Comments from the Center for Reproductive Rights in response to the call for submissions from the Office of the High Commissioner for Human Rights on maternal mortality and morbidity in humanitarian settings
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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, Kathmandu, Geneva, and Washington, D.C.—uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill. Since its inception twenty-five 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; preventing and addressing sexual violence; and the eradication of harmful traditional practices, including child marriage. We are pleased to provide this submission to the Office of the High Commissioner for Human Rights on good practices and challenges in the application of a human rights-based approaches to the elimination of preventable maternal mortality and morbidity.

This submission provides an overview of maternal morbidity and mortality in humanitarian settings and discusses how human rights legal obligations and principles provide critical guidance for reducing maternal morbidity and mortality in those settings.

I. Overview of Maternal Morbidity and Mortality in Humanitarian Settings

While there continues to be a need for more reliable data on maternal mortality and morbidity in humanitarian settings, there is little doubt that humanitarian crises exacerbates maternal mortality.[1] In 2015, a United Nations (UN) inter-agency report found that in countries designated as fragile states, the estimated lifetime risk of maternal mortality is 1 in 54, as compared to 1 in 180 global lifetime risk.[2] Maternal mortality ratios (MMRs) in countries affected by conflict remain high and have been shown to increase during periods of conflict.[3]

Studies have found that MMRs among refugees receiving humanitarian aid tend to be lower than among the host population or country of origin, and that delays in seeking and receiving care are among the most significant factors in maternal deaths[4]–factors that are likely exacerbated for asylum seekers in transit.[5] A recent study conducted among Syrian refugee women in Lebanon, for example, found that many women experienced or perceived challenges in accessing reproductive health services, primarily due to costs, distance or transport to facilities, or fear of mistreatment, with more than 35 percent reporting problems during pregnancy or complications during labor, delivery, or abortion.[6]

Lack of reproductive health services includes lack of access to contraception and abortion services and can also be linked to high rates of maternal morbidity and mortality.[7] According to a global evaluation by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG), the provision of contraception, particularly long-acting methods and emergency contraception, continues to lag behind in reproductive health services in emergencies.[8] Globally, unsafe abortion accounts for between 8 to 18 percent of maternal deaths, almost all of which occur in developing countries.[9]

Despite recent increased attention to maternal mortality, there has been much less attention and data collection on the global occurrence of non-fatal health outcomes associated with pregnancy and childbearing.[10] More data is needed on both mortality and morbidity, especially in humanitarian settings.[11]

II. Legal Framework

There are multiple, complementary bodies of law that address the right to safe pregnancy and abortion. International legal bodies have affirmed that fundamental human rights obligations, including those relevant for preventing maternal morbidity and mortality, continue to apply in humanitarian settings.[12] Although international human rights law (IHRL) permits states to derogate from certain civil and political rights in times of armed conflict and to limit certain obligations with respect to economic, social, and cultural rights depending on resource availability,[13] human rights treaty bodies have emphasized that such derogations are subject to strict conditions and that certain minimum core obligations are non-derogable.[14] Even where derogations are permitted, the measures taken cannot involve discrimination based solely on prohibited grounds, including sex.[15]

Sexual and reproductive health and rights (SRHR), including the right to safe pregnancy and childbirth, are central to the realization of fundamental human rights, including the rights to life, health, freedom from torture and ill-treatment, privacy, education, and non-discrimination, among others.[16] Human rights bodies consistently have emphasized that states' obligations to guarantee SRHR require ensuring women and girls have access to comprehensive reproductive health information and services.[17] As with other fundamental human rights obligations, obligations related to SRHR continue to apply in humanitarian settings.[18]

For women and girls who decide to carry a pregnancy to term, IHRL obligates states to ensure that women can survive pregnancy and childbirth, including by ensuring their access to adequate pre- and post-natal care, emergency obstetric services, and skilled birth attendants.[19] Human rights bodies have provided detailed guidance on women and girls' right to maternal health care, which encompasses the full range of services in connection with pregnancy and the post-natal period and the ability to access these services free from discrimination, coercion, and violence.[20]

In humanitarian settings, the CEDAW Committee has explicitly called on states to ensure access to "maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission and emergency obstetric care . . . complications of delivery or other reproductive health complications, among others."[21] In its recommendations to specific states, the CEDAW Committee has noted with concern the effects of humanitarian crises on SRHR and maternal mortality, in particular, calling on states affected by conflict to "accord priority to the provision of sexual and reproductive health services."[22] The Committee on Economic, Social, and Cultural Rights (CESCR Committee) considers the obligation to ensure reproductive and maternal health care to be comparable to a minimum core obligation with which states must comply at all times.[23]

Particularly, making contraception and safe legal abortion readily available in humanitarian settings is important for reducing maternal mortality and morbidity.[24] International human rights treaty monitoring bodies have found that all individuals, including adolescents and youth, have the right to access contraceptive information and services as a means of preventing pregnancy and sexually transmitted infections.[25] The CEDAW Committee has recognized that women often experience increased sexual violence in conflict, "which require[s] specific protective and punitive measures,"[26] and has explicitly called on states to ensure access to contraception, including emergency contraception, in humanitarian settings.[27]

Additionally, international human rights treaty bodies and experts have consistently found that denying access to abortion or imposing barriers to access undermines women's reproductive autonomy and creates circumstances in which women and girls are at a heightened risk for maternal morbidity and mortality.[28] At minimum, states must ensure that abortion is both legal and accessible when a woman's life or health is at risk, in cases of rape and incest, and in cases of severe or fatal fetal anomalies[29] and provide humane, quality post-abortion care to women, regardless of whether abortion is legal.[30] Human rights treaty bodies have raised concerns, in particular, about women raped in armed conflict and have found that the denial of safe abortion care to survivors of rape in armed conflict violates the rights to health and privacy and could amount to a violation of the prohibition on ill-treatment.[31] Human rights bodies have urged states to interpret exceptions to restrictive abortion laws broadly to consider, for example, mental health conditions as a threat to women's health,[32] as per the World Health Organization's definition of health.[33]

International humanitarian, criminal, and refugee laws place further obligations on states to address sexual and reproductive health. These laws are especially relevant for women and girls in humanitarian settings, because they contain provisions relevant to maternal morbidity and mortality. For instance, at minimum, international humanitarian law establishes an obligation to provide medical care and attention to pregnant women and victims of sexual violence.[34] International refugee law[35] also includes protections relevant to women and girls in humanitarian settings.[36] The 1951 Refugee Convention protects the rights of refugees to fundamental human rights, including the right to education, access to justice, and employment.[37] International criminal law has also evolved to contain provisions relevant to SRHR for women and girls in humanitarian settings, specifically with regard to sexual violence arising out of conflict.[38] Thus, the multiple bodies of law that protect the rights of women and girls to safe pregnancy and childbirth must be implemented and states must be held accountable for these obligations.

III. Human Rights Based Approach in Sexual and Reproductive Health Service Delivery in Humanitarian Settings

Humanitarian organizations play a significant role in fulfilling the human rights obligations detailed above, especially where state institutions are weakened, overwhelmed, or not functioning.[39] In fulfilling obligations, organizations should adopt a human rights-based approach, as it is critical for ensuring that humanitarian funding, programs, and policies are driven by, benefiting, and accountable to the individuals most directly affected by them.[40]

More specifically, principles of non-discrimination and equality are core tenants of a human rights-based approach and are central to ensuring that humanitarian programs and policies recognize and address the root causes of maternal mortality and morbidity in fragile and humanitarian settings.[41] Implementing organizations should ensure that affected individuals participate in, shape, and make decisions regarding programs and policies that are intended to be for their benefit.[42] This is especially important for reducing maternal morbidity and mortality.

Effective accountability mechanisms are another integral part of a human rights-based approach, as they require participation and transparency as well as the ability to confer meaningful and effective remedies to for violations of human rights, including preventable maternal mortality and morbidity.[43] While the coverage of SRH services in crisis settings has improved in recent years, there remain significant gaps in the comprehensive and systematic delivery of these services.[44] Meaningful and effective, human rights-based accountability is one tool that can be used to help increase effective delivery of sexual and reproductive health services. A human rights-based approach to accountability recognizes that:

- users of services must be at the center of the design and implementation of crisis response, and should be part of the monitoring to ensure that human rights based services are being implemented;
- complaint mechanisms and remedies must be available and known to users of sexual and reproductive health services who have been harmed; and
- facilities, information and services themselves must be accessible, acceptable, available, and of good quality on a basis of equality and without coercion or violence.

Women and girls in humanitarian settings face limited access to reproductive health care, which puts them at increased risk of maternal morbidity and mortality. Despite some improvements in recent years, there remain significant gaps in care. Yet, women and girls in humanitarian settings are protected by multiple international legal frameworks, which continue to apply in humanitarian settings and provide important and detailed protections related to SRHR that complement and reinforce obligations under international law. Thus, it is critical for states, including those experiencing humanitarian crises, those hosting refugees, and donor states, to prioritize SRHR by ensuring access to maternal health care, contraception, safe abortion care, post-abortion services, and remedies for violations in these settings. All service providers, including UN agencies and humanitarian organizations, should aim to ensure that programs and policies are developed, implemented, and monitored in accordance with human rights and that systems for meaningful and effective accountability to affected women and girls have been fully implemented.. For further information, see the Center's 2017 Briefing Paper, *Ensuring Sexual and Reproductive Health and Rights of Women and Girls Affected by Conflict* (annex 1[45]). Also, Rebecca Brown, Director of Global Advocacy, can be reached at rbrown@reprorights.org.

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[1] *See, e.g.*, Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, *Rep. on the right to health*, para. 43, U.N. Doc. A/68/297 (Aug. 9, 2013) (by Anand Grover) [hereinafter SR Health Report (2013)]; Therese McGinn, Sara Casey, Susan Purdin, and Mendy Marsh, *Reproductive Health for conflict-affected people: Policies, research and programmes*, 45 OVERSEAS DEVELOPMENT INSTITUTE

HUMANITARIAN PRACTICE NETWORK 10-11 (June 2004); Karen Hardee, Jill Gay, & Ann K. Blanc, *Maternal morbidity: Neglected dimension of safe motherhood in the developing world*, 7 GLOBAL PUBLIC HEALTH, 603, 610-11 (2012). *See also* Kayla McGowan, *Closing the Gaps of Maternal Health in Conflict and Crises*, MATERNAL HEALTH TASK FORCE BLOG (Dec. 15, 2016), https://www.mhtf.org/2016/12/15/closing-the-gaps-of-maternal-health-in-conflict-and-crisis/; Carla AbouZahr, *Global burden of maternal death and disability*, 67 BRITISH MEDICAL BULLETIN 1 (2003).

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

[3] For example, the Central African Republic has an MMR of 882 per 100,000 live births, which reflects improvement over the past 15 years but a slight increase since the start of the most recent period of unrest in 2013. *See id*.

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

[5] Moreover, studies noting the correlation between maternal stress, pregnancy-related complications, and fetal development suggest longer-term, intergenerational effects of conflict and displacement. *See, e.g.*, Delan Devakumar, Marion Birch, David Osrin, Egbert Sondorp, and Jonathan CK Wells, *The intergenerational effects of war on the health of children*, 12:57 BMC MEDICINE (Apr. 2014), *available at* https://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-12-57; E.J.H Mulder *et al.*, *Prenatal maternal stress: effects on pregnancy and the (unborn) child*, 70 EARLY HUMAN DEVELOPMENT 3 (June 2002); Lucy Ward, *Mother's stress harms fœtus, research shows*, THE GUARDIAN (May 31, 2007), https://www.theguardian.com/science/2007/may/31/childrensservices.medicineandhealth.

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

[7] *See* CEDAW Committee, *Concluding Observations: Malawi*, para. 31, U.N. Doc. CEDAW/C/MWI/CO (2006); CESCR Committee, *Concluding Observations: El Salvador*, para. 22, U.N. Doc. E/C.12/SLV/ CO/3-5 (2014); Human Rights Committee, *Concluding Observations: Panama*, para. 9, U.N. Doc. CCPR/C/PAN/CO/3 (2008); Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Haiti*, para. 46, U.N. Doc. CRC/C/15/ Add.202 (2003); Committee Against Torture, *Concluding Observations: Yemen*, para. 31, U.N. Doc. CAT/C/YEM/ CO/2/Rev. 1 (2010); CEDAW Committee, *Concluding Observations: Bangladesh*, para. 34, U.N. Doc. CEDAW/C/BGD/CO/8 (2016); CEDAW Committee, *Concluding Observations: Argentina*, para. 32, U.N. Doc. CEDAW/C/ARG/CO/7 (2016); Human Rights Committee, *Concluding Observations: Jamaica*, para. 25, U.N. Doc. CCPR/C/JAM/CO/4 (2016).

[8] Sarah K Chynoweth, *Advancing reproductive health on the humanitarian agenda: the 2012-2014 global review*, 9 (Suppl 1): I1 CONFLICT AND HEALTH 7 (2014), *available at* http://iawg.net/wp-content/uploads/2016/08/IAWG-Global-Evaluation-2012-2014-1.pdf. *See also* Sara E. Casey, *Evidence for the implementation of contraceptive services in humanitarian settings*, Columbia University Academic Commons (2016), *available at* http://dx.doi.org/10.7916/D8K937MH.

[9] GUTTMACHER INSTITUTE, *Induced Abortion Worldwide* 2 (May 2016), *available at* https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide. *See also* Therese McGinn and Sara E. Casey, *Why don't humanitarian organizations provide safe abortion services?,* 10:8 CONFLICT AND HEALTH (March 2016), *available at* https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-016-0075-8.

[10] Though there is not sufficient data on the frequency of maternal morbidity in humanitarian settings, a 2012 study collected data on the worldwide instances of maternal morbidity. The study found that of the 136 million annual births worldwide, 1.4 million women experience acute obstetric morbidity (near-miss) events; 9.5 million women experience other complications; and 20 million women suffer from long-term disabilities following complications during pregnancy or childbirth.[10] In 2013, the UN estimated that 10 to 15 million women and girls daily suffer life-changing disabilities that result from complications during pregnancy or childbirth. *See* Office of the High Commissioner for Human Rights, *Maternal mortality and morbidity and human rights*, UNITED NATIONS (August 2013), *available at* http://www.ohchr.org/Documents/Issues/Women/WRGS/OnePagers/Maternal_mortality_morbidity.pdf. *see also* Carla AbouZahr, *supra* note 1.

[11] *See* Karen Hardee, Jill Gay & Ann K. Blanc, *Maternal morbidity: Neglected dimension of safe motherhood in the developing world*, 7 GLOBAL PUBLIC HEALTH, 603, 611 (2012).
[12] *See* Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory, Advisory Opinion, 2004 I.C.J., para. 136 (July 9); Legality of the Threat or Use of Nuclear Weapons, Advisory Opinion, 1996 I.C.J., para. 25 (July 8); S.C. Res. 2122, preamble, U.N. Doc. S/RES/2122 (Oct. 18, 2013); S.C. Res. 1325, para. 9, U.N. Doc. S/RES/1325 (Oct. 31, 2000).
[13] Human Rights Committee, *General Comment No. 29: Article 4: Derogations during a State of Emergency*, para. 1, U.N. Doc. CCPR/C/21/Rev.1/Add.11 (2001) [hereinafter Human Rights Committee, *Gen. Comment No. 29*]; OHCHR, HUMAN RIGHTS IN ARMED CONFLICT, *supra* note 42, at 10. State obligations with respect to economic, social, and cultural rights, including the right to health, are subject to progressive realization, though states are obligated to take steps to the maximum of available resources to fully realize these rights. International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 2(1), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976); Convention on the Rights of the Child, *adopted* Nov. 20, 1989, art. 4, G.A. Res. 44/25, U.N. GAOR, U.N. Doc. A/RES/44/25 (1989) (*entered into force* Sept. 2, 1990); Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, art, 4(2), G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611 (1980) (*entered into force* May, 3 2008); *see also* CESCR Committee, *General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)*, para. 9, U.N. Doc. E/1991/23 (1990) [hereinafter CESCR, *Gen. Comment No. 3*].
[14] States cannot derogate from certain *jus cogens* norms, such as the prohibitions on torture, genocide, and slavery, even during situations of armed conflict. Human Rights Committee, *Gen. Comment No. 29*, *supra* note 13, para. 7. Minimum core obligations with respect to economic, social, and cultural rights are not subject to resource availability and are non-derogable. CESCR, *General Comment No. 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, para. 47, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR, *Gen. Comment No. 14*]; CESCR, *General Comment No. 15: The Right to Water (Arts. 11 and 12 of the Covenant)*, para. 40, U.N. Doc. E/C.12/2002/11 (2003); *see also* OHCHR, *Protection of Economic, Social and Cultural Rights in Conflict, Report of the High Commissioner for Human Rights*, 4-5 (2015), *available at* http://www.ohchr.org/Documents/Issues/ESCR/E-2015-59.pdf. At the regional level, the African Charter of Human and Peoples' Rights does not permit any grounds for derogation. African Charter for Human and Peoples' Rights, *adopted* June 27, 1981, art. 25, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) (Banjul Charter).
[15] Human Rights Committee, *Gen. Comment No. 29*, *supra* note 13, para. 8.
[16] CENTER FOR REPRODUCTIVE RIGHTS, REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS 5 (2009), *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/RRareHR_final.pdf.
[17] *See* CESCR, *General Comment No. 22 (2016) on the Right to sexual and reproductive health*, para. 5, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter CESCR, *Gen. Comment No. 22*]. Notably, IHL shares some of these goals, particularly as they relate to the non-discriminator provision of medical care in armed conflict. *See* Part III.b *infra*.
[18] Noting that the Covenant's obligations continue to apply in situations of armed conflict, The CESCR Committee has recommended that states increase efforts to ensure sexual and reproductive health services for populations affected by conflict or displacement. CESCR, *Gen. Comment No. 14*, *supra* note 14, paras. 40, 65 (affirming applicability of Covenant in conflict settings and state obligations to ensure minimum essential levels of Covenant rights); CESCR, *Gen. Comment No. 3*, *supra* note 13, para. 10; CESCR, *Concluding Observations: Israel*, paras. 19, 31, U.N. Doc. E/C.12/1/Add.90 (2003); CESCR, *Concluding Observations: Nepal*, para. 45, U.N. Doc. E/C.12/NPL/CO/2 (2008) (regarding the right to health more generally).
[19] Human rights bodies have provided detailed guidance on women and girls' right to maternal health care, which encompasses the full range of services in connection with pregnancy and the post-natal period and the ability to access these services free from discrimination, coercion, and violence. *See* CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, paras. 26-27, U.N. Doc. A/54/38/Rev. 1 (1999) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]; CESCR, *Gen. Comment No. 22*, *supra* note 17, para. 45; CESCR, *Gen. Comment No. 14*, *supra* note 14, para. 14. *See also* CEDAW Committee, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38/Rev.1 (1999); Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/ CO/77/MLI (2003); CRC Committee, *Concluding Observations: Democratic Republic of Congo*, paras. 33-34, U.N. Doc. CRC/C/COD/CO/2 (2009).
[20] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 12(2), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1980), U.N.T.S. 13 (*entered into force* Sept. 3, 1981); CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 19, para. 26.

[21] *See* CEDAW Committee, CEDAW Committee, *General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations*, para. 52 (c), U.N. Doc. CEDAW/C/GC/30 (2013) [hereinafter CEDAW Committee, *Gen. Recommendation No. 30*].

[22] CEDAW Committee, *Concluding Observations: Central African Republic*, para. 40(b), U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014); The CEDAW Committee also raised concerns about the restrictions imposed by the Syrian government that have forced women to give birth in unsafe conditions and recommended that the state "prioritize access to maternal health care services, including skilled delivery services for pregnant women irrespective of their area of residence." CEDAW Committee, *Concluding Observations: Syria*, para. 40, U.N. Doc. CEDAW/C/SYR/CO/2 (2014).

[23] CESCR, *Gen. Comment No. 14*, *supra* note 14, para. 43; CESCR, *Gen. Comment No. 3*, *supra* note 13, para. 10. *See also* SR Health Report (2013), *supra* note 1, para. 11.

[24] *See* UNFPA, *Shelter from the Storm: A transformative agenda for women and girls in a crisis-prone world* (2015). *See also* UNFPA, *Worlds Apart: Reproductive health and rights in an age of inequality* (2017); McGinn & Casey, *supra* note 9, at 8; R. Pearson & C. Sweetman, *Abortion, reproductive rights and maternal mortality* 2 FOCUS GEND. 45 (1994);

[25] States must ensure that contraceptives are affordable and that a comprehensive range of good quality, modern, efficient contraceptives are available, including emergency contraception, as part of their core obligation under the right to health. Access to contraceptives must not be hindered by legal restrictions or third-party authorization requirements. *See*, CESCR, *Gen. Comment No. 22*, *supra* note 17, paras. 6, 41; CESCR, *Gen. Comment No. 14*, *supra* note 14, para. 12(a); CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 19, para. 28; CRC Committee, *General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence*, paras. 59, 60 U.N. Doc. CRC/C/GC/20 (2016); CRC Committee, *General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, para. 69, U.N. Doc. CRC/C/GC/15 (2013); Human Rights Committee, *Concluding Observations: Moldova*, para. 18(a), U.N. Doc. CCPR/C/MDA/CO/3 (2016); CESCR, *Concluding Observations: Armenia*, para. 22, U.N. Doc. E/C.12/ARM/CO/2-3 (2014); CESCR, *Concluding Observations: Poland*, para. 49(a), U.N. Doc. E/C.12/POL/CO/6 (2016); CESCR, *Concluding Observations: Indonesia*, para. 33, U.N. Doc. ESCR/C.12/IDN/CO/1 (2014); CESCR, *Concluding Observations: Djibouti*, para. 5, U.N. Doc. E C.12/DJI/CO/1-2 (2014); CEDAW Committee, *Concluding Observations: Angola*, para. 32(e), U.N. Doc. CEDAW/C/AGO/CO/6 (2013); CEDAW Committee, *Concluding Observations: India*, para. 30-31, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); CEDAW Committee, *Concluding Observations: Hungary*, para. 31(b), U.N. Doc CEDAW/C/HUN/CO/7-8 (2013); CEDAW Committee, *Concluding Observations: Poland*, paras. 36-37, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014); CEDAW Committee, *Concluding Observations: China*, para. 39(d), U.N. Doc. CEDAW/C/CHN/CO/7-8 (2014); CEDAW Committee, *Concluding Observations: Honduras*, para 36(d), U.N. Doc. CEDAW/C/HND/CO/7-8 (2016); CRC Committee, *Concluding Observations: Indonesia*, paras. 49-50, U.N. Doc. CRC/C/IND/CO/3-4 (2014).

[26] CEDAW Committee, *General Recommendation No. 19: Violence against women*, para. 16, *in* U.N. Doc. A/47/38 (1992).

[27] For instance, the CEDAW Committee called on the Congo to "improve the availability of sexual and reproductive health services, including family planning, also with the aim of preventing early pregnancies and clandestine abortions." CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, paras. 35-36, U.N. Doc. CEDAW/C/COD/CO/5 (2006). *See also* CEDAW Committee, *Gen. Recommendation No. 30*, *supra* note 21, at para. 52(c); CEDAW Committee, *Concluding Observations: Central African Republic*, paras. 39-40, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014).

[28] The Committee Against Torture (CAT Committee) and Human Rights Committee have found that, in certain circumstances, denial of access to abortion services can lead to physical or mental suffering that amounts to ill-treatment. The CAT Committee has expressed concern that complete bans on abortion may constitute torture or ill-treatment. Similarly, the Human Rights Committee has found that the denial of access to abortion services can lead to physical or mental suffering amounting to torture or ill-treatment in certain circumstances *See, e.g.*, K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011); CAT Committee, *Concluding Observations: Poland*, para. 23, U.N. Doc. CAT/C/POL/CO/5-6 (2013); CAT Committee, *Concluding Observations: Sierra Leone*, para. 17, U.N. Doc. CAT/C/SLE/CO/1 (2014); CAT Committee, *Concluding Observations: Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); CAT Committee, *Concluding Observations: El Salvador*, para. 23, U.N. Doc. CAT/C/SLV/CO/2 (2009); CAT Committee, *Concluding Observations: Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009); CENTER FOR REPRODUCTIVE RIGHTS, REPRODUCTIVE RIGHTS VIOLATIONS AS TORTURE OR ILL-TREATMENT 22 (2010), *available*

at http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Reproductive_Rights_Violations_As_Torture.pdf.

[29] *See, e.g.*, CEDAW Committee, *Concluding Observations: Bahrain*, para. 42(b), U.N. Doc. CEDAW/C/BHR/CO/3 (2014); CAT Committee, *Concluding Observations: Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); Human Rights Committee, *Concluding Observations: Sierra Leone*, para. 14, U.N. Doc. CCPR/C/SLE/CO/1 (2014); Human Rights Committee, *Concluding Observations: Guatemala*, para. 20, U.N. Doc. CCPR/C/GTM/CO/3 (2012); CRC Committee, *Concluding Observations: Chad*, para. 30, U.N. Doc. CRC/C/15/Add.107 (1999); CRC Committee, *Concluding Observations: Chile*, para. 56, U.N. Doc. CRC/C/CHL/CO/3 (2007); CRC Committee, *Concluding Observations: Costa Rica*, para. 64(c), U.N. Doc. CRC /C/CRI/CO/4 (2011); ESCR Committee, *Concluding Observations: Dominican Republic*, para. 29, U.N. Doc. E/C.12/DOM/CO/3 (2010); CRC Committee, *Concluding Observations: Chile*, para. 53, U.N. Doc. E/C.12/1/Add.105 (2004).

[30] *See, e.g.*, CESCR, General Comment No. 22, *supra* note 17, para. 28; CAT Committee, *Concluding Observations: Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); U.N. Human Rights Council, *Report of the OHCHR: Practices in adopting a human-rights based approach to eliminate preventable maternal mortality and human rights*, para. 29, U.N. Doc. A/HRC/18/27 (2011).

[31] In its recommendations to Syria, the CEDAW Committee urged the state to "[e]xpand the grounds on which abortion is permitted to include, in particular, cases of rape, and prepare guidelines on post-abortion care to ensure that women who are pregnant as a result of rape have free access to safe abortion services." CEDAW Committee, *Concluding Observations: Syria*, para. 40, U.N. Doc. CEDAW/C/SYR/CO/2 (2014). *See also* CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, para. 32(e), U.N. Doc. CEDAW/C/COD/CO/6-7 (2013); Human Rights Committee, *Concluding Observations: Democratic Republic of the Congo*, paras. 13-14, U.N. Doc. CCPR/C/COD/CO/3 (2006).

[32] L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 9(b)(i), U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

[33] *Frequently Asked Questions*, WHO, http://www.who.int/suggestions/faq/en/.

[34] *See* ICRC, COMMENTARY ON THE FIRST GENEVA CONVENTION: CONVENTION (I) FOR THE AMELIORATION OF THE CONDITION OF THE WOUNDED AND SICK IN ARMED FORCES IN THE FIELD, art. 12, para. 1379, (2d ed. 2016), https://ihl-databases.icrc.org/ihl/full/GCI-commentary; ICRC, Customary IHL Database, *Rule 110*, https://www.icrc.org/customary-ihl/eng/docs/v1_rul_rule110 (last visited January 18, 2018).

[35] International legal obligations and standards for the protection of refugees, internally displaced persons (IDPs), and asylum seekers are found in treaties and the policies and guidelines of UNHCR, the UN Refugee Agency. *See* Convention relating to the Status of Refugees (Geneva, 28 July 1951) 189 U.N.T.S. 137, *entered into force* 22 April 1954 [hereinafter 1951 Refugee Convention]; Protocol relating to the Status of Refugees (New York, 31 Jan. 1967) 606 U.N.T.S. 267, *entered into force* 4 Oct. 1967. The 1951 Refugee Convention defines refugee status and state obligations with regard to basic standards of treatment.

[36] *See generally* UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR), HANDBOOK FOR PROTECTION OF WOMEN AND GIRLS (2008), http://www.unhcr.org/en-us/protection/women/47cfa9fe2/unhcr-handbook-protection-women-girls-first-edition-complete-publication.html.

[37] 1951 Refugee Convention, *supra* note 35, arts. 13, 16, 22 (noting that with respect to education, refugees shall be treated the same as nationals). It is important to note that obligations under refugee law extend to all refugees, and not only to those affected by conflict. *See* UNHCR, REFUGEE PROTECTION: A GUIDE TO INTERNATIONAL REFUGEE LAW 8-11 (Dec. 1, 2001), *available at* http://www.unhcr.org/publications/legal/3d4aba564/refugee-protection-guide-international-refugee-law-handbook-parliamentarians.html.

[38] *See e.g.* International Criminal Court (ICC), Office of the Prosecutor, Policy Paper on Sexual and Gender-Based Crimes, at 25 (June 2014), *available at* https://www.icc-cpi.int/iccdocs/otp/otp-Policy-Paper-on-Sexual-and-Gender-Based-Crimes--June-2014.pdf. *See also* Prosecutor v. Jean-Paul Akayesu, para. 11, Case No. ICTR-96-4-T (2 Sept. 1998); Prosecutor v. Furundžija, para. 42, Case No. IT-95-17/1-T ICTY (10 Dec. 1998).

[39] In fact, both IHL and IHRL envision a key role for aid organizations. IHL obligates parties to a conflict and third states to facilitate the passage of humanitarian relief to civilians in need. *See* ICRC, Customary IHL Database, *Rule 55*, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule55 (last visited May 31, 2017). *See also* CESCR, *Gen. Comment No. 14*, *supra* note 14, para. 65 (recognizing the important role of UN agencies in providing access to basic goods and services in humanitarian settings); SR Health Report (2013), *supra* note 1, para. 60.

[40] *See* UNITED NATIONS POPULATION FUND (UNFPA), THE HUMAN RIGHTS-BASED APPROACH, http://www.unfpa.org/human-rights-based-approach (last visited June 9, 2017) [hereinafter UNFPA, THE HUMAN RIGHTS-BASED APPROACH].

[41] *Cf.* OHCHR, PRINCIPLES AND GUIDELINES FOR A HUMAN RIGHTS APPROACH TO POVERTY REDUCTION STRATEGIES, para. 21, U.N. Doc. HR/PUB/06/12 (2006) (noting, in the poverty reduction context, that an approach based on these principles shifts focus from "narrow economic issues towards a broader strategy that also addresses the socio-cultural and political-legal institutions which sustain the structures of discrimination"); *see also* UNFPA, The Human Rights-Based Approach, supra note 40.

[42] The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies, HRBA PORTAL (March 2005), http://hrbaportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies; U UNFPA, THE HUMAN RIGHTS-BASED APPROACH, *supra* note 40.

[43] *See generally* United Nations General Assembly Res. 60/147, *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*, A/RES/60/147 (21 March 2006; *see also* SR Health Report (2013), *supra* note 1, paras. 61-67.

[44] Inter-Agency Working Group on Reproductive Health in Crises, Taking Stock of Reproductive Health in Humanitarian Settings: Key Findings from the IAWG on Reproductive Health in Crises', 2012-2014 Global Evaluation (2015), http://iawg.net/wp-content/uploads/2016/08/IAWG-GE-Summary_English.pdf; UNFPA, *Shelter from the Storm, State of the World Population* (2015), WHO, UNFPA, Escuela Andaluza de Salud Pública, Consejería de Salud, *Sexual and Reproductive Health During Protracted Crises and Recovery* 2 (2011), http://www.searo.who.int/entity/emergencies/documents/sexual_reproductive_health_protractedcrises_and_recovery.pdf?ua=1.

[45] CENTER FOR REPRODUCTIVE RIGHTS, ENSURING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF WOMEN AND GIRLS AFFECTED BY CONFLICT (2017), *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/ga_bp_conflictncrisis_2017_07_25.pdf .