# BREAKING GROUND 2018

*Treaty Monitoring Bodies on Reproductive Rights*

CENTER FOR REPRODUCTIVE RIGHTS

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This booklet summarizes the jurisprudence from United Nations treaty monitoring bodies on reproductive rights, particularly the standards on reproductive health information and contraception, maternal health care, and abortion. It is intended to provide treaty body experts and human rights advocates with succinct and accessible information on the standards being adopted across treaty monitoring bodies surrounding these important rights. Updated annually to reflect trends in reproductive rights, this is the third edition of this publication. This publication is current through August 2017.

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# TABLE OF CONTENTS

➔ indicates new TMB jurisprudence from 2016-2017; arrows next to bullet points indicate one or more new developments in that section

| | |
|---|---|
| **ART** | Assisted reproductive technology |
| **CAT** | Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment |
| **CEDAW** | Convention on the Elimination of Discrimination against Women |
| **CERD** | Convention on the Elimination of All Forms of Racial Discrimination |
| **CRC** | Convention on the Rights of the Child |
| **CRPD** | Convention on the Rights of Persons with Disabilities |
| **FGM** | Female genital mutilation |
| **GBV** | Gender-based violence |
| **ICCPR** | International Covenant on Civil and Political Rights |
| **ICESCR** | International Covenant on Economic, Social, and Cultural Rights |
| **STI** | Sexually transmitted infection |
| **WHO** | World Health Organization |

Please note that the term "women" is intended to include both women and girls unless otherwise noted.

# INTRODUCTION: REPRODUCTIVE RIGHTS IN CONTEXT

Reproductive rights are essential to the realization of all human rights. They encompass a spectrum of civil, political, economic, and social rights, from the rights to health and life, to the rights to equality and non-discrimination, privacy, information, and the right to be free from torture or ill- treatment. States' obligations to guarantee these rights require that women and girls[1] not only have access to comprehensive reproductive health information and services, but also that they experience positive reproductive health outcomes such as lower rates of maternal mortality, and have the opportunity to make fully informed decisions—free from violence, discrimination, and coercion—about their sexuality and reproductive lives.

This booklet summarizes the jurisprudence from United Nations treaty monitoring bodies on reproductive rights, particularly the standards on reproductive health information and contraception, maternal health care, and abortion. It is intended to provide treaty body experts and human rights advocates with succinct and accessible information on the standards being adopted across treaty monitoring bodies pertaining to these vital rights.

This section provides an overview of the legal and theoretical frameworks that treaty monitoring bodies have used to underpin international human rights standards on reproductive rights. These include substantive gender equality, the essential elements of the right to health, and reproductive autonomy.

## I. SUBSTANTIVE EQUALITY AND REPRODUCTIVE RIGHTS

Nearly all international human rights treaties explicitly recognize that gender equality is essential to the realization of human rights.[2] However, traditional models of gender equality, which have emphasized equal treatment of men and women under the law and in practice, have failed to address the historical roots of gender discrimination, gender stereotypes, and traditional understandings of gender roles that perpetuate discrimination and inequality.

### The Substantive Equality Framework

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.[3]
- 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.[4] Women also may face discrimination based on multiple grounds, including race, disability, age, or other marginalized statuses.[5]
- 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.[6]

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.[7] This requires that states take positive measures to create an enabling environment that ameliorates social conditions such as poverty and unemployment, factors which effect women's right to equality in health care.[8]
- 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.[9]
- 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."[10] 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."[11]

## II. THE RIGHT TO HEALTH AND REPRODUCTIVE RIGHTS

Many aspects of reproductive rights, including access to reproductive health information and services, stem from the right to the highest attainable standard of physical and mental health. In its General Comment No. 14, the ESCR Committee sets forth four interrelated and essential elements of the right to health, finding that health facilities, goods, and services must be available, accessible, acceptable, and of good quality.[12] In its subsequent General Comment No. 22, the ESCR Committee explicitly applies these principles to the right to sexual and reproductive health.[13] This framework has also been utilized by other treaty monitoring bodies, including the CRC and CEDAW Committees.[14] Under this framework, with respect to reproductive health and services, states must fulfill the following principles within the right to health, including the right to sexual and reproductive health:

**Availability:** States have an obligation to ensure adequate training of health care providers, a sufficient number of health facilities throughout the country, adequate sanitation and infrastructure for sexual and reproductive health services, including in rural areas, and essential drugs, as defined by the World Health Organization (WHO) Model List of Essential Medicines.[15]

**Accessibility:**[16] States must ensure that sexual and reproductive health information and services are accessible by guaranteeing:

- *Physical accessibility*: States must ensure that women do not have to travel long distances to health facilities and have access to transportation to ensure their right to health information and services.[17]
- *Economic accessibility (Affordability)*: States must ensure that health services and goods are affordable for everyone[18] and should provide free or low-cost reproductive health goods and services for women who cannot afford them.[19] The CRC Committee has called on states to provide

adolescents free reproductive health services, including access to contraception and safe abortion.[20]

- *Information accessibility*: Individuals must have access to the information and education necessary to enable them to freely determine the number and spacing of their children.[21] States may not censor, withhold, or intentionally misrepresent sexual and reproductive health information[22] and should ensure everyone access to comprehensive, age-appropriate, unbiased, and scientifically accurate sexuality education.[23] (See chapter 1 for more details on the right to sexual and reproductive health information.)

**Acceptability:** Sexual and reproductive health services must respect the rights to confidentiality and informed consent, be culturally appropriate, and be sensitive to gender and life-cycle requirements.[24] Further, they must be delivered in a way that respects women's dignity and is sensitive to their needs and perspectives.[25]

**Quality:** Health services must be scientifically and medically appropriate, which requires skilled medical personnel, scientifically approved and unexpired drugs, sufficient hospital equipment, safe and potable water, and adequate sanitation.[26]

In General Comment No. 22, the ESCR Committee reiterated states' obligation "to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to ensure the full realization of the right to sexual and reproductive health."[27] Although the right to health is considered a right of progressive realization, there are minimum core obligations related to the provision of reproductive health services, which states must fulfill regardless of resource constraints. These core obligations include:

- Ensuring that individuals are free from gender discrimination in the provision of health services.[28] This may require states

to take temporary measures to address long-standing oppressions.[29]

- Avoiding all retrogressive measures that would perpetuate existing, or establish new oppressions.[30]
- Providing essential medicines in accordance with the WHO Model List of Essential Medicines, which includes short- and long-term contraceptives, emergency contraception, and drugs for maternal health care and management of incomplete abortion and miscarriage.[31]
- Regulating and monitoring both private and public health facilities to ensure that women receive reproductive health services in compliance with human rights.[32]

General Comment No. 22 also notes that states must eliminate or remove all laws and policies that undermine the ability of certain individuals and groups to obtain the full range of reproductive health information, goods, and services.[33]

## Social and Other 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.[34] "Social determinants of health" refer 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.[35] 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.[36] 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.[37]

## III. AUTONOMY AND REPRODUCTIVE RIGHTS

Ensuring women's right to non-discrimination and substantive equality requires that women are able to exercise autonomy and self-determination, as well as make important life decisions without undue influence or coercion. Full exercise of autonomy requires that choices are meaningful, not limited by discrimination or lack of opportunities or possible results.

The principle of autonomy is reinforced in a number of rights outlined in international human rights law.[38] The right to reproductive autonomy is most clearly delineated in:

- **The right to decide on the number and spacing of children**, which appears in Article 16 of the CEDAW as an essential part of ensuring women's equality within the family.[39] The CEDAW Committee has stated that "the right to autonomy [for women] requires measures to guarantee the right to decide freely and responsibly on the number and spacing of their children."[40] It has also expressed concern over countries that fail to ensure the reproductive rights of women, which include "the right of women to autonomous decision-making about their health."[41]
- **The right to privacy**, which appears in Article 17 of the International Covenant on Civil and Political Rights and which the Human Rights Committee has found to be a critical component in ensuring protection for women's reproductive choices.[42]

### Legal, Policy, and Procedural Barriers to Reproductive Autonomy

Women are unable to exercise their reproductive autonomy where laws, policies, and practices restrict this autonomy, imposing arbitrary or unlawful restrictions on their right to access sexual and reproductive health services. Such restrictions include:

- **Third-Party Authorization Requirements:** The CEDAW Committee, CRC Committee, Committee against Torture (CAT Committee), CRPD Committee and Human Rights Committee have urged states to repeal third-party authorization requirements—such as those required from spouses, judges, parents, guardians, or health authorities—for reproductive health services, classifying these requirements as forms of discrimination against women and barriers to women's access to reproductive health services.[43] In its General Recommendation on access to justice, the CEDAW Committee calls on states to "abolish rules and practices that require parental or spousal authorization for access to services such as… health, including sexual and reproductive health."[44]
- **Inadequately Regulated Conscientious Objection:** States that permit health providers to invoke conscientious objection must adequately regulate the practice to ensure that it does not limit women's access to reproductive health services.[45] They must also implement a timely, systematic mechanism for referrals to an alternative health care provider and ensure that conscientious objection is a personal and not institutional practice.[46]
- **Insufficient Cultural and Linguistic Accommodations**: Language barriers, a lack of cultural awareness and other obstacles prevent migrant women and others from accessing health care facilities, including reproductive health services, and states must take steps to eliminate this barrier to access.[47] The CEDAW Committee maintains that states must "[e]nsure that medical professionals are aware of the cultural and linguistic barriers that migrant women face when accessing health care, and ensure the availability of female medical staff if requested; and take steps to introduce awareness-raising campaigns, in relevant languages, among migrant communities on how to gain access to health-care services, including sexual and reproductive health services."[48]

### Violence and Coercion

Treaty monitoring bodies have also recognized that women are denied reproductive 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.[49]
- **Gender-based violence (GBV)**, including sexual violence such as rape and so-called "survival sex,"[50] against women and the low rates of reporting such violations in and around refugee camps.[51] The CEDAW Committee has called on states to increase security within and around refugee camps[52] and has recommended that states establish specialized mechanisms to investigate allegations of human rights violations and acts of violence by security forces.[53] Women who are victims of GBV must be provided access to courts and other formal justice mechanisms.[54]
- **Harmful traditional practices**, which treaty monitoring bodies have recognized violate a number of human rights and have implications for reproductive 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.[55] Child marriage is often accompanied by early and frequent pregnancy and childbirth, which also results in increased maternal mortality rates.[56] This practice triggers a continuum of human rights violations that continue throughout a girl's life. The CEDAW, CRC, and Human Rights Committees have expressed concern of the prevalence of child marriage in refugee camps,[57] where adolescent refugee girls are often sold as brides.[58] Additionally, refugee women are frequently forced into marriages for socio-economic and "protection" purposes.[59] The treaty monitoring bodies are

also concerned with the high prevalence of female genital mutilation (FGM).[60] 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.[61] States must take immediate measures to address these harmful traditional practices by *inter alia* sharply reducing child and early marriage[62] and providing immediate support services, including medical, psychological, and legal services, to women who have undergone FGM.[63]

# THE RIGHT TO SEXUAL AND REPRODUCTIVE HEALTH INFORMATION AND CONTRACEPTION

Treaty monitoring bodies have consistently found that women have the right to access sexual and reproductive health information and contraception as a means of preventing sexually transmitted infections and pregnancy. Such access must not be hindered by legal restrictions or third-party authorization requirements. Moreover, contraceptives must be administered on the basis of informed consent and must be guaranteed under the obligations of the rights to health and information. Treaty monitoring bodies have linked violations of the right to access sexual and reproductive health information and contraceptives directly to gender inequalities, including gender stereotypes about women as mothers and caregivers and patriarchal attitudes, calling on states to increase access and raise awareness in order to ensure women's human rights.

## I. INTERNATIONAL HUMAN RIGHTS STANDARDS ON THE RIGHT TO CONTRACEPTIVE INFORMATION AND SERVICES

### Access to Contraceptives, as well as Access to Sexual and Reproductive Health Information

Treaty monitoring bodies have found that sexual and reproductive health information and contraception must be accessible, acceptable, available, and of good quality. For contraceptives in particular, they have noted that:

- Women should have **access to information** about contraceptives, including through comprehensive sexuality education and awareness programs about the importance of contraceptives.[64] States must also ensure access to information as a means of ensuring informed consent for contraceptive services, particularly sterilization.[65]
- Modern methods of contraception should be **affordable**, with treaty monitoring bodies increasingly recognizing that contraceptives should be subsidized, covered by public health insurance schemes, or provided free of charge to women and girls.[66]
- States must ensure that **a comprehensive range of good quality, modern, and effective contraceptives, including emergency contraception, are available** to everyone.[67] This is a core obligation of states under the right to health to ensure access to essential medicines from the WHO's Model List of Essential Medicines.[68] The ESCR Committee stresses that in order for goods and services to be of good quality, they must be evidence-based, scientifically and medically appropriate, and up-to-date—failure or refusal to incorporate technological advances and innovations jeopardizes the quality of care.[69]

## Comprehensive Sexuality Education

Treaty monitoring bodies call on governments to guarantee the rights of adolescents to health, life, education, and non-discrimination by providing them comprehensive sexuality education that is scientifically accurate and objective, age appropriate, and free of prejudice and discrimination.[70] The CRC Committee emphasizes that all adolescents have the right to access confidential, adolescent-responsive sexual and reproductive health information, education, and services, irrespective of age and without the consent of a parent or guardian.[71]

To ensure access to quality comprehensive sexual education, states must:

- Make mandatory, comprehensive, and age-appropriate education on sexual and reproductive health and rights a part of regular school curriculum.[72] The standards set by the state for sexual and reproductive health education should be in line with guidelines developed by the WHO and the United Nations Population Fund.[73] Adolescents should be involved in the development of the curriculum,[74] and states may not censor, withhold, or intentionally misrepresent sexual and reproductive health information.[75]
- Ensure that the curriculum is based on scientific evidence and human rights standards.[76] In addition to providing information on the biology of reproduction, contraception, and prevention of HIV/AIDS,[77] the curriculum must also integrate a strong gender perspective and address socialized gender roles and stereotypes, patriarchal attitudes, and unequal power dynamics.[78] There must also be discussion of responsible sexual behavior and the prevention of early pregnancy and sexually transmitted infections.[79] Attention should be given to gender equality, sexual diversity, sexual and reproductive health rights, and violence prevention.[80]
- Guarantee that comprehensive sexuality education is available to all adolescents, including out of school adolescents.[81] According to the CRC Committee, unequal access by adolescents to comprehensive, gender-sensitive sexual and health information, commodities and services amounts to discrimination.[82]
- Require teachers to be trained on delivering age-appropriate education on sexual and reproductive health and rights.[83] This includes helping teachers deliver sexuality education programs in a way that respects adolescents' right privacy and confidentially.[84]

## Restrictions on Access to Information

Access to accurate and timely information, including sexuality education, is essential to exercising autonomy and making informed choices to undergo medical procedures. As noted in the introduction, access to information in health care settings is an issue that affects all women, because laws may restrict the information that is available or require health care professionals to provide unnecessary or misleading information to women about their health. It is important to ensure that this information does not reflect biases and prejudices about the role of women and the health services that should be available to them.

## Access to Sexual and Reproductive Health Information and Contraceptives for Marginalized Groups

Treaty monitoring bodies have found that states should take extra efforts to ensure that women from marginalized groups have access to sexual and reproductive health information and contraceptives, including:

***Adolescents***

- The CRC Committee has found that both short- and long-term contraceptives should be made readily available to adolescents.[85] Treaty monitoring bodies recognize that adolescents and youth face specific barriers in accessing contraception,[86] including taboos about adolescent sexuality[87] and legal restrictions on contraceptives for unmarried women.[88]
- Treaty monitoring bodies have also found that adolescents must have access to sexual and reproductive health information, encompassing contraceptive information,[89] including as a mandatory part of school curricula[90] and through adolescent-friendly and confidential counselling.[91]
- The CRC Committee has noted the especially high rates of Sexually Transmitted Infections (STI) and pregnancy amongst children in street situations. The Committee calls

on states to provide access to sexual and reproductive health information and services, including family planning and prevention of STIs for children in street situations.[92]

***Rural Women***

- Treaty monitoring bodies acknowledge that rural women have a disproportionate unmet need for sexual and reproductive health care, including access to modern contraceptives,[93] because of particular difficulties that hinder access in rural areas, including lack of health facilities and transportation.[94] The CEDAW Committee calls on states to ensure that high quality health care facilities are physically accessible and affordable to rural women.[95] Moreover, women in rural and remote areas must be able to access all contraceptive services, including emergency contraception.[96]
- States must ensure culturally appropriate information and services are available in rural or remote areas. This requires that information on reproductive health care, including on modern forms of contraception, be widely disseminated in local languages and dialects through a variety of media.[97] Also, community health care workers and traditional birth attendants must be provided gender and culturally responsive trainings.[98]

***Refugees, Internally Displaced People, and Migrants***

- The CEDAW and CRC Committees have called on states to increase access to sexual and reproductive health services for refugees and internally displaced women.[99] According to the Committees, states must address the specific health care needs of diverse groups of refugee and internally displaced women who are subjected to multiple and intersecting forms of discrimination.[100]
- States must also take steps to introduce awareness raising campaigns, in relevant languages, among migrant communities on how to access reproductive health services.[101]

## Emergency Contraception

Treaty monitoring bodies have paid particular attention to the issue of access to emergency contraception, which helps prevent pregnancy following unprotected sexual intercourse. They have found that restrictions on free distribution of emergency contraception may violate a number of rights, including the rights to health, non-discrimination, gender equality, and freedom from ill-treatment.[102]

In addition to ensuring that emergency contraception is available as part of the range of modern contraceptive services outlined above, treaty monitoring bodies have specifically found that:

- **Access:** Emergency contraception should be available without a prescription,[103] should be free for victims of violence including adolescents,[104] and special measures should be taken to ensure that it is available to women in conflict and post-conflict zones.[105]
- **Ill-Treatment:** Emergency contraception must be legal and accessible for women who are victims of rape or sexual abuse, in order to prevent physical and mental suffering that may amount to ill-treatment.[106]

### Information, Contraception, Equality, and Autonomy

The CEDAW and ESCR Committees have found that denying women sexual and reproductive health information and contraception violates a number of women's rights related to gender equality.[107] The CEDAW Committee has gone further to say that the abuse or mistreatment of women seeking sexual and reproductive health information, goods, and services are forms of GBV.[108] To address this:

- The treaty monitoring bodies have called on states to work to eradicate gender stereotypes relating to women and men,[109] noting that patriarchal attitudes, cultural stigma, gender stereotypes, prejudices about sexual and reproductive health services, and taboos about sexuality outside of marriage all contribute to the lack of access to reproductive

health information and contraception.[110] The Committees have called on states to conduct public awareness campaigns to tackle gender inequalities as a means of improving access to reproductive health care information and service for women.[111]

- Additionally, treaty monitoring bodies, including the CEDAW, ESCR, CRC and Human Rights Committees, have called on states to ensure particular contraception-related health outcomes for women as a means of ensuring equality of results. These include fulfilling the unmet need for contraceptives and reducing teenage pregnancy through access to contraceptive information and services.[112]
- With regard to the legal capacity of adolescents to make autonomous decisions about their health, the CRC Committee urges states to give consideration "to the introduction of a legal presumption that adolescents are competent to seek and have access to preventive or time-sensitive sexual and reproductive health commodities and services."[113]

Women face many barriers to exercising their reproductive autonomy when accessing contraception, which is in violation of their rights to health, equality, privacy, ability to decide on the number and spacing of their children, and freedom from ill-treatment. In response, treaty monitoring bodies have found that there should be **no third-party authorization requirements** for accessing contraception, including spousal or parental consent requirements.[114] Additionally, the CRPD Committee has recognized that securing **informed consent** for contraceptives, including sterilization, is an essential component of women's human rights.[115]

## Substantive Equality, Autonomy, and Sterilization

Autonomy and equality are key issues for protecting women's reproductive rights, especially with respect to sterilization. Many women from marginalized groups are subjected to forced or coerced sterilization, which the treaty monitoring bodies have found that in certain situations violates their right to be free from torture or ill-treatment.[116] The CEDAW Committee has identified forced sterilization as a form of gender-based violence,[117] and has called for complaints about forced sterilization to be duly investigated and for the provision of remedies and redress that are "adequate, effective, promptly granted, holistic and proportionate to the gravity of the harm suffered."[118]

- ***Women with Disabilities:***
  - The CRPD Committee has considered forced sterilization and forced abortion as violations of the rights to bodily integrity, family and fertility, health, and legal capacity,[119] noting that women with disabilities are subjected to high rates of forced sterilization because they are denied control over reproductive decision-making.[120] The Committee has called on states to prohibit forced sterilization in all circumstances,[121] and provide remedies for women who have been victims of forced sterilization.[122]
  - The CEDAW Committee has found that women with disabilities should be given necessary support for making decisions about reproductive health, including sterilization.[123] The Committee further found that consent for sterilization must come from the women herself, not a third-party[124] and has called on states to ensure the training of health workers to protect the rights of women with disabilities. [125]
  - The CRC Committee has condemned the forced sterilization of children with disabilities and called on states to respect girls with disabilities' sexual and reproductive rights.[126]
  - The ESCR Committee expressed concern over mental health laws that allow compulsory treatment, including forced sterilization, of people with disabilities and called on states to repeal all legislation that permits medical intervention without their free, prior and informed consent.[127]

- ***Transgender Persons:*** The CEDAW Committee has found that laws requiring individuals to consent to sterilization in order to change their listed sex on identification documents constitutes gender stereotyping and is in violation of the CEDAW.[128]
- ***Roma Women:*** Because of a long history of forced and coerced sterilization of Roma women in countries throughout Europe, several treaty monitoring bodies have called on states to make particular efforts to ensure Roma women's informed consent before sterilization and to provide adequate training to health workers on issues related to Roma rights.[129]
- ***People with HIV:*** The CAT Committee noted concern with the forced sterilization of people with HIV.[130] The Committee called on states to adopt legislative and policy measures to prevent and criminalize forced sterilization of people with HIV.[131]

## II. RECOMMENDATIONS

Treaty monitoring bodies have embraced the right to sexual and reproductive health information and contraception as part of their mandates. In order to ensure the full protection of this right, treaty monitoring bodies should consider undertaking the following:

- Note and recommend in concluding observations that states address the social and other determinants that effect women's access to sexual and reproductive health information and contraception, including poverty, geography, access to education including sexuality education, legal restrictions on accessing services, and access to justice, among others.
- Explicitly recognize in concluding observations that denial of access to sexual and reproductive health information and contraceptives often results from gender stereotypes,

patriarchal attitudes, and taboos surrounding sexual activity for women, and that access to sexual and reproductive health information and contraception is essential to ensuring gender equality for women, because of their unique ability to become pregnant and the effect that childbearing has on their lives.

- Continue to condemn violations of women's autonomy in the context of contraceptive information and services, including the failure to obtain free and full informed consent and restrictions on women's decision-making such as third-party authorization requirements. Also note that any legal restrictions on access to contraception—including emergency contraception—constitute barriers to women's decision-making in the area of reproductive health, in violation of their right to decide on the number and spacing of their children and their right to privacy.

# THE RIGHT TO MATERNAL HEALTH CARE

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.[132] 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.[133] Finally, women must be able to exercise reproductive 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.

## I. INTERNATIONAL HUMAN RIGHTS STANDARDS

### Rights to Life and Health

Treaty monitoring bodies have grounded the right to maternal health care in the rights to life and health, recognizing that states must take positive measures to prevent maternal mortality[134] and to guarantee all women available, accessible, acceptable, and good quality maternal health services.[135]

- **Availability and Quality:** Treaty monitoring bodies have called on states to ensure adequate pre- and post-natal care, skilled birth attendants, and emergency obstetric

services if needed.[136] Therefore, states should guarantee hospitals stock sufficient obstetric supplies and emergency medicines, establish referral systems for obstetric emergencies, and ensure health workers have adequate training on quality maternal health services.[137]

- **Accessibility:** Maternal health care facilities should be accessible to all women on a non-discriminatory basis, in law and in fact, and must ensure:
    - **Physical Accessibility:** States should ensure that maternal health services are geographically accessible to women, particularly in rural areas.[138]
    - **Affordability:** Maternal health services must be affordable, with states granting free services where needed and should take into account the costs of transportation in accessing maternal health care.[139]
    - **Information Accessibility:** States should further ensure that women, their families, and their communities have adequate information about the signs of potentially dangerous obstetric complications and the availability of sexual and reproductive health services.[140]
- **Acceptability:** States must ensure that maternal health services are delivered in a way that respects the dignity of women, is sensitive to the needs and perspectives of women,[141] and recognizes that negative attitudes of health workers can deter women from seeking health services.[142]

## Assisted Reproductive Technology (ART)

Recent advances in technology have made ART a topic of global relevance. In recent country reviews, the Human Rights Committee has called on the elimination of excessive restrictions on the use of ART,[143] while the CEDAW Committee has praised states for passing legislation that regulates ART and guarantees access to all scientific methods of ART.[144] As with other reproductive health services, there is concern that access to ART is not available to all women.[145]

Treaty monitoring bodies have consistently linked high rates of **maternal mortality** with lack of comprehensive reproductive health services, restrictive abortion laws, unsafe or illegal abortion, adolescent childbearing, child and forced marriage, and inadequate access to contraceptives.[146]

- They have urged states to address these issues by **enabling women to prevent unintended pregnancy**, including through the provision of sexuality education and access to information, as well as comprehensive sexual and reproductive health services, including contraception and emergency contraception, and the means to access those services.[147]
- Furthermore, treaty monitoring bodies have indicated that states should **prevent unsafe abortion,** which can lead to higher rates of maternal mortality, through the liberalization of restrictive abortion laws,[148] guaranteeing women access to safe abortion services,[149] and providing women access to post-abortion care.[150]
- Treaty monitoring bodies have stressed the importance of **eliminating third-party authorization requirements** for accessing maternal health services, such as caesarean sections and abortions.[151]

### Equality and Non-Discrimination

The treaty monitoring bodies recognize that the 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.[152] The Committees have also indicated that ensuring equality of health results—including by lowering the maternal mortality rate—is an important indicator of a state's success in fulfilling reproductive rights.[153]

Treaty monitoring bodies have specifically recognized that intersectional discrimination can hinder women's access to reproductive health services. Treaty monitoring bodies have then 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.[154]

- **Adolescents:** The CRC, CEDAW, and Human Rights Committees have made the connection between adolescent pregnancy and high rates of maternal mortality—particularly when girls are subjected to child, early, and forced marriages—noting that complications from pregnancy are the leading cause of death for adolescent girls aged 15-19 in developing countries.[155] The CRC Committee notes that states should confirm that their respective health systems and services are able to meet the sexual and reproductive health needs of adolescents.[156] States must also "ensure that girls can make autonomous and informed decisions on their reproductive health" as a means of preventing maternal mortality.[157] The treaty monitoring bodies have expressed concern over the high rates of school dropout amongst adolescent girls due to early pregnancy,[158] which is due, in part, to the persistent stigmatization of pregnant adolescents and adolescent mothers in school.[159] Committees have urged states to ensure that pregnant students are able to

continue their education during pregnancy and after birth, by eliminating expulsions, suspensions, or wait periods for pregnant girls.[160] The CEDAW Committee has even called on states to provide scholarships to facilitate young mothers re-entry into school.[161]

- **Poor and Minority Women**: Treaty monitoring bodies have also addressed the needs of poor and minority women when accessing maternal health services, including the need to collect disaggregated data to track progress on reducing disparities in maternal mortality.[162]
    - In its 2011 decision in *Alyne da Silva Pimentel v. Brazil*, the CEDAW Committee found that Brazil had discriminated against Alyne, an Afro-Brazilian woman who died following pregnancy and post-natal complications, on the basis of her gender, race, and socioeconomic status when she was denied maternal health services.[163] The CEDAW Committee recommended that Brazil ensure affordable emergency obstetric services, train health workers, impose sanctions on health care providers who violate women's reproductive rights, and implement a national plan for maternal health care, among other recommendations.[164]

- **Rural Women:** The CEDAW and ESCR Committees have recognized that maternal health services—including skilled birth attendants, maternal, and postnatal, care—are often geographically inaccessible to women in rural areas.[165] There can also be long waiting periods for appointments to receive sexual and reproductive health services.[166] They have called on states to pay particular attention to ensuring access for rural women, including by increasing the number of health facilities, funding for health care, and training of providers to work in rural areas.[167]

### Freedom from Violence in Maternal Health Facilities

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[168] and when incarcerated women are shackled to beds during labor and delivery.[169] 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.[170]

## II. RECOMMENDATIONS

In order to ensure women's right to maternal health care, states must address the root causes of maternal mortality and morbidity, including gender and other forms of inequality, and strive towards the fulfillment of other human rights such as the rights to health and education. Treaty monitoring bodies can help reinforce this message by bringing the principles outlined in the Office of the High Commissioner for Human Rights' technical guidance on the application of a human rights-based approach to the implementation of policies and programs to reduce preventable maternal morbidity and mortality into their concluding observations to states.[171] Treaty monitoring bodies should recommend that states:

- Make broad investments in strong national health care systems that ensure quality and affordable maternal health services and other services that are essential to maternal health care, including access to clean water and nutritious

food; put greater emphasis on the quality of services, including skilled and respectful personnel and high-quality drugs and equipment; and monitor private health facilities to ensure quality and human rights-based maternal care.[172]

- Address how social and other determinants can affect maternal health, including harmful traditional practices such as child, early and forced marriage; access to education; poverty; access to justice; and women's equal employment opportunities.[173]
- Ensure that girls are able to continue their education after childbirth, *inter alia*, by providing scholarships for young mothers to facilitate their reentry into school, making childcare available at no cost for mothers while they are in school, and offering other support mechanisms that meet the particular needs of young mothers.
- Take targeted measures to address the higher levels of maternal mortality and morbidity faced by marginalized groups of women. Marginalized groups should be consulted in the design and implementation of maternal health care policies; health care workers should be trained on cultural sensitivity and the particular health needs of marginalized groups, hospitals and clinics must have non-discrimination policies and offer services that are affordable and accessible to those living in rural areas, ensure methods of accountability for rights violations, and collecting disaggregated information on maternal health care outcomes.[174]

# THE RIGHT TO ABORTION INFORMATION AND SERVICES

Treaty monitoring bodies have consistently recognized that the denial of abortion information and services profoundly affects women's lives and health and hinders the fulfillment of a range of civil, political, economic, and social rights. Because abortion is a medical service that only women need, access to abortion is also essential for ensuring gender equality. Treaty monitoring bodies have consistently found that denying access to abortion or imposing barriers to such access undermines women's reproductive autonomy and violates the rights to life, health, privacy, equality, and freedom from torture or ill-treatment.

## I. INTERNATIONAL HUMAN RIGHTS STANDARDS

### Restrictive Abortion Laws

Treaty monitoring bodies have found that restrictive abortion laws violate a range of human rights, including the rights to health, life, privacy, freedom from gender discrimination or gender stereotyping, and freedom from ill-treatment.[175] For instance, treaty monitoring bodies have repeatedly recognized the connection between restrictive abortion laws, high rates of unsafe abortion and maternal mortality.[176] Moreover, the CEDAW Committee has found that denying women access to certain reproductive health services or punishing women for seeking those services is a form of gender discrimination.[177]

In response to these human rights violations, treaty monitoring bodies have found that states should:

- Decriminalize abortion in all circumstances.[178]
- Ensure certain legal grounds for abortion. Specifically, treaty

monitoring bodies have recognized that abortion must be legal, at a minimum, when a woman's life or health is at risk, in cases of rape and incest, and in cases of severe or fatal fetal impairments.[179] The CEDAW Committee also calls on states to permit therapeutic abortion and other services necessary to protect the physical and mental health of pregnant women.[180]

- Interpret exceptions to restrictive abortion laws broadly to consider, for example, mental health conditions as a threat to women's health.[181]
- Eliminate punitive measures for women who undergo abortions and for health care providers who deliver abortion services, finding that criminalization of these services is a form of discrimination and a violation of the rights to health, life, and freedom from torture or ill-treatment.[182]
- Ensure that all women can access safe abortion care. The CRC Committee has noted that states should ensure that adolescents have access to safe abortion and post-abortion care, regardless of the legal status of abortion.[183] Furthermore, the CEDAW Committee advises states to "ensure that sexual and reproductive health care includes access to… safe abortion services,"[184] without qualification concerning the legality of abortion.
- Address the socio-economic needs of women seeking abortion services.[185]
- Consider establishing a legal presumption stating that adolescents are competent to seek and have access to sexual and reproductive health commodities and services, including abortion.[186]

### Access to Safe and Legal Abortion Information and Services

Treaty monitoring bodies have noted that, like other reproductive health services, legal abortion services must be available, accessible, affordable, acceptable, and of good quality[187] and

have urged states to liberalize their abortion laws to improve access.[188]

- **Availability:** States must ensure that where abortion is legal, it is also available to women. This requires states to establish a clear legal and policy framework on abortion that provides guidance on the circumstances in which abortion is legal,[189] and ensures timely remedy and redress for women who are denied access to legal abortion services.[190] It also requires that states provide post-abortion care to women, regardless of whether or not abortion is legal.[191]
- **Accessibility (Affordability):** The ESCR and CEDAW Committees have recognized that abortion services must be economically accessible, recommending that states lower the cost of abortion or otherwise provide financial support when needed.[192] The CEDAW Committee has explicitly described fees for abortion as being burdensome to women's informed choice and autonomy.[193] The CAT Committee has called on states to ensure free access to abortion in cases of rape.[194]
- **Information Accessibility:** Treaty monitoring bodies have consistently emphasized that access to information is a critical element of accessing abortion services.[195] They have found that states should not place criminal sanctions on providers who provide information about abortion.[196] Further, the CEDAW Committee has called on states to eliminate informational barriers to abortion services, such as mandatory biased counseling requirements,[197] and ensure that information provided is science- and evidence-based and includes both the risks of having an abortion and carrying a pregnancy to term, in order to ensure women's autonomy and informed decision-making.[198]
- **Acceptability:** Treaty monitoring bodies have stressed that abortion services must be culturally acceptable for the women seeking an abortion or other reproductive health services.[199] However, as the ESCR Committee notes, the

concept of acceptability may not be used to justify the denial of tailored services, goods or information to specific groups.[200]

- **Quality:** Several treaty monitoring bodies have called on states to ensure access to quality abortion services in line with the WHO's *Safe Abortion: technical and policy guidance for health systems*,[201] which provides for access to complete and accurate information to ensure informed consent, recommends women have access to both surgical and medical abortion, calls on states to ensure that abortion services are legal, and provides guidelines for post-abortion care when needed.[202] States should institutionalize gender sensitive training programs for health care providers and social workers that enable them to provide safe abortions and avoid them from discouraging women who seek an abortion.[203]

## Denial of Access to Abortion as Torture or Ill-Treatment

The Human Rights Committee has found that, in certain circumstances, denial of access to abortion services can lead to physical or mental suffering that amounts to ill-treatment. In particular:

- In *K.L. v. Peru*, the Human Rights Committee found that denial of access to abortion for an adolescent who was carrying a fetus with a fatal impairment, and was experiencing life-threatening pregnancy complications and severe mental suffering because she could not end her pregnancy, constituted ill-treatment. It also noted that her status as a minor made her more vulnerable to human rights violations.[204]
- In *L.M.R v. Argentina*, the Human Rights Committee found a violation of the right to be free from ill-treatment for a young woman with a disability who was denied access to a legal abortion and forced to undergo an illegal abortion, noting that the violation was made especially serious because of the victim's status as a woman with a disability.[205]
- In *Mellet v. Ireland*, the Human Rights Committee found that the prohibition and criminalization of abortion violated the rights to be free from cruel, inhuman, or degrading treatment, to privacy and to equality before the law of a woman who wanted to end a pregnancy affected by a fatal fetal impairment. The Committee affirmed that prohibiting abortion can cause women severe mental suffering. Their suffering can be exacerbated by the inability to receive care from trusted health professionals in their own country and by the financial, psychological and physical burdens imposed on them by having to travel abroad to access abortion care.[206]
- In *Whelan v. Ireland*, the Human Rights Committee reaffirmed that laws that prohibit abortion engage the responsibility of states for the cruel, inhuman or degrading treatment inflicted on women who are barred from ending a pregnancy in their own country. As in the *Mellet* decision, the Committee outlined the obligation of the state to remedy these violations by reforming its laws on abortion, and if necessary, its constitution.[207]

The CAT and the CEDAW Committees have found that delaying safe abortion or post-abortion care is a form of GBV, which may even amount to torture or cruel, inhuman or degrading treatment.[208]

### Procedural and Other Barriers to Abortion and Reproductive Autonomy

Treaty monitoring bodies have recognized that a number of restrictions on women's autonomy in accessing abortion violate human rights, including the rights to health, to privacy, to decide on the number and spacing of children, to non-discrimination and equality, and to be free from torture or ill-treatment. The following obstacles further hinder women from achieving their reproductive rights:

- **Third-party authorization requirements:** Treaty monitoring bodies have consistently found that requirements that make women obtain authorization before accessing abortion services are human rights violations.
    - The CEDAW Committee has directly linked **spousal consent** requirements for accessing abortion with gender stereotyping and recommended that states eliminate such requirements as a means of promoting gender equality.[209]
    - The CRC Committee has also recommended that states consider allowing access to safe abortion for adolescents without the need for **parental consent**[210] and that the views of pregnant adolescents regarding abortion should be heard and respected.[211]
    - The CAT Committee has found that, in some cases, requirements that women obtain **judicial authorization** before accessing an abortion may constitute an "insurmountable obstacle" to accessing abortion, and that when denial of such judicial authorization occurs for victims of rape, it may constitute torture or ill-treatment.[212]
    - The CEDAW Committee has also expressed concern about **multiple medical authorizations** for abortion services, such as permission from a panel of doctors.[213]

- **Waiting Periods:** The CEDAW Committee has recommended that states eliminate medically-unnecessary waiting periods for abortion.[214]
- **Impact of Conscientious Objection:** Treaty monitoring bodies have also found that, where states permit conscientious objection, they must adequately regulate its use to ensure it does not undermine access to abortion services,[215] and that a failure to do so may violate the right to be free from torture or ill-treatment.[216] Moreover, states should only permit individuals, and not institutions, to invoke conscientious objection.[217]
- **Violations of the Right to Privacy:** The Human Rights Committee has found that the failure to act in conformity with a woman's decision to undergo a legal abortion is a violation of the right to privacy, including when the judiciary interferes with such a decision.[218]
- **Stereotypes and Stigma**: The CEDAW Committee has noted that denial of access to abortion may be based on gender stereotypes about the traditional roles of women as mothers and caregivers, which may also constitute gender discrimination and undermine gender equality.[219] It has also expressed concern about situations where abortion is legal but stigmatized, which may lead women to resort to unsafe and clandestine abortions.[220]

## II. RECOMMENDATIONS

Treaty monitoring bodies should find that states have an obligation to ensure women's and girls' right to access abortion without restriction as to reason. They should also continue to incorporate the standards established by the World Health Organization's Safe Abortion Guidance into their cases, General Comments and Recommendations, and concluding observations. In particular, treaty monitoring bodies should consider:

- Systematically urging states to remove procedural barriers

to abortion services, including third-party authorization requirements and mandatory waiting periods, and to regulate the use of conscientious objection to guarantee women's right to equality and enable them to exercise their reproductive autonomy.

- Advising states to introduce a legal presumption that adolescents are competent to seek and have access to all sexual and reproductive health commodities and services.
- Encouraging states to make abortion services and post-abortion care affordable for all, including adolescents.
- Avoiding only urging states to create narrow exceptions to restrictive abortion laws, which do not fully enable women to exercise their reproductive autonomy, and instead frame such recommendations to more broadly address the numerous human rights implications of restrictive abortion laws (i.e. access to safe abortion), including on ensuring women's substantive equality and physical and mental health.
- Urging states to enact positive measures, such as informational campaigns, that tackle gender stereotypes about the traditional roles of women which often lead to discriminatory laws and policies on abortion.
- Encouraging states to provide meaningful and effective remedies for women whose right to safe abortion has been violated.

## Endnotes

1 Hereinafter, the term "women" is intended to include both women and girls unless otherwise noted.

2 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, art. 1, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; International Covenant on Civil and Political Rights (ICCPR), *adopted* Dec. 16, 1966, art. 3, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR]; International Covenant on Economic, Social and Cultural Rights (CESCR), *adopted* Dec. 16, 1966, art. 3, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976); Convention on the Rights of Persons with Disabilities (CRPD), *adopted* Dec. 13, 2006, art, 6, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611, (*entered into force* May 3, 2008) [hereinafter CRPD]; Convention on the Rights of the Child (CRC), *adopted* Nov. 20, 1989, art. 29(1)(d), 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).

3 CEDAW Committee, *General Recommendation No. 25: Article 4, paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures*, (2004), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 7-8, U.N. Doc. HRI/GEN/1/Rev.7 (2004) [hereinafter CEDAW Committee, *Gen. Recommendation No. 25*]; CEDAW Committee, *General Recommendation No. 28: The core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, (2010), para. 9, U.N. Doc. CEDAW/C/GC/28 (2010) [hereinafter CEDAW Committee, *Gen. Recommendation No. 28*]; Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights),* paras. 8, 9 & 39, U.N. Doc. E/C.12/GC/20 (2009) [hereinafter ESCR Committee*, Gen. Comment No. 20*].

4 CRC Committee, *General Comment No. 15: On the right of the child to the enjoyment of the highest attainable standard of health,* (2013), para. 9, U.N. Doc. CRC/C/GC/15 (2013) [hereinafter CRC Committee*, Gen. Comment No. 15*].

5 CRPD, *supra* note 2, art. 6; CEDAW Committee, *Gen. Recommendation No. 25, supra* note 3, para. 12; CEDAW Committee, *Gen. Recommendation No. 28, supra* note 3, para. 18; ESCR Committee*, Gen. Comment No. 20*, *supra* note 3, 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, 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*].

6 CEDAW Committee, *Gen. Recommendation No. 25, supra* note 3, paras. 8-10; ESCR Committee, *Gen. Comment No. 3*, *supra* note 3, para. 10; Human Rights Committee*, Gen. Comment No. 28, supra note 5, para. 3*; CEDAW Committee, *Gen. Recommendation No. 28, supra* note 3, para. 20.

7 Human Rights Committee, *Concluding Observations: Cape Verde*, para. 8, U.N. Doc. CCPR/C/CPV/CO/1 (2012); Human Rights Committee, *Concluding Observations: Jordan*, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010); Human Rights Committee, *Concluding Observations: Canada*, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999); CEDAW Committee*, Gen. Recommendation No. 25, supra* note 3, para. 10; CRC Committee, *Gen. Comment No. 15*, *supra* note 4, para. 10; CPRD Committee, *Concluding Observations: United Kingdom*, U.N. Doc. CRPD/C/GBR/CO/1 (2017).

8 Human Rights Committee, *Concluding Observations: Kyrgyzstan*, para. 13, U.N. Doc. CCPR/CO/69/KGZ (2000); CRC Committee, *Gen. Comment No. 15*, *supra* note 4, paras. 10, 24.

9 CEDAW Committee, *Concluding Observations: Argentina,* paras. 34-35, U.N. Doc. CEDAW/C/ARG/CO/7 (2016); CEDAW Committee, *Concluding Observations: Thailand,* para. 39, U.N. Doc. CEDAW/C/THA/CO/6-7 (2017); CEDAW Committee, *Concluding Observations: Congo*, para. 36(f), U.N. Doc. CEDAW/C/COG/CO/6 (2012); CRC Committee, *Concluding Observations: Central African Republic*, para. 55, U.N. Doc. CRC/C/CAF/CO/2 (2017); CRC Committee, *Concluding*

*Observations: Nigeria*, paras. 37-38, U.N. Doc. CEDAW/C/NGA/CO/7-8 (2017); ESCR Committee, *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, (34th Sess., 2005), para. 29, U.N. 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).

10 CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, (1999), para. 11, U.N. Doc. A/54/38/Rev.1, chap. I [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

11 ESCR Committee, *Gen. Comment No. 16*, *supra* note 9, para. 29.

12 ECSR Committee, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), para. 12, U.N. Doc. E/C.12/2000/4 [hereinafter ESCR Committee, *Gen. Comment No. 14*].

13 ESCR Committee, *General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social, and Cultural Rights)*, para. 39, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter ESCR Committee, *Gen. Comment No. 22*].

14 *See* CRC Committee, *Gen. Comment No. 15*, *supra* note 4; CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10.

15 ESCR Committee, *Gen. Comment No. 14*, *supra* note 12, paras. 12, 36; ESCR Committee, *Gen. Comment No. 22*, *supra* note 13, para. 49 (g).

16 ESCR Committee, *Gen. Comment No. 14*, *supra* note 12, para. 12 (b).

17 *Id.*, at para. 12(b); CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, paras. 21, 25.

18 ESCR Committee, *Gen. Comment No. 14*, *supra* note 12, para. 12(b); ESCR Committee, *Gen. Comment No. 22*, *supra* note 13, paras. 45-46.

19 *See, e.g.*, CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 27; CEDAW Committee, *Concluding Observations: Hungary*, para. 31(b), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); ESCR Committee, *Concluding Observations: Djibouti*, para. 5(e), U.N. Doc. E/C.12/DJI/CO/1-2 (2014); *Poland*, para. 27, U.N. Doc. E/C.12/POL/CO/5 (2009); *Armenia*, para. 22(b), U.N. Doc. E/C.12/ARM/CO/2-3 (2014); CRC Committee, *Concluding Observations: Mozambique*, para. 47(c), U.N. Doc. CRC/C/15/Add.172 (2002); Human Rights Committee, *Concluding Observations: Republic of Moldova,* para. 17(a), U.N. Doc. CCPR/C/MDA/CO/2 (2009); CAT Committee, *Concluding Observations: Philippines*, paras. 38-39, U.N. Doc. CAT/C/PHL/CO/ (2016).

20 CRC Committee, *Concluding Observations: Latvia*, para. 51, U.N. Doc. CRC/C/LVA/CO/3-5 (2016).

21 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 28; ESCR Committee, *Gen. Comment No. 14*, *supra* note 12, paras. 11-12.

22 ESCR Committee, *Gen. Comment No. 14*, *supra* note 12, para. 34.

23 *See* CEDAW Committee, *Concluding Observations: Italy*, para. 36, U.N. Doc. CEDAW/C/ITA/CO/7 (2017); *Nigeria,* paras. 33-34, U.N. Doc. CEDAW/C/NGA/CO/7-8 (2017); Ireland, para. 39 (c), U.N. Doc. CEDAW/C/IRL/CO/6-7 (2017); CRC Committee, *Concluding Observations: Antigua and Barbuda*, para. 45(a), U.N. Doc. CRC/C/ATG/CO/2-4 (2017); ESCR Committee, *Concluding Observations: Benin*, para. 42, U.N. Doc. E/C/12/1/Add.78 (2002).

24 ESCR Committee, *Gen. Comment No. 14, supra* note 12, para. 12(c); CEDAW Committee, Gen. Recommendation No. 24, supra note 10, para. 22.

25 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 22.

26 ESCR Committee, *Gen. Comment No. 14, supra* note 12, para. 12(d).

27 ESCR Committee, *Gen. Comment No. 22, supra* note 13, para. 45.

28 *Id.*, para. 43(a); CEDAW, *supra* note 2, art. 12; CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 2; CRC Committee, *Gen. Comment No. 15, supra* note 4, para. 8.

29 ESCR Committee, *Gen. Comment No. 22, supra* note 13, para. 36.

30 *Id.* at para. 38.

31 ESCR Committee, *Gen. Comment No. 22, supra* note 13, para. 49 (g); ESCR Committee, *Gen. Comment No. 14, supra* note 12, paras. 12(a), 43 (d); CRC Committee, *Gen. Comment No. 15,*

*supra* note 4, para. 37.

32 *See, e.g.*, Alyne da Silva Pimentel Teixeira v Brazil, CEDAW Committee, Commc'n No. 17/2008, para. 8(2)(d), U.N. Doc. CEDAW/C/49/D/17/2008 (2011).

33 ESCR Committee, *Gen. Comment No. 22, supra* note 13, paras. 34, 41.

34 *See, e.g.*, CEDAW Committee & CRC Committee, *Joint General Recommendation No. 31 & General Comment No. 18: On harmful practices,* (2014), paras. 68-9, 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; ESCR Committee, *Concluding Observations: Australia*, para. 28, U.N. Doc. E/C.12/AUS/CO/4 (2009).

35 WHO, About social determinants of health (2017), *available at* http://www.who.int/social_determinants/sdh_definition/en/ (last visited Oct. 16, 2017) [hereinafter WHO, About social determinants of health].

36 ESCR Committee, *Concluding Observations: Australia*, para. 28, U.N. Doc. E/C.12/AUS/CO/4 (2009); WHO, About social determinants of health, *supra* note 35.

37 WHO, About social determinants of health, *supra* note 35.

38 *See,* ICCPR, *supra* note 2; CEDAW, *supra* note 2; CRPD, *supra* note 2.

39 CEDAW, *supra* note 2, art. 16(e).

40 CEDAW Committee, *Decision 57/II Statement by the Committee on the Elimination of Discrimination against Women on sexual and reproductive health: beyond the 2014 review of the International Conference on Population and Development*, U.N. Doc. A/69/38 (2014).

41 CEDAW Committee, *Concluding Observations: Sierra Leone*, para. 32 (b), U.N. Doc. CEDAW/C/SLE/CO/6 (2014).

42 ICCPR, *supra* note 2, art. 17. *See also* K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005) (applying the right to privacy to reproductive rights).

43 *See, e.g.*, CEDAW Committee, *Concluding Observations: Indonesia*, paras. 41-2, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012); *Cook Islands,* para. 35, U.N. Doc. CEDAW/C/COK/CO/1 (2007); *Burkina Faso,* para. 38, U.N. Doc. CEDAW/C/BFA/CO/6 (2010); Human Rights Committee, *Concluding Observations: Bolivia,* para. 9(b), U.N. Doc. CCPR/C/BOL/CO/3 (2013); CRPD Committee, *General Comment No. 1: Article 12: Equal recognition before the law,* (11th Sess., 2014), para. 35, U.N. Doc. CRPD/C/GC/1 (2014) [hereinafter CRPD Committee, *Gen. Comment No. 1*]; CRPD Committee, *Gen. Comment No. 3, supra* note 5, para. 44; CRC Committee, *Gen. Comment No. 15*, *supra* note 4, para 31; Committee Against Torture (CAT Committee), *Concluding Observations: Bolivia*, para. 23, U.N. Doc. CAT/C/BOL/CO/2 (2013).

44 CEDAW, General Recommendation No. 33 on women's access to justice, (61st Sess., 2015), para 25(c)), U.N. Doc. CEDAW/C/GC/33 (2015) [hereinafter CEDAW Committee, *Gen. Recommendation No. 33*].

45 ESCR Committee, *General comment No. 22, supra* note 13, para. 43.

46 ESCR Committee, *General Comment No. 24 (2017) on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities*, para. 21, U.N. Doc. CESCR/C.12/GC/24 (2017) [hereinafter ESCR Committee: *General Comment No. 24*]; ESCR Committee, *Concluding Observations: Poland,* paras. 46-7, U.N. Doc. E/C.12/POL/CO/6 (2016); CEDAW Committee, *Concluding Observations: Poland,* para. 36-7, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014); *Slovakia,* para. 30-31, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); Human Rights Committee, *Concluding Observations: Columbia*, paras. 20-21, U.N. Doc. CCPR/C/COL/CO/7 (2016).

47 CEDAW Committee, *Concluding Observations: Switzerland*, paras. 38-39, U.N. Doc. CEDAW/C/CHE/CO/4-5 (2016).

48 *Id.*

49 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 22; CRPD Committee, *Gen. Comment No. 1, supra* note 43, para. 35.

50 Survival sex refers to the practice of exchanging sex for basic subsistence needs, including food,

clothing, and shelter.

51 CEDAW Committee, *Concluding Observations: Rwanda,* paras. 48, 49, U.N. Doc. CEDAW/C/RWA/CO/7-9 (2017).

52 *Id*.

53 CEDAW Committee, *Concluding Observations: Niger*, para. 11(c), U.N. Doc. CEDAW/C/NER/CO/3-4 (2017).

54 CEDAW Committee, *Concluding Observations: Turkey*, paras. 14, 15, U.N. Doc. CEDAW/C/TUR/CO/7 (2016).

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56 CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra* note 34, para. 22; CEDAW Committee, *Concluding Observations: Rwanda,* paras. 38, 39, U.N. Doc. CEDAW/C/RWA/CO/7-9 (2017).

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60 *See* CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra* note 34, para. 19. *See also* CRC Committee, *General Comment No. 20: on the implementation of the rights of the child during adolescence*, para. 27, U.N. Doc. CRC/C/GC/20* (2016) [hereinafter CRC Committee, *Gen. Comment No. 20*]; CEDAW Committee, *General Recommendation No. 34 on the rights of rural women,* paras. 22, 23, U.N. Doc. CEDAW/C/GC/34 (2016) [hereinafter CEDAW Committee, *Gen. Recommendation No. 34*]; ESCR Committee, *General Comment No. 22, supra* note 13, paras. 29, 49, 59; CEDAW Committee, *Concluding Observations: Liberia*, paras. 23, 24, U.N. Doc. CEDAW/C/LBR/CO/7-8 (2015); CEDAW Committee, *Concluding Observations: Germany*, paras. 23, 24, U.N. Doc. CEDAW/C/DEU/CO/7-8 (2017); Human Rights Committee, *Concluding Observations: Burkina Faso*, paras. 15, 16, U.N. Doc. CCPR/C/BFA/CO/1 (2016); Human Rights Committee, *Concluding Observations: Ghana,* paras 17, 18, U.N. Doc. CCPR/C/GHA/CO/1 (2016); CRC Committee, *Concluding Observations: Iran*, paras. 59, 60, U.N. Doc. CRC/C/IRN/CO/3-4 (2016); CRC Committee, *Concluding Observations: Sierra Leone*, paras. 22, 23, U.N. Doc. CRC/C/SLE/CO/3-5 (2016); CERD Committee, *Concluding Observations: Djibouti*, paras. 20, 21, U.N. Doc. CERD/C/DJI/CO/1-2 (2017).

61 *See* CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra* note 34, para. 19.

62 *See* Human Rights Committee, *Concluding Observations: Bangladesh*, paras. 13-14, U.N. Doc. CCPR/C/BGD/CO/1 (2017).

63 *See* CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra* note 34, para. 83.

64 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 28; Human Rights Committee, *Concluding Observations: Paraguay,* para. 13 U.N. Doc CCPR/C/PRY/CO/3 (2013); CRC Committee, *Gen. Comment No. 15, supra* note 4, para. 69.

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69 ESCR Committee, *General Comment No. 22*, *supra* note 13, para. 21.

70 CEDAW Committee, *Concluding Observations: Italy*, paras. 35, U.N. Doc. CEDAW/C/ITA/CO/7 (2017); *Nigeria,* para. 34 (e), U.N. Doc. CEDAW/C/NGA/CO/7-8 (2017); *Ireland*, para. 39 (c), U.N. Doc. CEDAW/C/IRL/CO/6-7 (2017); CRC Committee, *Concluding Observations: Antigua and Barbuda*, para. 45(a), U.N. Doc. CRC/C/ATG/CO/2-4 (2017); ESCR Committee, *Concluding Observations: Benin*, para. 42, U.N. Doc. E/C/12/1/Add.78 (2002)).

71 CRC Committee, *Gen. Comment No. 20*, *supra* note 60, paras. 39, 59.

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73 *See* ESCR Committee, *Gen. Comment No. 22, supra* note 13, para. 49. *See also* CEDAW Committee, *Concluding Observations: Italy*, para. 36, U.N. Doc. CEDAW/C/ITA/CO/7 (2017).

74 CRC Committee, *Gen. Comment No. 20*, *supra* note 60, para. 61.

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85 CRC Committee, *Gen. Comment No. 15*, *supra* note 4, para. 70.

86 *See, e.g.*, CRC Committee, *Concluding Observations: Guinea*, paras. 67-68, U.N. Doc CRC/C/GIN/CO/2 (2013); CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 10, para. 23.

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[89] CRC Committee, *Concluding Observations: Suriname*, para. 31, U.N. Doc. CRC/C/SUR/CO/3-4 (2016); Human Rights Committee, *Concluding Observations: Jamaica*, para. 26, U.N. Doc. CCPR/C/JAM/CO/4 (2016); CEDAW Committee, *Concluding Observations: Timor Leste*, para. 31(d), U.N. Doc. CEDAW/C/TLS/CO/2-3 (2015).

[90] CRC Committee, *Concluding Observations: Uzbekistan*, paras. 56-57, U.N. Doc. CRC/C/UZB/CO/3-4 (2013).

[91] *See, e.g.*, CRC Committee, *Concluding Observations: Guinea-Bissau*, para. 55(b), U.N. Doc CRC/C/GNB/CO/2-4 (2013); *Niue,* paras. 55-56, U.N. Doc CRC/C/NIU/CO/1 (2013).

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[93] CEDAW Committee, *Concluding Observations: Ghana*, paras. 36-37, U.N. Doc. CEDAW/C/GHA/CO/6-7 (2014); *Costa Rica*, paras. 30-31, U.N. Doc. CEDAW/C/CRI/CO/7 (2017).

[94] CEDAW Committee, *Concluding Observations: Georgia*, paras. 30-31, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014).

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[97] CEDAW Committee, *Gen. Recommendation No. 34*, *supra* note 60, paras. 37-39.

[98] *Id.*, paras. 38-39.

[99] CEDAW Committee, *Concluding Observations: Slovenia*, paras. 31, 32, U.N. Doc. CEDAW/C/SVN/CO/5-6 (2015); CRC Committee, *Concluding Observations: Lebanon*, para. 30, U.N. Doc. CRC/C/LBN/CO/4-5 (2017).

[100] CEDAW Committee, *Concluding Observations: Burundi*, paras. 46, 47, U.N. Doc. CEDAW/C/BDI/CO/5-6 (2016).

[101] CEDAW Committee, *Concluding Observations: Switzerland*, para. 39 (a), U.N. Doc. CEDAW/C/CHE/CO/4-5 (2016).

[102] Human Rights Committee, *Concluding Observations: Peru*, para. 14, U.N. Doc CCPR/C/PER/CO/5 (2013).

[103] CEDAW Committee, *Concluding Observations: Hungary*, para. 31(b), U.N. Doc CEDAW/C/HUN/CO/7-8 (2013).

[104] CEDAW Committee, *Concluding Observations: Peru*, paras. 35-36, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014); CRC Committee, *Concluding Observations: Costa Rica*, paras. 63-64, U.N. Doc. CRC/C/CRI/CO/4 (2011).

[105] CEDAW Committee, *Concluding Observations: Central African Republic*, paras. 39-40, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014).

[106] CAT Committee, *Concluding Observations: Peru*, para. 15, U.N. Doc CAT/C/PER/CO/5-6 (2013).

[107] CEDAW Committee, *Concluding Observations: Iraq,* paras. 42-43, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); *Hungary*, paras. 30-31, U.N. Doc CEDAW/C/HUN/CO/7-8 (2013); *Solomon Islands*, para. 36(b), U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014).

[108] CEDAW Committee, *Gen. Recommendation No. 35*, *supra* note 55, para. 18.

[109] *Id.*, at paras. 26, 34, 37; see also Human Rights Committee, *Concluding Observations: Azerbaijan*, para. 15, U.N. DOC. CCPR/C/AZE/CO/4 (2016).

[110] CEDAW Committee, *Concluding Observations: Iraq*, paras. 42-43, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); *Hungary*, paras. 30-31, U.N. Doc CEDAW/C/HUN/CO/7-8 (2013); *Solomon Islands*, para. 36(b), U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014); CRC Committee, *Concluding Observations: Suriname,* paras. 30-31, U.N. Doc. CRC/C/SUR/CO/3-4 (2016); *Bangladesh*, para. 35 (b), U.N. Doc. CEDAW/C/BGD/CO/8 (2016).

[111] CEDAW Committee, *Concluding Observations: Iraq*, paras. 42-43, U.N. Doc. CEDAW/C/IRQ/CO/4-

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116 *See, e.g., Id.*; CAT Committee, *Concluding Observations: Peru*, para. 19, U.N. Doc. CAT/C/PER/CO/5-6, (2012); CAT Committee, *Concluding Observations: Czech Republic,* para. 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012). *See also* CEDAW Committee, *Gen. Recommendation No. 35*, *supra* note 55, para. 18.

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130 CAT Committee, *Concluding Observation: Namibia*, paras. 34-35, CAT/C/NAM/CO/2 (2017).

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132 CEDAW, *supra* note 2, art. 12.

133 *See, e.g.,* CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra* note 34. *See also* CRC Committee, *Concluding Observations: Mongolia*,

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134 *See, e.g.,* CEDAW Committee, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38/Rev.1 (1999); Human Rights Committee*, Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003).

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137 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); *Marshall Islands,* para. 52(g), U.N. Doc. CRC/C/MHL/CO/2 (2007); *The Republic of the Congo*, para. 59, U.N. Doc. CRC/C/COG/CO/2-4 (2014); *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,* paras. 38(b), U.N. Doc. CEDAW/C/KEN/CO/7 (2011).

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141 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 22; CEDAW Committee, *Concluding Observations: Argentina*, paras. 34, 35, U.N. Doc. CEDAW/C/ARG/CO/7 (2016).

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144 CEDAW Committee, *Concluding Observations: Argentina,* paras. 4(d), 32, U.N. Doc. CEDAW/C/ARG/CO/7 (2016).

145 CEDAW Committee, *Concluding Observations: Portugal,* paras. 44-45, U.N. Doc. CEDAW/C/PRT/CO/8-9 (2015).

146 *See, e.g.,* CEDAW Committee, *Concluding Observations: Eritrea*, paras. 34, 35, U.N. Doc. CEDAW/C/ERI/CO/5 (2015); *Ghana,* paras. 36, 37, U.N. Doc. CEDAW/C/GHA/CO/6-7 (2014); ESCR Committee, *Concluding Observations: El Salvador,* para. 22, U.N. Doc. E/C.12/SLV/CO/3-5 (2014); Human Rights Committee, *Concluding Observations: Honduras,* paras. 16, 17, U.N. Doc. CCPR/C/HND/CO/2 (2017) *Panama*, para. 9, U.N. Doc. CCPR/C/PAN/CO/3 (2008); *Chile*, para. 15, U.N. Doc. CCPR/C/CHL/CO/6 (2014); CRC Committee, *Concluding Observations: Guatemala*, paras. 70, 71, U.N. Doc. CRC/C/GTM/CO/3-4 (2010); CAT Committee, *Concluding Observations: Yemen*, para. 31, U.N. Doc. CAT/C/YEM/CO/2/Rev.1 (2010).

147 *See, e.g.*, ESCR Committee*, Gen. Comment No. 14*, *supra* note 12, para. 14; CRC Committee, *Concluding Observations: Costa Rica,* paras. 63, 64, U.N. Doc. CRC/C/CRI/CO/4 (2011); CEDAW Committee, *Concluding Observations: Bangladesh,* paras. 31, 32, U.N. Doc. CEDAW/C/BGD/CO/7 (2011).

148 *See, e.g.*, CEDAW Committee, *Concluding Observations: Kenya,* paras. 37, 38, U.N. Doc. CEDAW/C/KEN/CO/7 (2011).

149 *See e.g.* CRC Committee, *Concluding Observations: Argentina*, para. 59(d), U.N. Doc. CRC/C/ARG/CO03-4 (2010).

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151 *See* ESCR Committee, *Gen. Comment No. 22*, *supra* note 13, para 43; CEDAW Committee, *Concluding Observations: Rwanda*, para. 38 (a), U.N. Doc. CEDAW/C/RWA/CO/7-9 (2017); CEDAW Committee, *Concluding Observations: Sri Lanka*, paras. 35 (b), U.N. Doc., CEDAW/C/LKA/CO/8 (2017); CRC Committee, *Concluding Observations: Zimbabwe*, para. 60 (c), U.N. Doc. CRC/C/ZWE/CO/2 (2016). *See also* CEDAW Committee, *Concluding Observations: Bahrain*, para. 41, U.N. Doc. CEDAW/C/BHR/CO/3 (2014); *Portugal*, paras. 36, 37, U.N. Doc. CEDAW/C/PRT/CO/8-9 (2015).

152 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); CRC Committee, *Gen. Comment No. 20*, *supra* note 60, para. 59.

153 *See* CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 21. See also Human Rights Committee, Concluding Observations: Rwanda, U.N. Doc. CCPR/C/RWA/CO/4 (2016).

154 *See, e.g.*, CEDAW Committee, *Concluding Observations: Thailand,* paras. 42-43, U.N. Doc. CEDAW/C/THA/CO/6-7 (2017); *Lesotho,* paras. 32-33, U.N. Doc. CEDAW/C/LSO/CO/1-4 (2011).

155 CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra* note 34, paras. 21-2; Human Rights Committee, *Concluding Observations: Sierra Leone*, para. 14, U.N. Doc. CCPR/C/SLE/CO/1 (2014).

156 *See* CRC Committee, *Gen. Comment No. 15*, *supra* note 4, para. 56.

157 *Id*.

158 CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra* note 34, paras. 63, 69(a); CEDAW Committee, *Concluding Observations: Barbados,* paras. 31-32, U.N. Doc. CEDAW/C/BRB/CO/5-8 (2017); *Costa Rica*, paras. 26-27, U.N. Doc. CEDAW/C/CRI/CO/7 (2017); *Micronesia*, paras. 32-33, U.N. Doc. CEDAW/C/FSM/CO/1-3 (2017); CRC Committee, *Concluding Observations: Cameroon,* paras. 38-39, U.N. Doc. CRC/C/CMR/CO/3-5 (2017).

159 CRC Committee, *Concluding Observations: Suriname*, paras. 34-35, U.N. Doc. CRC/C/SUR/CO/3-4 (2016).

160 CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra* note 34, paras. 63, 69(a); CEDAW Committee, *Concluding Observations: Barbados,* paras. 31-32, U.N. Doc. CEDAW/C/BRB/CO/5-8 (2017); *Burundi,* para. 35(c), U.N. Doc. CEDAW/C/BDI/CO/5-6 (2016); *Costa Rica*, paras. 26-27, U.N. Doc. CEDAW/C/CRI/CO/7 (2017); *Rwanda,* para. 33(c), U.N. Doc. CEDAW/C/RWA/CO/7-9 (2017); *Bangladesh*, para. 29(a), U.N. Doc. CEDAW/C/BGD/CO/8 (2016); CRC Committee, *Concluding Observations: Cameroon,* paras. 38-39, U.N. Doc. CRC/C/CMR/CO/3-5 (2017); *Mongolia,* para. 38, U.N. Doc. CRC/C/MNG/CO/5 (2017); *Tanzania*, para. 63, U.N. Doc. CRC/C/TZA/CO/3-5 (2015).

161 CEDAW Committee*, Concluding Observations: Argentina*, para. 29(b), U.N. Doc. CEDAW/C/ARG/CO/7 (2016).

162 *See* CEDAW Committee, *Concluding Observations: Romania*, paras. 40, 41, U.N. Doc. CEDAW/C/ROU/CO/7-8 (2017); *Costa Rica*, paras. 40, 41, U.N. Doc. CEDAW/C/CRI/CO/7 (2017); *Switzerland*, paras. 49, 50, U.N. Doc. CEDAW/C/BRB/CO/5-8 (2017).

163 Alyne da Silva Pimentel Teixeira v Brazil, CEDAW Committee, Commc'n No. 17/2008, paras. 7.3-7.7, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).

164 *Id*. paras. 7.6, 7.8.

165 *See, e.g.*, CEDAW Committee, *Concluding Observations: Sierra Leone*, para. 32, U.N. Doc. CEDAW/C/SLE/CO/6 (2014); ESCR Committee, *Concluding Observations: Djibouti*, para. 32, U.N. Doc. E/C.12/DJI/CO/1-2 (2014).

166 CEDAW Committee, *Concluding Observations: Estonia*, paras. 30-31, U.N. Doc. CEDAW/C/EST/

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167 *See, e.g.*, CEDAW Committee, *Concluding Observations: Cameroon*, para. 33, U.N. Doc. CEDAW/C/CMR/CO/4-5 (2014).

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175 *See, e.g.*, K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

176 *See, e.g.*, CEDAW Committee, *Concluding Observations: Paraguay*, paras. 30, 31, U.N. Doc. CEDAW/C/PRY/CO/6 (2011); *Chile*, paras. 34, 35, U.N. Doc. CEDAW/C/CHI/CO/5-6 (2012); ESCR Committee, *Concluding Observations: Philippines*, paras. 51, 52, U.N. Doc. E/C.12/PHL/CO5-6 (2016) Human Rights Committee, *Concluding Observations: Zambia*, para. 18, U.N. Doc. CCPR/C/ZMB/CO/3 (2007).

177 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, paras. 11, 14.

178 *See* CRC, *Concluding Observations: Bhutan*, para. 35(c), U.N. Doc. CRC/C/BTN/CO/3-5 (2017); *Cameroon,* para. 35(c), CRC/C/CMR/CO/3-5 (2017); *Sierra Leone*, para. 32 (c), U.N. Doc. CRC/C/SLE/CO/3-5 (2016); *Benin*, para. 57(c), U.N. Doc. CRC/C/BEN/CO/3-5 (2016); CEDAW Committee, *Concluding Observations: Micronesia*, para. 37(b), U.N. Doc. CEDAW/C/FSM/CO/1-3 (2017); *Niger*, para. 33(c), U.N. Doc. CEDAW/C/NER/CO/3-4 (2017); *Costa Rica,* para. 31(a), U.N. Doc. CEDAW/C/CRI/CO/7 (2017). *See also* Human Rights Committee, *Concluding Observations: Honduras*, para. 17, U.N. Doc. CCPR/C/HND/CO/2 (2017).

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180 *See* L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

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[205] L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, para. 9.2, U.N. Doc. CCPR/C/101/D/1608/2007 (2011).

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