the general obligation under IHL to treat every person humanely, in all circumstances, and without any adverse distinction[[117]](#endnote-117) founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.[[118]](#endnote-118) Implementing the obligation to treat persons humanely also means, for example, taking into account the specific physical and mental conditions, as well as the environmental barriers, affecting persons with disabilities.[[119]](#endnote-119)

The obligation humane treatment it is set forth in common article 3 of the Geneva Conventions, as well as in specific provisions of all four Conventions.[[120]](#endnote-120) This requirement is also recognized as a fundamental guarantee by Additional Protocols I and II.[[121]](#endnote-121) It is considered a norm of customary international law from which there can be no derogation, applicable in both international and non-international armed conflict.[[122]](#endnote-122) **C**ustomary IHL holds that that IHRL complements and shapes the understanding of humane treatment and specifically refers to the right to be free from cruel, inhuman, or degrading treatment or punishment as an analogous protection in IHRL.[[123]](#endnote-123) IHL’s prohibition of adverse distinction allows for differentiated treatment that in fact serves the purpose of realizing a person’s humane treatment. This is an important recognition, particularly in the area of SRHR, given that some of the challenges concerning the availability and accessibility of SRH information and services exist because of sex, gender, and sexual orientation, as well as related harmful gender stereotypes. [[124]](#endnote-124)

1. *Women and health in IHL*

Rule 134 of customary IHL provides that “[t]he specific protection, health and assistance needs of women affected by armed conflict must be respected” and notes that the rule should be viewed in the light of the “prominent place of women’s rights in human rights law.”[[125]](#endnote-125)ICRC’s 2016 Commentary, also notes that this norm requires “equal respect, protection and care based on all the needs of women” taking into account “the distinct set of needs of and particular physical and psychological risks facing women, including those arising from social structures”.[[126]](#endnote-126) IHL also provides a framework to ensure that persons with disabilities receive the medical care they required, to the fullest extent practicable, with the least possible delay and without discrimination.[[127]](#endnote-127) It further allows to state that the denial of medical treatment may constitute cruel or inhuman treatment, an outrage upon human dignity, or even torture, if the necessary criteria are met.[[128]](#endnote-128)

Customary IHL and provisions of IHL treaties require special care for pregnant women and mothers of young children with regard to the provision of food, clothing, medical assistance, evacuation, and transportation.[[129]](#endnote-129) Additional Protocol I provides that the protection and care due to the wounded and sick includes persons with disabilities and also covers maternity cases.[[130]](#endnote-130) Article 55 of the Fourth Geneva Convention also imposes a duty on occupying powers to ensure that the population has access to medical supplies (and affords those neutral states that are appointed as “protecting powers” the right to verify the state of such supplies).[[131]](#endnote-131)

IHL establishes an affirmative duty to provide care for the “wounded and sick” whether civilians or members of armed forces.[[132]](#endnote-132) The cause of the illness or wound, whether it results from an armed attack or from another source, is not to be taken into consideration and includes anyone in need of medical care. [[133]](#endnote-133) “Maternity cases” and “other persons who may be in need of immediate medical assistance or care and survivors of sexual violence, including rape, are also covered by the protections provided for the wounded and sick in armed conflict situations.[[134]](#endnote-134) Such persons are entitled to adequate medical care and priority in treatment based on medical grounds.[[135]](#endnote-135) Customary IHL rule 110 notes that this is an obligation of means and parties must make their “best efforts” to fulfil it, including by permitting humanitarian organizations to assist.[[136]](#endnote-136)

1. *Prohibition of sexual violence*

Customary IHL rule 93 prohibits sexual violence against any person, regardless of sex, in international and non-international armed conflicts.[[137]](#endnote-137) In non-international armed conflicts, sexual violence is prohibited by common article 3 of the Geneva Conventions. Common article 3 prohibits sexual violence in three ways: first, through its obligation of humane treatment;[[138]](#endnote-138) second, through its prohibition of violence to life and person (including mutilation, cruel treatment, and torture);[[139]](#endnote-139) and third, via its prohibition of outrages upon personal dignity.[[140]](#endnote-140) Additional Protocol II related to the protection of victims of non-international armed conflicts similarly prohibits sexual violence through its prohibition of outrages upon personal dignity.[[141]](#endnote-141) Further, article 27 of the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War, provides that, in addition to a general obligation to treat protected persons humanely and protect them from violence, “women shall be especially protected against any attack on their honour, in particular against rape, enforced prostitution, or any form of indecent assault.”[[142]](#endnote-142)

These practices constitute grave violations of IHL and have a long, history on disproportionally impacting women and girls with disabilities during armed conflicts.[[143]](#endnote-143) When directed against them, the view is that they constitute cruel or inhuman treatment in violation of common Article 3, as well as a violation of the prohibition on sexual and other gender-based violence against women and girls that is reinforced by various human rights provisions.[[144]](#endnote-144)

International and national bodies have increasingly acknowledged that sexual violence cannot be dismissed as “collateral damage” of war.[[145]](#endnote-145) Nevertheless, in its current application IHL falls short in guaranteeing access to the full range of SRH information and services for all persons, including survivors of SGBV. The failure to provide medical care or the denial of or forced medical treatment may constitute a violation of international law when, for instance, denying such health care violates the obligation of humane treatment or the prohibition of torture and other ill treatment enshrined in IHL and IHRL.[[146]](#endnote-146)

1. *Abortion*

The European Commission and some European countries, have explicitly recognized that IHL entails an obligation to provide abortion services to victims of rape in armed conflict situations, regardless of the content of national laws.[[147]](#endnote-147) This is an important step towards a more widely expressed state practice under IHL, on abortion that includes ensuring access to abortion on grounds of rape, but also more broadly, and is consistent with obligations under IHRL.[[148]](#endnote-148) As stated in the Vienna Convention on the Law of Treaties, a State party “may not invoke the provisions of its internal law as justification for its failure to perform a treaty.”[[149]](#endnote-149) Furthermore, a Commentary on the Geneva Conventions notes that the Conventions “do not prevent the interpretation of the notion of ‘medical care’ as including abortion.”[[150]](#endnote-150) It also notes that the “provision of non-discriminatory treatment obliges states at a minimum to ensure that all victims have access to the full range of health services, and to refer them to alternative health providers if those services refuse, for moral or legal reasons to provide for abortion.”[[151]](#endnote-151) This approach is consistent with IHRL where treaty monitoring bodies have developed extensive guidance for states that reinforce and complement state’s humanitarian legal obligations. Hence, an interpretation of IHL that is consistent with IHRL obligations includes ensuring access to abortion regardless of national law.[[152]](#endnote-152)

1. **International Criminal Law (ICL)**

Gross violations of human rights and serious violations of humanitarian law could entail individual criminal responsibility, including for members and leaders of non-State armed groups and private military contractors.[[153]](#endnote-153) States must ensure that all human rights violations are properly investigated, prosecuted and punished by bringing the perpetrators to justice.[[154]](#endnote-154)International Criminal Law (ICL) has indeed dealt with aspects of Sex Gender Based Violence (SGBV) and some egregious reproductive rights violations, such as forced sterilization and forced pregnancy.[[155]](#endnote-155) For example, the International Criminal Tribunal for the Former Yugoslavia has held that in certain circumstances, rape can amount to a war crime,[[156]](#endnote-156) a crime against humanity,[[157]](#endnote-157) and a form of torture.[[158]](#endnote-158) The International Criminal Tribunal for Rwanda has extended this principle even further, finding that rape and sexual violence can amount to genocide if committed with the specific intent to wholly or partially destroy a particular ethnic or racial group.[[159]](#endnote-159) The principles set out in these judgments have since been affirmed by the UN Security Council.[[160]](#endnote-160) Furthermore, sexual violence as such or as a form of inhumane act is recognized as a crime against humanity under the Rome Statute.[[161]](#endnote-161)

Nevertheless, ICL case law, in its understanding of reparations, has largely failed to ensure accountability for violations related to SRHR.[[162]](#endnote-162) The requirement of the element of unlawful confinement or detainment,[[163]](#endnote-163) has limited accountability for denial of SHR services.[[164]](#endnote-164) It has been argued, however, that in some circumstances, the denial of abortion may also constitute a crime against humanity (namely torture, persecution, or other inhumane act) or a war crime (namely torture or inhuman treatment)[[165]](#endnote-165) without the element of confinement.[[166]](#endnote-166) Other similar definitional challenges include the prohibition of “measures intended to prevent births within the group.” Although the definition rightfully targets the crimes of forced sterilization and forced abortion, it fails to address the full range of serious practices that should be encompassed within this provision, including measures causing infertility.[[167]](#endnote-167)

In order to provide redress for all survivors subjected to rape and sexual violence, including ensuring appropriate SRH information and services when appropriate, ICL must adopt a more inclusive understanding that address the full spectrum of abuses. ICL plays an important role in deterring international crimes, including SGBV, that have implications for SRHR, which means that it has the potential to ensure some level of accountability for reparations in the area of access to SRH information and services.[[168]](#endnote-168)

**Anex I. Recommendations**

We respectfully suggest that the Committee’s General Recommendation regarding article 11 of theConvention include clear and specific language and recommendations in relation to:

**Access to Sexual and Reproductive Health Information and Services in Humanitarian Settings**

* Affirm that the provision of the full range of sexual and reproductive health information and services, including abortion remains essential in risk and humanitarian settings, are key to humanitarian response and accountability without discrimination.
* Reiterate that reparations for SRHR should be considered and that they need to be prompt, transformative, timely, efficient, need to address the root causes that enabled violations to take place, and should include restitution, compensation, rehabilitation, satisfaction and guarantees of non-recurrence.
* Reiterate the specific vulnerabilities of women and girls with disabilities in risk and humanitarian context in regard to their bodily and reproductive autonomy and clearly articulate that sexual and reproductive health information and services are an integral part of rehabilitation measures and as such constitute a key component of reparations.
* Create an obligation for States to ensure access to abortion for women and girls with no restriction as to reason and no third-party intervention requirements, in line with WHO Abortion Care Guideline (2022) and in line with other treaty monitoring bodies emphasizing how all restrictions on access to abortion disproportionately impact individuals with disabilities in humanitarian and risk situations.
* Highlight those legal restrictions on women’s, girls’ autonomy and their exclusion from decision-making processes are rooted in and compounded by harmful intersecting stereotypes such as those based on disability and gender

**Intersectionality**

* Recognize that women and girls with disabilities facing intersectional discrimination -including diverse SOGIESC, racial or ethnic minorities, Romani, indigenous, refugee or migrant women, living in rural areas or socioeconomically disadvantaged or in adolescence (among other grounds)- suffer disproportionately and in cumulative ways the consequences of discrimination.
* Highlight the specific barriers to participation in decision-making structures faced by women, girls and persons of diverse SOGIESC with disabilities and reiterate the indication to read the CEDAW Convention through an intersectional lens as previously stated in CEDAW GR 28.
* Clarify legal obligations of States to address intersectional discrimination through the use of substantive equality in their policy-making, including in risk and humanitarian settings and with regards to women’s and girls’ and other persons with diverse SOGIESC with disabilities.
* Reiterate that international human rights law and international humanitarian law are interdependent, mutually complementary and that international human rights law continues to apply in risk and humanitarian settings, including during armed conflict .
* Reiterate that reproductive rights violations may amount to torture and CIDT and entail State’s obligation to prevent, punish, and redress such violations.
* Call on States to respect, protect and fulfil women’s and girls’ right to bodily autonomy and ensure accountability for reproductive rights violations in particular against forced abortions and sterilization and clearly state that these practices might constitute torture or CIDT even when they are conducted with the legal consent of the person’s guardian.
* Recognize that the full, equal, effective and meaningful participation of women and girls and other persons of diverse SOGIESC with disabilities in formal decision-making systems is essential to plan and implement humanitarian coherent and comprehensive responses and ensure accountability for women and girls.
* Specifically refer to the meaningful and efficient participation of women and girls with disabilities in the accountability processes and in the development, implementation and monitoring of laws, policies and programmes including budgets and use of public funds.
* States legal obligations to ensure that all human rights violations, including SHRH, are properly investigated, prosecuted and punished by bringing the perpetrators to justice.

**Monitoring and reporting**

* Recommend that States record and monitor health outcomes related to abortion laws and policies and report them to the Committee in their periodic reports even and especially during humanitarian situations.
* Clarify that state obligations on monitoring and accountability measures for sexual and reproductive health violations, including measures specifically targeting intersectional discrimination:

o 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.

o 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.

o Guarantee full and fair investigations into allegations of sexual and reproductive rights violations.

o 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.

o 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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2. UN HRC, Resolution 45/29 [↑](#endnote-ref-2)
3. International Review of the Red Cross, [IRRC No. 922](https://international-review.icrc.org/articles/the-protection-of-women-and-girls-with-disabilities-in-armed-conflict-922#footnoteref1_kd4htdj) *The protection of women and girls with disabilities in armed conflict: Adopting a gender-, age- and disability-inclusive approach to select IHL provisions,* November 2022 [hereinafter IRRC No. 922] [↑](#endnote-ref-3)
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45. *Id.* para. 18 (“Since the failure of the State to exercise due diligence to intervene to stop, sanction and provide remedies to victims of torture facilitates and enables non-State actors to commit acts impermissible under the Convention with impunity, the State’s indifference or inaction provides a form of encouragement and/or de facto permission.”). [↑](#endnote-ref-45)
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48. CAT Committee, *Gen. Comment No. 2*, para. 22 [↑](#endnote-ref-48)
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58. *See, e.g.*, 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); 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); CAT/C/POL/CO/7 (CAT 2019 ) paras. 35-36, CAT/C/CAN/CO/7 (CAT 2018 ) para.50, CAT/C/PER/CO/7 (CAT 2018 ), paras. 36-37 [↑](#endnote-ref-58)
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60. Special Rapporteur on Torture, *Promotion and Protection of All Human Rights* 2008, para. 38; *see also* Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, G.A. Res. 61/106, arts. 12(4), 23(1(b-c)), U.N. Doc. A/RES/61/106 (2006), 1249 U.N.T.S. 13 (*entered into force* May 3, 2008) [hereinafter CRPD]; Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, *Paul Hunt*, paras. 9, 12, U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005) (by Paul Hunt). [↑](#endnote-ref-60)
61. Special Rapporteur on Torture, *Promotion and Protection of All Human Rights* 2008, para. 69. [↑](#endnote-ref-61)
62. HRC, Juan Méndez, *Report of the UN Special Rapporteur on torture and other cruel, inhuman and degrading treatment,* UN Doc. A/HRC/22/53 (2013), para. 32. [↑](#endnote-ref-62)
63. Center for Reproductive Rights, *Breaking Ground 2018, at 30; See* also CEDAW/C/OP.8/GBR/1 para.65; HRC GC 36, para 8 [↑](#endnote-ref-63)
64. See e.g. Mellet v. Ireland (CCPR/C/116/D/2324/2013), paras. 7.4–7.8;. [↑](#endnote-ref-64)
65. *See, e.g.*, ESCR Committee, *Gen. Comment No. 14*,para. 12; K.L. v. Peru, Human Rights Committee, Commc’n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc’n No. 1608/2007, U.N. Doc. CCPR/ C/101/D/1608/2007 (2011); L.C. v. Peru, CEDAW Committee, Commc’n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011). [↑](#endnote-ref-65)
66. Committee on the Elimination of Discrimination against Women, General Recommendation 35 (2017), on gender-based violence against women, updating general recommendation

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67. Committee on the Elimination of Discrimination against Women and the Committee on the Rights of the Child, Joint General Recommendation 31/General Comment 18, para. 7 in Id. [↑](#endnote-ref-67)
68. CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18*, paras. 21-22; CEDAW Committee, *General Recommendation No. 35: On gender-based violence against women, updating General Recommendation No. 19*, at 15, para. 31, U.N. Doc. CEDAW/C/GC/35 (2017) [hereinafter CEDAW Committee, *Gen. Recommendation No. 35*]. [↑](#endnote-ref-68)
69. CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18*, para. 22; CEDAW Committee, *Concluding Observations: Rwanda,* paras. 38-39, U.N. Doc. CEDAW/C/RWA/CO/7-9 (2017). [↑](#endnote-ref-69)
70. *See* CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18*,para. 19. *See also* CRC Committee, *General Comment No. 20: On the implementation of the rights of the child during adolescence*, at 8, para. 27, U.N. Doc. CRC/C/GC/20\*(2016) [hereinafter CRC Committee, *Gen. Comment No. 20*]; CEDAW Committee, *General Recommendation No. 34: On the rights of rural women,* paras. 22-23, U.N. Doc. CEDAW/C/GC/34 (2016) [hereinafter CEDAW Committee, *Gen. Recommendation No. 34*];ESCR Committee, *Gen. Comment No. 22*, paras. 29, 49, 59; CEDAW Committee, *Concluding Observations: Liberia*, paras. 23-24, U.N. Doc. CEDAW/C/LBR/CO/7-8 (2015); CEDAW Committee, *Concluding Observations: Germany*, paras. 23-24, U.N. Doc. CEDAW/C/DEU/CO/7-8 (2017); Human Rights Committee, *Concluding Observations: Burkina Faso*, paras. 15-16, U.N. Doc. CCPR/C/BFA/CO/1 (2016); Human Rights Committee, *Concluding Observations: Ghana,* paras. 17-18, U.N. Doc. CCPR/C/GHA/CO/1 (2016); CRC Committee, *Concluding Observations: Iran*, paras. 59-60, U.N. Doc. CRC/C/IRN/CO/3-4 (2016); CRC Committee, *Concluding Observations:* *Sierra Leone*, paras. 22-23, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); CERD Committee, *Concluding* *Observations: Djibouti*, paras. 20-21, U.N. Doc. CERD/C/DJI/CO/1-2 (2017). [↑](#endnote-ref-70)
71. *See* CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18*,para. 19. [↑](#endnote-ref-71)
72. *See* Human Rights Committee, *Concluding Observations: Bangladesh*, paras. 13-14, U.N. Doc. CCPR/C/BGD/CO/1 (2017). [↑](#endnote-ref-72)
73. *See* CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18*,para. 83. [↑](#endnote-ref-73)
74. CAT Committee, *Concluding Observations: Kenya*, para. 27, U.N. Doc. CAT/C/KEN/CO/2 (2013) [↑](#endnote-ref-74)
75. CAT Committee, *Concluding Observations: United States of America*, para. 21, U.N. Doc. CAT/C/USA/CO/3-5 (2014). [↑](#endnote-ref-75)
76. Juan E. Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN Doc. A/HRC/31/57 (5 January 2016), para. 47. [↑](#endnote-ref-76)
77. WHO, Eliminating forced, coercive and otherwise involuntary sterilization An interagency statement OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO /2014) page 5. [↑](#endnote-ref-77)
78. *Id. See also CEDAW* Decision adopted by the Committee under article 4 (2) (c) of the

    Optional Protocol, concerning communication No. 138/2018 UN Doc CEDAW/C/75/D/138/2018 (2020) [↑](#endnote-ref-78)
79. International Covenant on Economic, Social and Cultural Rights, adopted Dec. 16, 1966, art. 2(1), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (entered into force Jan. 3, 1976) [hereinafter ICESCR]; CRC, supra note 58, art. 4; CRPD, supra note 58, art. 4(2); CESCR, An evaluation of the obligation to take steps to the “Maximum of available resources” under an Optional Protocol to the Covenant, para. 10(d), U.N. Doc E/C.12/2007/1 (2007) [hereinafter CESCR, Maximum of available resources under OP] in CRR technical paper 2021 [↑](#endnote-ref-79)
80. Whelan v. Ireland, 2017 Commc’n, supra note 170, paras. 7.7, 7.8, 7.9, 7.12. in CRR technical paper 2021 [↑](#endnote-ref-80)
81. Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) paras 65,64, 44a, 36 and 39 and General comment No. 22 (2016) paras 38 [↑](#endnote-ref-81)
82. CESCR, Gen. Comment No. 20: Non-discrimination in economic, social and cultural rights (Art. 2 of the International Covenant on Economic, Social and Cultural Rights), para. 2, U.N. Doc. E/C.12/GC/20 (2009) [hereinafter CESCR, Gen. Comment No. 20]; see also Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted Dec. 18, 1979, 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) [hereinafter CEDAW] in CRR Technical paper 2021 [↑](#endnote-ref-82)
83. CESCR, Gen. Comment No. 3, supra note 58, paras. 1, 10; CESCR, General Comment No. 12: The Right to Adequate Food (Art. 11 of the International Covenant on Economic, Social and Cultural Rights), para. 6, U.N. Doc. E/C.12/1999/5 (1999) [hereinafter CESCR, Gen. Comment No. 12]; CESCR, Poverty and the International Covenant on Economic, Social and Cultural Rights, para. 18, U.N. Doc. E/C.12/2001/10 (2001); CESCR, Gen. Comment No. 14, supra note 58, para. 47; CESCR, Gen. Comment No. 15: The Right to Water (Arts. 11, 12 of the International Covenant on Economic, Social and 54 Cultural Rights), para. 40, U.N. Doc E/C.12/2002/11 (2003) [hereinafter CESCR, Gen. Comment No. 15]; CESCR, Gen. Comment No. 22, supra note 4, para. 49 in CRR technical paper 2021 [↑](#endnote-ref-83)
84. General comment No. 22 (2016) on the right to sexual and reproductive health, para 49 [↑](#endnote-ref-84)
85. CESCR, General Comment No. 22, supra note 4, para. 49 in CRR technical paper 2021 [↑](#endnote-ref-85)
86. CESCR Committee, Gen. Comment No. 22, para. 49. [↑](#endnote-ref-86)
87. World Health Organization, [*Abortion Care Guideline*](https://www.who.int/publications/i/item/9789240039483.) (2022), Section 2.2.1 (pp. 24–25),. [↑](#endnote-ref-87)
88. Id. at Section 2.2.2 (pp. 26–27). 79 Id. at Section 2.2.3 (pp. 28–29). [↑](#endnote-ref-88)
89. Id. Section 2.2.1 (pp. 24–25), https://www.who.int/publications/i/item/9789240039483. [↑](#endnote-ref-89)
90. Id. at Section 3.3.1 (pp. 41–42). [↑](#endnote-ref-90)
91. Id. at Section 3.3.2 (pp. 42–44). [↑](#endnote-ref-91)
92. Id. at p. 42. [↑](#endnote-ref-92)
93. *Id*.; *see also* World Health Organization, [*COVID-19 Operational Guidance*](https://www.who.int/publications/i/item/covid-19-operational-guidance-for-%20maintaining-essential-health-services-during-an-outbreak), (June 1, 2020), (categorizing reproductive health as a “high priority” essential service and urging countries to maintain access to reproductive health services throughout the COVID-19 pandemic). [↑](#endnote-ref-93)
94. U.N. HRC, Guidance on a human rights-based approach, supra note 2, para. 47 in CRR technical paper 2021 [↑](#endnote-ref-94)
95. CEDAW Committee, Gen. Recommendation No. 28, supra note 149, para. 11 in technical paper 2021 [↑](#endnote-ref-95)
96. CEDAW Committee, Gen. Recommendation No. 30, supra note 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) in technical paper 2021 [↑](#endnote-ref-96)
97. CEDAW Committee, Gen. Recommendation No. 30, para 81 (g) [↑](#endnote-ref-97)
98. Id. para 16 [↑](#endnote-ref-98)
99. UN Human Rights Council, *Follow-up on the application of the technical guidance*; *see generally* Center for Reproductive Rights, [*Ensuring Sexual and Reproductive Health and Rights of Women and Girls Affected by Conflict*](https://reproductiverights.org/breaking-through-a-guide-to-sexual-and-reproductive-health-and-rights) (2017) [↑](#endnote-ref-99)
100. CEDAW Committee, General Recommendation No. 30, para. 77. [↑](#endnote-ref-100)
101. *Id*., paras. 77-79; [↑](#endnote-ref-101)
102. ICRC IHL and Persons with Disabilities, Legal factsheet, 4 October 2017 (2017) [↑](#endnote-ref-102)
103. Id [↑](#endnote-ref-103)
104. UNGA, OHCHR, *Thematic study on the rights of persons with disabilities under article 11 of the Convention on the Rights of Persons with Disabilities, on situations of risk and humanitarian emergencies* (2015), UN. Doc [A/HRC/31/30](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G15/271/74/PDF/G1527174.pdf?OpenElement)*,* para 4 and ICRC IHL and Persons with Disabilities, Legal factsheet, 4 October 2017 (2017) [↑](#endnote-ref-104)
105. ICRC IHL and Persons with Disabilities, Legal factsheet, 4 October 2017 (2017) [↑](#endnote-ref-105)
106. Geneva Conventions I-IV, Common Art 3: Conflicts not of an International Character (1949) ; Geneva Convention I, supra note 100, art. 3; Geneva Convention for the Amelioration of the Condition of Wounded, Sick, and Shipwrecked Members of the Armed Forces at Sea, art. 3, Aug. 12, 1949, 75 U.N.T.S. 85 [hereinafter Geneva Convention II]; Geneva Convention Relative to the Treatment of Prisoners of War, Aug. 12, 1949 [hereinafter Geneva Convention III]; Geneva Convention Relative to the Protection of Civilian Persons in Time of War, art. 3, 75 U.N.T.S. 287 (Aug. 12, 1949) [hereinafter Geneva Convention IV]; see also Geneva Convention IV, art. 27(4); Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflict (Protocol I), art. 75(1), June 8, 1977, 1125 U.N.T.S. 3 [hereinafter Additional Protocol I]; Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), art. 4(1), June 12, 1977, 1125 U.N.T.S. 609 [hereinafter Additional Protocol II]; ICRC, “[Adverse Distinction” in How Does Law Protect in War](https://casebook.icrc.org/glossary/adverse-distinction)? Glossary, in CRR technical paper 2021 [↑](#endnote-ref-106)
107. ICRC, 2016 Commentary on Geneva Convention I, supra note 94, art. 3, para. 578 in CRR technical paper 2021 [↑](#endnote-ref-107)
108. See, e.g., ICRC, 2016 Commentary on Geneva Convention I, supra note 94, art. 3, paras. 573-578 in CRR technical paper 2021 [↑](#endnote-ref-108)
109. ICRC IHL and Persons with Disabilities, Legal factsheet, 4 October 2017 (2017) [↑](#endnote-ref-109)
110. Economic and social Council Guiding Principles on Internal Displacement (1998) principle 19 in Id [↑](#endnote-ref-110)
111. Id principle 4 [↑](#endnote-ref-111)
112. ICRC, Customary IHL Database, supra note 95, rule 88 in CRR technical paper 2021 [↑](#endnote-ref-112)
113. Id. Paras 575-576 and ICRC, Customary IHL Database, supra note 95, rule 134; See also in relation to SRHR, A. Radhakrishnan, Protecting safe abortion, supra note 28 in CRR technical paper 2021 [↑](#endnote-ref-113)
114. ICRC, 2016 Commentary on Geneva Convention I, supra note 94, art. 3, para. 577 in CRR technical paper 2021 [↑](#endnote-ref-114)
115. Id., art. 3, para. 578; see also P. Sellers, Gender Jurisprudence, supra note 305 in CRR technical paper 2021 [↑](#endnote-ref-115)
116. Common Art. 3 to the Conventions, supra note 207; see also Geneva Convention I, supra note 100, art. 12; Geneva Convention II, supra note 207, art. 12; Geneva Convention IV, supra note 207, arts. 5, 27; Additional Protocol I, supra note 207, art. 75(1); Additional Protocol II, supra note 207, art. 4(1) in CRR technical paper 2021 [↑](#endnote-ref-116)
117. Adverse’ means differences in, or preferential treatment based on a person’s specific needs, including in relation to disabilities. For more information on the prohibition of adverse distinction, see: ICRC Commentary on the First Geneva Convention and, in particular, the [Commentary on common Article 3](https://reproductiverights-my.sharepoint.com/personal/tagosti_reprorights_org/Documents/Desktop/TMBs/CRPD/humanitarian%20settings/final%20submission/:%20https:/ihl%20databases.icrc.org/applic/ihl/ihl.nsf/INTRO/%20365?OpenDocumen), pp. 198–202, paragraphs 565–580 in ICRC IHL and Persons with Disabilities, Legal factsheet, 4 October 2017 (2017) [↑](#endnote-ref-117)
118. The inclusion of the phrase ‘or any other similar criteria’ indicates that the list is not exhaustive and that it may also include distinctions on the basis of disabilities. For more information, see the [ICRC Commentary](https://reproductiverights-my.sharepoint.com/personal/tagosti_reprorights_org/Documents/Desktop/TMBs/CRPD/humanitarian%20settings/final%20submission/:%20https:/ihl%20databases.icrc.org/applic/ihl/ihl.nsf/INTRO/%20365?OpenDocument) on the First Geneva Convention, 2nd edition, and, in particular, the Commentary on Art. 12, p. 495, para. 1393, t [↑](#endnote-ref-118)
119. ICRC IHL and Persons with Disabilities, Legal factsheet, 4 October 2017 (2017) in ICRC IHL and Persons with Disabilities, Legal factsheet, 4 October 2017 (2017) [↑](#endnote-ref-119)
120. ICRC, Customary IHL Database, supra note 95, rule 87 in CRR technical paper 2021 [↑](#endnote-ref-120)
121. Id. [↑](#endnote-ref-121)
122. Id. [↑](#endnote-ref-122)
123. ICRC, Customary IHL Database, supra note 96, rule 87 in CRR technical paper 2021 [↑](#endnote-ref-123)
124. CRR technical paper 2021, page 45 [↑](#endnote-ref-124)
125. ICRC, Customary IHL Database, supra note 95, rule 134 in CRR technical paper 2021. [↑](#endnote-ref-125)
126. ICRC, 2016 Commentary on Geneva Convention I, supra note 94, art. 12, paras. 1428-1430 in CRR technical paper 2021 [↑](#endnote-ref-126)
127. Id [↑](#endnote-ref-127)
128. ICRC IHL and Persons with Disabilities, Legal factsheet, 4 October 2017 (2017) [↑](#endnote-ref-128)
129. ICRC, Customary IHL Database, supra note 95, rule 134; ICRC, 2016 Commentary on Geneva Convention I, supra note 94, art. 12, paras. 1429-1430 in CRR technical paper 2021 [↑](#endnote-ref-129)
130. Additional Protocol I, supra note 207, art. 8(a) CRR technical paper 2021 and ICRC IHL and Persons with Disabilities, Legal factsheet, 4 October 2017 (2017) [↑](#endnote-ref-130)
131. Geneva Convention IV, supra note 207, arts. 55 (art. 56 imposes a further duty on occupying powers to maintain hospital establishments and services and public health and hygiene in the occupied territory) in CRR technical paper 2021 [↑](#endnote-ref-131)
132. Id. [↑](#endnote-ref-132)
133. See ICRC, 2020 [Commentary on Convention (III) relative to the Treatment of Prisoners of War, art. 3](https://ihldatabases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=31FCB9705FF00261C1258585002FB096# _Toc44265155) (2020); Oxford, 1949 Geneva Conventions Commentary, supra note 109, at 761, para. 19 (“it is worth recalling there that the Geneva Conventions address acts and omissions, including with regard to the wounded and sick, only where there is a nexus to the conflict”) in CRR technical paper 2021 [↑](#endnote-ref-133)
134. Oxford, 1949 Geneva Conventions Commentary, supra note 109, at 7623, para. 26 in CRR technical paper 2021 [↑](#endnote-ref-134)
135. ICRC, Customary IHL Database, supra note 95, rules 110, 134 in CRR technical paper 2021 [↑](#endnote-ref-135)
136. Id., rule 110 in CRR technical paper 2021 [↑](#endnote-ref-136)
137. ICRC, Customary IHL Database, supra note 95, rule 93; see also Additional Protocol I, supra note 207, art. 75 (2)(b); Additional Protocol II, supra note 207, art. 4(2)(e) in CRR technical paper 2021 [↑](#endnote-ref-137)
138. See, e.g., Geneva Convention IV, supra note 207, art. 3; see also ICRC, 2016 Commentary on Geneva Convention I, supra note 94, art. 3, para. 701 (noting that rape, enforced prostitution, and indecent assault are expressly identified as inhumane in article 27 of Geneva Convention IV and accordingly violate the obligation of humane treatment in common article 3 to the Conventions) in CRR technical paper 2021 [↑](#endnote-ref-138)
139. See, e.g., Geneva Convention IV, supra note 207; see also Prosecutor v. Dragoljub Kunarac, Radomir Kovač and Zoran Vuković IT-96–23 & 23/A (ICTY, June 12, 2002) [Appeals Chamber Judgment], para. 150 (characterizing sexual violence as an act of torture); Prosecutor v. Jadranko Prlić et al IT-04-74-T (ICTY, 29 May 2013) (Trial Chamber Judgment) para. 116 (finding sexual violence as inhuman treatment (synonymous with “cruel treatment” prohibited by common article 3 to the Conventions) in CRR technical paper 2021 [↑](#endnote-ref-139)
140. See, e.g., Geneva Convention IV, supra note 207; see also ICRC, 2020 Commentary, supra note 222, art. 3, paras. 705-707 (noting, inter alia, that article (4)(2)(e) of Additional Protocol II explicitly lists some acts of sexual violence—namely “rape, enforced prostitution and any form of indecent assault”—as outrages upon personal dignity). International tribunals have held multiple types of sexual violence to be outrages upon personal dignity; see, e.g., Prosecutor v. Bagosora et al., ICTR-98-41-T, Trial Chamber Judgment and Sentence (2008), para. 2254 (finding the defendant guilty of rape and, in turn, “guilty of outrages against personal dignity as violation of Common Article 3 and of Additional Protocol II”) in CRR technical paper 2021 [↑](#endnote-ref-140)
141. Additional Protocol II, supra note 207, art. 4(2)(e) in CRR technical paper 2021 [↑](#endnote-ref-141)
142. Geneva Convention IV, supra note 207, art. 27 CRR technical paper 2021 [↑](#endnote-ref-142)
143. See, for example, Constitutional Court of Colombia, Prohibición de Anticoncepción Quirurgica a Menores de Edad en Condición de Discapacidad, Case No. C-131/14, Judgment, 11 March 2014 [↑](#endnote-ref-143)
144. Regarding forced sterilization, see, for example, Committee against Torture, Consideration of Reports Submitted by States Parties under Article 19 of the Convention: Peru, UN Doc. CAT/C/PER/CO/4, 25 July 2006, para. 23 in IRRC No. 922 [↑](#endnote-ref-144)
145. U.N. Secretary-General, Report of the Secretary-General on Conflict-related Sexual Violence, para. 14, U.N. Doc. S/2017/249 (2017) in CRR technical paper 2021 [↑](#endnote-ref-145)
146. CRR technical paper 2021 page 32 [↑](#endnote-ref-146)
147. A. Radhakrishnan, Protecting safe abortion, supra note 28; GJC, Reference Language, supra note 254; Oxford, 1949 Geneva Conventions Commentary, supra note 109, pp 762-765; See also CRR, Expert Convenings 2020, supra note 1 CRR technical paper 2021 [↑](#endnote-ref-147)
148. CRR, Expert Convenings 2020, supra note 1; L.C. v. Peru, Commcation, No. 22/2009, para. 7.7, U.N. Doc. CEDAW/C/50/D/22/2009 (2011) (CEDAW); Human Rights Comm., Gen. Comment No. 36, supra note 57, para. 8; CEDAW Committee, Gen. Recommendation No. 30, supra note 30, para. 52(c) in CRR technical paper 2021 [↑](#endnote-ref-148)
149. Vienna Convention, supra note 79, art. 27; Human Rights Comm., Gen. Comment No. 31, supra note 56, para. 4 in CRR technical paper 2021 [↑](#endnote-ref-149)
150. Oxford, 1949 Geneva Conventions Commentary, supra note 109, at 765, para. 33;see also A. Radhakrishnan, Protecting safe abortion, supra note 28 and . CRR, Expert Convenings 2020, supra note 1 in CRR technical paper 2021 [↑](#endnote-ref-150)
151. Id.; see also Oxford, 1949 Geneva Conventions Commentary, supra note 109, at 1287, para. 53 in CRR Technical paper 2021 [↑](#endnote-ref-151)
152. CRR technical paper 2021 pg 32. [↑](#endnote-ref-152)
153. CEDAW, general Comment 30 Id. para 16 [↑](#endnote-ref-153)
154. ID 81 (i) [↑](#endnote-ref-154)
155. See, e.g., Prosecutor v. Dominic Ongwen, ICC-02/04-01/05, Trial Judgment (Feb. 4, 2021) in CRR technical paper 2021 [↑](#endnote-ref-155)
156. International Criminal Tribunal for the Former Yugoslavia, Prosecutor v. Tadić, Case No. IT-94-1-AR72, Decision (Appeals Chamber), para. 71 (Oct. 2, 1995) in CRR technical paper 2021 [↑](#endnote-ref-156)
157. International Criminal Tribunal for the Former Yugoslavia, Prosecutor v. Dragoljub Kunarac and Others, Case No. IT-96-23&23/1 (Trial Chamber) (Feb. 22, 2001) CRR technical paper 2021 [↑](#endnote-ref-157)
158. International Criminal Tribunal for the Former Yugoslavia, Prosecutor v. Zejnil Delalić and Others (Celebici case), Case No. IT96-21, Judgment (Trial Chamber) (Nov. 16, 1998); see also International Criminal Tribunal for the Former Yugoslavia, Prosecutor v. Anto Furundzija, Case. No. IT-95-17/1, Judgment (Trial Chamber) (Dec. 10, 1998) in CRR technical paper 2021 [↑](#endnote-ref-158)
159. Prosecutor v. Jean-Paul Akayesu, supra note 239 in CRR technical paper 2021 [↑](#endnote-ref-159)
160. U.N. SCOR, Resolution 1820 (2008) on women, peace and security, para. 4, U.N. Doc. S/RES/1820 (2008) in CRR technical paper 2021 [↑](#endnote-ref-160)
161. Rome Statute, supra note 119, arts. 7(1)(g), 7(1)(k) in CRR technical paper 2021 [↑](#endnote-ref-161)
162. CRR, Expert Convenings 2020, supra note 1; see also Ruth Rubio Marin, Reparations for Conflict-Related Violence, supra note 275 in CRR technical paper 2021 [↑](#endnote-ref-162)
163. Rome Statute, supra note 119, art. 7.2(f); Prosecutor v. Dominic Ongwen, ICC-02/02-01/15, Decision on the Confirmation of the Charges, 954, para. 2722 (Trial Judgment) (Feb. 4, 2021) in CRR technical paper 2021 [↑](#endnote-ref-163)
164. Amnesty International, [Forced Pregnancy a Commentary on the Crime in International Criminal Law](https://www.amnesty.org/download/Documents/IOR5327112020ENGLISH.pdf) (2020), in CRR technical paper 2021 [↑](#endnote-ref-164)
165. See Amnesty International, Amnesty International’s Policy on Abortion: Explanatory Note, 80 (2020) in CRR technical paper 2021 [↑](#endnote-ref-165)
166. Rome Statute, supra note 119, art. 7.2(f); Prosecutor v. Dominic Ongwen, ICC-02/02-01/15, Decision on the Confirmation of the Charges, 954, para. 2722 (Trial Judgment) (Feb. 4, 2021) in CRR technical paper 2021 [↑](#endnote-ref-166)
167. CRR technical paper 2021, page 35 [↑](#endnote-ref-167)
168. CRR, Expert Convenings 2020, supra note 1 in CRR technical paper 2021 [↑](#endnote-ref-168)