2 June 2022

FIGO & Ipas's submission

FOA: **Dr.Tlaleng Mofokeng, United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health**

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The International Federation of Gynecology and Obstetrics (FIGO) is a professional organisation that brings together more than 130 obstetrical and gynaecological (OBGYN) associations (working in the public and private health sector) from all over the world. FIGO's vision is that women and girls of the world achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives. FIGO is in official relations with the World Health Organization (WHO) and consultative status with the United Nations (UN).

Ipas is an international organization that works in more than 20 countries across Africa, Asia and Latin America to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion. We envision a world where everyone can make their own sexual and reproductive choices, and ultimately, determine their own future. We work with partners to make safe abortion and contraception widely available, to connect women with vital information so they can access safe services, and to advocate for safe, legal abortion. We strive to foster a legal, policy, and social environment supportive of women's rights to make their own sexual and reproductive health decisions freely and safely.

We are writing to share our evidence-based responses, that we hope will provide helpful considerations for you in relation to your forthcoming thematic report on "Racism and the right to health", which you will present to the General Assembly in October 2022.

Please find our response to your key questions below.

1. **What are the main ongoing manifestations of racism, and related forms of discrimination enabled by racism that may be prevalent in your country in the area of the right to health broadly including in underlying determinants of health, health outcomes and access to health care?**

"Moral wounds have this peculiarity—they may be hidden, but they never close; always painful, always ready to bleed when touched, they remain fresh and open in the heart."Alexandre Dumas[1]

We acknowledge the pain, anxiety and suffering of so many who have experienced racism and bias. Because of the work we do, we are deeply aware of the inequities experienced by women of colour and other minority groups, and the political and economic oppressive structures that perpetuate and

[1] As cited in Mitigating ethnic disparities in Covid-19 and beyond, BMJ 2021; 372 doi: https://doi.org/10.1136/bmj.m4921 15 January 2021.

maintain these inequities. The disparities we see in health and well-being are numerous, and we believe that all women in all their diversities' health and well-being is most often compromised, NOT because of a lack of medical knowledge, but rather intersectional discrimination because of several violations of basic human rights, including the right to health.

As raised by Dr.Tlaleng Mofokeng, Colonialism (and coloniality) are critical power structures that have developed and continue to inform the priorities of global health and social health determinants.[2]

Preventable maternal mortality and mortality (MMR)

MMR is rooted in gender injustice and intersectional inequalities. Globally, approximately 295,000 women died during and following pregnancy and childbirth in 2017. The vast majority of these deaths (94%) were of women of black, coloured or indigenous, marginalised religious and/or ethnic status and occurred in low-resource settings Sub-Saharan Africa and Southern Asia accounted for approximately 86% (254 000) of the estimated global maternal deaths in 2017.[3]

Progression in achieving gender/intersectional equality has been persistently elusive, as illustrated by the lack of progress made under SDG 3 target to reduce the global maternal mortality ratio (MMR) to fewer than 70 maternal deaths per 100,000 live births and 140 nationally, which has now been further compounded by COVID pandemic. A reduction in MMR is dependent on social determinants, access to and the enjoyment of social health determinants reflects the inequality and avoidable differences in health status seen within and between country populations.[4]

For example, in Brazil, one of the most worrying scenarios in relation to sexual and reproductive health is the greater vulnerability of pregnant and postpartum women to Covid-19, in particular black women, who suffer greater risks to their health and life. In 2021 alone, 2.796 women died, mostly living in peripherical urban areas, without access to primary care and emergency obstetric care, with an increase in 77% of maternal mortality rates in two years, before the pandemic[5]. According to the data produced by the Brazilian Obstetrical Observatory of Covid-19, until May 2021, deaths maternal rates among black women was 77% higher than among white women[6]. Brazil represents 75% of maternal deaths from the disease

[2] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng: Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic, para. 6 A/76/172, 16 July 2022.

3 https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

[4] https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

[5] Brazil. Maternal Mortality Panel, Ministry of Health, Ministry of Health, 2021. http://svs.aids.gov.br/dantps/centrais-de-conteudos/paineis-de-monitoramento/mortalidade/materna/ See also: https://noticias.uol.com.br/colunas/carlos-madeiro/2022/05/22/mortalidade-materna-salta-77-em-2-anos-pais-retrocede-a-taxa-de-anos-1990.htm

[6] CRIOLA. Dossiê Mulheres Negras e Justiça Reprodutiva 2020-2021. Available at: Criola lança dossiê com retrato de violações de direitos das mulheres negras e impactos na saúde reprodutiva – Criola

worldwide[7]. This scenario revealed Brazilian health system emblematic pattern of intersectional discrimination against poor black women living in poor urban areas, already noted by the CEDAW Committee's decision in *Alyne da Silva Pimentel case vs. Brazil*.[8] However, the high MMRs associated with Covid-19, civil society advocacy efforts, scientific publications on the subject and the systematization of data have not been enough to mobilize Brazilian state's effective actions to protect these women from preventable deaths.

Intersectional discriminatory enforcement of abortion laws

In the majority of countries, abortion care is the only health service that is regulated by the criminal/penal code, which not only fuels abortion-related stigma - shaming and criminalising those who seek abortion care, having a disproportionate impact on communities that have been historically marginalised and are at greater risk to harassment and intimidation by law enforcers. Ipas research globally illustrates that when abortion remains in the criminal law, the most marginalized groups of people suffer harm from criminalization of abortion

WHO's new updated safe abortion guidelines recommend full decriminalization of abortion, drawing on evidence WHO found that ground-based laws and abortion laws based on gestational limits act as a barrier to accessing safe and quality abortion care.[9] Moreover, scientific evidence illustrates that that women can safely self-manage their abortion care by using misoprostol with mifepristone or misoprostol alone to end a pregnancy without the involvement of a healthcare professional (up to 12 weeks gestation). Researchers have attributed abortion with pills outside formal health care settings to a worldwide decrease in abortion mortality.[10]

2. **Who are the most affected people and why? Please describe existing disparities in the provision of and access to health services that affect people of different racial and ethnic origin, descent as well as other groups, such as migrants. The lack of data, analysis or health indicators in this regard may also be reflected.**

There are continued challenges related to the availability of disaggregated data pertaining to health disparities experienced by populations with intersectional identities. this includes on the human rights of healthcare

[7] CRIOLA. Dossiê Mulheres Negras e Justiça Reprodutiva 2020-2021. Available at: Criola lança dossiê com retrato de violações de direitos das mulheres negras e impactos na saúde reprodutiva – Criola
[8] Cook RJ, Galli B. Invoking human rights to reduce maternal deaths. Lancet. 2004;363:73
[9] WHO abortion care guideline, 8 March 2022: https://www.who.int/publications/i/item/9789240039483
[10] Rossier, Clémentine. "Unsafe abortion still frequent across the world but less often fatal", *Population & Societies*, vol. 513, no. 7, 2014, pp. 1-4. Available at: Putting abortion pills into women's hands: realizing the full potential of medical abortion (contraceptionjournal.org)
Jelinska K, Yanow S. Putting abortion pills into women's hands: realizing the full potential of medical abortion. Contraception. 2018 Feb;97(2):86-89. doi: 10.1016/j.contraception.2017.05.019. Epub 2017 Aug 3. PMID: 28780241. Available at: Unsafe abortion still frequent across the world but less often fatal | Cairn International Edition (cairn-int.info)

workers with intersectional identities, who work to defend SRHR. Please find country examples that illustrate the harm caused by racial inequality and how historically marginalised women/girls are at even greater risk in having their reproductive rights violated.

UK – *Black, South Asian and mixed race women higher risk for maternal deaths*

Black women in the UK are four times more likely to die in pregnancy and childbirth than white women, while Asian and mixed race women are twice as likely.[11] Stillbirth rates in babies of black and black British ethnicity were more than twice those for white babies and neonatal mortality rates were 43% higher. For Asian and Asian British babies, stillbirth and neonatal mortality rates were around 60% higher than for white babies for both groups.[12] "These findings show how challenges facing the maternity system, including workforce shortages and a lack of long term consistent investment, can combine with systemic racism and structural barriers and leave women from minority ethnic backgrounds at increased risk and feeling unsafe during their maternity care," Royal College of Obstetrics and Gynecology (RCOG), President Edward Morris.[13]

Lebanon – *Syrian refugees, especially those with inter-sectional identities, have less access to primary healthcare serves than Lebanese population*[14]

Lebanon is hosting 1.5 million Syrian refugees, 75% percent of whom are women and children. According to the UN High Commissioner for Refugees (UNHCR), Syrian refugees have less access to primary healthcare services than the Lebanese population. Among Syrian refugees, the individuals most at risk of discrimination are survivors of gender-based violence (GBV) individuals with disabilities, unmarried women and girls, LGBTQI persons. Although 80% of the cost of primary health care is covered by the UNHCR, use is dwindling due to collateral medical costs and humiliation experienced during clinical visits.[15] A recent study found that Syrian refugees report lack of dignity as a main barrier to their use of healthcare services; experienced mainly in the form of long waiting times, attitudes of the medical personnel ("naming and shaming"), and the high cost of services refugees.[16] Embedding the right to human dignity in the delivery of healthcare is fundamental, and governments, donors and NGOs must ensure greater accountability when health care providers and health care systems deny the right to healthcare of vulnerable and marginalised populations.

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[11] Saving lives, improving mothers' care 2018, lay summary; mothers and babies: reducing risk through audits and confidential enquiries across the UK. www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202018%20-%20Lay%20Summary%20v1.0.pdf

[12] Perinatal mortality surveillance report uk, perinatal deaths for births from January to December 2019; mothers and babies: reducing risk through audits and confidential enquiries across the UK. www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-surveillance-report-2019/MBRRACE-UK_Perinatal_Surveillance_Report_2019_-_Final_v2.pdf.

[13] https://www.rcog.org.uk/news/rcog-responds-to-birthrights-inquiry-into-racial-injustice-in-maternity-care/ and Adele Waters, Racism is "at the root" of inequities in UK maternity care, finds inquiry, BMJ 2022; 377 doi: https://doi.org/10.1136/bmj.o1300 24 May 2022.

[14] Sexual and reproductive health and rights of refugee and migrant women: gynaecologists and obstetricians https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1002/ijgo.13111

[15] Ibid.

[16] Baroud M, Mouheildine O. Healthcare needs and barriers of persons with disabilities: An exploratory study among Syrian refugees, Palestine Refugees from Syria, and Lebanese. Beirut: The Issam Fares Institute for Public Policy and International Affairs (AUB Policy Institute), American University of Beirut; 2018. https ://www.aub.edu.lb/ifi/Docum ents/ publications/research reports/2018-2019/20181 004_healthcare_needs_persons_with_disa ilities.pdf.

Bolivia - Ipas investigated the intersectional discriminatory impact of criminal laws for marginalized women in Latin American countries. These barriers include requirement that only a medical professional provide the abortion, judicial authorization, and burdensome waiting periods, among others. For example, in Bolivia, in one troubling case, an indigenous 28-year-old woman in the city of Santa Cruz become pregnant as the result of rape. She attempted to self-induce an abortion and ended up in the hospital with severe complications. While in the hospital, she was reported to the police authorities by her doctor, was apprehended and handcuffed on charges of illegal abortion. She spent her 10-day hospital stay under police custody and was then transferred to a prison where she subsequently spent eight months in preventive detention.[17]

Covid-19 Pandemic and ethnic disparities on health outcomes

Covid-19 has disproportionately affected ethnic minority groups in developed countries.[18] In the UK, people of black ethnicity have had the highest diagnosis rates, with the lowest rates observed in white British people.[19] Data up to May 2020 show 25% of patients requiring intensive care support were of black or Asian background.[20] The mortality risk from covid-19 among ethnic minority groups is twice that of white British patients after potential confounding factors such as age, sex, income, education, housing tenure, and area deprivation have been taken into account.[21] Data from covid-19 inpatients in England showed that South Asian people had the highest death rates (350 deaths/1000 compared with 290/1000 for white people).[22]

These differences are highlighted in the covid-19 cases among key workers. Although black and Asian staff represent only 21% of the NHS workforce, early analysis showed that they accounted for 63% of deaths among health and social care workers.[23]

In the US, the case and admission rates are at least 2.5 and 4.5 times higher, respectively, among black, Hispanic, and Native American populations compared with white populations.[24] The American Public Media Research Laboratory has estimated a death rate of 61.6/100 000 population for African Americans, 1.7 times greater than that of indigenous Americans and 2.3 times of white and Asian American.[25]

3. **Under the right to health, States have a special obligation to refrain from denying or limiting equal access for all persons, comprising minorities, asylum seekers and migrants including**

[17] Kane, G., Galli, B., & Skuster, P. (2013). When abortion is a crime: The threat to vulnerable women in Latin America. Chapel Hill, NC: Ipas.
[18] Mohammad S Razai, Hadyn K N Kankam Azeem Majeed, Aneez Esmail and David R Williams Mitigating ethnic disparities in covid-19 and beyond, BMJ 2021; 372 doi: https://doi.org/10.1136/bmj.m4921, 15 January 2021.
[19] Public Health England. Disparities in the risk and outcomes of covid-19. PHE, 2020.
[20] Intensive Care National Audit & Research Centre (ICNARC). ICNARC report on COVID-19 in critical care. ICNARC, 2020.
[21] Public Health England. Disparities in the risk and outcomes of covid-19. PHE, 2020.
[22] Harrison EM, Docherty AB, Barr B, et al. Ethnicity and outcomes from covid-19: the ISARIC CCP-UK prospective observational cohort study of hospitalised patients Social Science Research Network, 2020. https://papers.ssrn.com/abstract=3618215
[23] Cook T, Kursumovic E, Lennane S. Exclusive: deaths of NHS staff from covid-19 analysed. Health Service Journal 2020 Jun 21. https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article
[24] US Centers for Disease Control and Prevention. COVID-19 hospitalization and death by race/ethnicity. 2020.https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html
[25] APM Research Lab. COVID-19 deaths analyzed by race and ethnicity. 21 Jun 2020 https://www.apmresearchlab.org/covid/deaths-by-race

undocumented migrants, to preventive, curative and palliative health services; abstain from enforcing discriminatory practices as a State policy as well as to ensure equal access to health care and health-related services provided by third parties. Please explain how the above point is implemented in your country, what works well and not so well and illustrate with disaggregated data if possible.

FIGO's member society, RCOG has urged the UK government to commit to a target to drive a sustained reduction in racial and ethnic disparities in maternity outcomes, accompanied by tangible, funded actions which acknowledge the government's role in tackling the social determinants of health.[26]

The UK Department of Health and Social Care has stated that the government had launched a Maternity Disparities Taskforce to level up maternity care for all women—particularly those living in deprived areas or from ethnic minority backgrounds. The NHS is investing £7m to tackle maternity inequalities and by 2024 it wants at least 75% of pregnant minority ethnic women cared for by the same midwives during and after pregnancy.[27]

FIGO has advocated for the UK to reinstate its overseas aid budget back to 0.7% gross national income. In November 2020 the government announced it was reducing its overseas aid budget to 0.5%. It has been revealed that this cut includes an 85% drop in funding to UNFPA's flagship programme for family planning. The UK Government will drastically reduce its agreed contribution of £154 million to just £23 million, with devastating consequences for women and girls- particularly those from communities who have been historically marginalised and discriminated against, health care workers and health systems globally, especially given the COVID-19 pandemic's impact on the availability of contraceptive services and supplies.[28]

Safe abortion care access remains unavailable to black, adolescent poor women due to provider's only regulation in mostly Global South countries

In the world's poorest countries, which have few healthcare providers per capita, legally requiring health care provider involvement is, in effect, a ban on abortion for black, indigenous, young, gender non-conforming and poor women and those who live in rural areas. In many former British colonies, particularly in Africa, doctors are scarce and laws that authorize only doctors to provide abortion care mean most women cannot access abortion legally.

Zambian law provides an example. Passed in 1972, the Zambian law largely mirrors the liberal law of the U.K. and requires the involvement of three medical practitioners for a legal abortion. Most women in Zambia cannot access legal abortion, as there are fewer than two physicians for every 10,000 people. Legal abortion in Zambia is therefore meaningless for the country's most vulnerable women, particularly for the 38% of Zambians who live in rural poverty.

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[26] Adele Waters, Racism is "at the root" of inequities in UK maternity care, finds inquiry, BMJ 2022; 377 doi: https://doi.org/10.1136/bmj.o1300 24 May 2022.
[27] ibid
[28]https://www.figo.org/figo-calls-reinstatement-funding-unfpa-following-cuts-uk-governments-overseas-aid-budget

Even in countries where there are no restrictions as to reason for termination, such as South Africa or Nepal, the criminal code sets out requirements for legal abortion that criminalize abortions without a health professional. Thus, community health workers and women seeking abortion face legal risk for using abortion pills outside of the formal health-care system, even when self-use can be safe, effective, and a key tool for reducing maternal injury, illness, and death from unsafe abortion.

Abortion can be safely provided by a wide range of health workers in a wide range of settings, and safely self-managed in earlier pregnancy. Provider restrictions are inconsistent with WHO's support for the optimization of the roles of health workers and, as such, are not based on sound evidence. Even in the most liberal legal environments, women choose self-managed abortion in their homes because of the dearth of health professionals willing and able to provide abortion and the overall global shortages of health care workers or choose to seek abortion outside the health sector because of concerns about privacy or stigma. Studies have attributed abortion with pills outside formal health care settings to a worldwide decrease in abortion mortality[29]. Despite this, most laws still require that a specified healthcare professional be involved in the abortion provision.

4. **Please share examples of good legal and policy frameworks that address past or ongoing racism and racial and related forms of discrimination, specifically in relation to access to underlying determinants as well as quality health care, goods, services and facilities, including sexual and reproductive health.**

Advancements of telehealth/self-managed abortion

As reported by the UN Special Rapporteur on Health (July 2021report)[30] Many former colonised countries still carry the legacy of their former European colonial regimes through their present day restrictive abortion laws.

However, telemedicine/self-managed abortions frameworks provide opportunity for women/girls to self-manage access to abortion, which can have significant impact particularly in the lives of marginalised women. FIGO shared its evidence with the UK government and contributed, along with its partners, to achieving UK Parliament's permanent adoption of telemedicine of abortion (March 2022).[31]

Strengthen regulation of 'Conscientious Objection' to increase 'Conscientiously Committed' health workers to support safe and quality abortion care

[29] Ganatra, B, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, Lancet, 2017, 390(101110):2372-2381.
[30] Dr. Tlaleng Mofokeng, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic, para. 6, A/76/17, 16 July 2021.
[31] https://www.figo.org/FIGO-endorses-telemedicine-abortion-services

FIGO through its Advocating for Safe abortion project[32] and via its work with the Committee on Safe abortion is actively working to strengthen access to safe abortion through the stronger regulation of 'Conscientious Objection.'[33]

"Conscientious objection' (CO) is the refusal to perform a role or discharge a responsibility because of personal, religious or moral beliefs. In the context of abortion care, invoking conscientious objection has become a widespread global phenomenon and one that constitutes a barrier to these services for many women and girls. Conscientious objection is manifest when a health care provider refuses to administer abortion services or information on the grounds of conscience or religious belief.

The right to sexual and reproductive health (SRH) is an essential part of the right to life, the right to health, the right to education and the right to equality and non-discrimination. Access to SRH services is a critical component of enabling women and girls to achieve the highest standards of health and wellbeing.

Countries across the world have committed to ensuring that women and girls have the right to make decisions about their health, bodies and lives. Yet several legal, policy, socio-cultural and systemic barriers continue to hinder access to lifesaving SRH procedures such as safe abortion, which is time-sensitive, essential health care. A significant barrier occurs when providers and allied staff have a conflict of conscience and claim the right to refuse safe abortion services.

Specific country examples where countries have aimed to completely prohibit the use of 'CO' (Venezuela, Ethiopia, Sweden, Finland, Bulgaria and Lithuania) other good country examples which have strong regulation in place to ensure access to save and quality abortion is in place include Colombia. The 'CO' World Map provides specific country detail on the legal frameworks governing 'Conscientious Objection'. [21] In its recent updated safe abortion care guidance WHO[34] has conducted 26 studies across 16 countries - in Australia, Brazil, Colombia, Ghana, Italy, Mexico, Nigeria, Norway, Portugal, South Africa, Slovakia, Switzerland, Tunisia, the United Kingdom, the USA and Zambia on the role 'CO' has which informed its key recommendation that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection.

In many of the countries FIGO's ASAP works in, abortion laws were set by European colonial regimes, which continue to regulate abortion under the penal code and on ground-based laws.[35] However, telemedicine/self-

[32] https://www.figo.org/what-we-do/figo-projects/advocating-safe-abortion-project

[33] https://www.figo.org/resources/figo-statements/conscientious-objection-barrier-care#:~:text=FIGO%20acknowledges%20that%20the%20terminology,recognises%20these%20%E2%80%9Cconscientious%20providers%E2%80%9D.

[34] https://www.who.int/publications/i/item/9789240039483 and see Supplementary material 1: Evidence-to-Decision frameworks for the law and policy recommendations p310 https://cdn.who.int/media/docs/default-source/reproductive-health/abortion/supplementary-material-1.pdf?sfvrsn=5bc94f18_7

[35] 'European colonial regimes set in place specific laws, including restrictions on abortion and consensual same-sex acts, which remain on the books today in formerly colonized countries. Indeed, in contrast to the popular narrative that the advancement of sexual rights and abortion rights internationally are modern forms of "colonization" by the West, in fact State-sponsored homophobia, the privileging of heterosexuality and restrictions on women's rights to bodily autonomy are a more precise legacy of colonial rule. They shape contemporary geopolitics of financing, services and audit regimes for sexual and reproductive health rights which enforce power disparities in health aid between bilateral donors and implementing countries. As M. Jacqui Alexander argues, in failing to overturn

managed abortions frameworks provide opportunity for women/girls to self-manage access to abortion, which can have significant impact particularly in the lives of marginalised women. FIGO shared its evidence with the UK government and contributed along with its partners to achieving UK Parliaments permanent adopt of telemedicine of abortion (March 2022).[36]

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these laws, the postcolonial or "neo-colonial" State "continues the policing of sexualized bodies … as if the colonial masters were still looking on". A de-colonial approach would require full bodily and erotic autonomy, allowing all people to make decisions free of intervention from States – colonial or otherwise.' Promotion and protection of human rights: human rights questions, including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms, para 6, A/76/172, 16 July 2021.

[36] https://www.figo.org/FIGO-endorses-telemedicine-abortion-services and https://www.rcog.org.uk/news/parliament-votes-to-make-telemedicine-for-early-medical-abortion-permanent-in-england/

[37] https://www.redaas.org.ar/conscientious-objection-map

[38]https://srhr.org/abortioncare/chapter-3/pre-abortion-3-3/law-policy-recommendation-22-conscientious-objection-3-3-9/ and also see WHO's Abortion care guideline Supplementary material 1: Evidence-to-Decision frameworks for the law and policy recommendations evidence framework here: https://cdn.who.int/media/docs/default-source/reproductive-health/abortion/supplementary-material-1.pdf?sfvrsn=5bc94f18_7 p 310

5. What are the historical and ongoing legacies and impacts of colonialism and slavery on the right to health in your country? And how has the lack of reparations for slavery, colonialism, apartheid and racial discrimination impacted the right to health in your country?

FIGO is working to strengthen access to safe and quality abortion in10 African countries,[39] where the ongoing colonial legacy is still evident in their national abortion laws.

Safe abortion care access remains unavailable to black, poor, adolescent women due to provider's only provision in colonial abortion laws

Regarding access to safe and legal abortion care, an analysis of 196 countries' laws using the World Health Organization's (WHO) Global Abortion Policies Database reveals that all but Canada and China criminalize abortion outside of the health-care system. Through criminal law, lawmakers impose penalties of imprisonment upon all who provide abortion without the education, training, certificate, or license required by statute. Those who procure abortions on their own and the individuals that help could face criminal penalties in nearly every country in the world.

Nearly every law that has changed since 1994 requires that a specified healthcare professional be involved in the abortion decision. For example, when lawmakers in former British colonies reform their abortion law, many of them modify British law enacted during colonial times or look to the current law of the U.K. for guidance. The required involvement of a healthcare professional may not be overly burdensome in the U.K. because of the relative accessibility of medical doctors. However, in the world's poorest countries, which have few healthcare providers per capita, required provider involvement is, in effect, a ban on abortion for Black, indigenous, young, gender non-conforming and poor women and those who live in rural areas. In many former British colonies, particularly in Africa, doctors are scarce and laws that authorize only doctors to provide abortion care mean most women cannot access abortion legally.

Zambian law provides an example. Passed in 1972, the Zambian law largely mirrors the liberal law of the U.K. and requires the involvement of three medical practitioners for a legal abortion. Most women in Zambia cannot access legal abortion, as there are fewer than two physicians for every 10,000 people. Legal abortion in Zambia is therefore meaningless for the country's most vulnerable women, particularly for the 38% of Zambians who live in rural poverty. Even in countries where there are no restrictions as to reason for termination, such as South Africa or Nepal, the criminal code sets out requirements for legal abortion that criminalize abortions without a health professional. Thus, community health workers and women seeking abortion face legal risk for using abortion pills outside of the formal health-care system, even when self-use can be safe, effective, and a key tool for reducing maternal injury, illness, and death from unsafe abortion.

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6. **Please also share good practices and examples of reparations for racial discrimination related to the right to health violations and abuses.**

Brazil

Alyne's case is emblematic of strategic litigation for advancing women's right to safe motherhood to address a pattern of structural failures within the public health system. The necessity of such litigation is demonstrated by the high maternal mortality rates in Brazil, which reflect both the persistence of inequalities and reproductive injustice affecting black and low-income women, as well as the consistent failure of measures designed to address the root causes and underlying social determinants of unequal health-care outcomes and human rights violations. The CEDAW Committee's decision clearly has the potential to generate a ripple effect in other countries in which the health-care systems are facing challenges. In this regard, assessment of the Brazilian state's compliance should not be measured solely in terms of inequalities in health outcomes but should instead take into account political processes generated by dialogues involving multiple stakeholders and by the establishment of an interministerial group to discuss the next steps in the implementation process with civil society organizations.[41]

The success of the implementation of the 2030 Sustainable Development agenda does not depend only on governments' political will and formal compliance with its international commitments only, but also relies on the full engagement of a multi-stakeholder partnership including civil society, private sector, and local authorities to demand accountability of their international human rights obligations regarding sexual reproductive health and rights, including the right to safe motherhood. In this regard, citizens and civil society have a common responsibility to engage with reality and translating the SDGs into policy actions, monitoring their progress, and holding governments accountable.[42] In Rio de Janeiro, a Perinatal Forum was created to discuss and monitor of Alyne's decision implementation with the participation of Public Prosecutor's Office

[40] Ganatra, B, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, Lancet, 2017, 390(101110):2372-2381.
[41] Galli B. Human Rights Accountability for Advancement of Gender Equality and Reproductive Justice in the Sustainable Development Agenda. W. Leal Filho et al. (eds.), Gender Equality, Encyclopedia of the UN Sustainable Development Goals, https://doi.org/10.1007/978-3-319-70060-1_42-1.
[42] Ibid.

and Public Defendant's Office aiming to prevent human rights violations in future cases according to CEDAW's decision human rights standards.[43]

India

The ground-breaking *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors, W.P.(C) Nos. 8853 of 2008*[44] for the first time in history held a government accountable for preventable maternal death. The final judgement clubbed together two individual cases of two women– Shanti Devi– a Scheduled Caste woman, Dalit, internally displaced, living in poverty and that of Fatima, a Muslim woman, homeless/living in poverty. The judgement not only awarded reparations to the family of (deceased Shanti Devi), and to the applicant Fatima; the judgement also provided clear instruction to the Union of India, to synthesise its various programmes/schemes and entitlements, in order to remove barriers/burdens - such as proof of below the poverty documentation, a challenge in of itself to obtain, which further burdens women/girls

43 Yamin AE, Galli B, Valongueiro S (2018) Implementing international human rights recommendations to improve obstetric care in Brazil. Int J Gynecol Obstet 143(1):114–120. https://doi.org/10.1002/ijgo.12579. Epub 2018 Jul 23. Available at: https://www.ncbi.nlm. nih.gov/pubmed/30035298

44 Jameen Kaur (2012) The role of litigation in ensuring women's reproductive rights: an analysis of the Shanti Devi judgement in India, Reproductive Health Matters, 20:39, 21-30, DOI: 10.1016/S0968-8080(12)39604-3 https://www.tandfonline.com/doi/pdf/10.1016/S0968-8080%2812%2939604-3?needAccess=true also cited in Former Special Rapporteur of Health Paul Hunt - Paul Hunt and Tony Gray (eds), Maternal Mortality, Human Rights and Accountability (London: Routledge, 2013)