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Women's and girls' sexual and reproductive health rights in crisis

Report of the Working Group on discrimination against women and girls

Summary

In the present report, the Working Group on discrimination against women and girls calls for a radical shift in how situations of crisis are identified and addressed, by drawing attention to the non-enjoyment by women and girls of their basic sexual and reproductive health rights as a significant impediment to gender equality, resulting from the persistent failure of States to adequately respect, protect and fulfil those rights. The Working Group examines a number of threats and risks posed to the sexual and reproductive health and autonomy of women and girls, before and during crisis-related events, which are underpinned and exacerbated by various forms of systemic disadvantages and discrimination. It notes promising practices and makes recommendations to address crucial gaps, which will require a radical shift in how crises are managed and addressed from the perspective of women and girls in accordance with their human rights.

Contents

I. Activities

1. The present report covers the activities of the Working Group on discrimination against women and girls, from the time of submission of its previous report (A/HRC/44/51) to April 2021.

A. Sessions

2. In the context of the restrictions due to the coronavirus disease (COVID-19) pandemic, the Working Group held three sessions virtually during the period under review. At its twenty-eighth session, from 6 to 10 July 2020, it held meetings with representatives of civil society organizations, discussed future position papers and methodological matters and focused on the present thematic analysis.

3. At the twenty-ninth session, held from 12 to 16 October 2020, the experts met with the then newly appointed Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the Special Rapporteur on the situation of human rights defenders. They also met with the main sponsor of the mandate of the Working Group and organized a farewell gathering for the outgoing member from the Latin America and Caribbean region and an introductory session for the new member of the Working Group.

4. At its thirtieth session, held on 19 and from 22 to 25 January 2021, the Working Group held meetings with civil society organizations, organized a well-attended meeting with Member States and worked on its thematic report. The Working Group also discussed possible future thematic priorities.

B. Country visits

5. The Working Group visited Romania from 24 February to 6 March 2020.[1] It thanks the Government for its cooperation and encourages other States to respond positively to its requests for visits, which will resume as soon as the global public health context allows.

C. Communications and press releases

6. The Working Group addressed communications to Governments, individually or jointly with other mandate holders. The communications concerned a wide range of subjects falling within its mandate, including discriminatory legislation and practices and allegations of the violations of the rights of women human rights defenders, gender-based violence and violations of the right to sexual and reproductive health.[2] The Working Group also issued press releases, individually or jointly with other mandate holders, treaty bodies and regional mechanisms.[3]

D. Other activities

7. The experts also undertook numerous activities in their capacity as members of the Working Group.[4] In particular, the chair of the Working Group addressed the sixty-fifth session of the Commission on the Status of Women and presented an oral report on its work to the General Assembly. The Working Group organized a side event on the theme “Girls’ activism: accomplishments, challenges and opportunity for social change”, with girl activists from various regions of the world during the session of the Commission and members of the

[1] See A/HRC/47/38/Add.1.
[2] See www.ohchr.org/EN/Issues/Women/WGWomen/Pages/Communications.aspx.
[3] See www.ohchr.org/EN/NewsEvents/Pages/NewsSearch.aspx?MID=WG_Women.
[4] See www.ohchr.org/EN/Issues/Women/WGWomen/Pages/Activities.aspx.

Working Group participated in a number of other side events. The Working Group also organized an event on the 10-year anniversary of the establishment of its mandate.[5]

II. Thematic analysis: women's and girls' sexual and reproductive health rights in crisis

A. Introduction

8. The full enjoyment of sexual and reproductive health rights is indispensable to the ability of women and girls to exercise all other human rights and for the achievement of gender equality. Access to sexual and reproductive health services, goods and information is essential at all times, especially in situations of crisis. Crises exact a disparate and heavy toll on the sexual and reproductive health of women and girls, compounding and further deepening the systemic disadvantages and discrimination that they face.[6] The COVID-19 pandemic has brought global economic strife and triggered multiple local and individual crises, against a backdrop of countless pre-existing crises, including political, social, economic, public health and environmental crises. Women and girls have been disproportionately affected by them all.

9. In the present report, the Working Group draws attention to the widespread failure of States to adequately recognize, respect, protect and fulfil the sexual and reproductive health rights of women and girls, both before and during times of crisis, as marked by specific events, and formulates a set of recommendations to address crucial gaps. The Working Group wishes to express its gratitude to all stakeholders for their contributions made to the preparation of the report, including by responding to a questionnaire and participating in consultations.

B. Conceptual and legal framework

1. Understanding crises from the perspective of the rights of women and girls

10. Crises are often defined as an event or a series of events representing a critical threat to the health, safety, security and/or well-being of a community or other large group of people.[7] They are understood to be times of great difficulty and danger or threatening situations, requiring urgent action,[8] and range broadly among various scenarios, from armed conflict and natural disasters to political instability and socioeconomic strife, as well as pandemics, to name a few.

11. The Working Group considers that the focus on the "event" in the understanding of a situation of crisis may divert attention from key underlying factors that make a given situation "critical" for various populations, especially women and girls, and may thereby affect the formulation of effective preventive measures and policy responses. If the focus is strictly placed on a sudden event or a series of events as the defining element of a crisis, the gendered impact experienced by women and girls and the underlying determinants of the crisis which affect them in very specific ways are at risk of not being fully addressed.

12. Gender inequality, manifesting in systemic disadvantages for women throughout their life cycle and gender-based violence, is viewed by many women around the world as a crisis in itself, one that has been normalized by centuries of patriarchal, colonial and racialized legal and policy frameworks and institutions and deepened by the non-implementation of

[5] See www.ohchr.org/EN/Issues/Women/SRWomen/Pages/UN_WGDAW_10_years_anniversary.aspx.

[6] See A/HRC/26/39; A/HRC/32/44; and the Working Group's statements, of 20 April 2020, entitled "Responses to the COVID-19 pandemic must not discount women and girls", and, of 14 July 2020, entitled "COVID-19 and increase in gender-based violence and discrimination against women".

[7] See A/HRC/28/76.

[8] Paul Shrivastava, "Crisis theory/practice: towards a sustainable future", *Industrial and Environmental Crisis Quarterly* vol. 7, No. 1. See also International Fund for Agricultural Development, "Guidelines for disaster early recovery", 2011.

legal protections and political commitments. Many crises experienced individually by women and girls, such as unplanned pregnancy and sexual violence, infringe on their dignity, restrict their freedoms and are tied to their sexual and reproductive status. They are linked to structural discrimination and fostered by the patriarchal oppression, pervasive gender stereotypes, stigma and taboos that drive gender inequality. Such crises are not officially recognized and continue to be ignored, notwithstanding their systemic nature and the grave consequences for women and girls.

13. The widespread occurrence of forced and early pregnancy caused by sexual abuse, lack of comprehensive sexuality education or harmful practices,[9] such as child marriage, as well as gang violence, have been identified by women and girls as seriously neglected crises. Many sexual and reproductive health concerns involve mental health aspects, which are also neglected and intensify in situations of crisis. The toxification of the planet is a less visible crisis, which has devastating consequences for the sexual and reproductive health of women and girls, contributing to infertility, miscarriages, premature births, early menstruation and menopause, cancers of the reproductive system and decreased lactation, among other things.[10]

14. A radical shift in the approach to identifying and addressing situations of crisis is needed, one that is gender responsive, intersectional and acknowledges the hidden, yet deep, trauma associated with the non-fulfilment of the sexual and reproductive health rights of women and girls, as well as the life-long and intergenerational impact thereof. Many situations of crisis are predetermined by cumulative layers of pre-existing inequalities and discrimination, which may be starkly exposed and deeply exacerbated by a specific event.[11] As recalled by the Human Rights Council Advisory Committee, patterns of human rights violations provide an early indication of a potential or emerging crisis.[12] During the COVID-19 pandemic crisis, women indeed highlighted that for them "the crisis already existed".[13]

15. No country in the world has successfully eliminated discrimination against women and girls or achieved full gender equality.[14] Laws and policies that deny women and girls their sexual and reproductive health rights are inherently discriminatory. States cannot be truly prepared for or recover from a crisis, if structural inequalities and gaps persist that deny women and girls the full range of sexual and reproductive health services and goods, undermine their autonomy and neglect the underlying determinants of health.

2. Sexual and reproductive health rights

16. The current non-enjoyment of sexual and reproductive health rights by women and girls is a significant challenge to gender equality and reveals deep inequities. An estimated 810 maternal deaths occur each day globally,[15] and 25 million unsafe abortions take place annually,[16] resulting in approximately 47,000 deaths every year,[17] primarily in developing countries and among members of socioeconomically disadvantaged and marginalized populations. Every 16 seconds there is a stillbirth.[18] More than 200 million women who want to avoid pregnancy are not using modern contraception, due to a range of barriers.[19] Millions of women and girls are denied the ability to manage their monthly menstrual cycle safely and with dignity.[20] Those outcomes and barriers increase significantly in times of crisis.

[9] See joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child (2019).

[10] E/C.19/2013/9, para. 21. See also Donatella Caserta and others, "Environment and women's reproductive health", *Human Reproduction Update*, vol. 17, No. 3.

[11] See Jane McAdam, "The concept of crisis migration", *Forced Migration Review* vol. 45, No. 10.

[12] A/HRC/28/76, paras. 42–43.

[13] Views expressed during the regional consultations held by the Working Group.

[14] See A/HRC/38/46.

[15] World Health Organization (WHO), "Maternal mortality", evidence brief, 2019.

[16] Ann M. Starrs and others, "Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher-*Lancet* Commission", *The Lancet*, vol. 391, No. 10140.

[17] WHO, "Safe abortion: technical and policy guidance for health systems", 2012.

[18] United Nations Children's Fund (UNICEF), "A neglected tragedy: the global burden of stillbirths", 2020.

[19] Ann M. Starrs and others, "Accelerate progress".

[20] UNICEF, "Guidance on menstrual health and hygiene", 2019.

17. In a context of rising fundamentalisms, backlash against gains in women's equality have too often targeted sexual and reproductive health rights.[21] Much of the discrimination that women and girls face in relation to their sexual and reproductive health rights can be ascribed to the instrumentalization and politicization of their bodies.[22]

18. The Working Group recalls that sexual and reproductive health rights are clearly established under international law. They are an integral part of a number of civil and political rights that underpin the physical and mental integrity of individuals and their autonomy, such as the rights to life, liberty and security of person, freedom from torture and other cruel, inhuman or degrading treatment, privacy and respect for family life, as well as economic, social and cultural rights, such as the rights to health, education and work and the right to enjoy the benefits of scientific progress, and the cross-cutting rights of non-discrimination and equality.[23] A woman's right to control her fertility is central to the realization of those rights and to her autonomy and agency.[24] States are obligated to ensure that sexual and reproductive health services are available, accessible, affordable, acceptable and of good quality.[25] The distinct sexual and reproductive health needs of women and girls must be addressed to ensure substantive equality.

19. Eliminating discrimination and ensuring sexual and reproductive health rights is a core and immediate obligation of States.[26] The Working Group has repeatedly drawn attention to the fact that equality in the area of health requires a differential approach with regard to women and men, in accordance with their biological needs.[27] It is discriminatory for a State to refuse to legally provide certain reproductive health services for women.[28] Intersecting forms of discrimination that compound violations of the sexual and reproductive health of women and girls rights fall within the scope of States' core obligation to eliminate discrimination.

20. International human rights standards concerning sexual and reproductive health continue to apply during situations of crisis.[29] States have the duty to continue to meet their core obligations when crisis strikes, which include the obligations to provide access to family planning services, including emergency contraception, maternal health services, safe abortion services and post-abortion care and counselling for those in need, to prevent and treat HIV/AIDS and other sexually transmitted infections, to ensure access to comprehensive education and information on sexual and reproductive health and to ensure that survivors of gender-based violence have access to comprehensive medical treatment, mental health care

[21] See A/HRC/35/29; and A/HRC/38/46.

[22] See A/HRC/32/44.

[23] Among others: International Covenant on Economic, Social and Cultural Rights (art. 12); Convention on the Elimination of All Forms of Discrimination against Women (art. 12); Convention on the Rights of the Child (arts. 17, 23–25 and 27); International Convention on the Elimination of All Forms of Racial Discrimination (art. 5 (e) (iv)); International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (arts. 28, 43 (1) (e), 45 (1) (c) and 70); and Convention on the Rights of Persons with Disabilities (arts. 23 and 25). See also Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), general comment No. 21 (2009) and general comment No. 22 (2016); and Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999).

[24] Convention on the Elimination of All Forms of Discrimination against Women (art. 16 (e)).

[25] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), paras. 11–21.

[26] See Committee on Economic, Social and Cultural Rights, general comment No. 3 (1990),general comment No. 14 (2000), general comment No. 16 (2005) and general comment No. 22 (2016); and Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999) and general recommendation No. 28 (2010).

[27] Working Group, "Women's autonomy, equality and reproductive health in international human rights: between recognition, backlash and regressive trends", position paper, 2017; and A/HRC/32/44.

[28] Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999), para. 11.

[29] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) and general comment No. 22 (2016); and Committee on the Elimination of Discrimination against Women, general recommendation No. 28 (2010), general recommendation No. 30 (2013) and general recommendation No. 37 (2018).

and psychosocial support, among other services.[30] International human rights obligations concerning sexual and reproductive health rights are complementary to those in international humanitarian, refugee and criminal law.[31] The Working Group recalls that non-State actors, such as armed groups, are also obliged to respect international human rights.[32]

21. The Programme of Action of the International Conference on Population and Development, the Beijing Declaration and Platform for Action and the 2030 Agenda for Sustainable Development include commitments to achieve gender equality by ensuring a range of sexual and reproductive health rights for women and girls. The importance of ensuring access to the full range of sexual and reproductive health services during and after a conflict has been highlighted by the Security Council, in its resolution 2122 (2013) on women and peace and security. More recently, in its resolutions 75/156 and 75/157, the General Assembly called for the allocation of resources to ensure the continuation of universal access to health-care services, including sexual and reproductive health-care services, within the responses to COVID-19. The Sendai Framework for Disaster Risk Reduction, 2015–2030, encompasses social safety net mechanisms that integrate sexual and reproductive health (para. 30 (j)). In the Granada Consensus on sexual and reproductive health in protracted crises and recovery, participants called for the prioritization of sexual and reproductive health.[33]

C. Main factors underlying and exacerbating the risks and threats

1. Discriminatory laws, policies and practices

22. Denial of access to various forms of reproductive health care, such as maternal health care, including emergency obstetric care, and the criminalization of abortion is a profound failure to meet the obligation to guarantee equality in the area of sexual and reproductive health.[34] The denial of access to a full range of contraceptive information and services, as well as the failure to remove barriers to access, including stereotypes portraying women's "natural role" as mothers to justify such denial, constitutes a form of discrimination against women and girls, which puts their well-being at risk.[35]

23. Violations of sexual and reproductive health rights are linked to structural discrimination. Such violations take many forms, including forced sterilization, forced abortion, forced pregnancy, as well as the criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, the forced continuation of pregnancy and the abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, which have been recognized as forms of gender-based violence, and which may amount to torture or cruel, inhuman or degrading treatment.[36] The prosecution and imprisonment of women and girls for miscarriages and stillbirths is discriminatory and violates a broad range of human rights.

[30] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) and general comment No. 22 (2016); Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999) and general recommendation No. 30 (2013); Inter-Agency Working Group on Reproductive Health in Crisis, "Field manual on reproductive health in humanitarian settings", 2018; A/HRC/32/44; and Working Group, position paper, "Women's autonomy".

[31] Committee on the Elimination of Discrimination against Women, general recommendation No. 30 (2013), para. 19.

[32] Ibid. See also www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26797&LangID=E.

[33] See www.who.int/hac/techguidance/pht/reproductive_health_protracted_crises_and_recovery.pdf.

[34] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016); A/HRC/21/22; Committee on the Elimination of Discrimination against Women, *Da Silva Pimentel v. Brazil* (CEDAW/C/49/D/17/2008); CEDAW/C/OP.8/PHL/1; and A/HRC/32/44. See also Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999) and general recommendations No. 33 (2015).

[35] CEDAW/C/OP.8/PHL/1, paras. 33, 36 and 43; and Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 28.

[36] Committee on the Elimination of Discrimination against Women, general recommendation No. 35 (2017). See also A/74/137.

24. Legal safeguards and protocols that ensure privacy, confidentiality and free and informed consent and decision-making, without coercion, discrimination or fear of violence, are necessary to guarantee the equal enjoyment of sexual and reproductive health rights for women and girls.[37] The stigma often assigned to sexual and reproductive health conditions, such as obstetric fistula, menstruation, abortion, adolescent pregnancy and sexually transmissible infections, is rooted in discriminatory gender stereotypes and patriarchal norms that must be dismantled through appropriate policies and interventions.[38]

2. Failure by States to prioritize sexual and reproductive health rights

25. States are consistently failing to comply with the full scope of their human rights obligations in relation to sexual and reproductive health rights before and during situations of crisis. The Working Group is deeply concerned that, of the countries reporting on the 2020 review and appraisal of the implementation of the Beijing Declaration and Platform for Action, only 20 per cent indicated that they had provided women and girls, including refugees, in humanitarian settings with access to sexual and reproductive health services.[39]

26. Responses to crisis too often lack a gender perspective and do not adequately meet the distinct needs of women and girls. The life-saving value of many vital sexual and reproductive health services are not recognized, and services are deprioritized or not provided at all.[40] Discrimination against women underpins the lack of prioritization of those services, "reflecting societal hierarchies about who matters and who does not".[41] Measures adopted by States during a crisis, such as the diversion of financial and human resources away from sexual and reproductive health care and the imposition of restrictions on services, thereby deeming them non-essential, amount in practice to a retrogression, which is incompatible with States' human rights obligations.[42] Such restrictions often continue to undermine access to sexual and reproductive health care after a crisis ends,[43] and, in the majority of cases, reconstruction programmes and recovery plans fail to prioritize sexual and reproductive health.[44] During the COVID-19 pandemic, delivery of a broad range of essential sexual and reproductive health services and goods has been suspended or postponed, including: contraceptive information and services; safe abortion services and post-abortion care; mammograms, cervical cancer detection and testing and treatment for HIV and other sexually transmitted infections; support services for women and girls subjected to female genital mutilation; and fertility treatments.[45] Treatments for gender dysphoria have also been disrupted, with serious psychological consequences for those concerned.[46]

27. The Working Group emphasizes the crucial role of various actors in the provision of sexual and reproductive health care. All sectors of society – individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector – have responsibilities regarding the realization of the right to health.[47] The State, besides exercising the obligations of due diligence over the actions of private individuals and non-State actors that might impair the sexual and reproductive health rights of women and girls, must provide

[37] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016); and Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999).
[38] See A/HRC/32/44.
[39] See E/CN.6/2020/3.
[40] A/HRC/42/24, para. 53.
[41] A/HRC/39/26, para. 47.
[42] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) and general comment No. 22 (2016).
[43] Submission by the Feminist Alliance for Rights about the experience during the Ebola virus disease crisis.
[44] See Office of the United Nations High Commissioner for Refugees (UNHCR), "Handbook for the protection of women and girls", 2008.
[45] See submissions by Danish Institute for Human Rights; Finland; El Salvador; Slovenia; Global Respectful Maternity Care Council; End FGM European Network; Marie Stopes International; and Comunidad de Derechos Humanos.
[46] See submissions by Finland and CHOICE for Youth and Sexuality.
[47] Committee on Economic, Social and Cultural Rights, general comment No. 12 (1999).

an enabling environment that facilitates the discharge of those responsibilities and promotes respect for those rights. Health service providers should be subject to regulations to avoid violations of sexual and reproductive health rights, for example, by obstructing access to goods and services, engaging in misinformation[48] or refusing care based on conscience or religion. Their conduct must be consistent with human rights standards and their ethical obligations as health-care professionals.

28. The Working Group recognizes as a promising practice the constitutional recognition of sexual and/or reproductive rights by some States and the integration of human rights standards into national legislation and policy. The formal recognition of sexual and reproductive health services as essential is also a promising practice, which, in some countries, has been achieved through national courts[49] and, in others, through the explicit inclusion of those services in emergency-related responses. In cases in which sexual and reproductive health services have been declared as essential only after the onset of a crisis, implementation has suffered, in the absence of a coherent and comprehensive response and the institutional mechanisms needed to support the design and implementation of such measures with the participation of women.[50]

29. WHO has called for the relaxation of certain requirements and the reduction of barriers during COVID-19 in order to avoid delays in acquiring access to certain essential sexual and reproductive health goods and services, including contraceptives and safe abortion and post-abortion care.[51] A promising practice by some States has been the expansion of access to self-managed medical abortion, including through telemedicine.[52] The Working Group notes that community-based midwifery can play a crucial role in responding to sexual and reproductive health needs during a crisis, supplementing scarce human resources and ensuring service coverage, in particular in remote areas, while allowing for an intercultural approach to care, which is a crucial component of acceptable and good quality care in certain communities.

3. Lack of investment in sexual and reproductive health-care services and shortcomings in foreign aid

30. States' failure to adequately prioritize the sexual and reproductive health rights of women and girls is reflected in the lack of gender budgeting and financial investment in that area, including in foreign aid, and it is further exacerbated by austerity and neoliberal measures encompassing the privatization of public services.[53] Government spending on sexual and reproductive health could double, at least in lower middle-income countries, if countries were to increasingly prioritize health within their own budgets.[54] Many States have shown a lack of capacity or willingness to commit adequate resources to sexual and reproductive health.[55]

31. The Working Group is concerned about structural barriers linked to mismanagement and corruption, ranging from bottlenecks that impede the flow of resources within States to

[48] See Committee on Economic, Social and Cultural Rights, general comment No. 24 (2017); and Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999).

[49] See www.icj.org/wp-content/uploads/2020/11/Nepal-Right-to-health-Advocacy-analysis-brief-2020-ENG.pdf.

[50] See submissions by ASEAN Disability Forum and the Defensor del Pueblo of Argentina.

[51] WHO, "Maintaining essential health services: operational guidance for the COVID-19 context", 2020.

[52] Submission by Centro de Estudios Legales y Sociales. See also Church et al, "Reproductive health under COVID-19 – challenges of responding in a global crisis", *Sexual and Reproductive Health Matters*, vol. 28, No. 1.

[53] See submission by AIDS and Rights Alliance for Southern Africa.

[54] Partnership for Maternal, Newborn and Child Health and others, "Funding for sexual and reproductive health and rights in low- and middle-income countries: threats, outlook and opportunities", 2019.

[55] See A/HRC/39/26.

tax evasion and illicit financial flows that limit the resources of States to deliver public services, including sexual and reproductive health services for women and girls.[56]

32. States are required under international human rights law to allocate adequate budgetary, human and administrative resources to ensure the sexual and reproductive health of women and girls without discrimination.[57] They have an immediate obligation to take deliberate, concrete and targeted steps towards the realization of the right of women and girls to sexual and reproductive health care and to act as expeditiously and effectively as possible, by mobilizing domestic resources and, if needed, seeking international cooperation.[58]

33. The Working Group notes with concern that the priorities of donors often drive interventions in situations of humanitarian crisis,[59] and gender equality is not always one of them. Seven of the 11 top Government donors reportedly allocated only 2 per cent of funds to targeted gender equality programming, although women and girls represent around 50 per cent of the population in humanitarian settings.[60] Sexual and reproductive health services are typically not considered essential or urgent, despite the specific risks and vulnerabilities faced by women and girls. Contraception, abortion and adolescent health are often not prioritized.[61] Menstrual health and pain management is barely addressed. In some cases, even maternity care is reportedly not adequately funded or prioritized because it is not perceived as a "humanitarian" concern.[62] Survivors of violence are frequently left without access to crucial goods and services, including emergency contraception, post-exposure prophylaxis, safe abortion services and psychological counselling.[63]

34. The "global gag rule" is a harmful policy instituted by a major donor country, which has been applied on and off to international aid. It has produced catastrophic consequences for women and girls and health systems in many developing countries, including an increase in unplanned pregnancy and unsafe abortion, in addition to stigmatizing abortion, inhibiting information about safe and legal abortion and stifling advocacy for law reform where restrictions exist.[64] Donor States and international actors have an obligation to comply with human rights standards pertaining to sexual and reproductive health and must not exert their influence to impose restrictions on information and services.[65]

4. Lack of accountability for violations of the sexual and reproductive health rights of women and girls

35. The Working Group is deeply concerned about the widespread impunity for violations of the sexual and reproductive health rights of women and girls. While some progress has been made in investigating and prosecuting crimes of sexual violence in situations of

[56] See A/HRC/28/73; and www.euro.who.int/en/data-and-evidence/evidence-informed-policy-making/publications/hen-summaries-of-network-members-reports/how-does-corruption-affect-health-care-systems,-and-how-can-regulation-tackle-it#:~:text=There%20is%20growing%20evidence%20that,the%20most%20vulnerable%20population%20groups.

[57] Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999); and Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) and general comment No. 22 (2016).

[58] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000).

[59] Neha Singh and others, "Delivering health interventions to women, children, and adolescents in conflict settings: what have we learned from ten country case studies?", *The Lancet*, vol. 397, No. 10273.

[60] CARE, "Time for a better bargain: how the aid system shortchanges women and girls in crisis", 2021.

[61] Ibid.

[62] See A/HRC/42/24.

[63] See CEDAW/C/CAF/CO/1-5.

[64] See submission by Global Justice Center; and Terry McGovern and Anand Tamang "Exporting bad policy: an introduction to the special issue on the GGR's impact", *Sexual and Reproductive Health Matters*, vol. 28, No. 3.

[65] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) and general comment No. 22 (2016).

conflict,[66] many violations of sexual and reproductive health rights continue to be either neglected or tolerated and occur with impunity.

36. Reliable data concerning the accessibility, availability and quality of sexual and reproductive health services, disaggregated by sex, gender, age and other grounds, remain scarce in general and in particular in humanitarian settings.[67] States continue to lag behind in the provision of those services based on precise plans, indicators, benchmarks and regular reviews, despite it being an integral component of States' human rights obligations and crucial to ensuring accountability.[68]

37. The Working Group emphasizes that accountability is needed at multiple levels and may take various forms, including administrative, social, political and legal. The implementation of a "circle of accountability" is a promising practice, as envisioned in the United Nations technical guidance on the application of a human right-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality.[69] It brings together local communities and governmental and other actors in a community-led monitoring effort to ensure accountability for sexual and reproductive health rights.[70]

38. The Working Group notes as a promising practice the interventions by national human rights institutions and courts aimed at protecting sexual and reproductive health rights during situations of crisis, including during the COVID-19 pandemic, by drawing attention to shortcomings in the design and/or implementation of crisis responses.[71] Another promising practice is the conduct of independent investigations by national and specially appointed international commissions that have exposed wide-ranging violations of the sexual and reproductive health rights of women and girls in various situations of crisis and offered clear guidance on reparations and structural reforms.[72]

39. Women and girls are entitled to receive adequate reparations, including restitution, compensation, satisfaction, rehabilitation and guarantees of non-repetition, for violations of their sexual and reproductive health rights, and States have a core obligation to ensure access to effective and transparent reparations.[73] However, women and girls continue to face a variety of barriers to access to justice in situations of crisis,[74] from the lack of recognition of the harm caused to them as being a violation of human rights to the absence of procedures and formal mechanisms. The Working Group welcomes the judicial recognition of the harms caused by sexual and reproductive violence during conflict and the provision of reparations.[75] States have been held responsible for failing to protect the sexual and reproductive health rights of women and girls in cases concerning access to therapeutic abortion,[76] non-

[66] See Kim Thuy Seelinger, "Close to home: a short history, and rough typology, of national courts prosecuting wartime sexual violence", *Journal of International Criminal Justice*, vol. 18, No. 2; and Daniela Kravetz, "Accountability for sexual and gender-based violence during mass repression and in conflict the experiences of Argentina and Guatemala", *Journal of International Criminal Justice* vol. 18, No. 2.

[67] See A/HRC/39/26.

[68] See Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999); and Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000).

[69] See A/HRC/21/22.

[70] See the submission by CARE and the Center for Reproductive Rights.

[71] See submissions by Procuraduría para la Defensa de los Derechos Humanos of El Salvador and National Human Rights Commission of India.

[72] See "Sexual and gender-based violence in Myanmar and the gendered impact of its ethnic conflicts", conference room paper; A/HRC/41/18; https://reliefweb.int/report/south-sudan/access-health-survivors-conflict-related-sexual-violence-south-sudan-may-2020; and www.mmiwg-ffada.ca/final-report/.

[73] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) and general comment No. 22 (2016).

[74] Among many others, see submissions by Argentina, Colombia, Greece and Mali and State of Palestine.

[75] Constitutional Court of Colombia, decision SU-599/19 of 11 December 2019.

[76] See *L.C. v. Peru* (CEDAW/C/50/D/22/2009).

discriminatory and timely access to maternal health care,[77] mistreatment during childbirth[78] and access to contraceptive information and services.[79]

40. The Working Group denounces in the strongest terms the prosecution and criminalization of women and girls accused of having abortions, including in situations of miscarriages and stillbirths. The Working Group condemns reporting requirements that contribute to a "hospital to prison pipeline" for women who have had or who are suspected of having abortions and the criminalization of involvement in the performance of abortions, which affects health-care workers, including midwives, especially in times of crisis when institutional health services are not readily available.[80]

5. Lack of support for feminist and women's rights organizations and violence against human rights defenders working in the area of sexual and reproductive health rights

41. Feminist and women's rights organizations working at the community level play a vital role in ensuring the sexual and reproductive health rights of women and girls, especially during a crisis. Many are directly involved in the provision of sexual and reproductive health services and information, stepping in where public goods and services are no longer unavailable.[81] States are required under international law to ensure that such groups are supported in discharging their role and involved in the planning, implementation and monitoring of crisis responses.[82] The Working Group notes however that their expertise and knowledge is often not taken into consideration.[83] Feminist leaders and organizations working on the front lines are not systematically included in decision-making processes. In addition, a recent assessment has revealed that, in situations of crisis, funding for women's rights is among the first things to be reduced.[84]

42. The Working Group is deeply concerned that women human rights defenders are targeted for violence and subjected to intimidation and retaliation because of their efforts to ensure women's sexual and reproductive health rights and for their demanding accountability for pervasive sexual violence and feminicides.[85]

6. Exclusion of women and girls from decision-making

43. Without autonomy and control over their reproductive functions and roles, women and girls continue to be subjugated in every sphere of life and are unable to realize their full potential. They are effectively denied the ability to participate in public life and to provide leadership. Legal restrictions on women's and girls' autonomy and their exclusion from decision-making processes are compounded by the tendency during a crisis to promote a certain image of women as mothers only and to essentialize their role through the use of harmful and discriminatory stereotypes, which leads to the further exclusion of their concerns and perspectives from the public policy discourse.[86]

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[77] See *Da Silva Pimentel v. Brazil*; and *S.F.M. v. Spain* (CEDAW/C/75/D/138/2018).

[78] See CEDAW/C/IRL/CO/6-7.

[79] See CEDAW/C/OP.8/PHL/1.

[80] See https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunication File?gId=25385; https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunication File?gId=25560; www.corteidh.or.cr/docs/tramite/manuela_y_otros.pdf; A/66/254; and A/HRC/41/33.

[81] See submission by Maat for Peace Development and Human Rights – Somalia and Ipas Pakistan.

[82] See also Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999).

[83] CARE, "Time for a better bargain"; African Commission on Human and Peoples' Rights, "Study on transitional justice and human and peoples' rights in Africa", 2019; and submission by Pathways for Women's Empowerment and Development.

[84] Ibid.

[85] See https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunication File?gId=25833; https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunication File?gId=25447; https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunication File?gId=25372; and A/HRC/41/33.

[86] Views expressed during the regional consultations; and submission by Latsi Nu Women Agency.

44. Cultural and traditional values are persistently invoked to justify resistance to women's political and public roles, and similar ideology is used to deny women and girls their sexual and reproductive health rights. It is imperative that States ensure the participation of women and girls in political and public life on an equal basis with men and boys, as well as the integration of women and girls into decision-making processes relating to crisis prevention, management and recovery,[87] encompassing the formulation of laws and policies, monitoring, implementation and accountability.

7. Lack of engagement and accountability of men and male allies

45. Men hold a disproportionate level of decision-making authority in the public and private spheres. In times of crisis, the lack of male support for prioritizing the sexual and reproductive health rights of women and girls is a major obstacle.[88] States have an obligation to direct a cultural shift to change patriarchal mindsets and attitudes by reinforcing men's accountability for gender equality and engaging them as allies in prioritizing gender equality in decision-making, including in relation to sexual and reproductive health rights.

46. States must also take steps to address toxic masculinity.[89] That can be done by eliminating sexism and misogyny in the public discourse and violence against women and girls. Social norms and gender stereotypes around toxic masculinity promote risky sexual behaviours and discourage boys and men from seeking access to sexual and reproductive health-care services. Moreover, many men consider sexual and reproductive health to be the exclusive responsibility of women and fail to recognize when their partners and their families are in urgent need of sexual and reproductive health care.[90] The Working Group notes as a promising practice the efforts of some male parliamentarians and activists in promoting positive messages on how men and boys can be active participants in fostering non-violent masculinities and encouraging positive behaviours among men in times of crisis, as has been done during the COVID-19 related lockdown measures.[91]

8. Ideological and religious opposition to sexual and reproductive health rights

47. Religious fundamentalists and their political allies have led an organized and well-funded global political backlash against gender equality by invoking religious freedom and traditional values.[92] The backlash has been particularly visible since consensus was achieved among Governments to promote and advance women's reproductive rights at the International Conference on Population and Development, and it has increased since sexual rights were recognized at the Fourth World Conference on Women. The Special Rapporteur on freedom of religion or belief has noted the increased use of religion or belief by certain actors in all regions of the world to advocate for the imposition of laws and policies that are directly or indirectly discriminatory against women and girls.[93] The Working Group reiterates that arguments framed in terms of cultural diversity and freedom of religion cannot be invoked to justify discrimination against women. Discriminatory, repressive and violent practices against women must be eliminated, whatever their origins, including those founded in certain interpretations of culture or religion.[94]

48. In recent years, the backlash has been propelled by some Governments, including at the Human Rights Council, by challenging the universality of human rights.[95] That development is central to the Working Group's concerns about the neglect and deprioritization of the sexual and reproductive health rights of women and girls in all situations, including in times of crisis. A core strategy of the organized opposition has been to undermine women's sexual and reproductive health rights as a whole by using their

[87] A/HRC/23/50, paras. 36 and 41.
[88] Submission by Somali Gender Justice.
[89] See A/75/289.
[90] Submission by MenEngage Alliance.
[91] Ibid.
[92] See A/HRC/38/46. See also Working Group, "Women's autonomy"; and Working Group, "Gender equality and gender backlash", position paper, 2020.
[93] See A/HRC/43/48.
[94] See A/HRC/29/40.
[95] See A/HRC/29/40.

ideological opposition to abortion as a lynchpin. The sexual and reproductive health rights of women and girls, including the options to prevent and safely terminate an unwanted pregnancy, must be fully recognized and supported at all times in order to guard against profound violations of their bodily integrity and autonomy.[96] More recently, some States have misleadingly alleged that proponents of gender equality are advancing a harmful "gender ideology", to deepen and instrumentalize the ideological divide and undermine legally guaranteed protections.[97]

49. The adoption of the so-called "Geneva consensus declaration on promoting women's health and strengthening the family" in 2020 is an example of the harmful mobilization of States with conservative and anti-women's rights agendas to undermine the well-established and globally recognized human rights of women and girls.[98] The Working Group welcomes the sustained commitment of many States to upholding the sexual and reproductive health rights of women and girls through joint diplomatic statements.[99]

9. Additional challenges in times of crisis

50. Crises bring additional challenges to health systems that are already deficient in the provision of essential sexual and reproductive health services, including the collapse of or reduction in the functioning of health infrastructure, public transportation, water, sanitation, waste management and other underlying determinants of access to health care.[100] Breakdowns in health systems that reduce availability and access can give rise to a loss of privacy in health-care settings and deter women and girls from seeking sexual and reproductive health care.

51. The availability of services is often disrupted by the inability of health-care workers to provide services due the breakdown of the health system and violence that may be directed towards them. Combined with sudden disruptions in the supply chain, the poor management of barriers and gaps considerably deepens the impact of a crisis on the sexual and reproductive health of women and girls.[101] A militarized response to a crisis, such as by handing over the management of a natural disaster to the armed forces, can lead to increased threats and acts of violence against women and girls.[102]

52. Measures imposed during a crisis often set back crucial progress made on the sexual and reproductive health rights of women and girls. It has been estimated that, due to COVID-19 containment measures, 2 million cases of female genital mutilation, which would otherwise have been averted, are likely to occur over the next decade, and an additional 13 million child marriages could take place by 2030.[103] Unplanned pregnancies are projected to increase by several million.[104] A one-third reduction in progress towards ending gender-based violence by 2030 is expected.[105] An increase in disrespectful maternity care and cases of obstetric violence has been observed, alongside a reduction in antenatal and childbirth services.[106]

53. Situations of crisis may be exploited to restrict access for women and girls to certain reproductive health services. During the COVID-19 pandemic, a number of countries restricted access to abortion services and suspended the operations of mobile outreach teams

[96] See also Working Group, "Women's autonomy".
[97] Working Group, "Gender equality and gender backlash".
[98] See https://geneva.usmission.gov/wp-content/uploads/sites/290/GenevaDeclaration.pdf. The new Administration of the United States of America has distanced itself from the declaration.
[99] See www.government.nl/documents/diplomatic-statements/2019/09/23/joint-statement-on-srhr-in-uhc.
[100] Submissions by Ipas Pakistan and ECKO Greece.
[101] See submissions by Ipas Pakistan and Refugee Commission.
[102] See submissions by Latsi Nu Women Agency and Global Justice Center.
[103] United Nations Population Fund (UNFPA), "Impact of the COVID-19 pandemic on family planning and ending gender-based violence, female genital mutilation and child marriage", 2020.
[104] See https://news.un.org/en/story/2020/04/1062742.
[105] UNFPA, "Impact of the COVID-19 pandemic".
[106] See Working Group's statement of 20 April 2020; and submission by Global Respectful Maternity Care Council.

providing contraceptive services to rural and marginalized communities, by deeming them non-essential, and further rollbacks of existing laws and policies have been attempted.[107]

D. Women and girls facing compounded barriers and threats

54. Certain groups of women and girls are at increased risk of violations of their sexual and reproductive health rights, and their situation is worsened in times of crisis, due to multiple and intersecting forms of discrimination. The impact of a crisis is exacerbated by the pre-existing inequalities and discrimination in their socioeconomic status combined with gaps in legal and policy frameworks and crisis responses.[108] Some groups have been historically subjected to a "persistent state of crisis" on racial and ethnic grounds. The Working Group takes note of a selected few cases below.

1. Girls and adolescent girls

55. Girls and adolescent girls are at increased risk of sexual violence, early and unplanned pregnancy, coerced sex and harmful practices in general and in particular in situations of crisis.[109] Those risks are driven by lack of access to information, goods and services,[110] combined with pervasive stereotyping and taboos. School closures and lockdown measures during the COVID-19 crisis have led to a crucial loss of access to sexual and reproductive health information and missed opportunities to detect and report cases of violence.[111]

56. During the Ebola virus disease outbreak, adolescent girls in crisis-stricken communities became pregnant at twice the rate of those in communities that were less affected.[112] During a crisis, arranged and forced marriages increase, driven by harmful traditional practices in the context of aggravated poverty.[113] Married-off girls face a higher risk of pregnancy-related mortality and obstetric fistula, a preventable and devastating pregnancy-related injury which causes incontinence and can lead to stigma, abandonment and social exclusion.[114] Nevertheless, child marriage and adolescent girls' sexual and reproductive health needs remain largely unaddressed in humanitarian settings.[115]

2. Rural women and girls

57. Rural areas are generally underserved, leaving rural women and girls even more exposed to violations of their sexual and reproductive health rights when crises arise. Contraceptive access is low,[116] and maternal mortality and morbidities, such as obstetric fistula and uterine prolapse, are high among rural women and girls.[117] There is a higher incidence of stillbirths.[118] Barriers commonly faced by rural women and girls include long

[107] Colleen Marcoux, "Sexual and reproductive health during the COVID-19 crisis", International Women's Health Coalition, 2020; Center for Reproductive Rights, "Sexual and reproductive rights during COVID-19 response and beyond: standards from the United Nations", 2020; submission by Marie Stopes International; and www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=26290&LangID=E.

[108] See submissions by Mexico, ASEAN Disability Forum, Women Enabled International, Global Interfaith Network, Latsi Nu Women Agency and Choice for Youth and Sexuality.

[109] UNFPA, "Adolescent girls in disaster and conflict", 2016; UNHCR, "Handbook"; and Plan International, "Adolescent girls in crisis: voices from the Sahel", 2020.

[110] See submission by Choice for Youth and Sexuality.

[111] See submissions by Kenya and Finland; and Colleen Marcoux, "Sexual and reproductive health".

[112] World Bank, "Empowering adolescent girls in a crisis context: lessons from Sierra Leone in the time of Ebola", policy brief No. 34, 2019.

[113] See CRC/C/SYR/CO/5; joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child (2019); and submissions by the Feminist Alliance for Rights and Mali.

[114] See www.who.int/news-room/facts-in-pictures/detail/10-facts-on-obstetric-fistula.

[115] See submission by Plan international.

[116] See www.choiceforyouth.org/assets/Docs/198f89dc19/PositionPaper_CSW_DEF.pdf.

[117] Committee on the Elimination of Discrimination against Women, general recommendation No. 34 (2016).

[118] See https://data.unicef.org/resources/a-neglected-tragedy-stillbirth-estimates-report/.

distances from health centres, cost, lack of trained providers, long wait times, lack of information and confidentiality and the constraints of a heavy workload.[119] Many of those barriers come into play more acutely in situations of crisis.

58. Land-grabbing and the operations of extractive industries in the rural territories of indigenous peoples and other communities are experienced by women and girls as a crisis,[120] threatening their very survival. They are often targeted for sexual violence, including in the form of sexual exploitation and trafficking, which has been linked to higher incidences of sexually transmitted infections and HIV.[121]

3. Women and girls with disabilities

59. In crisis responses, the needs of women and girls with disabilities, for example, through reasonable accommodations, such as the installation of ramps and the provision of portable beds and wheelchairs, to ensure their access to sexual and reproductive health goods and services, are often not specifically taken into account.[122] Information is often not available in accessible formats, which leads to difficulties in seeking services and communicating with staff.[123] Women and girls with disabilities face a higher risk of abuse and violence as result of the breakdown of support systems to which they may previously have had access.[124] Negative stereotypes linked to their sexual and reproductive health status can lead to the further marginalization of their needs and concerns in situations of crisis.[125] The sexual and reproductive health needs of women and girls who develop disabilities due to physical and emotional injuries from violence and armed conflict are widely neglected.[126]

4. Migrant, refugee and internally displaced women and girls

60. Migrant, refugee and internally displaced women and girls often arrive carrying the traumas of violence, persecution, conflict and poverty. Reception structures and arrangements are often lacking the capacity to respond to their heightened need for sexual and reproductive health services.[127] Many live in camps under a persistent threat of violence, including from intimate partners,[128] while sexual and reproductive health is typically deemed a taboo topic.[129] Cultural and linguistic barriers impede the flow of crucial information.[130] Some have recounted traumatic experiences with unplanned and forced pregnancies as "triggering a crisis" in the precarious and dire circumstances of the camps.[131]

61. Many rely on "transactional sex" to secure their basic material needs, and sex may be demanded of those fleeing a crisis while in transit,[132] increasing the likelihood of unplanned pregnancies and other reproductive health risks for which services are lacking. In some destination countries, migrant women have been put in detention centres, denied basic reproductive health goods and services and subjected to non-consensual and medically unnecessary reproductive health procedures.[133]

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119 See www.choiceforyouth.org/assets/Docs/198f89dc19/PositionPaper_CSW_DEF.pdf.

120 Views expressed during the regional consultations. See also submission by Pathways for Women's Empowerment and Development.

121 See Inter-American Commission on Human Rights, "Indigenous and tribal peoples of the pan-Amazon region", 2019; A/HRC/36/46/Add.1; A/HRC/39/17/Add.3; and E/C.19/2013/9.

122 See submission by ASEAN Disability Forum.

123 See submission by Kenya.

124 See submission by Finland.

125 Committee on the Rights of Persons with Disabilities, general comment No. 3 (2016); and submission by the Castan Centre for Human Rights Law.

126 Views expressed during the regional consultations.

127 See submissions by Greece, Pathways for Women's Empowerment and Development and EKO.

128 See submission by the Feminist Alliance for Rights.

129 Ibid.

130 See submissions by Greece, Pathways for Women's Empowerment and Development and EKO.

131 Views expressed during the regional consultations.

132 See www.tandfonline.com/doi/full/10.1080/26410397.2020.1822493?src=recsys.

133 See https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=25835.

62. Relief programmes often do not take into account the specific needs of women and girls, including routine menstrual hygiene and pain management,[134] which has physical and emotional consequences for women, who have pointed out that the "[United Nations] provides good health services for pre- and post-natal care, but, after that, there is nothing".[135]

5. Women and girls in a "persistent state of crisis"

63. There are communities of women and girls whose lives have been shaped by histories of oppression, enslavement, exclusion, racial discrimination, forced assimilation and apartheid, linked to conquest and colonization, as well as systematic violence and disregard for their culture, spirituality and traditions, and, as a result, have been subjected to a "persistent state of crisis". Many have been systematically subjected to reproductive violence, including forced pregnancy and sterilization, while others have been separated from their children. Certain groups are highlighted below, although there are women belonging to other ethnic and minority groups in a state of deep crisis, including Dalit, Rohingya, Yazidi and Uighur women.[136]

(a) Indigenous women and girls

64. Indigenous women and girls are a diverse community, bound by their histories of being subjected to conquest, colonization, forced assimilation and the continuing dispossession of their peoples' lands, and many have also been subjected to acomplex spectrum of human rights abuses[137] involving discriminatory and coercive practices, such as eugenically imposed birth control, forced sterilization and systemic sexual abuse and rape.[138] Pregnancy-related morbidity and mortality rates are relatively higher among indigenous women and girls.[139] The absence of health services that specifically incorporate indigenous knowledge, their worldview and an intercultural approach contributes to language and cultural barriers, cost barriers and poorer reproductive health outcomes.[140]

65. In urban areas, indigenous women and girls may have greater access to facilities than their rural counterparts, but they often "suffer from invisibility and discrimination" based on their indigenous identity.[141] In many cases, the criminalization of indigenous midwifery and the denial of the opportunity to give birth on the land of their ancestors, which in many traditions breaks the spiritual connection of the newborn with the community, also contributes to the overall feeling of insecurity and the distress of pregnant women during childbirth.[142] For indigenous women, the connection to ancestral lands and the environment is fundamental to their health status.[143]

(b) Women and girls of African descent

66. The legacies of slavery, systemic racism, structural discrimination and coercive practices against women of African descent are reflected in contemporary situations of

[134] See https://plan-international.org/because-i-am-a-girl/menstrual-hygiene-matters-refugee-girls.
[135] See submission by the Feminist Alliance for Rights.
[136] See A/HRC/32/18; https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublic CommunicationFile?gId=19319; https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublic CommunicationFile?gId=22468; and https://spcommreports.ohchr.org/TMResultsBase/DownLoad PublicCommunicationFile?gId=25780.
[137] A/HRC/30/41, para. 5.
[138] See submission by the Castan Centre.
[139] See E/2019/43; www.un.org/esa/socdev/unpfii/documents/2014/press/shrr.pdf; www.paho.org/hq/dmdocuments/2011/gdr-gender-equity-and-indigenous-women-health-americas.pdf; and submissions by the Castan Centre and Native Women's Association of Canada.
[140] See www.unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2018_EN_human_rights_report.pdf.
[141] Ibid.
[142] See submissions by the Castan Centre and Native Women's Association of Canada.
[143] See www.paho.org/hq/dmdocuments/2011/gdr-gender-equity-and-indigenous-women-health-americas.pdf.

socioeconomic disadvantage and profound inequalities.[144] The disparities are starkly visible in the poor sexual and reproductive health status of, and the range of human rights violations perpetrated against, women and girls of African descent, including the mistreatment of pregnant women in health-care settings and significantly higher rates of maternal mortality.[145] Racial stereotyping by health-care providers against women of African descent that leads to negligent and deliberate delays in care is one of the factors underlying the high incidence of preventable maternal deaths.[146]

67. Racism within the health system can be intensified by widespread State policing and surveillance and mandatory reporting requirements in relation to suspicions of drug use and child abuse or neglect, which often deters pregnant women from seeking reproductive health care and undermines their trust in health service providers.[147] Such norms and practices exist against the backdrop of a harmful narrative about "Black maternal unfitness",[148] which has been used to legitimize State-sanctioned violence against Black women in the form of coerced sterilization[149] and the separation of mothers from their children.[150]

68. As a promising practice, drawing on human rights and, more specifically, in response to their experiences, some Black activist women have developed their own advocacy framework, known as the "reproductive and birth justice framework", which recognizes three interconnected components of reproductive justice, namely, the right to have a child, the right to not have a child and the right to parent children in a safe and healthy environment.[151]

(c) Roma women and girls

69. Historically, Roma women and girls across Europe have been subjected to anti-Gypsyism and have faced egregious violations of their sexual and reproductive health rights. The forced sterilization of Roma women was widespread in some European countries until the 1990s,[152] creating a legacy of institutionalized abusive practices and mistrust in the health system. The ethnic segregation of Roma women in maternal health facilities in which basic standards of hygiene and safety are not ensured is a discriminatory practice. Health professionals may refuse their services entirely, due to the perceived inability of Roma to pay,[153] or avoid treating them based on harmful stereotypes,[154] leading to low quality of care and deliberate delays in the provision of services.[155]

70. There are disproportionately high teenage pregnancy rates among Roma girls, in part due to high rates of early or child marriage.[156] They have a higher unmet need for contraceptive information and services and face an increased risk of sexually transmitted infections, including HIV,[157] and period poverty. Discriminatory assumptions about their

144 See Durban Declaration and Programme of Action; Committee on the Elimination of Racial Discrimination, general recommendation No. 34 (2011); Arachu Castro and others, "Assessing equitable care for Indigenous and Afrodescendant women in Latin America", *Rev Panam Salud Publica*, vol. 38, No. 2; Cynthia Prather and others, "Racism, African American Women and their sexual and reproductive health: a review of historical and contemporary evidence and implications for health equity", *Health Equity*, vol. 2, No. 1.

145 See submission from Birth Justice.

146 See *Da Silva Pimentel v. Brazil*.

147 See submission from Birth Justice.

148 Ibid.

149 See submission Her Rights Initiative South Africa.

150 See submission from Birth Justice.

151 Ibid.

152 See www.euro.who.int/__data/assets/pdf_file/0015/330090/4-Advancing-womens-sexual-reproductive-rights-in-Europe.pdf?ua=1.

153 Ibid.

154 Nadia Rusi, "Discrimination of Roma women regarding their access to reproductive health services in Albania", *European Journal of Multidisciplinary Studies*, vol. 2, No. 1.

155 Ibid.

156 See https://eeca.unfpa.org/en/publications/inequities-roma-womens-health?page=4%2C0%2C4.

157 Ibid.

fitness to become mothers are frequently employed by the authorities to take away their children.[158]

III. Conclusions and recommendations

A. Conclusions

71. The sexual and reproductive health rights of women and girls are systematically neglected, not because of a lack of resources or technical knowledge but because of the widespread disregard for women's dignity, bodily integrity and autonomy. Sexual and reproductive health matters are intrinsic to every woman and girl and tied to their ability to live with dignity and exercise their agency. The failure to ensure the sexual and reproductive health rights of women and girls is discriminatory and constitutes a major crisis in itself.

72. Crisis events cannot always be prevented, but States can be better prepared. They must rapidly establish safeguards to mitigate and address the harm experienced by women and girls to their sexual and reproductive health: it is their foremost duty. Crisis responses must be gendered and require a combination of emergency and long-term measures, specifically in relation to sexual and reproductive health. They must be developed and implemented with the active participation of women and girls, taking into account their urgent medical needs and the pervasive structural discrimination against them, while protecting individual autonomy and freedoms, through a coordinated and holistic approach.[159]

73. The COVID-19 pandemic has struck a planet that was already torn by many crises. As the world strives to recover from the combined effects of multiple crises and many States face the prospect of austerity measures – another foreseeable crisis that will disproportionately affect women and girls in relation to their sexual and reproductive health[160] – the question of how to ensure that the sexual and reproductive health rights of women and girls are fully recognized and guaranteed must be at the fore. The management and recovery phases of a crisis provide a unique opportunity for reform, innovative thinking and transformation. The status quo, with millions of women and girls around the world highly exposed to gendered risks to their sexual and reproductive health, is unacceptable. The risks and harms that women and girls face in relation to their sexual and reproductive health must not be treated as unavoidable tragedies or collateral damage, but recognized as the outcomes of policy failures and as indicative of serious human rights violations.

74. Unless women and girls are able to fully enjoy their sexual and reproductive health rights, they will not be able to make progress in other fields. The sexual and reproductive health rights of women and girls can and must be realized through coherent laws and policies that affirm those rights and stronger accountability and immediate implementation of existing human rights obligations and political commitments, which unfortunately continue to be ignored with impunity.

B. Recommendations

75. **There are five interrelated sets of actions which can ensure progress towards securing the sexual and reproductive health rights of women and girls at all times, especially in situations of crisis.**

[158] See https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=23724.

[159] See A/HRC/23/50; A/HRC/26/39; A/HRC/29/40; and A/HRC/32/44.

[160] See A/HRC/26/39.

1. Prioritize sexual and reproductive health rights

76. **The Working Group recommends that States:**

(a) **Recognize the sexual and reproductive health rights of women and girls as essential and fully integrate them into crisis prevention, response, assessment, management, recovery, rehabilitation and reconstruction plans;**

(b) **Adhere to the WHO Model List of Essential Medicines, at a minimum, and ensure timely access to life-saving medicines and interventions;**

(c) **Address the unmet need for reliable sexual and reproductive health information, goods and services in situations of crisis, including through temporary special measures, and tackle misinformation to ensure informed and autonomous decision-making;**

(d) **Ensure the safety and decent working conditions of health-care workers in local communities, including midwives, at all times and especially in situations of crisis, while promoting midwifery and other forms of community-based care and support;**

(e) **Expand the availability of sexual and reproductive health services, including through telemedicine and mobile clinics, to reach diverse populations, including women and girls with disabilities, those living in rural areas and adolescent girls;**

(f) **Invest in and build the resilience of physical infrastructure, including water and sanitation, public transportation and telecommunications, and health systems, to ensure the continued availability of sexual and reproductive health services for all women and girls, taking a gender-responsive approach;**

(g) **Leverage existing institutional arrangements, networks and facilities to ensure the distribution of sexual and reproductive health commodities and information in local communities, including through transportation services, the postal services and libraries;**

(h) **Increase public funding for community-based organizations focusing on the sexual and reproductive health rights of women and girls and on meeting the increased demand for services;**

(i) **Meet the threshold of 0.7 per cent gross national income for official development assistance and cooperation, without harmful restrictions on sexual and reproductive health rights, and make the provision of comprehensive sexual and reproductive health goods and services a core component of humanitarian aid programmes.**

2. Eliminate discriminatory laws, policies and practices

77. **The Working Group recommends that States:**

(a) **Ensure access to a full range of contraceptive information and services for women and girls, including emergency contraceptives, and increase their availability in situations of crisis;**

(b) **Decriminalize abortion, expand access to safe abortion services, including medical abortion and post abortion care, and remove legal barriers to abortion in situations of crisis;**

(c) **Ensure timely access to maternal health services and emergency obstetric care, including treatment for pregnancy-related morbidities, without surveillance and reporting requirements that violate individual privacy, and establish safeguards to prevent and redress obstetric violence;**

(d) **Conduct a national audit to assess the sexual and reproductive health needs of women and girls, including neglected issues linked to violence and period poverty, and develop a coherent and gender-responsive legal and policy framework,**

accompanied by gender budgeting and financial investment, to ensure access to and the affordability of sexual and reproductive health services;

(e) **Make women's and girls' agency, autonomy, privacy and informed consent central to all sexual and reproductive health laws and policies and ensure access to accurate information thereon, remove requirements that result in delays or denials of sexual and reproductive health care and undermine women's and girls' autonomy, such as third-party consent requirements and approvals by medical boards, and regulate refusals of care based on conscience or religion;**

(f) **Address the overmedicalization and paternalistic approach to sexual and reproductive health services for women and girls in policy and practice and reorient them around norms and procedures aimed at safeguarding their bodily integrity, autonomy and agency;**

(g) **Ensure access to respectful and non-coercive sexual and reproductive health services for all women and girls and take additional steps to build trust with communities that have been historically subjected to discrimination, coercion and/or violence;**

(h) **Adopt an intercultural and participatory approach to sexual and reproductive health to ensure that indigenous and ethnic and other minority women and girls are actively involved in shaping and implementing the sexual and reproductive health programmes offered to them, including through their own institutions and communities;**

(i) **Develop policies and commit additional resources to address the multiple and intersecting forms of discrimination that contribute to reproductive health disparities and the specific risks faced by adolescent girls, women and girls with disabilities and migrant, refugee and displaced women and girls, among others;**

(j) **Eliminate discriminatory stereotypes of women and girls and the stigma and taboos associated with sexual and reproductive health in law, policy and practice.**

3. Institutionalize and strengthen monitoring and accountability for sexual and reproductive health rights

78. **The Working Group recommends that States:**

(a) **Adopt and enforce clear and coherent legal and policy frameworks to guide the provision of services, in accordance with human rights obligations, and simultaneously address social norms and discriminatory stereotypes that obstruct implementation, including by establishing clear channels for reparations and accountability;**

(b) **Compile data, disaggregated by sex, gender, race, ethnicity and other factors, to determine the sexual and reproductive health rights status and needs of the diverse populations of women, throughout their life cycles, for the purpose of developing, monitoring and strengthening the implementation of sexual and reproductive health laws and policies, while protecting personal data and preventing misuse;**

(c) **Legally recognize and implement a broad set of reparations for violations of sexual and reproductive health rights, including through structural measures, such as guarantees of non-repetition;**

(d) **Take effective measures to end violence and harassment against human rights defenders advocating for sexual and reproductive health rights and ensure accountability for perpetrators of such acts;**

(e) **Fully implement the recommendations of the international human rights mechanisms and the legal decisions of regional and national bodies and courts that recognize the sexual and reproductive health rights of women and girls;**

(f) **Take steps to ensure that health service providers undertake their professional duties in accordance with human rights and comply with their ethical obligations.**

4. Ensure the participation of women and girls and promote male accountability

79. **The Working Group recommends that States:**

(a) **Increase the representation and effective participation of women and girls in decision-making processes at all levels and ensure gender parity, including in crisis prevention, management and recovery processes;**

(b) **Systematically engage diverse women's rights organizations and feminist organizations in the development, implementation, monitoring, evaluation and continual improvement of law, policy and practice relating to sexual and reproductive health and in the identification and removal of barriers;**

(c) **Build participatory processes that are empowering, inclusive, accessible and non-discriminatory, with special attention given to women and girls who have been disproportionately affected by crisis, including in disenfranchised and marginalized populations, such as migrants, refugees and internally displaced persons;**

(d) **Integrate gender, age, disability and intercultural perspectives into all policies and practices and promote leadership by women and young people;**

(e) **Promote male engagement and accountability to address pervasive sexism, misogyny, violence and toxic masculinity and to promote the sexual and reproductive health rights of women and girls.**

5. Push back against conservative and anti-human rights ideologies and misinformation

80. **The Working Group recommends that States:**

(a) **Actively push back against conservative religious and racialized political ideologies that undermine gender equality;**

(b) **Oppose misinformation and religious positions that subvert the sexual and reproductive health rights of women and girls;**

(c) **Ensure that international aid and assistance, including humanitarian assistance, is provided and operationalized in accordance with human rights standards and prioritizes respect for the human rights of women and girls, without harmful restrictions;**

(d) **Support the United Nations system in countering religious ideologies opposing the sexual and reproductive health rights of women and girls and ensure that all United Nations processes are coordinated and conducted with full respect for those rights;**

(e) **Refrain from using political and financial influence with States and non-State actors to undermine and retrogress the rights of women and girls by leading or supporting ideological agendas that are antithetical to human rights norms.**