BREAKING GROUND 2016

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 maternal health care, abortion, and contraception. It is intended to provide treaty body experts and human rights advocates with succinct, 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 second edition of this publication.

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↑ indicates new TMB jurisprudence from 2016

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 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 reproduction.

This booklet summarizes and provides an annual update of jurisprudence from United Nations treaty monitoring bodies on reproductive rights, particularly the standards on maternal health care, abortion, and contraception. It is intended to provide treaty body experts and human rights advocates with succinct, accessible information on the standards being adopted across treaty monitoring bodies surrounding these important 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 gender discrimination, gender stereotypes, and traditional 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 and girls 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 gender stereotypes and traditional gender roles, and analyze the role that gender plays within them. Substantive equality then requires that states change institutions in order to address the inequalities experienced by women, rather than requiring women to change to conform to a male norm;[3]

Recognize Difference: States should recognize that women and men experience different kinds of rights violations due to discriminatory social norms, including in the context of health, and that equal treatment may not be sufficient to overcome inequalities, particularly when equal treatment disadvantages women.[4] Women also may face discrimination based on multiple grounds, including race, disability, age, or other marginalized statuses;[5]

Ensure Equality of Results: States should focus on ensuring equal outcomes for women, including different groups of women, which may require that states take positive measures

and mandate potentially different treatment of men and women, 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), 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 about women in family and society, 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, which impact 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 lowering rates of maternal mortality, fulfilling unmet need for contraceptives, 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] This framework has been adopted by other treaty monitoring bodies[13] and the CEDAW Committee's General Recommendation No. 24 explicitly applies these principles to women's health, particularly their 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.[14]

Accessibility:[15]

- *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.[16]
- *Economic accessibility (Affordability)*: States must ensure that health services and goods are affordable for everyone[17] and should provide free or low-cost reproductive health goods and services for women who cannot afford them.[18]

- *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.[19] States may not censor, withhold or intentionally misrepresent sexual and reproductive health information[20] and should ensure everyone access to comprehensive, unbiased, scientifically accurate sexuality education.[21] The CEDAW Committee has expressed concern about sexuality education that only focuses on health and prevention of pregnancy and diseases, calling for sexuality education to integrate a strong gender perspective and address socialized gender roles and stereotypes, patriarchal attitudes, and unequal power dynamics (UN Docs. CEDAW/C/PRT/CO/8-9, para. 33; CEDAW/C/TLS/CO/2-3, para. 27(d)).

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.[22] Further, they must be delivered in a way that respects women's dignity and is sensitive to their needs and perspectives.[23]

Quality: Health services must be scientifically and medically appropriate, which requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.[24]

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;[25]
- Providing essential medicines in accordance with the WHO Model List of Essential Medicines, which includes short- and long-term contraceptives, including emergency contraception, and drugs for maternal health care and management of incomplete abortion and miscarriage;[26]
- Taking actions to the maximum available resources "to ensure that women realize their rights to health care," including by ensuring that states tackle health issues that have a particular impact on women and girls by ensuring their access to reproductive health services;[27]
- Regulating and monitoring both private and public health facilities to ensure that women and girls receive reproductive health services in compliance with human rights.[28]

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.[29] "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.[30] 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.[31] These determinants impact the choices and meaningful agency that individuals can exercise with respect to their sexual and reproductive health, and as such, states must address these factors 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.[32]

III. AUTONOMY AND REPRODUCTIVE RIGHTS

Ensuring women's right to non-discrimination and substantive equality requires that women are able to exercise autonomy and 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.[33] 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 Convention on the Elimination of Discrimination against Women (CEDAW) as an essential part of ensuring women's equality within the family.[34] 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," and that reproductive rights include "the right of women to autonomous decision-making about their health."[35]
- **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 is an important part of ensuring protection for women's reproductive choices.[36]

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), Committee on the Rights of Persons with Disabilities (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.[37] 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" (UN Doc. CEDAW/C/GC/33, para. 25(c)).
- **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. They must also implement a timely, systematic mechanism for referrals to an alternative health care provider and ensure that conscientious objection is a personal, not institutional, practice.[38]

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.[39]

- **Harmful traditional practices**, which treaty monitoring bodies have recognized violate a number of human rights and have implications for reproductive autonomy. The CRC and CEDAW Committees have noted that child, early, and forced marriages can increase levels of violence and limit girls' opportunities for decision-making, including in the economic and social spheres and particularly when it comes to sexuality and reproduction.[40] This practice triggers a continuum of human rights violations throughout the girl's life."

Restrictions on Access to Information

Finally, access to accurate and timely information, including sexuality education, is essential to exercising autonomy and making informed choices to undergo medical procedures. As noted above, 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.[41] 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.[42]

THE RIGHT TO MATERNAL HEALTH CARE

Treaty monitoring bodies have developed strong human rights standards on women and girls' 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 women's rights 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.[43] Furthermore, treaty monitoring bodies have found that social and other determinants of health must be addressed in order to enable women and girls to seek and access the maternal health services they need.[44] Finally, women and girls 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[45] and to guarantee all women available, accessible, acceptable, and good quality maternal health services.[46]

Availability and Quality: Treaty monitoring bodies have called on states to ensure all women and girls adequate pre- and post-natal care, emergency obstetric services, and skilled birth attendants.[47] 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.[48]

Accessibility: Maternal health care facilities should be accessible to all women and girls 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.[49]
- **Information Accessibility:** States should further ensure that women and girls, their families, and their communities have adequate information about the signs of potentially dangerous obstetric complications and information about the availability of sexual and reproductive health services.[50]
- **Affordability:** Maternal health services must be affordable, with states granting free services where needed,[51] and taking into account the costs of transportation in accessing maternal health care.[52]

Acceptability: States must ensure that maternal health services are delivered in a way that respects the dignity of women and girls, is sensitive to the needs and perspectives of women,[53] and recognizes that negative attitudes of health workers can deter women from seeking health services.[54]

Maternal Mortality

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.[55]

- 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.[56]
- 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,[57] guaranteeing women access to safe abortion services,[58] and providing women access to post-abortion care.[59]
- Treaty monitoring bodies have also recommended that states ensure that there are **no third-party authorization requirements** for accessing maternal health services, such as caesarean sections.[60]

Equality and Non-Discrimination

The CEDAW Committee recognizes 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 particular health needs.[61] Treaty monitoring bodies 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.[62]

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 and girls, including adolescents, poor women, minority women, rural women, and women with disabilities.[63]

Adolescents: The CRC and CEDAW Committees have made the connection between adolescent pregnancy and high rates of maternal mortality[64]—particularly when girls are subjected to child, early, and forced marriages[65]--noting that complications from pregnancy are the leading cause of death for adolescent girls aged 15-19 in developing countries.[66] The CRC Committee has specifically recommended that health systems meet the sexual and reproductive health needs of adolescents and "ensure that girls can make autonomous and informed decisions on their reproductive health" as a means of preventing maternal mortality.[67] The CEDAW and CRC Committees have also condemned the expulsion of pregnant adolescents from schools and urged states to ensure that pregnant students are able to continue their education.[68]

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.[69]

- 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 had died following pregnancy and post-natal complications, on the basis of her gender, race, and socioeconomic status when she was denied needed maternal health services.[70] 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, among other recommendations.[71]

Rural Women: The CEDAW and ESCR Committees have recognized that maternal health services—including skilled birth attendants, including skilled birth attendants and postnatal and maternal care—are often geographically inaccessible to women in rural areas.[72] 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.[73]

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 inability to pay their maternal health bills[74] and when incarcerated women are shackled to beds during labor and delivery.[75] 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 (UN Doc. CEDAW/C/PRT/CO/8-9, paras. 36-37).

II. RECOMMENDATIONS

In order to ensure women's and girls' right to maternal health care, states must address the root causes of maternal mortality and morbidity including gender and other forms of inequality, and 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 programmes to reduce preventable maternal morbidity and mortality into their concluding observations to states.[76] In particular, treaty monitoring bodies can recommend that states:

- Make broad investments in a strong national health care system that ensure quality and affordable maternal health services and other services that are essential to maternal health, including access to clean water and nutritious food; put greater emphasis on the quality of services, including skilled band respectful personnel and high-quality drugs and equipment; and also monitor private health facilities to ensure quality and human rights-based maternal care.[77]
- Recommend that states 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.
- Take targeted measures to address the higher levels of maternal mortality and morbidity faced by marginalized groups of women. These measures include involving marginalized groups in the design and implementation of maternal health policies, training health care workers on cultural sensitivity and the particular health needs of marginalized groups, ensuring hospitals and clinics have non-discrimination policies and are affordable and accessible in rural areas, ensuring methods of accountability for violations of rights, and collecting disaggregated information on maternal health outcomes.[78]

THE RIGHT TO CONTRACEPTIVE INFORMATION AND SERVICES

Treaty monitoring bodies have consistently found that women and girls have the right to access contraceptive information and services as a means of preventing pregnancy and sexually transmitted infections. 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 contraceptive information and services 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 Contraceptive Information and Services under the Right to Health

Treaty monitoring bodies have found that contraceptive information and services must be accessible, acceptable, available, and of good quality.[79] In particular, they have noted that:

- Women and girls should have **access to information** about contraceptives, including through comprehensive sexuality education and awareness programs about the importance of contraceptives.[80] States must also ensure access to information as a means of ensuring informed consent for contraceptive services, particularly sterilization;[81]
- Contraceptives 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;[82]
- States must ensure that **a comprehensive range of good quality, modern, efficient contraceptives are available**, including emergency contraception,[83] as part of their core obligation under the right to health to ensure access to essential medicines from the World Health Organization's Model List of Essential Medicines;[84]

Access to Contraceptive Information and Services for Marginalized Groups

Treaty monitoring bodies have found that states should take particular efforts to ensure that women and girls from marginalized groups have access to 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 particular 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 should have "unimpeded access" to contraceptive information and services,[89] including as a mandatory part of school curricula[90] and through adolescent-friendly and confidential counselling.[91]

Rural Women

- Treaty monitoring bodies acknowledge that rural women

and girls have a disproportionate unmet need for contraceptives,[92] because of particular difficulties that hinder access in rural areas, including lack of health facilities and transportation.[93] States need to make special efforts to ensure access in rural and remote areas to all contraceptive services, including emergency contraception.[94]

Emergency Contraception

Treaty monitoring bodies have made particular recommendations about 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.[95]

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, [96] should be free for victims of violence including adolescents,[97] and special measures should be taken to ensure that it is available to women and girls in conflict and post-conflict zones;[98]
- **Ill-Treatment:** Emergency contraception must be legal and accessible for women and girls who are victims of rape or sexual abuse, in order to prevent physical and mental suffering that may amount to ill-treatment. [99]

Contraception, Equality, and Autonomy

The CEDAW and ESCR Committees have made the connection between denial of access to contraception and violations of a number of women's rights related to gender equality, 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 contraception.[100] The CEDAW and ESCR Committees have then called on states to conduct public awareness campaigns to tackle these gender inequalities as a means of improving access to contraceptives for women.[101]

Treaty monitoring bodies, including the CEDAW, ESCR, CRC and Human Rights Committees, have also called on states to ensure particular contraception-related health outcomes for women and girls, as 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.[102]

Women and girls face many barriers to exercising their reproductive autonomy in accessing contraception, in violation of their rights to health, equality, privacy, decide on the number and spacing of their children, and freedom from ill-treatment.

- ➔ For instance, treaty monitoring bodies have found that there should be **no third-party authorization requirements** for accessing contraception, including spousal or parental consent requirements.[103]
- ➔ Additionally, treaty monitoring bodies have recognized that securing **informed consent** for contraceptives, particularly sterilization, is an essential part of women's human rights. The CEDAW Committee has noted that consent for sterilization must come from the women herself and not a third party.[104]

Substantive Equality, Autonomy, and Sterilization

Autonomy and equality are key issues for protecting women's reproductive rights, particularly in regards to sterilization. Many women and girls from marginalized groups are subjected to forced or coerced sterilization, which the CAT Committee has consistently found violates their right to be free from torture or ill-treatment.[105] The CEDAW Committee 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." (UN Doc. CEDAW/C/SVK/CO/5-6, para. 33(d); see also CEDAW Committee, General recommendation on access to justice, para. 19(d)).

- **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,[106] noting that women with disabilities are subjected to high rates of forced sterilization because they are denied control over reproductive decision-making.[107]

  The CEDAW Committee has found that women with disabilities should be given necessary support for making decisions about reproductive health, including sterilization,108 and has called on states to ensure the training of health workers to protect their rights.[109]

The CRC has condemned the forced sterilization of children with disabilities and called on states to respect girls with disabilities' sexual and reproductive rights (UN Docs. CRC/C/CHL/CO/4-5, para. 56; CRC/C/BRA/CO/2-4, paras. 51-52).

- **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 a violation of the CEDAW Convention.[110]
- **Roma Women:** Because of a long history of forced and coerced sterilization of Roma women in countries in Europe, several treaty monitoring bodies have called on states to make particular efforts to ensure their informed consent before sterilization and to provide adequate training to health workers on issues related to Roma rights.[111]

II. RECOMMENDATIONS

Treaty monitoring bodies have embraced the right to contraceptive information and services 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 of health related to access to contraceptive information and services, 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 contraceptive information and services often results from gender stereotypes, patriarchal attitudes, and taboos surrounding sexual activity for women and girls, and that access to contraceptive information and services is essential to ensuring gender equality for women, because of their unique ability to become pregnant and the impact 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 rights to privacy, equality, and to decide on the number and spacing of their children.

THE RIGHT TO SAFE 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.[112] For instance, they have repeatedly recognized the connection between restrictive abortion laws, high rates of unsafe abortion and maternal mortality.[113] The CEDAW Committee has in particular noted that it is a form of gender discrimination for a state party to "refuse to provide legally for the performance of certain reproductive health services for women" or to punish women who seek those services.[114] It has also found that pregnant women must have access to services to protect their physical and mental health, including therapeutic abortion.[115]

As part of these recommendations, treaty monitoring bodies have specifically found that:

States must ensure certain legal grounds for abortion: 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 anomalies.[116]

- Additionally, treaty monitoring bodies have urged states to interpret exceptions to restrictive abortion laws broadly to consider, for example, mental health conditions as a threat to women's health.[117]
- They have called on states to eliminate punitive measures for women and girls 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.[118]

States should consider decriminalizing abortion altogether and ensure all women and girls access to safe abortion care: The CRC Committee has noted that states should ensure adolescents have access to safe abortion services, regardless of the legal status of abortion.[199] Further, the CRC has repeatedly called on states to decriminalize abortion **in all circumstances** (UN Docs. CRC/C/ARE/CO/2, para. 58(d); CRC/C/BRA/CO/2-4, para. 60; CRC/C/CHL/CO/4-5, para. 61 (emphasis added)). In its general recommendation on women in conflict, the CEDAW Committee advises states to "ensure that sexual and reproductive health care includes access to… safe abortion services,"[120] without qualification concerning the legality of abortion.

Access to Safe and Legal Abortion Information and Services

Treaty monitoring bodies have noted that legal abortion services must be available, accessible (including affordable),

acceptable, and of good quality,[121] and have urged states to liberalize their abortion laws to increase access.[122]

Non-Discrimination and Gender Equality: The CEDAW Committee has found that denial of access to abortion may be based on gender stereotypes about the traditional roles of women as mothers and caregivers, which constitute gender discrimination and undermine gender equality.[123] It has also expressed concern about situations where abortion is legal but stigmatized, which may lead women to resort to unsafe and clandestine abortions;[124]

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.[126] The CEDAW Committee has explicitly described fees for abortion as being burdensome to women's informed choice and autonomy (UN Doc. CEDAW/C/PRT/CO/8-9, para. 37). The CAT Committee has called on states to ensure free access to abortion in cases of rape.[127]

Information Accessibility: Treaty monitoring bodies have consistently emphasized that access to information is a critical element of accessing abortion services.[128] They have found that states should not place criminal sanctions on providers who provide information about abortion.[129] Further, the CEDAW Committee has called on states to eliminate informational barriers to abortion services, such as mandatory biased counselling requirements,[130] 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 (UN Doc. CEDAW/C/SVK/CO/5-6, para. 31(e)).

Denial of Access to Abortion as Ill-Treatment

The CAT and Human Rights Committees have found that, in certain circumstances, denial of access to abortion services can lead to physical or mental suffering that amounts to ill-treatment.[135]

- 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.[136]
- 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.[137]

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,[130] and ensures timely remedy and redress for women who are denied access to legal abortion services.[131] It also requires that states provide post-abortion care to women, regardless of whether abortion is legal.[132]

Quality: Several treaty monitoring bodies have called on states to ensure access to quality abortion services in line with the World Health Organization's *Safe Abortion: Technical and policy guidance for health systems*,[133] 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.[134]

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.

Third-party authorization requirements: Treaty monitoring bodies have consistently found that requirements that women and girls obtain authorization for abortion 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.[138]
- The CRC Committee has also recommended that states consider allowing access to safe abortion for adolescents without the need for **parental consent**[139] and that the views of pregnant teenagers regarding abortion should be heard and respected.[140]
- 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.[141]
- The CEDAW Committee has expressed concern about **multiple medical authorizations** for abortion services, such as permission from a panel of doctors (UN Doc. CEDAW/C/TLS/CO/2-3, para. 31(a)).

Waiting Periods: The CEDAW Committee has recommended that states eliminate medically-unnecessary waiting periods for abortion.[142]

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,[144] and that a failure to do so may violate the right to be free from torture or ill-treatment.[145] Moreover, states should only permit individuals, and not institutions, to invoke conscientious objection.[146]

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.[146]

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 could 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;
- ➔ Avoid 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, 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.

Endnotes

1 Throughout, 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, *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, *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 Committee on the Elimination of Discrimination Against Women (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*, (30th Sess., 2004), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 7, 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*, (47th Sess., 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. 3*].

4 Committee on the Rights of the Child (CRC Committee), *General Comment No. 15: On the right of the child to the enjoyment of the highest attainable standard of health,* (62nd Sess., 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. 3, 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*]; K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, para. 6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).

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); *Jordan*, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010); *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.

8 Human Rights Committee, *Concluding Observations: Kyrgyzstan*, para. 401, U.N.

Doc. A/55/40 (2000); CEDAW Committee, *Gen. Recommendation No. 25, supra* note 3, para. 81; CRC Committee, *Gen. Comment No. 15*, *supra* note 4, para. 10.

9 *See* CEDAW Committee, *Concluding Observations: Congo*, para. 35(f), U.N. Doc. CEDAW/C/COG/CO/6 (2012); *Uruguay,* para. 203, U.N. Doc. A/57/38 (2002); 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), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 29, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee*, Gen. Comment No. 16*].

10 CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health),* (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [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), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee*, Gen. Comment No. 14*].

13 *See, e.g.*, CRC Committee, *Gen. Comment No. 15*, *supra* note 4.

14 ESCR Committee*, Gen. Comment No. 14*, *supra* note 12, para. 36.

15 States must ensure that sexual and reproductive health information and services are accessible, including by ensuring non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility. *Id*. para. 12(b).

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

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

18 *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, 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(b), U.N. Doc. CRC/C/15/Add.172 (2002); Human Rights Committee, *Concluding Observations; Madagascar,* para. 17(a), U.N. Doc. CCPR/C/MDA/CO/2 (2009).

19 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 28; ESCR Committee*, Gen. Comment No. 14*, *supra* note 12, para. 12(b).

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

21 *See, e.g.*, CEDAW Committee, *Concluding Observations: Eritrea*, para. 23, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); CRC Committee, *Concluding Observations: Antigua and Barbuda*, para. 54, U.N. Doc. CRC/C/15/Add.247 (2004); ESCR Committee, *Concluding Observations: Benin*, para. 42, U.N. Doc. E/C/12/1/Add.78 (2002); Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*, para. 65(l) U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover); *see also* Special Rapporteur on the right to education, *Rep. of the Special Rapporteur on the right to education by Note of the Secretary-General,* U.N. Doc. A/65/162 (July 23, 2010) (Vernor Muñoz).

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

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

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

25 *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.

26 ESCR Committee*, Gen. Comment No. 14*, *supra* note 12, paras. 12(a), 43 (d) & 44 (a); CRC Committee, *Gen. Comment No. 15*, *supra* note 4, para. 37.

27 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 17.

28 *See, e.g.*, Alyne da Silva Pimentel Teixeira v Brazil, CEDAW Committee, Commc'n No. 17/2008, para. 8(1)(d), U.N. Doc. CEDAW/C/49/D/17/2008 (2011).

29 See, e.g., CEDAW Committee & CRC Committee, *Joint General Recommendation No. 31 & General Comment No. 18: On harmful practices,* (2014), 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) (calling on states to address the social determinants of health generally).

30 WHO, What are social determinants of health? (2013), *available at* http://www.who.int/social_determinants/sdh_definition/en/ [hereinafter WHO, What are social determinants of health?].

31 *See, e.g.*, ESCR Committee, *Concluding Observations: Australia*, para. 28, U.N. Doc. E/C.12/AUS/CO/4 (2009); WHO, What are social determinants of health?, *supra* note 30.

32 WHO, What are social determinants of health?, *supra* note 30.

33 ICCPR, *supra* note 2, art. 17; CEDAW, *supra* note 2, art. 26; CRPD, *supra* note 2, art. 12.

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

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

36 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).

37 *See, e.g.*, CEDAW Committee, *Concluding Observations: Indonesia,* para. 17, U.N. Doc. CEDAW/C/IDN/CO/5 (2007); *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); Committee on the Rights of Persons with Disabilities (CRPD Committee), *General Comment No. 1: Article 12: Equal recognition before the law,* (11th Sess., 2014), U.N. Doc. CRPD/C/GC/1 (2014) [hereinafter CRPD Committee*, Gen. Comment No. 1*]; CRC Committee, *Gen. Comment No. 15*, *supra* note 4; Committee Against Torture (CAT Committee), *Concluding Observations: Bolivia*, para. 23, U.N. Doc. CAT/C/BOL/CO/2 (2013).

38 *See* ESCR Committee, *Concluding Observations: Poland,* para. 28, U.N. Doc. E/C.12/POL/CO/5 (2009); CEDAW Committee, *Concluding Observations: Poland,* para. 25, U.N. Doc. CEDAW/C/POL/CO/6 (2007); *Slovakia,* para. 29, U.N. Doc. CEDAW/C/SVK/CO/4 (2008).

39 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 22; CRPD Committee*, Gen. Comment No. 1, supra* note 37.

40 CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra* note 29, paras. 21 & 67.

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

42 CEDAW Committee, *Concluding Observations: Hungary,* para. 30, U. N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *See also Mandatory Delays and Biased Counseling for Women Seeking Abortions*, Center for Reproductive Rights (Sept. 30, 2010), http://reproductiverights.org/en/project/mandatory-delays-and-biased-counseling-for-women-seeking-abortions (last visited Dec. 15, 2014).

43 CEDAW, *supra* note 2, art. 12(2); CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 26.

44 *See, e.g.,* CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra* note 29, para. 21.

45 *See, e.g.,* CEDAW Committee, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38/Rev.1 (1999) ("[T]he Committee notes that the level of maternal mortality due to clandestine abortions may indicate that the Government does not fully implement its obligations to respect the right to life of its women citizens."); Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003) ("So as to guarantee the right to life, the State should strengthen its efforts . . . in ensuring the accessibility of health services, including emergency obstetric care."); CRC Committee, *Concluding Observations: Democratic Republic of Congo*, paras. 33-34, U.N. Doc. CRC/C/COD/CO/2 (2009).

46 ESCR Committee, *Gen. Comment No. 14*, *supra* note 12, para. 12; CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, paras. 26-27.

47 ESCR Committee, *Gen. Comment No. 14*, *supra* note 12, para. 12(b); ESCR Committee, *Concluding Observations: United Republic of Tanzania,* para. 24, U.N. Doc. E/C.12/TZA/CO/1-3 (2012). *See, e.g.*, Human Rights Committee, *Concluding Observations: Mali,* para. 14, U.N. Doc. CCPR/CO/77/MLI (2003). *See, e.g.*, CEDAW Committee, *Concluding Observations: Guinea-Bissau,* para. 38, U.N. Doc. CEDAW/C/GNB/CO/6 (2009).

48 ESCR Committee, *Concluding Observations: Brazil,* para. 28(d), U.N. Doc. E/C.12/BRA/CO/2 (2009); CRC Committee, *Concluding Observations: Marshall Islands,* para. 2(g), U.N. Doc. CRC/C/MHL/CO/2 (2007); *The Republic of the Congo*, para. 59(f), U.N. Doc. CRC/C/COG/CO/1 (2006); *Turkmenistan,* para. 52(g), 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).

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

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

51 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 27. *See, e.g.*, CEDAW Committee, *Concluding Observations: Lao People's Democratic Republic,* para. 38, U.N. Doc. CEDAW/C/LAO/CO/7 (2009).

52 Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover – Addendum – Mission to Ghana,* U.N. Doc. A/HRC/20/15/Add.1 (Apr. 10, 2012).

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

54 CEDAW Committee, *Concluding Observations: Kenya*, para. 37-38, U.N. Doc. CEDAW/C/KEN/CO/6 (2007).

55 *See, e.g.,* CEDAW Committee, *Concluding Observations: Malawi*, para. 31, U.N. Doc. CEDAW/C/MWI/CO (2006); *Mexico*, para. 32, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); *Morocco*, paras. 30-31, U.N. Doc. CEDAW/C/MAR/CO/4 (2008); *Paraguay*, paras. 30-31, U.N. Doc. CEDAW/C/PRY/CO/6 (2011); *Mozambique*, para. 36, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007); *Indonesia*, paras. 36-37, U.N. Doc. CEDAW/C/IDN/CO/5(2007); *Eritrea*, para. 22, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); *Ghana,* paras. 31-32, U.N. Doc. CEDAW/C/GHA/CO/5 (2006); ESCR Committee, *Concluding Observations: El Salvador,* para. 22, U.N. Doc. E/C.12/SLV/CO/3-5 (2014); Human Rights Committee, *Concluding Observations: Panama*, para. 9, U.N. Doc. CCPR/C/PAN/CO/3 (2008); *Chile*, para. 8, U.N. Doc. CCPR/C/CHL/CO/5 (2007); *Madagascar*, para. 14, U.N. Doc. CCPR/C/MDG/CO/3 (2007); CRC Committee, *Concluding Observations: Haiti*, para. 46, U.N. Doc. CRC/C/15/Add.202 (2003); *Guatemala*, para. 40, U.N. Doc. CRC/C/15/Add.154 (2001); CAT Committee, *Concluding Observations: Yemen*, para. 31, U.N. Doc. CAT/C/YEM/CO/2/Rev. 1 (2010).

56 *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).

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

58 *See e.g.* CRC Committee, *Concluding Observations: Argentina*, para. 59(d), U.N. Doc. CRC/C/ARG/C003-4 (2010).

59 *See e.g.,* ESCR Committee, *Concluding Observations: El Salvador,* para. 22, U.N. Doc. E/C.12/SLV/CO/3-5 (2014).

60 CEDAW Committee, *Concluding Observations: Bahrain*, para. 41, U.N. Doc. CEDAW/C/BHR/CO/3 (2014).

61 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); CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, paras. 17 & 26.

62 CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 27.

63 *See, e.g.*, CEDAW Committee, *Concluding Observations: Lesotho,* paras. 32-33, U.N. Doc. CEDAW/C/LSO/CO/1-4 (2011).

64 *See, e.g.,* Human Rights Committee, *Concluding Observations: Sierra Leone*, para. 14, U.N. Doc CCPR/C/SLE/CO/1 (2014).

65 CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra* note 29, para. 21.

66 *Id.*

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

68 CEDAW Committee & CRC Committee, Joint Gen. Recommendation No. 31 & Gen. Comment No. 18, supra note 29, para. 63 & 69(a); CEDAW Committee, *Concluding Observations: Madagascar,* para. 29(c), U.N. Doc. CEDAW/C/MDG/CO/6-7 (2015); CRC Committee, *Concluding Observations: Tanzania*, para 56(c), U.N. Doc. CRC/C/TZA/CO/2 (2006).

69 *See, e.g.*, Committee on the Elimination of Racial Discrimination, *Concluding Observations: United States of America*, para. 15, U.N. Doc. CERD/C/USA/CO/7-9 (2014).

70 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).

71 *Id.* paras. 7.6 & 8.

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

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

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

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

76 Office of the United Nations High Commissioner for Human Rights, *Technical guidance on the application of human rights-based approach to implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, U.N. Doc. A/HRC/21/22 (July 2, 2012).

77 *Id.*, paras. 14, 20(d), 27 & 74.

78 *Id.*, para. 16.

79 ESCR Committee, *Concluding Observations: Armenia*, para. 22, U.N. Doc. E/C.12/ARM/CO/2-3 (2014).

80 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); *Peru,* para. 14 U.N. Doc CCPR/C/PER/CO/5 (2013); CRC Committee, *Gen. Comment No. 15*, *supra* note 4, para. 69.

81 A.S. v. Hungary, CEDAW Committee, Commc'n No. 4/2004, para. 11.2, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).

82 CEDAW Committee, *Concluding Observations: Angola*, para. 32(e), U.N. Doc

CEDAW/C/AGO/CO/6 (2013); *India*, para. 30-31, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Hungary*, para. 31(b), U.N. Doc CEDAW/C/HUN/CO/7-8 (2013); *Poland*, paras. 36-37, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014); *China*, para. 39(d), U.N. Doc. CEDAW/C/CHN/CO/7-8 (2014); ESCR Committee, *Concluding Observations: Djibouti*, para. 5, 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(b), U.N. Doc. CRC/C/15/Add.172 (2002); Human Rights Committee, *Concluding Observations; Madagascar,* para. 17(a), U.N. Doc. CCPR/C/MDA/CO/2 (2009).

83 CEDAW Committee, *Concluding Observations: Cyprus*, para. 30(b), CEDAW/C/CYP/CO/6-7 (2013); *Hungary*, para. 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *India,* paras. 30-31, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Sierra Leone*, paras. 32-33, U.N. Doc. CEDAW/C/SLE/CO/6 (2014); ESCR Committee, *Concluding Observations:* Rwanda, para. 26, U.N. Doc. E/C.12/RWA/CO/2-4 (2013).

84 ESCR Committee, *Gen. Comment No. 14*, *supra* note 12, para. 12(a).

85 CRC Committee, *Gen. Comment No. 15*, *supra* note 4, para. 30.

86 *See, e.g.*, CRC Committee, *Concluding Observations: Guinea*, paras. 67-68, U.N. Doc CRC/C/GIN/CO/2 (2013); CEDAW Committee, GR24, para. 23.

87 CRC Committee, *Concluding Observations: Holy See*, para. 57, U.N. Doc. CRC/C/VAT/CO/2 (2014).

88 CRC Committee, *Concluding Observations: Indonesia*, para. 49, U.N. Doc. CRC/C/IND/CO/3-4 (2014).

89 CEDAW Committee, *Concluding Observations: Poland*, para. 37, U.N. Doc. CEDAW/C/POL/CO/7-8 (2014).

90 CRC Committee, *Concluding Observations: Uzbekistan*, para. 56(a), 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,* para. 55, U.N. Doc CRC/C/NIU/CO/1 (2013); *India*, paras. 65-66, U.N. Doc. CRC/C/IND/CO/3-4 (2014).

92 CEDAW Committee, *Concluding Observations: Ghana*, para. 38, U.N. Doc. CEDAW/C/GHA/CO/6-7 (2014).

93 ESCR Committee, *Concluding Observations: Rwanda,* para. 26, U.N. Doc. ESCR/C.12/RWA/CO/2-4 (2013); CEDAW Committee, *Concluding Observations: Georgia*, paras. 30-31, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014).

94 Human Rights Committee, *Concluding Observations: Peru,* para. 14, U.N. Doc CCPR/C/PER/CO/5 (2013); ESCR Committee, *Concluding Observations: Azerbaijan,* para. 16, U.N. Doc. ESCR/C.12/AZE/CO/3 (2013); CEDAW Committee, *Concluding Observations: Lithuania*, para. 39, U.N. Doc. CEDAW/C/LTU/CO/5 (2014).

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

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

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

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

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

100 CEDAW Committee, *Concluding Observations: Iraq,* paras. 42-43, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); *Hungary*, paras. 30 & 31(a), U.N. Doc CEDAW/C/HUN/CO/7-8 (2013); *Georgia*, paras. 30-31, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014); *Solomon Islands*, para. 36(b), U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014); ESCR Committee, *Concluding Observations: Ecuador,* para. 28, U.N. Doc. E/C.12/ECU/CO/3 (2012).

101 CEDAW Committee, *Concluding Observations: Iraq*, paras. 42-43, U.N. Doc. CEDAW/C/IRQ/CO/4-6 (2014); ESCR Committee, *Concluding Observations: Ecuador,* para. 28, U.N. Doc. E/C.12/ECU/CO/3 (2012).

102 CEDAW Committee, *Concluding Observations: Angola*, para. 31(c), U.N. Doc CEDAW/C/AGO/CO/6 (2013); *Former Yugoslav Republic of Macedonia*, para. 33, U.N. Doc CEDAW/C/MKD/CO/4-5 (2013); *Cameroon*, para. 32, U.N. Doc. CEDAW/C/CMR/CO/4-5 (2014); CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 17 ("Studies such as those that emphasize…the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of Possible breaches of their duties to ensure women's access to health care."); CRC Committee, *Concluding Observations: Kyrgyzstan*, paras. 51-52, U.N. Doc. CRC/C/KGZ/CO/3-4 (2014); Human Rights Committee, *Concluding Observations: Malawi,* para. 9, U.N. Doc. CCPR/C/MWI/CO/1/Add.1 (2014); ESCR Committee, *Concluding Observations: El Salvador*, para. 23, U.N. Doc. ESCR/C.12/SLV/CO/3-5 (2014).

103 ESCR Committee, *Concluding Observations: Indonesia*, para. 33, U.N. Doc. ESCR/C.12/IDN/CO/1 (2014); CRC Committee, *Concluding Observations: Indonesia*, paras. 49-50, U.N. Doc. CRC/C/IND/CO/3-4 (2014).

104 CEDAW Committee, *Concluding Observations: Finland,* paras. 28-29, U.N. Doc. CEDAW/C/FIN/CO/7 (2014); *Belgium*, para. 35, U.N. Doc. CEDAW/C/BEL/CO/7 (2014).

105 CAT Committee, *Concluding Observations: Peru*, para. 19, U.N. Doc. CAT/C/PER/CO/6, (2012); CAT Committee, *Concluding Observations: Czech Republic,* para. 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012).

106 CRPD Committee, *Concluding Observations: Spain*, paras. 37-38, U.N. Doc. CRPD/C/ESP/CO/1 (2011); *China*, para. 34, U.N. Doc. CRPD/C/CHN/CO/1 (2012); *Argentina*, paras. 31-32, U.N. Doc. CRPD/C/ARG/CO/1 (2012); *Peru*, para. 35, U.N. Doc. CRPD/C/PER/CO/1 (2012).

107 CRPD Committee, *Gen. Comment No. 1, supra* note 3, para. 35.

108 CEDAW Committee, *Concluding Observations: Finland,* paras. 28-29, U.N. Doc. CEDAW/C/FIN/CO/7 (2014); *Belgium*, para. 35, U.N. Doc. CEDAW/C/BEL/CO/7 (2014).

109 CEDAW Committee, *Concluding Observations: Hungary*, paras. 32 & 33(b). U.N. Doc CEDAW/C/HUN/CO/7-8 (2013).

110 CEDAW Committee, *Concluding Observations: Finland,* paras. 28-29, U.N. Doc. CEDAW/C/FIN/CO/7 (2014).

111 CAT Committee, *Concluding Observations: Czech Republic,* para. 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012); Human Rights Committee, *Concluding Observations: Czech Republic*, para. 11, U.N. Doc CCPR/C/CZE/CO/3 (2013); A.S. v. Hungary, CEDAW Committee, Commc'n No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).

112 *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); CRC Committee, *Gen. Comment No. 15*, *supra* note 4, para. 70.

113 *See, e.g.*, CEDAW Committee, *Concluding Observations: Paraguay*, para. 31(a), U.N. Doc. CEDAW/C/PRY/CO/6 (2011); *Chile*, para. 20, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); ESCR Committee, *Concluding Observations: Philippines*, para. 31, U.N. Doc. E/C.12/PHL/CO/4 (2008); Human Rights Committee, *Concluding Observations: Zambia*, para. 18, U.N. Doc. CCPR/C/ZMB/CO/3 (2007).

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

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

116 *See, e.g.*, L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 12(b), U.N. Doc. CEDAW/C/50/D/22/2009 (2011); K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005). Human Rights Committee, *Concluding Observations: Ireland*, para. 9, U.N. Doc. CCPR/C/IRL/CO/4 (2014); CEDAW Committee, *Concluding Observations: Bahrain*, para.

42(b), U.N. Doc. CEDAW/C/BHR/CO/3 (2014); CAT Committee, *Concluding Observations: Paraguay,* para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011)*2*; Human Rights Committee, *Concluding Observations: Sierra Leone*, para. 14, U.N. Doc CCPR/C/SLE/CO/1 (2014); CRC Committee, *Concluding Observations: Chad*, para. 30, U.N. Doc. CRC/C/15/Add.107 (1999); *Chile*, para. 56, U.N. Doc. CRC/C/CHL/CO/3 (2007); *Costa Rica,* para. 64(c), U.N. Doc. CRC /C/CRI/CO/4 (2011); Human Rights Committee, *Concluding Observations: Guatemala*, para. 20, U.N. Doc. CCPR/C/GTM/CO/3 (2012); ESCR Committee, *Concluding Observations: Dominican Republic*, para. 29, U.N. Doc. E/C.12/DOM/CO/3 (2010); *Chile*, para. 53, U.N. Doc. E/C.12/1/Add.105 (2004).

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

118 *See, e.g.*, CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, para. 14; Human Rights Committee, *Concluding Observations: Costa Rica*, para. 11, U.N. Doc. CCPR/C/79/Add.107 (1999); CRC Committee, *Concluding Observations: Nicaragua*, para. 59(b), U.N. Doc. CRC/C/NIC/CO/4 (2010); CAT Committee, *Concluding Observations: El Salvador*, para. 23, U.N. Doc. CAT/C/SLV/CO/2 (2009); *Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).

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

120 CEDAW Committee, *General Recommendation No. 30: On women in conflict prevention, conflict and post-conflict situations*, (56th Sess., 2013), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 52(c), U.N. Doc. CEDAW/C/GC/30 (2013).

121 *See, e.g.*, ESCR Committee*, Gen. Comment No. 14*, *supra* note 12, para. 12; K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011); L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

122 ESCR Committee, *Concluding Observations: Kenya,* U.N. Doc. E/C.12/KEN/CO/1 (2008).

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

124 CEDAW Committee, *Concluding Observations: Hungary,* para. 30, U. N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Ghana*, para. 38(d), U.N. Doc. CEDAW/C/GHA/CO/6-7 (2014).

125 ESCR Committee, *Concluding Observations: Slovakia*, para. 24, E/C.12/SVK/CO/2 (2012); CEDAW, *Concluding Observations: Austria,* paras. 38-39, CEDAW/C/AUT/CO/7-8 (2013).

126 CAT Committee, *Concluding Observations: Peru*, para. 15(a), U.N. Doc. CAT/C/PER/CO/5-6 (2012).

127 CEDAW, *Concluding Observations: Zambia,* para. 33(b), U.N. Doc. CEDAW/C/ZMB/CO/5-6 (2011); CAT Committee, *Concluding Observations: Peru*, para. 15(e), U.N. Doc. CAT/C/PER/CO/5-6 (2012).

128 Human Rights Committee, *Concluding Observations: Ireland*, para. 9, U.N. Doc. CCPR/C/IRL/CO/4 (2014).

129 CEDAW Committee, *Concluding Observations: Hungary*, para. 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013). Biased counselling requirements mandate that doctors provide women with information provided by the state that is often medically inaccurate and can be politically motivated. Women should instead have the right to receive unbiased information from their doctors about a decision to have an abortion.

130 *See, e.g.*, CAT Committee, *Concluding Observations: Poland*, para. 23, U.N. Doc. CAT/C/POL/CO/5-6 (2013); ESCR Committee, *Concluding Observations: Peru*, para. 21, U.N. Doc. E/C.12/PER/CO/2-4 (2012); CEDAW Committee, *Concluding Observations: Costa Rica*, paras. 32, 33(c), U.N. Doc. CEDAW/C/CRI/CO/5-6 (2011); *Kuwait*, paras. 42-43, U.N. Doc. CEDAW/C/KWT/CO/3-4 (2011).

131 K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, paras. 6.2 & 7, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.16, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

132 *See, e.g.,* CAT Committee, *Concluding Observations: Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011).

133 CAT Committee, *Concluding Observations: Poland*, para. 23, U.N. Doc. CAT/C/POL/CO/5-6 (2013); *Sierra Leone*, para. 17, U.N. Doc. CAT/C/SLE/CO/1 (2014); CEDAW Committee, *Concluding Observations: Hungary*, para. 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).

134 World Health Organization (WHO), Safe Abortion: Technical and Policy Guidance for Health Systems 21-22 (2nd ed. 2012).

135 *See, e.g.*, CAT Committee, *Concluding Observations: Poland*, para. 23, U.N. Doc. CAT/C/POL/CO/5-6 (2013); *Sierra Leone*, para. 17, U.N. Doc. CAT/C/SLE/CO/1 (2014); K.L. v. Peru*,* Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011).

136 K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, paras. 6.3-6.6 & 7, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).

137 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).

138 CEDAW Committee, *Concluding Observations: India*, paras. 16-17, U.N. Doc. CEDAW/C/IDN/CO/5 (2007); CEDAW Committee, *Concluding Observations: Kuwait*, para. 43(b), U.N. Doc. CEDAW/C/KWT/CO/3-4 (2011).

139 CRC Committee, *Gen. Comment No. 15*, *supra* note 4, para. 31.

140 *See, e.g.*, CRC Committee, *Concluding Observations: India*, para. 66(b), U.N. Doc. CRC/C/IND/CO/3-4 (2014).

141 *Id*.

142 CEDAW Committee, *Concluding Observations: Hungary*, para. 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).

143 *See, e.g.*, CEDAW, *Concluding Observations: Slovakia*, para. 29, U.N. Doc. CEDAW/C/SVK/CO/4 (2008); *Hungary*, paras. 30-31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Poland*, para. 25, U.N. Doc. CEDAW/C/POL/CO/6 (2007); *Slovakia*, paras. 28-29, U.N. Doc. CEDAW/C/SVK/CO/4 (2008); ESCR Committee, *Concluding Observations: Poland*, para. 28, U.N. Doc. E/C.12/POL/CO/5 (2009).

144 CAT Committee, *Concluding Observations: Poland*, para. 23, U.N. Doc. CAT/C/POL/CO5-6 (2013).

145 CEDAW, *Concluding Observations: Hungary*, paras. 30-31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).

146 K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, para. 6.4, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, para. 9.3, U.N. Doc. CCPR/C/101/D/1608/2007 (2011).

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