CENTER *for*
REPRODUCTIVE
RIGHTS

Submission from the Center for Reproductive Rights following the call for submissions of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health for her report on 'Racism and the right to health'.

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.—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 UN, including with the Special Procedures of the Human Rights Council.

The Center for Reproductive Rights is pleased to provide this submission on racism and the right to health. This submission will focus on the systemic racial and intersectional discrimination experienced in the context of the right to sexual and reproductive health.

I. Introduction

Women and girls and other persons who can get pregnant protected by the Convention on the Elimination of Racial Discrimination (the Convention) face discrimination, acts of violence and violations of their sexual and reproductive rights. Systemic racism and racial discrimination also undermine their access to social and other determinants of health, which makes them more vulnerable to human rights violations and further infringes on their ability to realize the right to sexual and reproductive health. These women and girls also confront intersectional discrimination, such that subgroups of women experience sexual and reproductive rights violations in 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 on the Elimination of Racial Discrimination provides protection from discrimination to a range of individuals.[1]

II. Intersectional Discrimination and Sexual and Reproductive Health

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, refugee, migrant and asylum status, age, disability, sexual orientation, gender identity, political or other opinion, religion, class, 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 the rights violations the same way.[2]

Intersectional discrimination, a term coined by Professor Kimberlé Williams Crenshaw,[3] 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."[4] Instead, as the 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."[5] These inseparable grounds of discrimination function together to produce a distinct disadvantage.

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"[6]—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**.[7]

Although UN 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,"[8] 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 intersecting discrimination serves only to perpetuate that situation of discrimination.[9] 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."[10]

The Need to Advance Standards on Intersectional Discrimination in the Context of Sexual and Reproductive Health and Rights

Although this and other treaty monitoring bodies have consistently recognized the harms of multiple and intersecting 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[11] and has explicitly underscored the need for measures to address intersectional discrimination in the context of sexual and reproductive health;[12] however, the Committee has not articulated robust state obligations or recommendations in this regard.

Although the 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 . . . ."[13] 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."[14] The CEDAW Committee has also consistently acknowledged the impact of intersectional discrimination on women and girls,[15] including rural women,[16] migrant women,[17] women in conflict,[18] women refugees and asylum-seekers,[19] 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."[20] 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.[21]

In *A.S. v. Hungary*, the CEDAW Committee found that the sterilization of A.S., a Hungarian woman of Roma origin, without her full and truly informed consent was a violation of her rights under the Convention.[22] This decision was groundbreaking in many ways; however, it failed to acknowledge that the violation occurred because she was a Roma woman. In so doing, they have not recognized that fueling these practices are health care providers' stereotypes about Roma women, who are depicted as promiscuous and "hyper-fertile."[23] 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."[24] In this context, the Committee 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."[25] The Committee has also called attention to multiple discrimination against women members of descent-based communities,[26] female non-citizens,[27] Roma women,[28] and women and girls of African descent.[29]

This Committee has further addressed intersectional discrimination in its concluding observations, expressing serious concerns to Slovakia over the discriminatory treatment and segregation of Roma 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 a number of state measures to address this discrimination.[30] The Committee has also expressed 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.[31]

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 sexual and reproductive health and rights. 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.[32]

III. International Legal Framework: Sexual and Reproductive Health and Rights and Substantive Equality

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."[33] 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."[34] 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.[35]

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.[36] Acceptability requires that facilities, goods, information and services are respectful of medical ethics and culturally appropriate, "respectful of the culture of individuals, minorities, peoples and communities."[37] 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:[38]

- 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 and marginalized 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 taking 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.[39] It extends beyond sexual and reproductive health care and services to include the underlying and social determinants of sexual and reproductive health.[40] 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 and other human rights violations that have a negative impact on the right to sexual and reproductive health."[41]

The CESCR Committee has further underscored the role of systemic 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 based on grounds identified by the Committee are all social determinants of sexual and reproductive health, which also have an impact on the enjoyment of an array of other rights as well. The nature of these social determinants, which are often expressed in laws and policies, limits the choices that individuals can exercise with respect to their sexual and reproductive health. **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."**[42]

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, and reducing rates of adolescent pregnancy.[43] 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.[44] 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."[45]

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.[46]

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;[47] and implement temporary special measures. These measures should:

- Address discriminatory power structures.[48]
- Recognize that women and men experience different kinds of rights violations due to discriminatory social and cultural norms, including in the context of health,[49] and that, women may also face multiple and intersecting discrimination, based on multiple grounds, including race, disability, age or other marginalized statuses.[50]
- Ensure equality of results.[51]

IV. Informed Consent

Health care providers must *always* seek women's informed consent to health care interventions; they may

never substitute their beliefs about the best course of treatment for those of the women. In pregnancy-related health care, such nonconsensual treatment is often justified on the basis of the purported interests of the fetus but reinforces the stereotype that women are unable to make rational decisions and reduces them to objects of intervention without agency.[52] The CEDAW Committee has noted reports of "interference with women's reproductive health choices in hospitals, including the routine application of medical interventions, reportedly often without the woman's free, prior and informed consent or any medical indication."[53] Notably, the Working Group on Discrimination against Women in Law and in Practice has recognized that "… unnecessary medicalization …[has] functioned as [a] form[]of social control exercised by patriarchal establishments to preserve the gender roles of women."[54]

Informed consent to medical care is fundamental in both human rights law and in ethics.[55] Patients have the right to receive accurate, evidence-based information and ask questions about recommended treatments so that they can make informed and well-considered decisions about care. The CESCR Committee has stated that a core obligation for states is to ensure "free, informed and responsible decision-making, without coercion, discrimination or fear of violence, in relation to the sexual and reproductive needs and behaviours of individuals."[56]

As noted by the CEDAW Committee, informed consent is a process of ongoing communication and interaction between patient and provider, and a signature alone is not indication of informed consent.[57] The provider should "be proactive in their provision of information. For consent to be valid, it must be voluntary and informed. Consent of the patient is needed regardless of the procedure and consent can be withdrawn at any time."[58] It is a patient-centered approach.

The information provided should include complete information about the advantages and disadvantages, health benefits, risks and alternatives to treatment and it should enable comparison of various options of treatment. It should be high quality, accurate and provided in a manner and language that is understandable, accessible and appropriate to the needs of the individual making the decision. It should be "presented in a manner acceptable to the person consenting."[59]

"Educational level, physical or intellectual impairments and the age of the individual should be considered in determining the manner in which counselling and information is provided; individual needs and preferences should be respected. Persons with disabilities should be provided with all the necessary support for making their decisions."[60] The CRPD Committee has called upon states to adopt effective affirmative action measures "to provide women with disabilities access to the support they may require to exercise their legal capacity . . . to give their free and informed consent and to take decisions about their own lives."[61] Further, the CRPD has made clear that, in guaranteeing the right to health, states "have an obligation not to permit substitute decision-makers to provide consent on behalf of persons with disabilities."[62] "Extreme caution must be exercised, especially in the case of individuals who have limited ways of being understood by others, to ensure that decisions that should be made using the process of supported decision-making are not de facto substituted decisions."[63]

To guarantee the right to informed consent, the Special Rapporteur on the right to health has specifically recommended that state authorities implement protective laws and policies, undertake relevant capacity-building on informed consent and address implementation barriers at the community level.[64] The Special Rapporteur on health has further underscored that States should give special consideration to ensuring the protection of vulnerable groups in fulfilling their obligation to safeguard informed consent as a critical element of the right to health. Specifically: "To ensure non-discrimination, States must: (a) actively identify and overcome structural sources of vulnerability and stigma and discrimination; and (b)

subsequently develop and provide the tools and mechanisms necessary for the protection of vulnerable groups."[65]

V. The Impact of Systemic Racism and Intersectional Discrimination on Sexual and Reproductive Health and Rights

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 globally. More broadly, 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. This discrimination and abuse are also experienced when seeking other forms of sexual and reproductive health care, including fertility treatments, contraception, or in other sexual and reproductive health contexts. This continuum of discrimination and abuse is often targeted against women and girls 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 and marginalized communities—communities facing intersectional discrimination—and exacerbate social inequality.

In the United States, for example, abortion bans and restrictions are escalating,[66] disproportionately impacting Black, Indigenous, and other people of color (BIPOC) experiencing intersectional discrimination.[67] 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.[68]

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 effectively makes abortion care unavailable beginning at this early stage of pregnancy to anyone who cannot afford to travel out of state.[69] Black, Indigenous, and Latina women in Texas, who already face substantial barriers to accessing reproductive health care because of systemic racism,[70] struggle to overcome the tremendous financial and logistical hurdles of seeking care out of state and may be forced to carry an unwanted pregnancy to term.[71] 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.[72]

The United States Supreme Court is currently considering a case in which the state of Mississippi has asked it to overturn nearly 50 years of precedent protecting the constitutional right to choose to terminate a pregnancy before viability.[73] If the Court agrees with Mississippi, as it appears poised to do,[74] BIPOC and people working to make ends meet will be particularly devastated given that they already face significant barriers to accessing health care due to systemic racism, implicit biases, and other forms of discrimination.[75]

Human Rights Standards

Treaty monitoring bodies have long recognized the connection between restrictive abortion laws, high rates of unsafe abortion, and maternal mortality[76] 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.[77] In General Comment No. 36 on the right to life, the Human Rights Committee has reaffirmed that States have a duty to ensure that women and girls do not have to undertake unsafe abortions as part of preventing foreseeable threats to the right to life.[78] 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.[79]

Treaty monitoring bodies recognize that abortion must be decriminalized, legalized at a minimum on certain grounds, and services must be available, accessible, affordable, acceptable, and of good quality and that any regulation of abortion must not force women and girls to undergo unsafe abortion.[80] The Human Rights Committee indicated that States must provide safe, legal and effective access to abortion, *inter alia*, "when carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering.[81] Treaty monitoring bodies recommend that States should liberalize their abortion laws to improve access and remove legal, financial, and practical barriers that deny effective access by women and girls to safe and legal abortion, including medically unnecessary barriers to abortion and third-party authorization requirements.[82]

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.[83] In its most recent Abortion Care Guideline, the World Health Organization (WHO) also recommends the full decriminalization of abortion[84] 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.[85] It further recommends against gestational age limits,[86] mandatory waiting periods for abortion[87] and third-party authorization.[88]

The WHO 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. For example, their guidance notes: "The evidence . . . indicates that mandatory waiting periods increase the cost of abortion and they may make abortion unattainable, resulting in the continuation of pregnancy against the wishes of the abortion seeker, especially among women with fewer resources, adolescents, younger women, those from racial or ethnic minorities and those who need to travel further for an abortion."[89] Similarly, 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."[90]

Maternal Health and Obstetric Violence

Women experience a wide range of rights violations when seeking maternal health care. In 2015, in a statement on disrespect and abuse during facility-based childbirth, the WHO 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."[91]

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, women from marginalized groups, such as migrants and refugees, may be "expected to pay higher rates for services or to pay bribes" in order to receive care.[92] 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.[93]

Some maternity hospitals have adopted discriminatory practices of segregating women within the facility based on race or ethnicity. For example, Roma women in Slovakia are placed in "Roma-only" rooms in maternity hospitals. These designated rooms are often over-crowded, with more beds than the "non-Roma" rooms; rather than use vacant beds in other rooms, the hospital may force Roma women to sleep two to a bed or place a Roma woman's bed in the hallway.[94]

In the U.S., black and indigenous women face a maternal health crisis, with significantly higher rates of maternal mortality[95] and pregnancy complications[96] than white women. In hospital settings, where most Black women in the United States give birth, racism and sexism facilitate mistreatment and abuse. Black women report being ignored, disrespected, coerced, threatened, and denied information and the opportunity to give or refuse consent to medical interventions.[97] Evidence shows that repeated exposure to racism, including interpersonal racism in medical settings, has a physiological "weathering" effect that harms Black women and birthing people's health and contributes to adverse birth outcomes.[98]

In addition, government laws, policies, and practices that seek to control Black people's bodies and reproductive lives infringe on their human rights to decide whether and when to have children and to raise the children they do have in safe, supportive environments.[99] Pregnant people in states across the country have been subjected to criminal prosecution or other punitive legal systems because of their pregnancy or an outcome of their pregnancy.[100] This punishment disproportionately affects BIPOC and immigrant women, especially those living in poverty. Despite Constitutional legal protections for reproductive autonomy and decision-making, state and local law enforcement officers and agencies misuse laws to criminalize and arrest pregnant people for pregnancy loss,[101] for having or seeking an abortion,[102] and for any conduct believed to have posed a risk to a fetus.[103] Government child welfare agencies play a similar role, using the civil legal system to punish women for creating a perceived risk to a fetus by forcibly separating them from their newborn and any existing children. As medical and public health experts have cautioned,[104] 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.

In Peru, indigenous women have historically experienced serious violations of their sexual and reproductive rights, including being subjected to obstetric violence during childbirth. The case of Eulogia and her son, Sergio, is one such example. When Eulogia,[105] 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 she was violently and physically forced by a nurse to give birth in a horizontal position against her ancestral customs. During this struggle, Sergio, her son, 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.[106]

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,"[107] this violence also illustrates the impact of intersectional discrimination on the provision of care during childbirth.[108]

Human Rights Standards

In 2014, noting that "a growing body of research on women's experiences during pregnancy, and particularly childbirth, paints a disturbing picture," the WHO issued a statement on the prevention and elimination of disrespect and abuse during facility-based childbirth. In its Statement, endorsed by over 90 civil society and health professional organizations, the WHO highlighted that: "Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. This statement calls for greater action, dialogue, research and advocacy on this important public health and human rights issue."[109]

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.[110] In General Recommendation No. 24, the CEDAW Committee recommended that States should "require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice."[111]

States must guarantee all women available, accessible, acceptable, and good quality maternal health services.[112] As the Special Rapporteur on health has noted, 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."[113] Furthermore, treaty monitoring bodies have 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.[114] 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 should 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.[115]

Treaty monitoring bodies have 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 from marginalized groups, including adolescents, poor women, minority women, rural women, migrant women, and women with disabilities. This requires the collection of disaggregated data on maternal mortality.[116]

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.[117]

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."[118]

Forced Sterilization

The forced or coerced sterilization of women is a global phenomenon that disproportionately impacts certain subgroups of women, including indigenous peoples[119] and ethnic or racial minorities. As the 2014 UN interagency statement on forced sterilization underscores, "these discriminatory practices are often founded on wrongful stereotyping based on gender, race and ethnicity."[120]

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.[121] 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.

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."[122] 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."[123]

Although the widespread and systematic practice of forced and coercive sterilization of Roma women in several central and eastern European countries is a well-documented past practice 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 Roma women who were forcibly sterilized have been unable to obtain redress.[124]

Human Rights Standards

Forced reproductive health procedures, including forced or coerced sterilization, are violations of women's rights to health-related decision-making and informed consent.[125] Human rights bodies and experts, including this Committee, have repeatedly emphasized the need to obtain informed consent for sterilization procedures.[126]

Women from marginalized groups are subjected to forced or coerced sterilization, which the treaty monitoring bodies have found violates their right to be free from torture or ill-treatment.[127] The CERD 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."[128] In *A.S. v. Hungary*, the CEDAW Committee found that the sterilization of A.S., a Hungarian woman of Roma origin, without her full and truly informed consent was a violation of her rights to health information, maternal health care and to decide freely and responsibly on the number and spacing of her children.[129]

The CEDAW Committee has identified forced sterilization as a form of gender-based violence[130] 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."[131]

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, in conflict and post-conflict settings, and that these violations disproportionately impact women and girls from particular racial or ethnic groups,[132] as well "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."[133] 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."[134]

Conflict also disrupts access to health services, including essential sexual and reproductive health services, 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."[135] This lack of access to essential health care has a disproportionate impact on already vulnerable populations. As the Special Rapporteur on health has underscored: "Conflict may aggravate women's vulnerability to ill-health, discrimination and gender-based violence. Women often experience higher incidence of poor health outcomes in conflict owing to their physical and reproductive needs during pregnancy and childbirth. . . . Women in conflict situations are more likely to turn to unsafe abortion services when facing an unplanned pregnancy."[136]

States fail to prioritize sexual and reproductive health services in their responses to conflict, as they "are typically not considered essential or urgent."[137] This 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."[138]

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 ensuring access to services for women and girls who are

survivors of gender-based violence.[139] Treaty monitoring bodies have developed extensive guidance for States which reinforce and complement State's humanitarian legal obligations.

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

- Ensure access to maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission, and emergency obstetric care.[140]
- 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.[141]
- "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."[142]

The CEDAW and CESCR Committees have noted that refugees, stateless persons, asylum seekers and undocumented migrants are in a situation of vulnerability due to their legal status, which requires the State to take additional steps to ensure their access to affordable and quality sexual and reproductive information, goods, and healthcare.[143]

VI. Monitoring and Accountability to Address Intersectional Discrimination in Health

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.[144] Key to ensuring accountability are strong mechanisms for budgeting, monitoring and evaluation and ensuring the participation of affected communities in the development of policies and programs. Financial and budgetary allocation is critical to the realization of rights and ensuring accountability.[145]

A human rights-based approach also requires establishing accountability mechanisms to ensure redress for victims of mistreatment and violence, including financial compensation, acknowledgement of wrongdoing and a formal apology, and guarantees of non-repetition.[146] Institutional and health system accountability requires that complaint procedures be instituted in all health care facilities, including appeals procedures, and maternal death reviews or audits "be conducted routinely in order that lessons may be learned at all levels of the health system" in order to "prevent future maternal deaths."[147] 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 marginalized and vulnerable groups, including indigenous women, women of African descent, Dalit women, Roma 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 are active and informed participants in accounting for their experiences and redesigning systems to ensure accountability.[148] These efforts must be inclusive of the voices of women who have experienced multiple, intersecting forms of discrimination.

VII. Recommendations

CENTER *for*
REPRODUCTIVE
RIGHTS

We respectfully suggest that the Special Rapporteur's report on racism and the right to health include clear and specific language and recommendations that:

- Affirm that:
    - States have an obligation to guarantee access to comprehensive sexual and reproductive health services, including maternal health care, abortion services, access to contraceptives and care for survivors of sexual violence, including in humanitarian settings.
    - States must also guarantee the underlying determinants of sexual and reproductive health, including the right to health information and to comprehensive sexuality education.
    - Sexual and reproductive right encompasse the right to free and fully informed consent to treatment.
- Provide a clear and comprehensive definition of intersectional discrimination, as distinct from multiple and intersecting forms of discrimination.
- Recognize that structural racism creates significant barriers to the enjoyment and realization of sexual and reproductive rights and that women and girls with intersecting identities—including racial or ethnic minorities, Roma, indigenous or migrant women, living in rural areas or socioeconomically disadvantaged or in adolescence—suffer disproportionately and in cumulative ways the consequences of all forms of violence and discrimination, in particular sexual violence, reproductive violence, and lack of access to sexual and reproductive health services.
- 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 intersecting 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 marginalized 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 that states, in their periodic reports, report on the intersectional discrimination and compounded stereotypes 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.

- **Affirm, in line with other treaty monitoring bodies and the WHO's 2022 abortion guidance (noting that the CESCR Committee has required states to be guided by the "most current international guidelines" from the WHO[149]), 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.
- 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. Require states to include disaggregated data on maternal mortality in their periodic reports.
- Affirm that forced 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 Roma women and indigenous women. Call upon states to guarantee accountability for these violations and underscore their obligation to ensure the active participation of victims in the creation of accountability and monitoring mechanisms.
- 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.
- 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.

[1] The Convention defines racial discrimination as "any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin." Article 1.1 of the Convention. Through General Recommendations, this Committee has affirmed that discrimination against indigenous peoples, Roma, people of African descent, migrants, refugees, asylum-seekers, undocumented non-citizens and "persons who cannot establish the nationality of the State on whose territory they live," among others, falls under the scope of the Convention. This Committee has further clarified that "discrimination based on 'descent' includes discrimination against members of communities based on forms of social stratification such as caste and analogous systems of inherited status which nullify or impair their equal enjoyment of human rights." See General Recommendation No. 23 (The rights of indigenous peoples), 1997, para. 1, available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCERD%2fGEC%2f7495&Lang=en (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."); General Recommendation No. 27 (Discrimination against Roma), 2000, available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCERD%2fGEC%2f7499&Lang=en; General Recommendation No. 34 (Racial Discrimination against people of African descent) 2011, available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fGC%2f34&Lang=en; General Recommendation No. 30 (Discrimination against non-citizens), 2005, Preamble, available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCERD%2fGEC%2f7502&Lang=en; General Recommendation No. 29 on Article 1, paragraph 1, of the Convention (Descent), 2002, Preamble, available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCERD%2fGEC%2f7501&Lang=en.

[2] See, e.g., SR VAW report, para. 101 (2011) ("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.")

[3] 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.

[4] *Id.* at 139.

[5] CRPD Committee, GC No. 3, para. 4c.

[6] CRPD Committee, GC No. 3, para. 5.

[7] CRPD Committee, GC No. 3, para. 16 (emphasis added).

[8] CRPD Committee, GC No. 3, para. 4c.

[9] SR VAW 2011 report, paras. 42-43, 49.

[10] Crenshaw at 140.

[11] CESCR Committee, GC 20, para. 27.

[12] CESCR Committee, GC 22, paras. 30-32. The ESCR 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." GC 22, para. 30.

[13] CEDAW, GR 28, para. 18. See also CEDAW Committee, GR 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.").

[14] CEDAW Committee, GR 25, para. 12.
[15] See, for example, CEDAW and CRC joint re on harmful practices, paras. 5, 14, 15, 54, U.N. Doc. CEDAW/C/GC/31-CRC/C/GC/18 (2014).
[16] CEDAW, GR 34, paras. 14-15.
[17] CEDAW, GR 26, para. 6.
[18] CEDAW, GR 30, paras. 7, 57.
[19] CEDAW, GR 32, para. 16.
[20] 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).
[21] *Id.* para 8.
[22] Committee on the Elimination of Discrimination against Women, *A.S. v. Hungary*, Communication No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).
[23] *See, for e.g., Report of the UN Working Group on the issue of discrimination against women in law and in practice*, U.N. Doc. A/HRC/32/44 (2016), para. 57. See also World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* (2014).
[24] General Recommendation No. 25 (Gender-related dimensions of racial discrimination), 2000, para. 3, available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCERD%2fGEC%2f7497&Lang=en.
[25] Id. at para. 2.
[26] CERD, GR 29, section 2.
[27] CERD, GR 30, para. 8.
[28] CERD, GR 27, paras. 6, 22, 34.
[29] CERD, GR 34, paras. 22-24, 26.
[30] CERD Committee, *Concluding Observations: Slovakia*, paras. 23-24, U.N. doc. CERD/C/SVK/CO/11-12 (2018).
[31] 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).
[32] 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).
[33] Committee on Economic, Social and Cultural Rights, *General Comment No. 22: On the right to sexual and reproductive health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights*), para. 45, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter CESCR Committee, *Gen. Comment No. 22*]. See also CESCR, GC 14, para. 8.
[34] CESCR Committee, GC 22, para. 5.
[35] *Id.* paras. 5, 10, 30. "...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".
[36] CESCR Committee, *Gen. Comment No. 22*, paras. 12-21.; Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12),* (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 12, U.N. Doc. E/C.12/2000/4 (2000).
[37] CESCR Committee, *Gen. Comment No. 14*, paras. 12(c), 27; CESCR Committee, *Gen. Comment No. 22*, para. 20.
[38] CESCR Committee, *Gen. Comment No. 22*, para. 49.
[39] CESCR Committee, *Gen. Comment No. 22*, para. 10.
[40] CESCR Committee, Gen. Comment No. 22, paras. 7-8.
[41] CESCR Committee, GC 22, para. 7.
[42] CESCR Committee, GC 22, para. 8 (emphasis added).
[43] CEDAW Committee, *Gen. Recommendation No. 24*, para. 21.; CESCR Committee, *Gen. Comment No. 16*, para. 29.; *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).

[44] 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).

[45] CEDAW Committee, *Gen. Recommendation No. 33,* paras. 47, 51(l).; CEDAW Committee, *Gen. Recommendation No. 24,* para. 11.

[46] 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; 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). See also CRPD, GC 3.

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

[48] CEDAW Committee, General Recommendation No. 25: Article 4, para. 9; CESCR, General Comment No. 20, paras. 8, 9 & 39.

[49] CRC Committee, General Comment No. 15, para. 9.

[50] 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; ESCR Committee, Gen. Comment No. 20, para. 17; Human Rights Committee, General Comment No. 28, para. 30; CRPD Committee, General Comment No. 3, paras. 3, 4, 38.

[51] CEDAW Committee, Gen. Recommendation No. 25, paras. 8-10; ESCR Committee, Gen. Comment No. 3, para. 10; Human Rights Committee, Gen. Comment No. 28, para. 3; CEDAW Committee, Gen. Recommendation No. 28, para. 20.

[52] Liiri Oja & Alicia Ely Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?" (2016) 32(1) *Columbia Journal of Gender and Law*, p. 77.

[53] CEDAW Committee, *Concluding Observations: Czech Republic*, UN Doc. CEDAW/C/CZE/5 (2010) para. 36.

[54] *Report of the UN Working Group on the issue of discrimination against women in law and in practice*, UN Doc. A/HRC/32/44 (2016), para. 73.

[55] See, for example, World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* (2014), p.9.

[56] CESCR Committee, *Gen. Comment No. 22*, para. 49(d).

[57] *Views on communication 4/2004*: Ms. A.S. v. Hungary. New York, United Nations Committee on the Elimination of Discrimination against Women, 2006 (UN Doc CEDAW/C/36/D/4/2004); *Female sterilization guidelines*. London, International Federation of Gynecology and Obstetrics, 2012.

[58] 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*, UN. Doc. A/74/137, para. 38 (2019).

[59] WHO abortion care guideline (2022) at p. 10.

[60] 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*, UN. Doc. A/74/137, para. 38 (2019) (citing to *Guidelines regarding informed consent*, Lyon, International Federation of Gynecology and Obstetrics, 2007; see also *Female sterilization guidelines*. London, International Federation of Gynecology and Obstetrics, 2012; *Convention on the Rights of Persons with Disabilities*. Adopted 13 December 2006, entered into force 3 May 2008. New York, United Nations General Assembly, 2006 (UN Doc A/ RES/61/106, 2515 UNTS 3); World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary*

Sterilization: An Interagency Statement (2014)). *See also* CRPD, General Comment No. 3 (2016): Women and girls with disabilities, paras. 31-32, 62(b)(ii).
[61] CRPD, General Comment No. 3 (2016): Women and girls with disabilities, para. 62(b)(ii).
[62] CRPD, General Comment No. 1 (2014): Article 12: Equal recognition before the law, para. 41. See also CRPD, General Comment No. 3 (2016): Women and girls with disabilities, para. 44.
[63] 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*, UN. Doc. A/74/137, para. 38 (2019) (citing to *Guidelines regarding informed consent*, Lyon, International Federation of Gynecology and Obstetrics, 2007; see also *Female sterilization guidelines*. London, International Federation of Gynecology and Obstetrics, 2012; *Convention on the Rights of Persons with Disabilities*. Adopted 13 December 2006, entered into force 3 May 2008. New York, United Nations General Assembly, 2006 (UN Doc A/ RES/61/106, 2515 UNTS 3); World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* (2014)). *See also* CRPD, General Comment No. 3 (2016): Women and girls with disabilities, paras. 31-32, 44, 62(b)(ii).
[64] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, para. 95, U.N. Doc. A/64/272 (2009).
[65] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, para. 98, U.N. Doc. A/64/272 (2009).
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[78] Human Rights Committee, Gen. Comment No. 36, para. 8.
[79] CEDAW Committee, *Gen. Recommendation No. 35*, para. 18.; CEDAW Committee, *Gen. Recommendation No. 24*, paras. 11, 14.
[80] CESCR Committee, Gen. Comment No. 22, paras. 11- 21.
[81] Human Rights Committee, Gen. Comment No. 36, para. 8.
[82] *Ibid.* See also: Human Rights Committee, Gen. Comment No. 28, paras. 10-11; CESCR Committee, Gen. Comment No. 22, paras. 28, 34, 40, 41, 45, 49(a), 49(e), 57; CEDAW Committee, Gen. Recommendation No. 24, para. 14; CEDAW Committee, Gen. Recommendation No. 35, para. 29(c)(i); CEDAW Committee, Gen. Recommendation No. 34, para. 39(c); CRC Committee, Gen. Comment No. 20, para. 60 U.N. Doc. CRC/C/GC/20 (2016); CRC Committee, Gen. Comment No. 15, paras. 31, 70, U.N. Doc. CRC/C/GC/15 (2013); Human Rights Committee, Concluding Observations: Angola, paras. 21-22, U.N. Doc. CCPR/C/AGO/CO/2 (2019); CESCR Committee, Concluding Observations: Cameroon, para. 59, U.N. Doc. E/C.12/CMR/CO/4 (2019); CEDAW Committee, Concluding Observations: Colombia, paras. 37-38, U.N. Doc. CEDAW/C/COL/CO/R.9 (2019); CRC Committee, Concluding Observations: Bahrain, para. 38, U.N. Doc. CRC/C/BHR/CO/4-6 (2019).
[83] CESCR Committee, *Gen. Comment No. 22*, para. 49.
[84] WHO, Abortion Care Guideline (2022), Section 2.2.1 (pp. 24–25).
[85] *Id.* at Section 2.2.2 (pp. 26–27).
[86] *Id.* at Section 2.2.3 (pp. 28–29).
[87] *Id.* at Section 3.3.1 (pp. 41–42).
[88] *Id.* at Section 3.3.2 (pp. 42–44).
[89] Id. at p. 42.
[90] Id. at p. 43.
[91] World Health Organization (WHO) statement, "The prevention and elimination of disrespect and abuse during facility-based childbirth", WHO/RHR/14.23 (2015). 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*, 11 July 2019, UN. Doc. A/74/137.
[92] M.A. Bohren, J.P. Vogel, E.C. Hunter, et al., The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review, PLOS Medicine 12(6) (2015) at p. 10.
[93] *See, e.g.*, CENTER FOR REPRODUCTIVE RIGHTS, PERILOUS PREGNANCIES: BARRIERS IN ACCESS TO AFFORDABLE MATERNAL HEALTH CARE FOR UNDOCUMENTED MIGRANT WOMEN IN THE EUROPEAN UNION (2018), *available at*
https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Perilous- Pregnancies-Health-Care-For-Undocumented-Migrant-Women-EU.pdf
[94] One Roma mother explained: "There were two of us sleeping in one bed...[If only they'd put us] in the room next door when there were vacancies, but they wouldn't." Center for Reproductive Rights, *Vakeras Zorales – Speaking Out: Roma Women's Experiences in Reproductive Health Care in Slovakia* (2017) p.13.

[95] 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/.
[96] 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.
[97] 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.
[98] Arline Geronimus et al., "*Weathering" and Age patterns of Allostatic Load Scores Among Blacks and Whites in the United States*, AM J PUBLIC HEALTH (May 2006), https://pubmed.ncbi.nlm.nih.gov/16380565/; Jeanne Alhusen et al., *Racial Discrimination and Adverse Birth Outcomes: An Integrative Review*, J MIDWIFERY WOMEN'S HEALTH (Oct. 13, 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5206968/.
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[100] *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.
[101] NY Times Editorial Board, *A Woman's Rights*, NY TIMES (Dec. 28, 2018), https://www.nytimes.com/interactive/2018/12/28/opinion/pregnancy-women-pro-life-abortion.html?searchResultPosition=1 (hereinafter *A Woman's Rights*)
[102] Emily Bazelon, *Purvi Patel Could be Just the Beginning*, NY TIMES (Apr. 1, 2015), https://www.nytimes.com/2015/04/01/magazine/purvi-patel-could-be-just-the-beginning.html.
[103] *A Woman's Rights*,
[104] *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.
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[106] PROMSEX. *Eulogia, Hechos del Caso*. Available at: https://incidenciainternacional.promsex.org/2020/06/23/eulogia/
[107] CRR and PROMSEX, Case of Eulogia Guzman and her son Sergio v. Peru (2022), p. 4.
[108] 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.").
[109] World Health Organization, *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*, WHO/RHR/14.23 (2015).
[110] CEDAW, art. 12.
[111] CEDAW Committee, *Gen. Recommendation No. 24*, para. 31(e).
[112] 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.
[113] SR health, Reducing maternal mortality: the contribution of the right to health, para. 17(c) (2006), available at https://documents-dds-ny.un.org/doc/UNDOC/GEN/N06/519/97/PDF/N0651997.pdf?OpenElement.

[114] 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.
[115] Human Rights Committee, *Gen. Comment No. 36*, para. 26. See also SR health, Reducing maternal mortality: the contribution of the right to health, paras. 31-36 (2006).
[116] CESCR Committee, *Gen. Comment No. 14*, para. 20.; CESCR Committee, *Gen. Comment No. 20*, para. 20.; Committee on the Elimination of Discrimination against Women, *General Recommendation No. 9: Statistical data concerning the situation of women*, (8th Sess., 1989), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. A/44/38 (1989); Committee on the Rights of the Child, *General Comment No. 5: General measures of implementation of the Convention on the Rights of the Child (arts. 4, 42 and 44, para. 6)*, (34th Sess., 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 45, U.N. Doc. CRC/GC/2003/5 (2003); 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).
[117] CEDAW Committee, *Alyne v. Brazil* (2011), para. 7.7.
[118] SR VAW, report on mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence (2019) paras. 43-44, 81(t).
[119] 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* (2014) p. 5.
[120] WHO, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement* (2014) p. 4.
[121] 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); SR VAW, A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence (2019), para. 21.
[122] 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.
[123] 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. 33; see also WHO, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement* (2014).
[124] *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; CLAUDE CAHN, HUMAN RIGHTS, STATE SOVEREIGNTY, AND MEDICAL ETHICS: EXAMINING STRUGGLES AROUND COERCIVE STERILISATION OF ROMANI WOMEN (2015).
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[126] *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).

[127] CRPD Committee, *Gen. Comment No. 3*, paras. 44, 63(a).; 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).; *See also*, CEDAW Committee, *Gen. Recommendation No. 35*, para. 18; Human Rights Committee, *General Comment No. 28*, para. 20.

[128] CERD Committee, General Recommendation No. 25: Gender related dimensions of racial discrimination, para. 2 (2000).

[129] Committee on the Elimination of Discrimination against Women, *A.S. v. Hungary*, Communication No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).

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[132] CERD, General Rec. 25, para. 2. See also SR on health report, para. 49 ("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".").

[133] CEDAW, Gen Rec 30, para. 36. See also SR on HR defenders report, U.N. Doc. A/HRC/43/51 (2019) para 28.

[134] CEDAW Committee, GC 30, para. 34

[135] CEDAW Committee, GC 30, para. 50

[136] Para. 43 of SR on health report.

[137] WGDAWG, women and girls' sexual and reproductive health in crisis (2020), para. 33.

[138] WGDAWG, women and girls' sexual and reproductive health in crisis (2020), para. 60-61.

[139] CEDAW Committee, *Gen. Recommendation No. 30*,
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: The nature of the general legal obligation imposed on States parties to the Covenant*, (80th Sess., 2004), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 11, U.N. Doc. CCPR/C/21/ Rev.1/Add.13 (2004).; Human Rights Committee, *General Comment No. 29: States of emergency (Article 4)*, (72nd Sess., 2001), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 3, U.N. Doc. CCPR/C/21/Rev.1/Add.11 (2001).; Legality of the Threat or Use of Nuclear Weapons, Advisory Opinion, 1996 I.C.J., para. 22 (July 8).; Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory, Advisory Opinion, 2004 I.C.J., para. 106 (July 9).; Armed Activities on the Territory of the Congo (Democratic Republic of the Congo v. Uganda), Judgment, 2005 I.C.J., para. 216 (Dec. 19); CRPD, Article 11.; 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.

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

[141] 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).
[142] CEDAW Committee, *Gen. Recommendation No. 30, para. 57(b)*
[143] CESCR Committee, *Concluding Observations: Czech Republic*, U.N. Doc. E/C.12/CZE/CO/2 (2014).; CESCR Committee, *Concluding Observations: Slovakia*, U.N. Doc. E/C.12/SVK/CO/3 (2019).; CEDAW Committee, *Concluding Observations: Lithuania*, U.N. Doc. CEDAW/C/LTU/CO/4 (2008).; Convention on the Elimination of All Forms of Racial Discrimination, *adopted* Dec. 21, 1965, G.A. Res. 2106, Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195 (*entered into force* Jan. 4, 1969).
[144] 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
[145] UN Committee on Economic, Social and Cultural Rights, General Comment 22 on the Right to the Sexual and Reproductive Health (2016).
[146] 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*).*
[147]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).
[148] 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), at pgs. 11-14.
[149] CESCR Committee, *Gen. Comment No. 22*, para. 49.