**The Center for Reproductive Rights (the Center)—an international nonprofit 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; on the right to bodily autonomy; preventing and addressing sexual violence; and the eradication of harmful traditional practices.**

We are pleased to present this submission to the Working Group on Discrimination Against Women and Girls for their report on human security of women and girls in the context of poverty and inequality.

This submission looks at the legal frameworks on sexual and reproductive rights in the context of human security, socioeconomic inequality, and poverty. Building off the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’s assertion that “intersectionality is the bridge to substantive equality and must be placed at the center of the operationalization of the right to health,”[[1]](#footnote-1) this submission also pays close attention to the situation of women and girls in other ethnic and racial minority and disadvantaged groups who are economically marginalized, and how intersectional discrimination often disproportionately prevents their access to sexual and reproductive health and rights. The submission will also briefly look at concrete examples of restrictive abortion laws and their disproportionate impact on economically marginalized and impoverished individuals, reproductive legislation that has addressed States’ responsibility to make sexual and reproductive health and rights accessible and affordable for all, and of women and girls in other ethnic and racial minority and disadvantaged groups who are economically marginalized across various regions. The Center urges the Working Group to address all these issues in its forthcoming report.

1. **Introduction**

Sexual and reproductive health and rights (SRHR) are essential to preserving the right to bodily autonomy and the freedom necessary to make important decisions about one’s lives. While the Committee on Economic, Social, and Cultural Rights (CESCR) and the Committee on the Elimination of Discrimination Against Women (CEDAW) have made clear that States are obligated to respect, protect, and fulfill the right to sexual and reproductive health,[[2]](#footnote-2) systemic barriers remain. Barriers to SRHR often manifest through deep-rooted and intersectional inequalities that render women and girls effectively unable to access their right to adequate SRHR care. Prominent among these systemic barriers have been poverty and socioeconomic inequality. Socioeconomic inequality, poverty, and gender discrimination often intersect, exacerbating the marginalization of women and girls and operating to create a cycle of transgenerational poverty in the process.

The state of SRHR is particularly concerning amid a growing rate of socioeconomic inequality and soaring poverty levels today— fueled further by the COVID-19 pandemic.[[3]](#footnote-3) Women and girls, especially those with disabilities and members of ethnic, racial, and religious minorities and indigenous peoples are among those hardest hit, “creating even greater age, gender and racial inequalities.”[[4]](#footnote-4) It is within this context of growing socioeconomic inequality and poverty that makes imperative an assessment of their impact on SRHR and recommendations towards protecting and ensuring adequate SRHR care.

1. **SRHR Legal Framework**

The principle of universality—that all persons are equally entitled to human rights— is a bedrock principle of international human rights law and critical to its effective application. The universality principle rests on the concept that human rights are interdependent in the sense that various rights often intersect and cannot be enjoyed without the other. Recognizing, then, the various interdependent and intersectional factors critical to the protection and fulfillment of SRHR rights, States and UN treaty bodies have consistently highlighted SRHR within a spectrum of other core civil, political, economic, and social rights provided in the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (CESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), the Convention on the Rights of Persons with Disabilities (CRPD), and the Convention against Torture (CAT).[[5]](#footnote-5) While SRHR are rooted in the right to the highest attainable standard of physical and mental health,[[6]](#footnote-6) treaty monitoring bodies and human rights experts have recognized that analyzing the interdependence of other rights and forms of discrimination within SRHR—such as race, indigenous origin or identity, disability, and poverty, among others— is essential to effectively respecting, protecting, and fulfilling the SRHR of women and girls and other persons who can get pregnant. Critically, as women and girls do not all experience rights violations in the same way, treating SRHR violations homogenously would be ineffective and incommensurate with the daily realities of women who face SRHR violations. Thus, in analyzing SRHR violations in a context of poverty, rising economic inequality and States’ socioeconomic obligations on SRHR, it is also critical to assess States’ protections and fulfillment of these obligations through an intersectional approach.

Intersectional discrimination 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.”[[7]](#footnote-7) Instead, as the Committee on the Rights of Persons with Disabilities (CRPD Committee) has explained: “Intersectional discrimination refers to a situation where several grounds operate and interact with each other at the same time in such a way that they are inseparable.”[[8]](#footnote-8) These inseparable prohibited grounds of discrimination function together to produce a distinct disadvantage.

For example, Romani women have been involuntarily and forcibly sterilized not only because they are women or because they are Roma, but because they are *Romani women*. In this case, racism and sexism function together to create a distinct form of discrimination that is based on negative stereotypes about Romani women’s sexuality and fertility, among other harmful notions. Notably, the CRPD Committee has observed that harmful intersectional stereotyping, such as that based on gender and disability, can lead to structural or systemic discrimination, “inextricably linked to a lack of policies, regulation and service provision specifically for women with disabilities.”[[9]](#footnote-9)

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 seekers and internally displaced women; . . . and women from different ethnic, religious and racial backgrounds” —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… which requires targeted measures with respect to disaggregated data collection, consultation, policymaking, enforceability of non-discrimination and provision of effective remedies.”[[10]](#footnote-10) And although U.N. treaty monitoring bodies and Special Procedures often equate or link intersectional discrimination with multiple discrimination, they are conceptually distinct. Multiple discrimination refers to discrimination on “two or several grounds, in the sense that discrimination is compounded or aggravated,”[[11]](#footnote-11) with each type of discrimination operating separately.

1. *Socioeconomic Obligations*

Under Article 12 of the CESCR, state obligations on SRHR include the protection of various freedoms and provision of entitlements without which women and girls and other persons could not fully enjoy the right to sexual and reproductive health.[[12]](#footnote-12) Among these freedoms and entitlements is the obligation of States to make sexual and reproductive health care affordable, either “at no cost or based on the principle of equality to ensure that individuals and families are not disproportionately burdened with health expenses.”[[13]](#footnote-13) States’ obligation to ensure accessible sexual and reproductive health care requires, among other things, that services be non-discriminatory, universal, and economically accessible.[[14]](#footnote-14) Socioeconomic obligations in the protection and fulfillment of sexual and reproductive health care flows, in large part, from the principle that social and economic status is an underlying determinant of health influencing “participation in health-related decision-making processes, information on sexual and reproductive health, literacy, nutrition, non-discrimination and gender equality,”[[15]](#footnote-15) among other essential health needs. Not only does the cost of health services often influence decisions in seeking sexual and reproductive health care, it also “correlates to a large extent with economic inequality.”[[16]](#footnote-16)

1. *SRHR Obligations*
2. *General Standards*

The right to sexual and reproductive health requires States to implement steps towards the progressive realization of SRHR in public policies, domestic law, and practices.[[17]](#footnote-17) States’ obligations to respect, protect, and fulfill the right to sexual and reproductive health 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.[[18]](#footnote-18) At minimum, levels of satisfaction of the right to sexual and reproductive health should “be guided by contemporary human rights instruments and jurisprudence, well as the most current international guidelines and protocols established by United Nations agencies, in particular the World Health Organization (WHO) and the United Nations Population Fund.”[[19]](#footnote-19) More specifically, the obligations include:

1. Prevent[ing] unsafe abortions and to provide post-abortion care and counselling for those in need; (b) To ensure all individuals and groups have access to comprehensive education and information on sexual and reproductive health that are non-discriminatory, non-biased, evidence-based, and that take into account the evolving capacities of children and adolescents; (c) To provide medicines, equipment and technologies essential to sexual and reproductive health, including based on the WHO Model List of Essential Medicines; (d) To ensure access to effective and transparent remedies and redress, including administrative and judicial ones, for violations of the right to sexual and reproductive health.”[[20]](#footnote-20)

The WHO, together with Treaty monitoring bodies, have further recognized that SRHR is often dependent on and “deeply affected by” social determinants of health, such as access to housing, safe drinking water, effective sanitation systems, equal access to justice, safe and healthy working conditions, and freedom from violence.[[21]](#footnote-21) Indeed, “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.”[[22]](#footnote-22) Moreover, “[p]overty, income inequality, systemic discrimination and marginalization…are all social determinants of sexual and reproductive health, which also have an impact on the enjoyment of an array of other rights as well.”[[23]](#footnote-23) Within this context, treaty monitoring bodies have established that SRHR obligations comprise a range of specific services to which individuals are entitled.

1. *SRHR Services*

Treaty monitoring bodies have consistently recognized that fundamental to the protection and fulfillment of SRHR is both the provision of effective contraceptives (including emergency contraception) and adequate distribution of contraceptive information and education. Additionally, condoms, medicines for abortion and post-abortion care, and medicines, including generic medicines, for the prevention and treatment of sexually transmitted infections and HIV, physical and mental health care for victims of sexual and domestic violence in all situations, including access to post-exposure prevention, emergency contraception and safe abortion services are considered essential and States have an obligation for their adequate provision.[[24]](#footnote-24) Ideologically based policies or practices cannot serve as a barrier to these services.[[25]](#footnote-25) Similarly, States are obligated to provide an adequate supply of health care providers willing and able to provide such services at all times within reasonable geographical proximity.[[26]](#footnote-26)

Treaty monitoring bodies and human rights experts have also emphasized the obligation of States to eliminate barriers to SRHR for disadvantaged groups, and to this end, “must also take affirmative measures to eradicate social barriers in terms of norms or beliefs that inhibit individuals of different ages and genders, women, girls and adolescents from autonomously exercising their right to sexual and reproductive health.”[[27]](#footnote-27) According to the CESCR Committee, economic accessibility requires states to ensure that health services and goods are affordable for everyone, with payment for services based on the principle of equity,[[28]](#footnote-28) and thus requires that poorer households should not be disproportionately burdened with health expenses as compared to richer households.[[29]](#footnote-29) For reproductive health services, the CEDAW Committee in its General Recommendation No. 24 has asked states to “supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women.”[[30]](#footnote-30) The CEDAW Committee has further explained that states parties must provide “safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources” and also recommended that states provide free or low-cost contraception to women.[[31]](#footnote-31) Economic accessibility is particularly important for women with disabilities, who are often more economically disadvantaged than others in their communities.

1. *Migrants and Refugees*

Less discussed in the context of restrictive sexual and reproductive laws amid rising economic inequality and poverty are states’ obligations with respect to migrant and refugee communities. The CESCR provides that everyone has rights with regard to health, without mention of citizenship or legal residency.[[32]](#footnote-32) Article 2 of the CESCR further provides that these rights apply without discrimination of any kind as to “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”[[33]](#footnote-33) The CESCR Committee notes that non-nationals have the right to access “non-contributory schemes for income support, affordable access to health care and family support,” should enjoy equal treatment in access to non-contributory schemes, that any restrictions be proportionate and reasonable, and that “All persons, irrespective of their nationality, residency or immigration status, are entitled to primary and emergency medical care.”[[34]](#footnote-34) 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.[[35]](#footnote-35) Indeed, migrants and refugees often face policies and institutions that exert multidimensional, intersecting forms of discrimination—xenophobia, racism, sexism, and classism— that leave them uniquely vulnerable, socially isolated, and often deprived of their SRHR.

1. *Accountability and Redressability*

Violations of SRHR may occur either through States “or entities insufficiently regulated by the State.”[[36]](#footnote-36) Violations may occur affirmatively or by omission.[[37]](#footnote-37) For example, a State’s failure to ensure formal and substantive equality in the enjoyment of SRHR constitutes a violation by omission.[[38]](#footnote-38) States are thus obligated to eliminate de jure as well as de facto discrimination for the equal enjoyment of the right to sexual and reproductive health.[[39]](#footnote-39) Merely avoiding violations, however, is not enough. Article 8 of the UDHR and subsequent international human rights treaties further reinforce the obligation of States to provide an effective remedy for violations of international human rights and international humanitarian law, guaranteeing everyone “the right to an effective remedy for violations of fundamental rights granted ... by the constitution or by the law.”[[40]](#footnote-40) States must also ensure victims of SRHR violations have an effective remedy such as reparations that are proportionate to the violation committed, that are holistic, and guarantee non-repetition.[[41]](#footnote-41)

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;[[42]](#footnote-42) and implement temporary special measures.[[43]](#footnote-43) These measures should:

* Address discriminatory power structures.[[44]](#footnote-44)
* Recognize that women and men experience different kinds of rights violations due to discriminatory social and cultural norms, including in the context of health,[[45]](#footnote-45) and that, women may also face multiple and intersectional discrimination, based on multiple grounds, including race, disability, age or other statuses.[[46]](#footnote-46)
* Ensure equality of results.[[47]](#footnote-47)
1. **SRHR in the Context of Poverty and Inequality**
2. *Disproportionate Impact of Restrictive Abortion Laws*

Although treaty monitoring bodies and human rights experts have consistently recognized the harms of intersectional discrimination–including the impact of poverty and inequality– most treaty monitoring bodies are currently in the process of developing a clear and robust intersectional analysis in their views in individual complaints, concluding observations, or general recommendations/comments linking sexual and reproductive health to economic inequality and human security. Treaty monitoring bodies have yet to clearly and comprehensively articulating state responsibilities in securing SRHR in the context of economic inequality and poverty. The growing rate of inequality today combined with new restrictive sexual and reproductive health laws makes imperative an analysis of States’ obligations and the impact these new laws have on economically marginalized groups.[[48]](#footnote-48)

 1. *Alyne da Silva Pimental (“Alyne”) v. Brazil (CEDAW, 2007)*

In 2007, CEDAW held in *Alyne v. Brazil*—the first ever maternal mortality case decided by an international human rights body—that Brazil failed to provide timely, nondiscriminatory, and appropriate maternal health services in violation of the Convention.[[49]](#footnote-49) The case involved an impoverished 28-year-old Afro-Brazilian woman, Alyne da Silva Pimentel, who died of complications resulting from pregnancy after her local health center misdiagnosed her symptoms and delayed providing her with emergency care. The Committee further that States have a human rights obligation to address and reduce maternal mortality, to ensure women’s rights to safe motherhood, and to provide affordable access to adequate emergency obstetric care, meeting the specific and distinctive health needs of women, particularly women from lower-socioeconomic backgrounds and historically marginalized groups.

1. *Ireland Cases*

In 2016, the UN Human Rights Committee (“the Committee”) made a landmark ruling in *Mellet v. Ireland*, explicitly holding for the first time in a decision on an individual complaint that prohibiting and criminalizing abortion violates women’s human rights.[[50]](#footnote-50) In doing so, the Committee held that Ireland violated Ms. Mellet’s rights to freedom from cruel, inhuman or degrading treatment under CAT, and privacy, and equality before the law under Articles 7, 17 and 26 of the ICCPR by prohibiting and criminalizing abortion.[[51]](#footnote-51) The Committee found that Ireland’s highly restrictive abortion law forced Ms. Mellet to “choose between continuing her non-viable pregnancy or traveling to another country while carrying a dying fetus, at personal expense and separated from the support of her family, and to return while not fully recovered.”[[52]](#footnote-52) In doing so, the Committee further found that having to travel abroad to access abortion services imposed significant “financial, psychological and physical burdens” on Ms. Mellet.[[53]](#footnote-53) Placed entirely outside of the Irish public health system, Ms. Mellet had to rely on her own resources to obtain the care she needed in another country.[[54]](#footnote-54) As a result, the Committee held that Irish law “failed to adequately take into account her medical needs and socio-economic circumstances,” and thus discriminated against Ms. Mellet and denied her equal protection of the law.[[55]](#footnote-55)

In 2017, the Committee reaffirmed its *Mellet v. Ireland* holding in *Whelan v. Ireland*. Acknowledging the financial, social, and health-related burdens placed on women when laws force them to choose between continuing a pregnancy or travelling to another country to access abortion care, the Committee found it well-established that Ms. Whelan was in a highly vulnerable position,”[[56]](#footnote-56) and found that her suffering was exacerbated because the restrictive abortion law forced her to “choose between continuing her non-viable pregnancy or traveling to another country while carrying a dying fetus, at personal expense and separated from the support of her family.”[[57]](#footnote-57)

The Committee’s decisions in the 2016 and 2017 Ireland abortion law cases displayed the socioeconomic effects of restrictive abortion laws. Such laws impermissibly distinguish between similarly situated women and girls and other persons who can get pregnant, fail to consider their socioeconomic circumstances, and leave only those women and girls and other persons who can get pregnant that can afford to travel outside the country or make extreme financial sacrifices to do so able to receive a legal abortion. Viewed in the context of rising economic inequality and poverty, restrictive abortion laws exert a disproportionate effect on economically marginalized women and girls and other persons who can get pregnant, frequently leaving economically marginalized groups either with the excessive financial (among others) burdens and sacrifices that come with seeking abortion elsewhere or simply unable to access their right to abortion at all.

1. *United States: Dobbs v. Jackson Women’s Health Organization*

On June 24, 2022 the U.S. Supreme Court in *Dobbs v. Jackson Women’s Health Organization* overturned a half-century of precedent protecting the federal right to abortion, instead leaving the right to an abortion for individual states to decide.[[58]](#footnote-58) Individual states that have passed laws restricting abortions are now presumed constitutionally valid and will be upheld by the U.S. Supreme Court as long as they are rationally related to a legitimate state interest—the most lenient level of constitutional scrutiny.[[59]](#footnote-59) Predictably, after *Dobbs* a spate of abortions bans and other restrictions have gone into effect in states throughout the U.S. The ensuing bans and other restrictions have fallen disproportionately hard on economically marginalized people who also face discriminatory obstacles to health care, such as Black, Indigenous, and other people of color, people with disabilities, people in rural areas, young people, and undocumented people.[[60]](#footnote-60) With state bans going into effect and clinics shutting down, in many instances people seeking abortion in the U.S. must now travel across state lines (sometimes multiple state lines) to reach a clinic, which exacerbates the hardships many already experience.[[61]](#footnote-61) As the UN Human Rights Committee also recognized in traveling between countries in order to receive abortions in the *Mellet* and *Whelan* cases, for the economically marginalized and impoverished the costs associated with traveling across state lines where abortion remains legal will often be unfeasible. The bans and restrictions that have taken effect in at least 14 states since *Dobbs* also creates severe impacts on fertility care, care for miscarriage management, and care needed for pregnancy complications.[[62]](#footnote-62) For example, many of the restrictions enacted by states target medical providers who provide abortion care, sowing fear and confusion among providers concerning whether certain procedures are legal or not, resulting in many healthcare professionals delaying or refusing necessary, appropriate treatment due to fear of prosecution.[[63]](#footnote-63)

The *Dobbs* ruling is particularly concerning when viewed alongside the impact of economic inequality and poverty on women and girls and other persons who can get pregnant seeking abortion in the U.S. Many women seeking abortion face economic hardship, with nearly half in the U.S. living below its federal poverty line and about three quarters struggling to pay for food, housing, and transportation.[[64]](#footnote-64) Denial of abortion tends to exacerbate the economic hardships of women even when accounting for the support women can obtain from domestic public assistance programs.[[65]](#footnote-65) Ultimately, preventing women from obtaining abortions “may result in reductions in full-time employment, increased incidence of poverty, more women raising children alone, and greater reliance on public assistance.”[[66]](#footnote-66)

UN independent human rights experts, including the UN Working Group on Discrimination Against Women and Girls, the UN Special Rapporteur on Health, and the UN Special Rapporteur on Violence Against Women, denounced the *Dobbs* ruling, concluding that the U.S. Supreme Court “completely disregarded the United States’ binding legal obligations under international human rights law, including those stemming from its ratification of the International Covenant on Civil and Political Rights, which protects a woman’s right to life from the harmful impact of abortion restrictions.”[[67]](#footnote-67) The UN CERD Committee also expressed deep concerns with the decision and recommended that the U.S. address the disparate impact that it will have on racial and ethnic minorities, Indigenous women, and those with low incomes who are unable to overcome barriers to obtaining safe abortions.[[68]](#footnote-68) As a state party to a number of core international human rights treaties such as the ICCPR, CAT, CERD, and as a signatory to others such as the CESCR and CEDAW, the U.S. must refrain from defeating the object and purpose of these treaties. Yet, treaty bodies and human rights experts have consistently recognized that protections for abortion access are necessary to fulfill the rights to equality and non-discrimination, life, privacy, health, and freedom from torture, cruel, inhuman and degrading treatment, freedom from gender-based violence, and to provide unhindered access to sexual and reproductive health care. By stripping away these protections, the U.S. has defeated the object and purpose of these treaties by permitting restrictive abortion laws and by failing to protect the rights of economically marginalized individuals from the disproportionate impact of the new laws on their sexual and reproductive rights and care.

1. *Guaranteeing Economic Access: Lakshmi Dhikta v. Nepal*

While the *Dobbs* ruling in the U.S. represented a dangerous rollback of SRHR in a context of growing socioeconomic inequality and poverty, the Supreme Court of Nepal in *Lakshmi Dhikta v. Nepal* (2009) provides an exemplary path towards securing the SRHR in a context of extreme socioeconomic inequalities and poverty. Lakshmi Dhikta, a mother of five children, filed suit in Nepal’s Supreme Court because she could not afford an abortion, representative of many people in Nepal who could not afford abortions despite its decriminalization of the procedure in 2002. Ruling in favor of Lakshmi Dhikta, Nepal’s Supreme Court held that the right to abortion can be realized only if it is accessible and affordable,” and that it is the state’s responsibility to “enable individuals to exercise their rights according to their needs.”[[69]](#footnote-69) Based on these obligations, the Court directed the government to introduce a comprehensive abortion law and create a fund to cover the cost of services for women living on low incomes or women without income and that would ensure fees charged by abortion providers at government or non-governmental facilities would be “commensurate with the ability to pay and fair.”[[70]](#footnote-70)

The Nepal Supreme Court’s ruling in *Lakshmi Dhikta* not only reflects the positive obligations articulated by the CESCR Committee and other treaty bodies and Special Procedures, but also an acceptance of the idea that universal health coverage in sexual and reproductive health care is the responsibility of the State. Universal health coverage ensures that all individuals can receive the care they need without financial hardship, removing the financial burdens that often come with a privatized health system that tends to remove State responsibility in providing accessible, affordable, and quality health care.[[71]](#footnote-71)

1. **Conclusions and Recommendations**

Treaty monitoring bodies and human rights experts have increasingly approached SRHR violations through an intersectional lens, addressing multidimensional, intersecting forms of discrimination that leave marginalized populations uniquely vulnerable. Nonetheless, SRHR violations amid rising inequality and poverty have yet to be addressed in a clear and comprehensive fashion despite international human rights treaties clearly articulating States’ obligations to make SRHR universal, accessible, and affordable to all. We submit that recent restrictive abortion laws highlight the importance of addressing the connection between inequality, poverty, and human security in securing SRHR. These laws disproportionately impact economically disadvantaged women and girls and other persons who can get pregnant, and especially those minority groups that are already socially isolated or have experienced generations of discrimination. Beyond recent restrictive abortion laws, SRHR encompass a broader range of services that while may not be legally restricted remain too often unaffordable for social and economically marginalized individuals— and which an environment of extreme socioeconomic inequality and poverty dangerously exacerbates.

In line with the central issues raised above, we respectfully recommend key elements for the Working Group’s report to highlight:

1. In line with the WHO’s newly updated Abortion Care Guideline,[[72]](#footnote-72) we recommend the report highlights the need for States to fully decriminalize abortion, and notes the obligation of States to remove all laws and policies otherwise punishing abortion, provide abortion care, contraception, maternal health care, and other sexual and reproductive health services with no restrictions as to reason and to make such services universally accessible and affordable;
2. We also recommend that the report highlights the obligation of States and international financial institutions to not impede access to SRHR care through any conditionalities such as austerity measures, privatization requirements, or structural adjustments programs;
3. We recommend that the report emphasizes the need for an intersectional rights-based approach to protecting and fulfilling SRHR, as it is imperative both for successfully identifying and understanding the structural or root causes of a violation and for determining appropriate and effective remedies to achieve non-discrimination and equality. The failure to recognize intersectional discrimination serves only to perpetuate that situation of discrimination, particularly in the context of socioeconomic inequality and poverty; and
4. We further recommend that the report calls for the creation or strengthening of accountability mechanisms specifically for socioeconomic discrimination and disproportionate socioeconomic impacts of restrictive sexual and reproductive health laws, both within domestic health care settings and within local justice systems through, for example: mechanisms of professional accountability, institutional accountability, health system accountability, private actor accountability, donor accountability, and reparations that guarantee non-repetition.

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1. Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, *Racism and the right to health*, UN. Doc. [A/77/197](https://daccess-ods.un.org/tmp/4136531.35299683.html), para. 5 (2022) (“SR Report on Racism and the Right to Health”). [↑](#footnote-ref-1)
2. *See, e.g.,* CEDAW Committee, [*Gen. Recommendation No. 25*](https://www.un.org/womenwatch/daw/cedaw/recommendations/General%20recommendation%2025%20%28English%29.pdf), paras. 7-8; 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),* U.N. Doc. [E/C.12/GC/22](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/089/32/PDF/G1608932.pdf?OpenElement) (2016) (“CESCR Committee, Gen. Comment No. 22”), paras. 35-36. [↑](#footnote-ref-2)
3. *See also* SR Report on Racism and the Right to Health, para. 16. [↑](#footnote-ref-3)
4. Francisco H.G. Ferreira, *Inequality in the Time of COVID-19*, International Monetary Fund, 2021, available at: <https://www.imf.org/external/pubs/ft/fandd/2021/06/inequality-and-covid-19-ferreira.htm#:~:text=The%20severe%20impact%20of%20the,extreme%3A%20the%20wealth%20of%20billionaires>; Michelle Bachelet, Equality is at the Heart of Human Rights, December 10, 2021, available at: <https://www.ohchr.org/en/2022/01/equality-heart-human-rights> (noting that “[i]nequalities have widened both within and between countries, with most developed economies forecast to grow in 2022, while the lowest-income countries are projected to endure continued recession, pushing their people even further behind”); *see also* United Nations Population Fund, *World’s Apart: Reproductive health and rights in an age of inequality*, 2017, available at: <https://www.unfpa.org/sites/default/files/sowp/downloads/UNFPA_PUB_2017_EN_SWOP.pdf>, p. 11-12 (describing “new facets” of multiple inequalities that especially exacerbate and feed off of each other in a context of rising economic inequality). [↑](#footnote-ref-4)
5. *See* [Convention on the Elimination of Discrimination against Women](https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women), December 18, 1979 (entered into force September 3, 1981), art. 16(1)(e) (ensures women have equal rights in deciding “freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”); *see* Committee on Economic and Social Rights, *General Comment 14*, *The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights),* UN Doc. [E/C.12/2000/4](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G00/439/34/PDF/G0043934.pdf?OpenElement), (2000); Human Rights Committee, *General Comment 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life*, UN Doc. [CCPR/C/GC/36](https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/1_Global/CCPR_C_GC_36_8785_E.pdf), para. 8 (2018) (articulating State obligations in protecting SRHR, particularly where regulations are inconsistent with the right to life provided in Article 8 of the Covenant); *see* Committee on the Rights of the Child, *General Comment No. 4 on Adolescent Health and development in the context of the Convention on the Rights of the child*, UN Doc. [CRC/GC/2003/4](https://www.unicef-irc.org/portfolios/general_comments/GC4_en.doc.html), (2003); *see* Convention on the Rights of Persons with Disabilities, adopted Dec. 13, 2006, art. 6, G.A. Res. [A/RES/61/106](https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_61_106.pdf), U.N. GAOR, 61st Sess., U.N. Doc. A/61/611, (entered into force May, 3 2008), art. 23(1)(b); *see e.g.,* CAT Committee, *Concluding Observations: Ireland*, paras. 29-30, [U.N. Doc. CAT/C/IRL/CO/2](https://daccess-ods.un.org/tmp/1807726.32360458.html) (2017)(expressing concern at Ireland’s “absence of specific training for public officials on the absolute prohibition of torture,” and in particular, on dealing with victims of sexual violence and other health consequences emanating from torture and ill-treatment). [↑](#footnote-ref-5)
6. *See generally* CESCR Committee, [*Gen. Comment No. 22*](file:///C%3A%5CUsers%5Ckieferkofman%5CDesktop%5CE%5CC.12%5CGC%5C22). [↑](#footnote-ref-6)
7. 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), p. 139, available at: <https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf>. [↑](#footnote-ref-7)
8. CRPD Committee, [*Gen. Comment No.*](https://digitallibrary.un.org/record/1314848?ln=en) *3*, para. 4(c). [↑](#footnote-ref-8)
9. Zampas C, Lamačková A. *Forced and coerced sterilization of women in Europe,* 114 INT J GYNAECOL OBSTET, 163-166 (2011). [↑](#footnote-ref-9)
10. CRPD Committee, [*Gen. Comment No.*](https://digitallibrary.un.org/record/1314848?ln=en) *3*, para. 16. [↑](#footnote-ref-10)
11. *Id.*, para. 4(c). [↑](#footnote-ref-11)
12. *Id.*, para. 5. [↑](#footnote-ref-12)
13. *Id.*, para. 17. General Comment No. 22 also provides that where individuals cannot afford sexual and reproductive costs, “[p]eople without sufficient means should be provided with the support necessary to cover the costs of health insurance and access to health facilities providing sexual and reproductive health information, goods and services.” [↑](#footnote-ref-13)
14. *Id.*, paras. 45; 49(c); 53. [↑](#footnote-ref-14)
15. United Nations, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc. [A/61/338](file:///C%3A%5CUsers%5Ckieferkofman%5CDesktop%5CClerkship%20Apps%5CA%5C61%5C338) (2006), para. 18. [↑](#footnote-ref-15)
16. United Nations Population Fund, [*Worlds Apart: Reproductive health and rights in an age of inequality*](https://esaro.unfpa.org/en/publications/worlds-apart-reproductive-health-and-rights-age-inequality.) (2017), p. 12. [↑](#footnote-ref-16)
17. *See* CESCR Committee, [Gen. Comment No. 22](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/089/32/PDF/G1608932.pdf?OpenElement), para. 33. [↑](#footnote-ref-17)
18. CESCR Committee, [Gen. Comment No. 22](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/089/32/PDF/G1608932.pdf?OpenElement), paras. 12-21; CESCR Committee, *General Comment No. 14*: *The right to the highest attainable standard of health* (Art. 12), para. 12, U.N. Doc. [E/C.12/2000/4](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G00/439/34/PDF/G0043934.pdf?OpenElement) (2000). [↑](#footnote-ref-18)
19. CESCR Committee, [Gen. Comment No. 22](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/089/32/PDF/G1608932.pdf?OpenElement), para. 49. [↑](#footnote-ref-19)
20. *Id.*, para. 49(e-h). [↑](#footnote-ref-20)
21. *Id.*, para. 7. [↑](#footnote-ref-21)
22. *Id.,* para. 8. [↑](#footnote-ref-22)
23. *Id.*; *see also* Human Rights Committee, *General Comment No. 36: On the right to life (Art. 6 of the International Covenant on Civil and Political Rights),* para. 26, U.N. Doc. [CCPR/C/GC/36](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G19/261/15/PDF/G1926115.pdf?OpenElement) (2018) (recognizing that the duty to protect life implies that States parties “should take appropriate measures to address the general conditions in society that may give rise to direct threats to life or prevent individuals from enjoying their right to life with dignity,” such as various social policy measures in an effort to “fight the stigmatization associated with disabilities and diseases, including sexually transmitted diseases, which hamper access to medical care… and for improving access to medical examinations and treatments designed to reduce maternal and infant mortality,” among other things.) [↑](#footnote-ref-23)
24. CESCR Committee, [Gen. Comment No. 22,](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/089/32/PDF/G1608932.pdf?OpenElement) para. 13. [↑](#footnote-ref-24)
25. *Id.*, para. 14. [↑](#footnote-ref-25)
26. *Id.*, paras. 13-14. [↑](#footnote-ref-26)
27. *Id*., paras. 46, 48. [↑](#footnote-ref-27)
28. CESCR Committee*,* [*Gen. Comment No. 14*](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G00/439/34/PDF/G0043934.pdf?OpenElement)*,* para. 12(b). The principle of equity in the health care context requires that care be affordable to all regardless of whether the care is private or public, and particularly for socially marginalized groups. [↑](#footnote-ref-28)
29. *Id.* [↑](#footnote-ref-29)
30. CEDAW Committee, [*Gen. Recommendation No. 24*](https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_GEC_4738_E.pdf)*,* para. 27. [↑](#footnote-ref-30)
31. *Id.* [↑](#footnote-ref-31)
32. See generally [International Covenant on Economic, Social, and Cultural Rights](https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx), December 16, 1966, 993 UNTS, (entered into force 3 January 1976). [↑](#footnote-ref-32)
33. *Id.*, Art. 2. [↑](#footnote-ref-33)
34. CESCR Committee, *General Comment No. 19: The right to social security (art. 9),* [E/C.12/GC/19](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G08/403/97/PDF/G0840397.pdf?OpenElement) (2008), paras. 37-38. [↑](#footnote-ref-34)
35. CESCR Committee, Concluding Observations: Czech Republic, U.N. Doc. [E/C.12/CZE/CO/2](https://daccess-ods.un.org/tmp/3133017.12274551.html) (2014); CESCR Committee, Concluding Observations: Slovakia, U.N. Doc. [E/C.12/SVK/CO/3](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G19/324/46/PDF/G1932446.pdf?OpenElement) (2019); CEDAW Committee,

Concluding Observations: Lithuania, U.N. Doc. [CEDAW/C/LTU/CO/4](https://daccess-ods.un.org/tmp/6398117.54226685.html) (2008); *see generally* 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](https://documents-dds-ny.un.org/doc/UNDOC/GEN/NR0/756/46/IMG/NR075646.pdf?OpenElement) (1966), 660 U.N.T.S. 195 (entered into force Jan. 4, 1969). [↑](#footnote-ref-35)
36. *Id.*, para. 54. [↑](#footnote-ref-36)
37. *Id.* [↑](#footnote-ref-37)
38. *Id.* [↑](#footnote-ref-38)
39. *Id.* [↑](#footnote-ref-39)
40. Universal Declaration of Human Rights, G.A. Res. 217 (III) A, UN Doc. [A/RES/217](https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_217%28III%29.pdf) (III) (Dec. 10, 1948), Art. 8; *see, e.g.,* [International Covenant on Civil and Political Rights](https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx), opened for signature December 16, 1966, 999 UNTS 171 (entered into force 23 March 1976) Art. 2(3); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, UN Doc. [A/39/41](https://www.ohchr.org/en/professionalinterest/pages/cat.aspx) (1984), entered into force on 26 June 1987, Art. 14 [↑](#footnote-ref-40)
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*Recommendation No. 33: on women’s access to justice, in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 19(d), U.N. Doc. [CEDAW/C/GC/33](https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/CEDAW_C_GC_33_7767_E.pdf)

(2015); CEDAW Committee, Concluding Observations: Slovakia, para. 33(d), U.N. Doc. [CEDAW/C/SVK/CO/5-6](https://daccess-ods.un.org/tmp/9822173.11859131.html) (2015); CEDAW Committee, Concluding Observations: Barbados, paras. 41-42, U.N. Doc. [CEDAW/C/BRB/CO/5-](https://daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=CEDAW/C/BRB/CO/5&Lang=E)8 (2017). [↑](#footnote-ref-41)
42. CESCR Committee*, Gen. Comment No. 22*, paras. 22-28; CESCR Committee, *Gen. Comment No. 16,* para. 29. [↑](#footnote-ref-42)
43. [↑](#footnote-ref-43)
44. CEDAW Committee, *Gen. Recommendation No. 25*, para. 9; CESCR Committee, *Gen. Comment No. 20*, paras. 8, 9, 39. [↑](#footnote-ref-44)
45. CRC Committee, *General Comment No. 15*, para. 9. [↑](#footnote-ref-45)
46. CRPD Committee, *General Comment No. 6*, paras. 19 and 21; CEDAW Committee, *Gen. Recommendation No. 25*, para. 12; CEDAW Committee, *Gen. Recommendation No. 28*, para. 18; CESCR Committee, *Gen. Comment No. 20*, para. 17; Human Rights Committee, *Gen. Comment No. 28*, para. 30; CRPD Committee, *General Comment No. 3*, paras. 3, 4, 38. [↑](#footnote-ref-46)
47. CEDAW Committee, *Gen. Recommendation No. 25*, paras. 8-10; CESCR Committee, *Gen. Comment No. 3*, para. 10; Human Rights Committee, *Gen. Comment No. 28*, para. 3; CEDAW Committee, *Gen. Recommendation No. 28*, para. 20. [↑](#footnote-ref-47)
48. *See* U.N. Human Rights Council, *Report of the Special Rapporteur on Extreme Poverty and Human Rights on His Mission to the United States of America*, para. 56, U.N. Doc. [A/HRC/38/33/Add.1](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G18/125/30/PDF/G1812530.pdf?OpenElement) (May 4, 2018) (acknowledging that lack of access to abortion services traps many women in cycles of poverty) (citing Diana Greene Foster and others, “Socioeconomic outcomes of women who receive and women who are denied wanted abortions in the United States”, 108 AM J. PUBLIC HEALTH 407 (2018)). [↑](#footnote-ref-48)
49. [↑](#footnote-ref-49)
50. *Mellet v. Ireland*, Human Rights Committee, Commc’n No. 2324/2013, U.N. Doc. [CCPR/C/116/D/2324/2013](https://daccess-ods.un.org/tmp/2250995.63598633.html), (2016). [↑](#footnote-ref-50)
51. *Id.*  [↑](#footnote-ref-51)
52. *Id.*, para. 7.4. [↑](#footnote-ref-52)
53. *Id.*, para. 7.10. [↑](#footnote-ref-53)
54. *Id.* [↑](#footnote-ref-54)
55. *Id.* [↑](#footnote-ref-55)
56. *Whelan v. Ireland*, Human Rights Committee, Commc’n No. 2425/2014, paras. 7.5 U.N. Doc. [CCPR/C/119/D/2425/2014](https://daccess-ods.un.org/tmp/3637643.45645905.html) (2017). [↑](#footnote-ref-56)
57. *Id.* [↑](#footnote-ref-57)
58. *Dobbs v. Jackson Women’s Health Org.,* [No. 19-1392, 2022 WL 2276808](https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf) (U.S. June 24, 2022) (majority opinion). [↑](#footnote-ref-58)
59. *Id.*  [↑](#footnote-ref-59)
60. *See* Center for Reproductive Rights, *The constitutional right to reproductive autonomy: realizing the*

*promise of the 14th amendment* (2022), p. 20-37, available at: <https://reproductiverights.org/wp-content/uploads/2022/07/Final-14th-Amendment-Report-7.26.22.pdf>. [↑](#footnote-ref-60)
61. *See* Br. of Economists as Amici Curiae in Support of Respondents, *Dobbs v. Jackson Women’s Health Org.,* No. 19-1392 (U.S. Sept. 20, 2021); Br. of Abortion Funds & Practical Support Orgs. as Amici Curiae in Support of

Respondents, *Dobbs v. Jackson Women’s Health Org*., No. 19-1392 (U.S. Sept. 20, 2021); Br. Of California Women’s Law Ctr. as Amici Curiae in Support of Respondents, *Dobbs v. Jackson Women’s Health Org.,* No. 19-1392 (U.S. Sept. 20, 2021). [↑](#footnote-ref-61)
62. Center for Reproductive Rights, *Abortion Laws by State*, available at: <https://reproductiverights.org/maps/abortion-laws-by-state/>; *see also* The New York Times, *Tracking the States Where Abortion Is Now Banned*, available at: <https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html>. [↑](#footnote-ref-62)
63. *See, e.g.,* Jessica Winter, *The Dobbs Decision Has Unleashed Legal Chaos for Doctors and Patients*, The New Yorker, July 2, 2022, available at: <https://www.newyorker.com/news/news-desk/the-dobbs-decision-has-unleashed-legal-chaos-for-doctors-and-patients>; Selena Simmons-Duffin, *Doctors weren't considered in Dobbs, but now they're on abortion's legal front lines*, National Public Radio, July 3, 2022, available at: <https://www.npr.org/sections/health-shots/2022/07/03/1109483662/doctors-werent-considered-in-dobbs-but-now-theyre-on-abortions-legal-front-lines>; American Medical Association, *Ambiguous anti-abortion laws are putting patients at risk*, September 16, 2022, available at: <https://www.ama-assn.org/delivering-care/population-care/ambiguous-anti-abortion-laws-are-putting-patients-risk>. [↑](#footnote-ref-63)
64. Heather Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, Guttmacher Institute, July 14, 2016, <https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters>; *see also* Diana Greene Foster et. al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, American Public Health Association, vol. 108, no. 3, 2018, p. 411, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803812/pdf/AJPH.2017.304247.pdf>. [↑](#footnote-ref-64)
65. Diana Greene Foster et. al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 J. AM. PUBLIC HEALTH ASSOC. 411 2018, p. 411, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803812/pdf/AJPH.2017.304247.pdf>. [↑](#footnote-ref-65)
66. *Id.*, p. 413. [↑](#footnote-ref-66)
67. Working Group on Discrimination Against Women and Girls, Special Rapporteur on the Right of

Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health & Special Rapporteur on Violence Against Women, Its Causes and Consequences, *Joint Web Statement by UN Human Rights Experts on*

*Supreme Court Decision to Strike Down Roe v. Wade*, June 24, 2022, available at: <https://elcaminowomen.com/blog/birth-control/joint-web-statement-by-un-human-rights-experts-on-supreme-court-decision-to-strike-down-roe-v-wade.html>. [↑](#footnote-ref-67)
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69. Center for Reproductive Rights, *Lakshm Dhikt Case Summary and Translated Excerpts*, 2009, p. 9, available at: <https://reproductiverights.org/sites/crr.civicactions.net/files/documents/Lakshmi%20Dhikta%20-%20English%20translation.pdf>. [↑](#footnote-ref-69)
70. *Id,* p. 10. [↑](#footnote-ref-70)
71. *See* World Health Organization, *Abortion Care Guideline*, 2022, p. 13, available at: <https://www.who.int/publications-detail-redirect/9789240039483> (noting that the public provision universal health coverage for sexual and reproductive health care is essential for effective coverage and care, and is also integral to the achievement of sustainable development target 3.8.). [↑](#footnote-ref-71)
72. *Id.*, p. 24. [↑](#footnote-ref-72)