

Submission from the Center for Reproductive Rights following the call for submissions by the Special Rapporteur on Violence Against Women, its causes and consequences on mistreatment and violence against women during reproductive health care with a focus on childbirth

The Center for Reproductive Rights (the Center)—an international nonprofit 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 25 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. We are pleased to provide this submission for the report of the Special Rapporteur on Violence Against Women, its causes and consequences on mistreatment and violence against women during reproductive health care with a focus on childbirth.

This submission examines mistreatment and violence against women and girls during reproductive health care as acts that can amount to torture, cruel, inhuman, and degrading treatment (TCIDT). Mistreatment and violence against women and girls during reproductive health care are not only violations perpetrated by individuals: States also have clear legal obligations under current human rights standards. The framing on TCIDT can help reinforce the urgency of addressing these issues and challenge impunity for such conduct. Such violations disproportionately affect women and girls who are subjected to multiple and intersecting forms of discrimination, in violation of the rights to, *inter alia*, non-discrimination and equality and to sexual and reproductive health. This submission will therefore also address the issue of social determinants of sexual and reproductive health, including how health systems impact women and girls’ enjoyment of their right to sexual and reproductive health as it pertains to maternal health. This submission will also look at multiple and intersecting forms of discrimination, focusing especially on the specific types of violence and mistreatment in reproductive health care faced by women and girls affected by conflict and in humanitarian settings. It will therefore center the conversation around violence against women and girls in reproductive health care around the central notions of bodily autonomy, control, power dynamics and imbalances, structural forms of discrimination, and accountability.

1. Legal framework

a. Maternal health

Treaty monitoring bodies have developed strong human rights standards on women’s right to maternal health care, rooting this right within the rights to life, health, equality and non-discrimination, and freedom from ill-treatment. The right to maternal health care encompasses a woman’s right to the full range of services in connection with pregnancy and the postnatal period and the ability to access these services free from discrimination, coercion, and violence.ⁱ Furthermore, treaty monitoring bodies have found that social and other determinants of health must be addressed in order for women to be able to seek and access the maternal health services they need.ⁱⁱ Finally, women must be able to exercise reproductive and bodily autonomy in determining the number and spacing of their children, have adequate information about maternal health care, and be empowered to utilize maternal health services. While not every form of mistreatment would be considered violence against women or TCIDT, it is important to recognize that other human rights are implicated, placing obligations on States to respect, protect and fulfill these rights as well.

- **Right to life:** States must take positive measures to protect individuals from arbitrary and preventable loss of life and address direct threats to enjoying a life with dignity, including preventable maternal death. Human Rights Committee General Comment No. 36 on the right to life affirms that preventable maternal deaths are a violation of the right to life and that States should develop strategic plans “for improving access to medical examinations and treatments designed to reduce maternal and infant mortality.”ⁱⁱⁱ The Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW Committee)^{iv} and the Committee on the Rights of the Child (CRC Committee)^v also interpret the right to life to include State obligations to prevent and address maternal mortality.
- **Right to health:** In accordance with article 12.1 of ICESCR, States parties recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and article 12.2 illustrates “steps to be taken by the States Parties ... to achieve the full realization of this right”.^{vi} Maternal health is grounded in the right to health; and the ESCR Committee indicates that States’ obligations to guarantee maternal health care is comparable to a core obligation under this right to health.^{vii}
- **Availability, Accessibility, Acceptability, and Quality**^{viii}: States must ensure adequate pre and postnatal care, skilled birth attendants, and emergency obstetric services if needed.^{ix} Facilities should be accessible in law and in fact, thus: physically accessible, affordable, and adequate information available. States should guarantee that hospitals stock sufficient supplies, medicines, established referral systems for obstetric emergencies, and that health workers have adequate training on quality maternal health services.^x Under ICESCR, States have a core obligation to ensure that commodities on the World Health Organization’s (WHO) Model List of Essential Medicines are provided. This includes medicines for the prevention and treatment of pre-eclampsia and eclampsia, post-partum hemorrhage, and maternal sepsis, as well as for the provision of safe abortion and management of incomplete abortion.
- **Right to equality and non-discrimination**^{xi}: The treaty monitoring bodies recognize that failure to provide women with quality maternal health services violates the rights to equality and non-discrimination, because these are services that only women need to meet their specific health needs.^{xii} They have also specifically recognized that intersectional discrimination can hinder women’s access to reproductive health services, and recommended that States put a particular focus on the maternal health needs of marginalized groups of women: adolescents, women living with HIV, poor women, minority women, rural women, and women with disabilities.^{xiii}
- **Right to freedom from cruel, inhuman, and degrading treatment:** The Committee against Torture (CAT Committee) has expressed concern about high maternal mortality rates, particularly those resulting from unsafe abortion, demonstrating that preventable maternal deaths may violate protections against the right to freedom from cruel, inhuman, and degrading treatment.^{xiv} The CAT Committee and CEDAW Committee have raised concerns about maltreatment of women seeking maternal health care and abuse in maternal health facilities that can amount to ill-treatment. For example, the shackling of women detainees during labor and delivery^{xv} and post-delivery detainment of pregnant women who are unable to pay their medical bills.^{xvi}

b. Violence against women and girls in reproductive health care as acts of torture, cruel, inhuman, and degrading treatments (TCIDTs)

• **The Torture, Cruel, Inhuman and Degrading Treatment Framework**

In addition to guaranteeing women access to maternal health services, treaty monitoring bodies recognize that states must guarantee women the right to be free from violence when seeking maternal health services. In certain instances, treaty monitoring bodies have recognized that the disrespect and abuse women face in maternal health facilities can amount to ill-treatment, including when women are detained and abused post-delivery for the inability to pay their maternal health care bills^{xvii} and when incarcerated women are shackled to beds during labor and delivery.^{xviii}

The CEDAW Committee has also expressed concern that women are often not consulted during delivery and are subjected to overly medicalized births. It has called for safeguards to ensure that overly medical procedures during childbirth, such as cesarean sections, only be carried out when necessary and with the patient's informed consent.^{xx}

As the United Nations (UN) Committee against Torture (CAT Committee) has repeatedly stated, the right to be free from torture and cruel, inhuman, and degrading treatment (CIDT) carries with it non-derogable state obligations to prevent, punish, and redress violations of this right. Recognizing reproductive rights violations as forms of torture or CIDT reinforces states' legal obligations to provide appropriate remedies and reparations.

Human rights bodies and experts have also begun to recognize that specific harms experienced by women and girls can constitute torture or CIDT and that these harms have particular consequences for their lives.^{xx} The former UN Special Rapporteur on Torture or Other Cruel, Inhuman or Degrading Treatment or Punishment (Special Rapporteur on Torture) has stated that the torture and CIDT framework should be applied "in a gender-inclusive manner with a view to strengthening the protection of women from torture."^{xxi}

The CAT Committee, for example, has reaffirmed that states' obligations to prevent, punish, and redress torture and ill-treatment apply not only to prisons but also to other "contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm."^{xxii}

Under international human rights law, states have the obligation to prevent, punish, and redress torture and CIDT committed by state agents and others acting in an official capacity.^{xxiii} Furthermore, states also bear responsibility for acts of torture or ill-treatment committed by non-state or private actors when state authorities or others acting in an official capacity know or have reasonable grounds to believe that these acts are taking place and do not exercise due diligence to "prevent, investigate, prosecute and punish" these acts.^{xxiv} The Special Rapporteur on Torture has affirmed that the definition of torture under the Convention against Torture (CAT) "clearly extends State obligations into the private sphere and should be interpreted to include State failure to protect persons within its jurisdiction from torture and ill-treatment committed by private individuals."^{xxv}

The UN Human Rights Committee has also affirmed that torture and CIDT prohibitions "clearly [protect] not only persons arrested or imprisoned, but also ... patients in educational and medical institutions."^{xxvi} The CAT Committee, through the adoption of the Optional Protocol to the CAT, has also broadened the concept of "deprivation of liberty" by creating a subcommittee to inspect locations

that involve “any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.”^{xxxvii} An example of this in the context of reproductive rights would be a hospital where women are detained due to an inability to pay their medical bills.^{xxxviii} Moreover, treaty monitoring bodies including the Human Rights Committee and the CAT Committee have emphasized that state obligations to address torture and CIDT extend to contexts of custody and control such as schools, other institutions that provide care to children, and health care settings.^{xxxix} States are also obligated to address torture and ill-treatment in “other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm.”^{xxxx} Thus, the protection extends to both public and private educational settings, for example, where girls are subjected to sexual violence at the hands of teachers and administrators who exercise control and authority over them.^{xxxxi}

The CAT Committee has also confirmed that women are vulnerable to torture or ill-treatment in the context of “deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence by private actors in communities and homes,”^{xxxxii} and that they may be subject to violations of the CAT “on the basis of their actual or perceived non-conformity with socially determined gender roles.”^{xxxxiii} A clear example of this is the ill-treatment of women who seek post-abortion care, which is often a form of punishment for noncompliance with their traditional role as child-bearers.^{xxxxiv}

- **TCIDTs, Consent and Bodily and Reproductive Autonomy**

Women seeking medical care may experience abuse and mistreatment at the hands of health care personnel, who hold clear positions of authority and often exercise significant control over women in these contexts. In certain situations, women may find themselves dependent on health care providers who deliberately limit their ability to make autonomous decisions about their treatment and care. Health care providers are generally in a position of authority over patients; thus, women may find themselves in a state of powerlessness that makes them vulnerable to abuse. These abuses are often exacerbated when the health services they seek, such as abortion, are highly stigmatized.

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

- **Forced reproductive health procedures**, including forced or coerced sterilization, forced or coerced abortion, and mandatory testing for pregnancy or sexually transmitted diseases, all of which violate women’s rights to health-related decision-making and informed consent.^{xxxxv}

Coercive sterilization is a grave human rights violation that is frequently targeted at women from marginalized segments of society. Experts recognize that the permanent deprivation of one’s reproductive capacity and bodily autonomy without informed consent generally results in psychological trauma, including depression and grief.^{xxxxvi}

The Human Rights Committee has stated that coercive sterilization violates the right to be free from torture and CIDT, as provided under the International Covenant on Civil and Political Rights (ICCPR).^{xxxxvii} Similarly, the CEDAW Committee has stated that “States parties should not permit forms of coercion, such as non-consensual sterilization … that violate women’s rights to informed consent and dignity,” affirming that coercive sterilization infringes on the rights to human dignity and physical and mental integrity.^{xxxxviii}

Moreover, human rights bodies and experts have repeatedly emphasized the need to obtain informed consent for sterilization procedures.^{xxxxix} Notably, the Special Rapporteur on Violence against Women has asserted that “forced sterilization is a method of medical control of a woman’s fertility without the

consent of a woman. Essentially involving the battery of a woman—violating her physical integrity and security—forced sterilization constitutes violence against women.”^{xli}

In recent years, the CAT Committee has explicitly addressed coercive sterilization in its concluding observations. Finally, the Special Rapporteur on Torture has emphasized that forced abortions and sterilization of women with disabilities may constitute torture or CIDT when they are conducted with the legal consent of the person’s guardian but against the disabled woman’s will.^{xli} The Special Rapporteur has also asserted that “forced abortions or sterilizations carried out by State officials in accordance with coercive family planning laws or policies may amount to torture....”^{xlii}

Women and girls seeking reproductive health care services may experience denial of care due to discrimination, stigma, and negative gender stereotypes. In many instances, for example, abortion and post-abortion medical care are necessary to safeguard women’s and girls’ lives and health. But all too often, women and girls are denied access to these medical services due to restrictive laws and policies or health care personnel’s decision not to provide legal services because of their own objections or discriminatory attitudes toward the woman seeking services.

Furthermore, women may be denied medical care solely on the basis of their social status, such as being from a minority ethnic community or being HIV positive. Human rights bodies have recognized that, in some circumstances, these denials of service may violate the right to be free from torture or CIDT. International and regional human rights bodies have increasingly recognized that restrictive abortion laws violate women’s human rights.^{xliii} Moreover, they have affirmed that in cases where abortion is legal, abortion services need to be safe and available, accessible, acceptable and of good quality.^{xliv} However, women are often denied access to abortion arguably with the discriminatory and improper purpose of discouraging them from terminating a pregnancy. This denial can cause tremendous pain and suffering and have long-lasting consequences for women’s health and lives.

- **Harmful traditional practices**, which treaty monitoring bodies have recognized violate a number of human rights and have implications for reproductive and bodily autonomy. Specifically, child, early, and forced marriages can increase levels of violence and limit women’s opportunities for decision-making, particularly when it comes to sexuality and reproduction.^{xlv} Child, early, and forced marriage is often accompanied by early and frequent pregnancy and childbirth, which also results in increased maternal mortality rates.^{xlvi} This practice triggers a continuum of human rights violations that continue throughout a girl’s life. The treaty monitoring bodies are also concerned with the high prevalence of female genital mutilation (FGM).^{xlvii} The CEDAW and CRC Committees note that there is no medical reason for FGM and explain that the practice can cause immediate and long-term health consequences, including shock, severe pain, infections, complications during childbirth, and other long-term gynecological problems.^{xlviii} States must take immediate measures to address these harmful traditional practices by, *inter alia*, sharply reducing child and early marriage^{xlix} and providing immediate support services, including medical, psychological, and legal services, to women and girls who have undergone FGM.¹

c. **Intersectionality**

- **The substantive equality framework**

Treaty monitoring bodies have specifically recognized that intersectional discrimination can hinder women’s access to reproductive health services. Treaty monitoring bodies have thus recommended that states put a particular focus on the maternal health needs of marginalized groups of women, including adolescents, poor women, minority women, rural women, and women with disabilities.^{li}

The principle of substantive equality seeks to remedy entrenched discrimination by requiring states to take positive measures to address the inequalities that women face. To achieve substantive equality, states must take the following steps:

Address Discriminatory Power Structures: States should examine and address current societal power structures, such as traditional family and work-place roles, and analyze the role that gender plays within them. Substantive equality then requires states to change institutions in order to address the inequalities experienced by women, rather than requiring women to change to conform to masculine norms.^{lvi}

Recognize Difference: States should recognize that women and men experience different kinds of rights violations due to discriminatory social and cultural norms, including in the context of health.^{lvi} Women also may face discrimination based on multiple grounds, including race, disability, age, or other marginalized statuses.^{lv}

Ensure Equality of Results: Given that discrimination manifests itself differently between and among men and women, states should address these inequalities accordingly. States should focus on ensuring equal outcomes for women, including different groups of women, which may require states to take positive measures and mandate potentially different treatment of men and women, as well as between different groups of women, in order to overcome historical discrimination and ensure that institutions guarantee women's rights.^{lv}

Almost all treaty monitoring bodies have recognized the need to use a substantive equality approach to ensure gender equality in the context of reproductive rights. For instance:

The Committee on the Rights of the Child (CRC Committee), the Committee on the Elimination of Discrimination against Women (CEDAW Committee), the Committee on Economic, Social and Cultural Rights (ESCR Committee), the Committee on the Rights of Persons with Disabilities (CRPD Committee), and the Human Rights Committee have urged states to address both *de jure* and *de facto* discrimination in private and public spheres, adopt measures to eliminate gender stereotypes regarding women, and address practices that disproportionately impact women.^{lvii} This requires that states take positive measures to create an enabling environment that ameliorates social conditions such as poverty and unemployment, factors which affect women's right to equality in health care.^{lviii}

Treaty monitoring bodies have also called on states to not only ensure access to reproductive health services but to also ensure positive reproductive health outcomes, such as fulfilling unmet need for modern contraceptives, lowering rates of maternal mortality, or reducing rates of adolescent pregnancy.^{lvix}

Treaty monitoring bodies have repeatedly condemned laws that prohibit health services that only women need. The CEDAW Committee has stated that "it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."^{lx} Furthermore, the ESCR Committee has made clear that equality in the context of the right to health "requires at a minimum the removal of legal and other obstacles that prevent men and women from accessing and benefitting from healthcare on a basis of equality."^{lx}

- **Social Determinants of Health**

Increasingly, treaty monitoring bodies are recognizing the interlinkages between the realization of a range of human rights and of women's reproductive health, often called social and other determinants of health.^{lxii} "Social determinants of health" refers to the conditions in which people are born, grow, live, work, and age, which are shaped by power structures and resource distribution at the local, national, and global levels.^{lxiii} Social and other determinants of health include access to housing, safe drinking water

and effective sanitation systems, access to justice, and freedom from violence, among other factors.^{lxiii} These determinants impact the choices and meaningful agency that individuals can exercise with respect to their sexual and reproductive health; thus states must address them in laws, institutional arrangements, and social practices in order to ensure that they do not prevent individuals from effectively enjoying their reproductive rights in practice.^{lxiv}

- **Reproductive health care for women and girls in humanitarian settings**

While there continues to be a need for more reliable data on maternal mortality in conflict and displacement settings, there is little doubt that conflict exacerbates maternal mortality.^{lxv}

In 2015, a United Nations (UN) inter-agency report found that in countries designated as fragile states, which include conflict-affected settings, the estimated lifetime risk of maternal mortality is 1 in 54, as compared to 1 in 180 global lifetime risk.^{lxvi}

Moreover, maternal mortality ratios (MMRs) in countries affected by conflict remain high and have been shown to increase during periods of conflict. 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.^{lxvii} Similarly, Syria's MMR has increased from 49 to 68 per 100,000 live births since the start of the conflict in 2011.^{lxviii}

Studies have found that MMRs among refugees receiving humanitarian aid tend to be lower than among the host population or country of origin, but that delays in seeking and receiving care are among the most significant factors in maternal deaths^{lxix} – factors that are likely exacerbated for asylum seekers in transit.^{lxx} A recent study conducted among Syrian refugee women in Lebanon 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% reporting problems during pregnancy or complications during labor, delivery, or abortion.^{lxxi}

International human rights bodies, including the CEDAW, CRC, and Human Rights Committees, have affirmed that fundamental human rights obligations, including economic, social, and cultural rights, continue to apply even in humanitarian settings. Although international human rights law permits states to derogate from certain civil and political rights in some humanitarian settings and to limit certain obligations with respect to economic, social, and cultural rights depending on resource availability,^{lxxii} human rights treaty bodies have emphasized that such derogations are subject to strict conditions and that certain minimum core obligations are non-derogable.^{lxxiii} Even where derogations are permitted, the measures taken cannot involve discrimination based solely on prohibited grounds, including sex.^{lxxiv}

With the prevalence of sexual violence in humanitarian settings, human rights bodies increasingly have provided recommendations regarding gender-based violence experienced by women and girls, explaining that the right to be free from gender-based violence still applies in humanitarian settings. In its General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, the CEDAW Committee urges states to prevent, investigate, and punish all forms of gender-based violence and to ensure survivors' access to justice, comprehensive medical treatment, and psychosocial support.^{lxxv} The Committee also specifically calls on states to safeguard refugees and internally displaced persons (IDPs) from child, early, and forced marriage, to provide them with immediate access to medical services, and to create accountability mechanisms for gender-based violence in all displacement settings.^{lxxvi}

Moreover, within the context of humanitarian settings, human rights bodies hold that the right to equality and non-discrimination applies.^{lxxvii} In its General Recommendation No. 28, the CEDAW Committee

affirmed that, even during disasters and public emergencies, women’s rights are not suspended, and states must continue to respect, protect, and fulfill women’s right to equality, which includes their reproductive rights.^{lxxviii} The CEDAW Committee has found that “[p]rotecting women’s human rights at all times, advancing substantive gender equality before, during, and after conflict, and ensuring that women’s diverse experiences are fully integrated into all . . . reconstruction processes are important objectives of the Convention.”^{lxxix} The CEDAW Committee has noted that, instead of suspending rights protections, states should “adopt strategies and take measures addressed to the particular needs of women in . . . states of emergency.”^{lxxx}

Five Human Rights Council Resolutions on maternal mortality have passed (see for instance A/HRC/RES/11/8, A/HRC/RES/15/17, and A/HRC/RES/18/2 on preventable maternal mortality and morbidity and human rights^{lxxxi} and A/HRC/RES/39/10 on preventable maternal mortality and morbidity and human rights in humanitarian settings). In accordance with the Human Rights Council request in resolution 11/8, OHCHR issued [technical guidance](#) on the application of a human rights-based approach to the implementation of policies and programs to reduce preventable maternal mortality and morbidity. The report provides guidance on how policymakers should devise, implement, and monitor programs to improve health outcomes and foster accountability in accordance with human rights standards.

A comprehensive resolution on preventable maternal mortality and morbidity and human rights in humanitarian settings (A/HRC/RES/39/13), led by New Zealand, Colombia, Burkina Faso, and Estonia, was adopted by consensus on Thursday, September 27, 2018. This initiative is part of a long-term push by states, civil society organizations (CSOs) and U.N. agencies to address the human rights violations contributing to preventable maternal mortality and morbidity.

This resolution focuses on addressing the disproportionately high maternal mortality and morbidity rates (MMMRs) affecting women and girls in humanitarian settings, addressing pre-existing patterns and structures of discrimination and inequalities such as patriarchal values and norms, that are exacerbated by conflict and disasters and that contribute to the negative pregnancy-related outcomes for women and girls in these situations. The resolution also focuses on sexual and reproductive rights violations faced by women and girls in humanitarian settings and the impact of lack of access to sexual and reproductive health care services, including safe abortion, on affected women and girls.

Most importantly, the resolution emphasizes the need for accountability for the full range of rights violations of women and girls in humanitarian settings, sending a clear message that States must take responsibility for ensuring women and girls’ right to an effective remedy, including reparation, and to guarantee non-recurrence in these settings. While accountability for women and girls affected by conflict has largely been addressed through the lens of the criminal responsibility of perpetrators of violations, thus putting them rather than the affected women and girls at the center of interventions and discussions, this resolution reframes the conversations on women and humanitarian settings around women and girls themselves.

2. Case Studies

a. Africa: Kenya and Nigeria

Maternal mortality remains very high in sub-Saharan Africa and West and Central Africa with mortality rates of 546 and 679 per 100000 live births.^{lxxxii} The majority of these deaths are preventable and manageable if quality reproductive health services are provided during pregnancy and childbirth. Mistreatment and violence against women during childbirth remains one of the leading causes of maternal mortality in Africa. Anecdotal evidence shows that a majority of women shy away from

attending health facilities due to mistreatment and abuse. As a result, only few women and girls give birth under skilled birth attendance. For instance, a Confidential Enquiry into Maternal Deaths in Kenya revealed that nine out of ten maternal deaths had been caused by sub-standard care in health facilities.^{lxxxiii} According to the report, poor quality of care was identified in the care of 92.4% of women who died.^{lxxxiv} In Nigeria, 58,000 women died due to pregnancy related or childbirth complications.^{lxxxv} The common forms of mistreatment and violence against women during childbirth include: physical and verbal abuse, lack of privacy during delivery, nonconsensual examinations, detention in health facilities post-delivery due to inability to pay medical bills, and denial of life-saving services while being detained in health facilities. The cases below represent the situation of women and girls in Kenya and Nigeria, and abuses meted on them during childbirth.

- **Case A: J O O (also known as J M) v. Attorney General & 6 others (2018) (Kenya)**

In 2013, an unemployed 29-year-old mother of two was admitted to a health facility for the delivery of her third child. Despite the Presidential Directive on Free Maternity in Kenya, the mother of two was asked to buy essentials, including cotton wool. During her admission, she noted that the hospital did not have enough beds both at the labor ward and in the delivery room. She was forced to share a bed with another woman. At the onset of her labor, she was asked by nurses to walk to the delivery room from the labor ward. She called out for assistance while in intense pain but was told that she was not ready without any physical check on her. She walked back to the delivery room and found the only three delivery beds already occupied by women delivering at that moment. Extremely weak and in pain, she left the delivery room and began to walk back to the labor ward. She collapsed on the floor along the corridor, where she delivered. She regained consciousness and found two female nurses shouting at her and slapping her for soiling the floor.

In this case, (**J O O (also known as J M) v. Attorney General & 6 others (2018)**), the Court recognized that neglect and physical and verbal abuse of women seeking maternity services is a violation of rights guaranteed by the Constitution of Kenya and a host of international instruments. Further, the Court declared that physical and verbal abuse on women during delivery amounts to a violation of the right to dignity and the right not to be subjected to cruel, inhuman, and degrading treatment. The Court also found that the National and County Government had failed to implement and/or monitor the standards of free maternal health care and services, thus resulting in the mistreatment of the women during delivery and the violation of their rights.

- **Case B: M A & Another v Honorable Attorney General & 4 others (2016) (Kenya)**

In 2010, two women delivered at various times in Pumwani Maternity Hospital, the largest maternity facility in Kenya. The two women, who were both unemployed, were detained for several days (20 and 12 days respectively) for failure to pay medical bills post-delivery. This detention included restricted movement, being made to sleep on the floor, deliberate lack of attention, including failure to provide medical treatment, and verbal abuse. In one instance, a pair of scissors was left in one of the women's stomach by operating doctors during the cesarean section; she developed a ruptured bladder after being left unattended and bleeding on a bench for more than two hours before the cesarean section. As a result, she suffered further complications requiring surgery and insertion of a catheter. She was detained for the second time for six days.

In Kenya, the Center for Reproductive Rights has successfully litigated this case on mistreatment and violence against women during childbirth. In the first case on detention of women post-delivery due to their inability to pay medical bills (**M A & Another v Honorable Attorney General & 4 others [2016]**), the Court declared that the detention of women post-delivery due to an inability to pay medical bills is a violation of fundamental rights, including the right to be free from cruel, inhuman, and degrading treatment. The Court also found that the mistreatment of the women while being detained in health facilities falls short of the acceptable standards of health care that would guarantee protection of the right to dignity and, further, that the women were discriminated against on the basis of their gender and economic status.

In Kenya, various policies guarantee the right to informed consent to treatment. The National Patients' Rights Charter provides for the right to informed consent to treatment, including "full and accurate information in a language one understands about the nature of illness, diagnostic procedures, proposed treatment, alternative treatment and the costs involved for one to make a decision except in emergency cases."^{lxxxvi}

With the Center's support, the Kenya National Assembly has been having discussions on how to address the issue of detention of patients due to inability to pay medical bills including women who are unable to pay medical bills post-delivery. The National Assembly plans to introduce a Bill on detention of patients due to inability to pay medical bills. If enacted, the Bill will outlaw detention of patients due to inability to pay in health facilities.

One of the main challenges remains the lack of implementation of Court decisions; despite the Court directing compensation of women who have been experienced mistreatment and whose rights have been violated during childbirth, the government of Kenya has yet to compensate the victims. Additionally, several cases of women and girls being detained and mistreated during childbirth continue to be reported.

Lack of adequate budget allocation, inadequate workforce, and essential equipment in health facilities contributes to poor quality of care during childbirth. Despite Kenya introducing a free maternity policy and piloting Universal Health Coverage, the doctor-patient ratio remains high. Women are also forced to pay for essential services given the limited benefits package. As a result, detention of women post-delivery due to inability to pay remains pervasive.

- **Case C: Women Advocates Research and Documentation Centre v. The Attorney General of the Federation & 3 others (Nigeria)**

In August 2014, Folake went to hospital to deliver her fourth child. After delivery, she developed an infection after her cesarean section and was referred to a government facility, the Lagos University Teaching Hospital (LUTH), for emergency care. Her lengthy stay in the ICU racked up a fee of almost 1.4 million Naira (approx. \$4,000) that became impossible for her and her husband to pay. When it was time for her to be discharged, the hospital refused to let her go. Instead, they moved Folake to a guarded ward, where she was detained. After one month and 13 days of detention, without receiving any care, Folake developed further complications, and was denied emergency care leading to her death on Dec. 13, 2014.

- **Case D: Isa Ali's Sister's story- Fufore IDP Camp in Yola, Adamawa State (Nigeria)**

The protracted conflict in North East Nigeria has led to many women and girls being internally displaced. The majority of these women and girls are of reproductive age. Isa Ali and her sister lived in Fufore IDP Camp in Yola, Adamawa State. Isa's sister had attended all the antenatal care visits that the clinic at the IDP camp had provided. She was not ill at any point during the pregnancy and had quickly gone to the camp's clinic as soon as she went into labor. Her sister was immediately discharged after delivery and asked to return to her tent because there were not enough beds in the clinic. During the night her sister bled to death. Several other women at Fufore IDP camp, who had recently given birth or were pregnant at the time acknowledged that they had access to antenatal care but expressed reservations about delivery and postnatal care services, confirming that there were no overnight stays in the camp's health clinic unless a woman gave birth during the night. Further women confirmed that they lacked enough food to sustain nursing after delivery.

In Nigeria, the Patients' Bill of Rights provides for the rights of patients including the right to be treated with respect. While the policies are clear about informed consent to treatment, the patriarchal nature of many communities in Kenya and Nigeria remain a barrier to women making informed decisions about maternal health services. According to Demographic Health Surveys in Kenya^{lxxxvii} and Nigeria,^{lxxxviii} women in certain communities must seek their husband's approval before seeking maternal health services including delivery in health facilities. This means that women from these communities may not make informed decisions about facility-based delivery. At the facility level, limited/lack of information sharing affects women ability to make informed decisions. The majority of cases of detention in health facilities are a result of limited or lack of information sharing by facilities on the available benefits package.

Most health facilities lack well-functioning accountability mechanisms. In cases where health facilities have complaints desks, proactive disclosure of information does not regularly occur. This contributes to high numbers of women and girls seeking maternal health services in health facilities not seeking appropriate redress in case of violations or demanding respectful treatment when seeking services.^{lxxxix} Other complaints mechanisms include regulatory and professional bodies such as the Medical and Dental Council, the Nursing and Midwifery council and the Clinical Officers Council. These complaint mechanisms deal with professional misconduct.^{xc}

In countries like Kenya, the Constitutional Commissions, which include the Kenya National Commission on Human Rights, the Commission on Administrative Justice, and the National Gender and Equality Commission, have constitutional mandate to receive and investigate human rights violations. However, lack of physical accessibility and lack of awareness among women and girls of reproductive age contribute to low reporting.

The majority of policies broadly address violations against patients at health facilities. In Kenya, the Patients' Rights Charter broadly provides for a complaint mechanism either to the regulatory bodies or to the courts.

b. Asia: India, Nepal and Pakistan

Approximately one third of maternal deaths worldwide take place in South Asia.^{xcii} This is indicative of the significant barriers faced by women and girls in accessing quality maternal health care services. The leading factors contributing to the high rates of maternal deaths common to countries across South Asia

include postpartum hemorrhage, eclampsia, obstructed labor, postpartum sepsis, and complications caused by unsafe abortions.^{xcii} The mistreatment and abuse of women during the reproductive health care process contributes towards these factors. Across South Asia, women experience mistreatment and violence during pregnancy and childbirth through deliberate acts of omission and commission by health care providers. Mistreatment is reflected in the form of blatant neglect that amounts to abuse, as well as in acts of gross negligence and verbal and physical harassment.

- **Cases of Mistreatment**

Women in India, particularly those from low-income and marginalized backgrounds, face widespread abuse and mistreatment while seeking reproductive health care. In 2010, the Delhi High Court recognized the reproductive rights violations faced by poor women in its decision on petitions filed on behalf of two women who experienced severe mistreatment and deliberate neglect during pregnancy and childbirth.^{xciii} One of the women, Shanti Devi, living in the state of Haryana, fell down the stairs while she was pregnant for the fifth time. She was denied health care at several hospitals due to her inability to pay medical fees and the refusal of hospital staff to recognize her below poverty line status. Finally, she was able to have the fetus removed five days after it had died. Soon after, she became pregnant again and died after giving birth at home prematurely without a skilled birth attendant. The Delhi High Court decision also dealt with the case of Fatema, a homeless woman who experienced severe epileptic fits while she was pregnant. She was denied care at a maternity home and eventually was forced to give birth under a tree. In 2010, the Delhi High Court declared that the mistreatment faced by the women was the result of the non-implementation of schemes and policies that were intended to improve access to reproductive health care.^{xciv}

Recent fact-finding studies by the NGO, Human Rights Law Network, highlight continuing mistreatment and abuse experienced by women during pregnancy and childbirth. In 2018, for example, a woman in Delhi had to experience a long ordeal of abuse and degrading treatment after doctors negligently left a piece of cloth inside her after she underwent a cesarean section.^{xcv} She complained of heaviness and uneasiness after the operation, but the doctors did not examine her. She was discharged but continued to experience extreme pain. She returned to the hospital and vomited in the ward, causing the hospital staff to “lash out at her.” Eventually the doctors performed an x-ray and told her that she needed immediate surgery. She had two more rounds of surgery and the doctor asked her to return for one more. Upon her return, however, the doctor refused to perform another surgery and yelled at her and her husband because he had filed a police complaint against the hospital.

In another case that took place in Delhi, a woman by the name of Ms. Shanti Devi was misinformed by doctors that her baby had died after she gave birth prematurely.^{xcvi} She and her husband took the baby home for funeral rites, but then they noticed that the baby was breathing. They took the baby back to the hospital, where he was put on a ventilator, but died a day later. In the state of Assam, a woman was forced to give birth in an ambulance because the Primary Health Center where she had gone for the delivery of her baby was closed when she arrived.^{xcvii} She experienced excessive loss of blood during childbirth. When the Primary Health Care facility (PHC) opened several hours later, she was told to go to another hospital since the PHC was unable to deal with her case. There, she was told that she needed surgery, but she was unable to pay for it and so was turned away. These cases from India are emblematic of the disrespect and mistreatment women face at health facilities during pregnancy and childbirth. The disrespect ranges from gross negligence and dismissive and callous behavior to refusal to provide health care services.

Pakistan has a high maternal mortality ratio (178 deaths per 100,000 live births)^{xcviii} in large part due to the neglect of women during pregnancy and childbirth, especially of low-income women who are unable

to afford high quality reproductive health care, as well as negligence on the part of health care providers. Poor quality of services leads not only to maternal deaths but also maternal morbidities such as obstetric fistula that lead to unbearable pain and suffering. Hundreds of women in Pakistan develop obstetric fistula every year due to absence of antenatal care as well as prolonged obstructed labor in the absence of a skilled medical attendant.^{xcix} Maternal health experts also report that many women in Pakistan develop iatrogenic fistula due to negligence by doctors while performing cesarean section surgery.^c Women who develop obstetric fistula are forced to live with this condition for many years due to the non-availability of affordable fistula repair surgery. The neglect of women persists due to weak monitoring and regulation of doctors and health professionals.

In **Nepal**, the mistreatment of women during pregnancy and childbirth is apparent in the sharply rising trend of cesarean section rates, ranging from 20-81% at different hospitals.^{ci} The World Health Organization suggests that no region in the world is justified in having a cesarean section rate higher than 10% to 15%.^{ci} While a cesarean section is a life-saving obstetric emergency surgical intervention, it may also lead to significant and sometimes permanent complications. The rising rates of cesarean sections in Nepal is indicative of over-medicalization and commercialization of reproductive health services and pose significant threats to the health of women of reproductive age and indicate the need for greater monitoring and regulation of obstetric practices.^{ciii}

- **Need for Effective Redress**

Women facing mistreatment and abuse during pregnancy and childbirth in South Asia can approach courts to seek accountability for the violation of their fundamental human rights. They are also entitled to financial compensation for medical negligence on the part of doctors and health care facilities. However, as has been well-documented, access to justice for women across South Asia is challenging due to cultural barriers and poor availability of legal aid.^{civ} In spite of the existence of accountability mechanisms, women and girls are often be unable to attain redress for the violations of their rights during pregnancy and childbirth.

In **India**, the superior courts have recognized the right to health as a fundamental constitutional guarantee. In the case of *Laxmi Mandal v. Deen Dayal Harinagar Hospital*,^{civ} the Delhi High Court held that the failure of the government to ensure access to reproductive health services constitutes a violation of the right to life under Article 21 of the Constitution as well as a violation of India's commitments under international human rights treaties, including the International Covenant on Economic Social and Cultural Rights. Courts in India also recognize that individuals are entitled to compensation for medical negligence.^{cvi} High Courts in India have passed positive orders in other cases involving denial of quality reproductive health services. In a petition filed on behalf of a woman who developed obstetric fistula in part due to neglect at a primary health facility, the High Court of Uttar Pradesh ordered that the government immediately remedy deficiencies in the public health system in the state, including by filling vacancies in hospitals and ensuring necessary supplies of medicine.^{cvi}

In **Pakistan**, courts recognize medical negligence as a tort for which individuals are entitled to compensation. Superior Courts in Pakistan have recognized the right to health as a fundamental right guaranteed under the "right to life" in the Constitution of Pakistan. Aggrieved persons may approach Superior Courts directly for the enforcement of fundamental rights under the Constitution. Women facing mistreatment and abuse during pregnancy and childbirth may, therefore, approach Superior Courts for the violation of their rights to life, health, and dignity. In 2015, a petition was filed in a Pakistani High Court, with the technical support of the Center for Reproductive Rights, on behalf of a woman who developed obstetric fistula after giving birth to her baby at home in the absence of a skilled birth attendant.^{cvi} For eight years she was unable to receive treatment for her condition since

government health facilities did not provide fistula repair surgery and private facilities were too costly. The High Court directed the Sindh government to establish four fistula repair centers across Sindh and also to recruit and appoint more gynecologists in government health facilities.^{cix}

- **Existing laws and policies regulating maternal health care**

While a number of laws and policies exist across the region that call for the provision of quality reproductive health services and regulate the misconduct of health care professionals, the effectiveness of these measures in tackling mistreatment faced by women during pregnancy and childbirth is limited. In **India**, the government introduced the National Rural Health Mission (NRHM)/Reproductive and Child Health (RCH)-II program to ensure universal coverage of all births with skilled attendance, both at the institutional and at the community level and to provide access to emergency obstetric and neonatal care services for women and newborns, and thereby restrict the number of maternal and newborn deaths in the country.^{cx}

Although India has achieved considerable success towards reducing the overall maternal mortality ratio for the country,^{cxi} women from poor and marginalized backgrounds continue to face mistreatment and neglect during the reproductive care process, as is evident from the case studies above. The implementation of reproductive health policies is inconsistent, and weak regulation of the private sector contributes to negligence and malpractice in reproductive health care. The 2010 Clinical Establishments (Registrations and Regulations) Act prescribes minimum standards to be followed by health care professionals and facilities. However, the implementation of the law remains a challenge.^{cxii}

In **Pakistan**, the provinces of Sindh and Punjab have passed laws providing for the establishment of Healthcare Commissions that are to improve the quality of maternal health services and work towards the elimination of “quackery.”^{cxiii} In **Nepal**, the Safe Motherhood and Reproductive Health Act was passed in 2018, which contains a number of important provisions pertaining to the need for respectful maternal care and calling for the prohibition of discrimination in reproductive health services.

c. Europe

Although compared to other regions Europe now has the lowest rates of maternal mortality and morbidity in the world, serious problems persist and cross-regional data masks considerable variations in maternal health outcomes, both between and within European countries.^{cxiv} Moreover, across Europe certain groups of women still face serious forms of discrimination in access to affordable reproductive and maternal health care, and there are deeply concerning reports of continuing failures to observe adequate standards of care and ensure respect for women’s rights, dignity, and autonomy during childbirth.^{cxv}

- **Exclusions and barriers in access to quality care**

For some women living in Europe accessing maternal health care, in particular antenatal care, remains very difficult. For example, particularly harmful restrictions and obstacles confront undocumented migrant women in Europe^{cxvi} as legal and policy exclusions or financial and practical barriers severely curtail these women’s ability to access affordable maternal health care throughout pregnancy. Many European countries maintain laws and policies that prevent or impede many undocumented migrant women from obtaining affordable maternal health care throughout pregnancy by requiring them to cover the costs of some, or in most cases all, of this care themselves. In other countries, even though regulations provide for cost coverage for undocumented migrant women, a lack of firewalls separating the provision of health services from immigration control as well as administrative barriers, language barriers, and social exclusion also often dissuade undocumented migrant women from seeking medical assistance during pregnancy. A recent report by the Center for Reproductive Rights titled *Perilous*

Pregnancies: Barriers in Access to Affordable Maternal Health Care for Undocumented Migrant Women in the European Union addresses this matter in detail for the 28 European Union member states. Failures to ensure women's access to affordable maternal health care and restrictions on women's legal entitlements to certain forms of maternal health care have serious implications for their health and lives. When women are unable to obtain good quality affordable antenatal care, they face elevated risks of severe adverse pregnancy outcomes, including maternal death.

- **Mistreatment, abusive and coercive practices**

Reports have emerged that failures to ensure adequate standards of care and respect for women's rights, dignity and autonomy in childbirth are affecting women from all backgrounds in a range of European countries.

Reports from women across Europe, particularly in central and eastern Europe (see, for example, recent reports by the Slovak organizations titled *Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia* and *Women – Mothers – Bodies II Systemic Aspects of Violations of Women's Human Rights in Birth Care Provided in Healthcare Facilities in Slovakia*; studies on maternal health care in Hungary; and complaints on abuse and mistreatment in reproductive health care settings in Croatia)^{cxvii} indicate that, in these and other countries, women may face physical and verbal abuse from the health care staff, suturing of birth injuries without adequate pain relief, failures to safeguard women's privacy during labor, and deprivation of food and water during childbirth. In addition, allegations of disregard for women's decisions during labor are also commonplace, as are failures to ensure women's full and informed consent and ability to make informed decisions prior to medical interventions and procedures during childbirth. These interventions may often be highly invasive and regularly include fundal pressure (a practice involving the use of manual or instrumental pressure on the maternal abdomen), episiotomy (a surgical cut to the perineum), or cesarean section. There are also indications that systems of informal payments or bribes exist in maternal health care contexts in some European states.

The Committee on the Elimination of Discrimination against Women has expressed concerns with respect to a number of European countries over the lack of oversight to ensure adequate standards of care and protection of women's rights, dignity, and autonomy during childbirth. The Committee recommended that the respective State parties put in place adequate safeguards to ensure women have access to appropriate and safe childbirth procedures in line with adequate standards of care, respect for women's autonomy and the requirement of free, prior and informed consent.^{cxviii}

- **Segregated maternity care and ethnic discrimination and mistreatment**

The risk of exposure to abusive and discriminatory treatment in the context of maternal health care is exacerbated for certain groups of women in Europe, and for Roma women in a number of central and eastern European countries in particular. Reports indicate that the ethnic segregation of Roma women in maternal health facilities remains a reality in certain parts of Europe. Roma women are sometimes assigned to separate rooms, bathroom facilities, and eating areas within maternity hospitals or departments. In these separate facilities, overcrowding and inadequate sanitation services frequently prevail, in contrast to areas designated for non-Roma women. There are reports of two Roma women being placed in the same bed after giving birth, of patients being given beds in corridors when segregated rooms became full, and of failures to change soiled bedclothes and to ensure clean toilet facilities. These discriminatory practices have recently been documented by the Center for Reproductive Rights and Poradňa pre občianske a ľudské práva in a report titled *Vakeras Zorales – Speaking Out: Roma Women's Experiences in Reproductive Health Care in Slovakia*.^{cix} The report documents personal stories of 38 Roma women from marginalized communities who reported suffering discrimination and abuse in

reproductive and maternal health care facilities in eastern Slovakia. The report also recommends action steps that the Slovak authorities should take to respect the human rights of Roma women. Serious allegations of pervasive racial harassment and discrimination against Roma women by medical professionals in the context of childbirth and provision of reproductive health care are also common in other central and eastern European countries.^{cxx}

In addition to experiencing ethnic segregation and racial harassment and abuse in maternal health care settings, Roma women also face racist and sexist verbal abuse and harassment in other sexual and reproductive health care settings in Europe. Financial, practical, social, and policy barriers also have serious implications for their access to sexual and reproductive health care. Roma women are regularly denied access to relevant health services due to their perceived inability to pay medical bills or travelling lifestyle, a lack of health insurance, or a lack of relevant identity documents.

The Committee on the Elimination of Racial Discrimination has recently expressed serious concerns over the discriminatory treatment and segregation of Roma women and girls in health care facilities and the reports about “verbal and physical violence faced by Roma women when accessing sexual and reproductive health services” in Slovakia. The Committee has urged Slovak authorities to: “(a) [a]dopt all necessary measures to prevent and combat all forms of discrimination and segregation against Roma in the health-care system; (b) [e]nsure that Roma, particularly women and girls, are treated with respect and without discrimination when accessing health-care services; (c) [i]nvestigate effectively all acts of verbal and physical violence as well as discriminatory treatment, against Roma in the health-care system, and prosecute and sanction those responsible; and (d) [c]arry out activities and training aimed at raising awareness among medical personnel to eliminate racially discriminatory acts or practices.”^{cxxi}

In addition, the widespread and systematic practice of forced and coercive sterilization of Roma women in several central and eastern European countries is a well-documented past practice and has been the subject of repeated condemnation. Although a small number of individual women have obtained compensation following arduous litigation over many years, most Roma women who were forcibly sterilized have been unable to obtain redress. Countries such as the Czech Republic and Slovakia are still failing to accept responsibility for these practices and establish comprehensive inquiries and reparation schemes.^{cxxii}

We are grateful for this opportunity to input in the Special Rapporteur’s report. Should the mandate need any additional information, please do not hesitate to reach out to Rebecca Brown, Senior Director for Global Advocacy, at rbrown@reprorights.org and Paola Salwan Daher, Senior Global Advocacy Advisor, at pdaher@reprorights.org.

ⁱ Convention on the Elimination of All Forms of Discrimination against Women, *adopted Dec. 18, 1979, art. 12, 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)* [hereinafter CEDAW].

ⁱⁱ See, e.g., Committee on the Elimination of Discrimination against Women (CEDAW Committee) & Committee on the Rights of the Child (CRC Committee), *Joint General Recommendation No. 31 & General Comment No. 18: On harmful practices* (2014), at 18, paras. 68-69, U.N. Doc. CEDAW/C/GC/31-CRC/C/GC/18 (2014) [hereinafter CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18*]. See also CRC Committee, *Concluding Observations: Mongolia*, para. 51(a), U.N. Doc.

CRC/C/MNG/CO/3-4 (2010); Committee on Economic, Social and Cultural Rights (ESCR Committee), *Concluding Observations: Australia*, para. 28, U.N. Doc. E/C.12/AUS/CO/4 (2009).

ⁱⁱⁱ Human Rights Committee, *General Comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life* (2018), at 7, para. 26, U.N. Doc. CCPR/C/GC/36 (2018) [hereinafter Human Rights Committee, *Gen. Comment No. 36*].

^{iv} CEDAW Committee, *Report of the Committee on the Elimination of Discrimination against Women*, (20th Sess., 1999), at 52, para. 56, U.N. Doc. A/54/38/Rev.1 (1999) (“[T]he Committee notes that the level of maternal mortality due to clandestine abortions may indicate that the Government does not fully implement its obligations to respect the right to life of its women citizens.”).

^v CRC Committee, *Concluding Observations: Democratic Republic of Congo*, paras. 33-34, U.N. Doc. CRC/C/COD/CO/2 (2009).

^{vi} International Covenant on Economic, Social and Cultural Rights, adopted Dec. 16, 1966, art. 12, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR].

^{vii} ESCR Committee, *General Comment No. 14 (2000): The right to the highest attainable standard of health* (Art. 12) (22nd Sess., 2000), at 5, para. 14, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter ESCR Committee, *Gen. Comment No. 14*]; ESCR Committee, *General Comment No. 22 (2016): On the right to sexual and reproductive health* (Art. 12), (2016), at 12, para. 49, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter ESCR Committee, *Gen. Comment No. 22*]. See also Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, transmitted by Note of the Secretary-General, para. 30-31, U.N. Doc. A/59/422 (Oct. 8, 2004) (by Paul Hunt).

^{viii} ESCR Committee, *Gen. Comment No. 22*, *supra* note vii, paras. 12-21.

^{ix} CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, (20th Sess., 1999), para. 11, U.N. Doc. A/54/38/Rev.1, chap. I (1999) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]; ESCR Committee, *Gen. Comment No. 14*, *supra* note vii, para. 12.

^x ESCR Committee, *Concluding Observations: Brazil*, para. 28, U.N. Doc. E/C.12/BRA/CO/2 (2009); CRC Committee, *Concluding Observations: Uzbekistan*, para. 25, U.N. Doc. CRC/C/UZB/CO/3-4 (2013); CRC Committee, *Concluding Observations: Marshall Islands*, para. 52(g), U.N. Doc. CRC/C/MHL/CO/2 (2007); CRC Committee, *Concluding Observations: The Congo*, para. 59, U.N. Doc. CRC/C/COG/CO/2-4 (2014); CRC Committee, *Concluding Observations: Turkmenistan*, para. 52, U.N. Doc. CRC/C/TKM/CO/1 (2006); Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, para. 8(2)(b), U.N. Doc. CEDAW/C/49/D/17/2008 (2011). See also CEDAW Committee, *Concluding Observations: Kenya*, para. 38(b), U.N. Doc. CEDAW/C/KEN/CO/7 (2011).

^{xi} ESCR Committee, *Gen. Comment No. 22*, *supra* note vii, paras. 22-24, 30-32.

^{xii} ESCR Committee, *Gen. Comment No. 14*, *supra* note vii, para. 43(d).

^{xiii} CENTER FOR REPRODUCTIVE RIGHTS, BREAKING GROUND 2018: TREATY MONITORING BODIES ON REPRODUCTIVE RIGHTS 26-27 (2018), available at

<https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Breaking-Ground-2018.pdf> [hereinafter BREAKING GROUND 2018]. See also Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW

Committee, Commc'n No. 17/2008, paras. 7.6-7.7, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).

^{xiv} Committee Against Torture (CAT Committee), *Concluding Observations: Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); CAT Committee, *Concluding Observations: Peru*, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013).

^{xv} CAT Committee, *Concluding Observations: United States of America*, para. 33, U.N. Doc. CAT/C/USA/CO/2 (2006).

^{xvi} CAT Committee, *Concluding Observations: Kenya*, para. 27, U.N. Doc. CAT/C/KEN/CO/2 (2013).

^{xvii} *Id.*

^{xviii} CAT Committee, *Concluding Observations: United States of America*, para. 21, U.N. Doc. CAT/C/USA/CO/3-5 (2014).

^{xix} *Id.*

^{xx} See, e.g., CAT Committee, *Concluding Observations: Chile*, para. 7(m), U.N. Doc. CAT/C/ CR/32/5 (2004); 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); CAT Committee, *Concluding Observations: Peru*, para. 23, U.N. Doc. CAT/C/PER/CO/4 (2006).

See also Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development*, (7th Sess.), U.N. Doc. A/HRC/7/3 (2008) (by Manfred Nowak) [hereinafter Special Rapporteur on Torture, *Promotion and Protection of All Human Rights* 2008]; Human Rights Committee, *General Comment No. 28: Equality of Rights between Men and Women* (Art. 3), (68th Sess., 2000), in *Compilation of General Comments and Recommendations by Human Rights Treaty Bodies*, at 228, para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter Human Rights Committee, *General Comment No. 28*] (establishing that violations of article 7 on the right to be free from torture and CIDT include forced abortion as well as denial of access to safe abortion for women who have become pregnant as a result of rape).

^{xxi} Special Rapporteur on Torture, *Promotion and Protection of All Human Rights* 2008, *supra* note xx, para. 26.

^{xxii} CAT Committee, *General Comment No. 2: Implementation of article 2 by States parties*, (39th Sess., 2007), at 4, para. 15, U.N. Doc. CAT/C/GC/2 [hereinafter CAT Committee, *Gen. Comment No. 2*].

^{xxiii} *Id.*

^{xxiv} *Id.* para. 18 (“Since the failure of the State to exercise due diligence to intervene to stop, sanction and provide remedies to victims of torture facilitates and enables non-State actors to commit acts impermissible under the Convention with impunity, the State’s indifference or inaction provides a form of encouragement and/or de facto permission.”).

^{xxv} Special Rapporteur on Torture, *Promotion and Protection of All Human Rights* 2008, *supra* note xx, para. 31 (The Special Rapporteur has confirmed that Article 1 of the CAT “should be seen as reinforcing—and reinforced by—the Declaration on the Elimination of Violence against Women adopted by the General Assembly in resolution 48/104.”).

^{xxvi} For example, the Human Rights Committee has confirmed that Article 7 of the ICCPR “clearly protects not only persons arrested or imprisoned, but also pupils and patients in educational and medical institutions.” See Human Rights Committee, *General Comment No. 7: Prohibition of torture or cruel, inhuman or degrading treatment or punishment* (Art. 7), (16th Sess., 1982), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 178, para. 2, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. 1) (2008). The Human Rights Committee’s General Comment 20 subsequently replaced General Comment 7 to further develop interpretations of Article 7. To that end, General Comment 20 reaffirms that Article 7 “protects, in particular, children, pupils and patients in teaching and medical institutions.” See Human Rights Committee, *General Comment No. 20: Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment)*, (44th Sess., 1992), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 200, para. 5, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. 1) (2008) [hereinafter Human Rights Committee, *Gen. Comment No. 20*].

^{xxvii} OP-CAT, Article 4 of the Optional Protocol to the Convention against Torture, broadly defines a place of detention, stating that “deprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.” This definition thus includes health care facilities, psychiatric institutions, and orphanages, among other settings. Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *adopted* Dec. 18, 2002, arts. 1, 4(2), G.A. Res. A/RES/57/199, 57th Sess., U.N. Doc. A/RES/57/199 (2003) [hereinafter OP-CAT].

^{xxviii} See CENTER FOR REPRODUCTIVE RIGHTS & FEDERATION OF WOMEN LAWYERS—KENYA, FAILURE TO DELIVER: VIOLATIONS OF WOMEN’S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES 56-59 (2007), available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf [hereinafter FAILURE TO DELIVER].

^{xxix} CAT Committee, *Gen. Comment No. 2*, *supra* note xxii, para. 15; Human Rights Committee, *Gen. Comment No. 20*, at 200, para. 5.

^{xxx} CAT Committee, *Gen. Comment No. 2*, *supra* note xxii, para. 15.

^{xxxi} See CAT Committee, *Concluding Observations: Ecuador*, para. 18, U.N. Doc. CAT/C/ECU/CO/4-6 (2010) (expressing concern regarding sexual violence against girls in schools, particularly when the aggressor is a teacher).

^{xxxii} CAT Committee, *Gen. Comment No. 2*, *supra* note xxii, para. 22

^{xxxiii} *Id.*

^{xxxiv} See CENTER FOR REPRODUCTIVE RIGHTS, IN HARM’S WAY: THE IMPACT OF KENYA’S RESTRICTIVE ABORTION LAW 14 (2010), available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/InHarmsWay_2010.pdf (“Women and providers interviewed for this report often raised the issue of the harassment of post-abortion care patients by

providers. One provider reported overhearing a nurse tell a woman, ‘You had sex, you had your excitement. Now you’re crying, who will help you?’’); *see also* CENTER FOR REPRODUCTIVE RIGHTS, FORSAKEN LIVES: THE HARMFUL IMPACT OF THE PHILIPPINE CRIMINAL ABORTION BAN 16 (2010), available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/phil_report_Spreads.pdf (“...women who seek post-abortion care [in the Philippines] are frequently harassed, intimidated, abused, and threatened with criminal prosecution by health service providers.... Several women described how providers deliberately delayed care in their cases in order to ‘teach them a lesson.’’”).

^{xxxv} CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note ix, para. 22; Committee on the Rights of Persons with Disabilities (CRPD Committee), *General Comment No. 1* (2014), Article 12: *Equal recognition before the law*, (11th Sess., 2014), at 9, para. 35, U.N. Doc. CRPD/C/GC/1 (2014).

^{xxxvi} See STEVEN G. GABBE ET. AL., OBSTETRICS: NORMAL AND PROBLEM PREGNANCIES 704 (1996).

^{xxxvii} Human Rights Committee, *General Comment No. 28*, *supra* note xix, para. 20

^{xxxviii} CEDAW Committee, *General Recommendation No. 24*, *supra* note ix, para. 22.

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^{xliii} BREAKING GROUND 2018, *supra* note xiii, at 30.

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^{liv} CRPD, *supra* note xli, art. 6; CEDAW Committee, *Gen. Recommendation No. 25*, *supra* note lii, para. 12; CEDAW Committee, *Gen. Recommendation No. 28*, *supra* note lii, para. 18; ESCR Committee, *Gen. Comment No. 20*, *supra* note lii, para. 17; Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, (68th Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 233, para. 30, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter Human Rights Committee, *Gen. Comment No. 28*]; CRPD Committee, *General Comment No. 3 (2016) on women and girls with disabilities*, paras. 3, 4, 38, U.N. Doc. CRPD/C/GC/3 (2016) [hereinafter CRPD Committee, *General Comment No. 3*].

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Doc. E/C.12/2005/4 [hereinafter ESCR Committee, *Gen. Comment No. 16*]; ESCR Committee, *Concluding Observations: Namibia*, para. 65 (a), U.N. Doc. E/C.12/NAM/CO/1 (2016).

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^{lx} ESCR Committee, *Gen. Comment No. 16*, *supra* note lviii, para. 29.

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^{lxix} Michelle Hynes, Ouahiba Sakani, Paul Spiegel, & 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).

^{lxx} 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, & Jonathan CK Wells, *The intergenerational effects of war on the health of children* (Apr. 2014), 12:57 BMC MEDICINE, 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* (June 2002), 70 EARLY HUMAN DEVELOPMENT 3; Lucy Ward, *Mother’s stress harms foetus, research shows*, THE GUARDIAN (May 31, 2007), <https://www.theguardian.com/science/2007/may/31/childrensservices.medicineandhealth>.

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

^{lxxii} Human Rights Committee, *General Comment No. 29: States of Emergency* (Article 4), para. 1, U.N. Doc. CCPR/C/21/Rev.1/Add.11 (2001) [hereinafter Human Rights Committee, *Gen. Comment No. 29*]; OHCHR, INTERNATIONAL LEGAL PROTECTION OF HUMAN RIGHTS IN ARMED CONFLICT 10 (2011), available at http://www.ohchr.org/Documents/Publications/HR_in_armed_conflict.pdf. 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. ICESCR, *supra* note vi, art. 2(1); Convention on the Rights of the Child, *adopted* Nov. 20, 1989, art. 4, G.A. Res. 44/25,

annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989), (*entered into force* Sept. 2, 1990) [hereinafter CRC]; CRPD, *supra* note xli, art. 4(2); *see also* ESCR Committee, *General Comment No. 3, supra* note lv, para. 9.

^{lxxiii} States cannot derogate from certain *jus cogens* norms, such as the prohibitions on torture, genocide, and slavery, even during situations of armed conflict. *See* Human Rights Committee, *Gen. Comment No. 29, supra* note lxxii, para. 7. Minimum core obligations with respect to economic, social, and cultural rights are not subject to resource availability and are non-derogable. *See* ESCR Committee, *Gen. Comment No. 14, supra* note vii, para 47; ESCR Committee, *General Comment No. 15: The right to water (arts. 11 and 12 of the International Covenant on Economic, Social and Cultural Rights)*, at 13, 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. *See* 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).

^{lxxiv} Human Rights Committee, *Gen. Comment No. 29, supra* note lxxii, para. 8.

^{lxxv} CEDAW Committee, *General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations*, para. 38(e), U.N. Doc. CEDAW/C/GC/30 (2013) [hereinafter CEDAW Committee, *Gen. Recommendation No. 30*]; *see also* CAT Committee, *Concluding Observations: Iraq*, para. 13, U.N. Doc. CAT/C/IRQ/CO/1 (2015).

^{lxxvi} CEDAW Committee, *Gen. Recommendation No. 30, supra* note lxxv, para. 57.

^{lxxvii} *See generally* BREAKING GROUND 2018, *supra* note xiii.

^{lxxviii} States' obligations under the treaty "do not cease in periods of armed conflict or in states of emergency resulting from political events or natural disasters." The CEDAW Committee explained that these situations "have a deep impact on and broad consequences for the equal enjoyment and exercise by women of their fundamental rights" and called upon states to pursue strategies and measures aimed at addressing the particular needs of women during such states of emergency. CEDAW Committee, *General Recommendation No. 28 on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, at 3, para. 11, U.N. Doc. CEDAW/C/GC/28 (2010) [hereinafter CEDAW Committee, *Gen. Recommendation No. 28*]. *See also* CEDAW Committee, *Gen. Recommendation No. 30, supra* note lxxv, para. 2 ("The Committee reiterates that States parties' obligations continue to apply during conflict or states of emergency without discrimination between citizens and non-citizens within their territory or effective control, even if not situated within the territory of the State party.").

^{lxxix} CEDAW Committee, *Gen. Recommendation No. 30, supra* note lxxv, para. 2.

^{lxxx} CEDAW Committee, *Gen. Recommendation No. 28, supra* note lxxviii, para. 11.

^{lxxxi} *See* Human Rights Council (HRC), *Resolution 11/8: Preventable maternal mortality and morbidity and human rights*, (11th Sess., 2009), U.N. Doc. A/HRC/RES/11/8 (2009).

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^{xcvii} Human Rights Law Network, *A Live Premature Delivery Declared Dead By Safdarjung Hospital: Fact Finding Report, June 2017*, available at <https://hrln.org/wp-content/uploads/2018/02/safdarjung-fact-finding-report.pdf>.

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^{cxvi} For more information on mistreatment and abuse in reproductive health care settings in Europe, see COMMISSIONER FOR HUMAN RIGHTS OF THE COUNCIL OF EUROPE, WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN EUROPE (2017), available at <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead>.

^{cxvii} *See, e.g.*, CENTER FOR REPRODUCTIVE RIGHTS, PERILOUS PREGNANCIES: BARRIERS IN ACCESS TO AFFORDABLE MATERNAL HEALTH CARE FOR UNDOCUMENTED MIGRANT WOMEN IN THE EUROPEAN UNION (2018), available at <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Perilous-Pregnancies-Health-Care-For-Undocumented-Migrant-Women-EU.pdf>.

^{cxvii} See, e.g., Debrecéniová, J. (ed.), ŽENY – MATKY – TELÁ: ĽUDSKÉ PRÁVA ŽIEN PRI PÔRODNEJ STAROSTLIVOSTI V ZDRAVOTNÍCKYCH ZARIADENIACH NA SLOVENSKU [WOMEN – MOTHERS – BODIES: WOMEN'S HUMAN RIGHTS IN OBSTETRIC CARE IN HEALTHCARE FACILITIES IN SLOVAKIA] (2015), Občan, demokracia a zodpovednosť & Ženské kruhy, at 206-209 (English version), available at http://odz.sk/wp-content/uploads/Z-M-T_publ_el1_pod_sebou.pdf (Slovk.); http://odz.sk/en/wp-content/uploads/Women-Mothers-Bodies_summ_EN.pdf (Engl.); WOMEN – MOTHERS – BODIES II SYSTEMIC ASPECTS OF VIOLATIONS OF WOMEN'S HUMAN RIGHTS IN BIRTH CARE PROVIDED IN HEALTHCARE FACILITIES IN SLOVAKIA (2016), Občan, demokracia a zodpovednosť & Ženské kruhy, available at http://odz.sk/wp-content/uploads/ZMT2_systemmove_apekty_v6_w.pdf; Roda – Parents in Action, *Complaints sent to UN Bodies on Obstetric Violence in Croatia* (2018), available at <http://www.roda.hr/en/reports/complaints-sent-to-un-bodies-on-obstetric-violence-in-croatia.html>; Imre Szabik et al., *Ethical Implications of Obstetric Care in Hungary: Results from the Mother-Centred Pregnancy Care Survey*, 13 EUROPEAN JOURNAL OF MENTAL HEALTH, 51-69 (2018); Nicholas Rubashkin et al., *Assessing quality of maternity care in Hungary: Expert validation and testing of the mother-centered prenatal care (MCPC) survey instrument*, 14:152 REPRODUCTIVE HEALTH (2017);

Petra Baji et al., *Informal cash payments for birth in Hungary: Are women paying to secure a known provider, respect, or quality of care?*, 189 SOCIAL SCIENCE & MEDICINE 86-95 (2017).

^{cxviii} See, e.g., CEDAW Committee, *Concluding Observations: Croatia*, paras. 30-31, U.N. Doc.

CEDAW/C/HRV/CO/4-5 (2015); CEDAW Committee, *Concluding Observations: Slovakia*, paras. 30-31, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); CEDAW Committee, *Concluding Observations: Czech Republic*, paras. 30-31, U.N. Doc. CEDAW/C/CZE/CO/6 (2016). See also Human Rights Committee, *Concluding Observations: Slovakia*, paras. 24, 25(d), CCPR/C/SVK/CO/4 (2016).

^{cix} Center for Reproductive Rights & Poradňa pre občianske a ľudské práva (Center for Civil and Human Rights), VAKERAS ZORALES – SPEAKING OUT: ROMA WOMEN'S EXPERIENCES IN REPRODUCTIVE HEALTH CARE IN SLOVAKIA (2017), available at <https://www.reproductiverights.org/sites/crr.civicactions.net/files/webform/GLP-SlovakiaRomaReport-Final-Print.pdf>.

^{cxx} See, e.g., European Roma Rights Centre (ERRC) v. Bulgaria, Complaint No. 151/2017, European Committee of Social Rights; ERRC, *Romani woman harassed by racist hospital staff during childbirth wins case*, Jan. 18, 2017, <http://www.errc.org/press-releases/romani-woman-harassed-by-racist-hospital-staff-during-childbirth-wins-case> (last visited May 22, 2019).

^{cxxi} CERD Committee, *Concluding Observations: Slovakia*, paras. 23-24, U.N. doc. CERD/C/SVK/CO/11-12 (2018).

^{cxxii} See, e.g., CEDAW, *Concluding Observations: Czech Republic*, paras. 28-29, U.N. Doc.

CEDAW/C/CZE/CO/6 (2016); Human Rights Committee, *Concluding Observations: Slovakia*, paras. 26-27, U.N. Doc CCPR/C/SVK/CO/4 (2016).

See also ERRC, COERCIVE AND CRUEL: STERILISATION AND ITS CONSEQUENCES FOR ROMANI WOMEN IN THE CZECH REPUBLIC (1966-2016) (2016), available at http://www.errc.org/uploads/upload_en/file/coercive-and-cruel-28-november-2016.pdf; Center for Reproductive Rights & Poradňa pre občianske a ľudské práva, VAKERAS ZORALES – SPEAKING OUT: ROMA WOMEN'S EXPERIENCES IN REPRODUCTIVE HEALTH CARE IN SLOVAKIA (2017), <https://www.reproductiverights.org/sites/crr.civicactions.net/files/webform/GLP-SlovakiaRomaReport-Final-Print.pdf>; CLAUDE CAHN, HUMAN RIGHTS, STATE SOVEREIGNTY, AND MEDICAL ETHICS: EXAMINING STRUGGLES AROUND COERCIVE STERILISATION OF ROMANI WOMEN (2015).