ENSURING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF WOMEN AND GIRLS AFFECTED BY CONFLICT
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Acknowledgments

This briefing paper is a publication of the Center for Reproductive Rights (the Center). It was conceptualized by Rebecca Brown, Director of Global Advocacy, and Meera Shah, Global Advocacy Adviser, and drafted by Meera Shah. The paper was reviewed and edited by Rebecca Brown; Katherine Mayall, Senior Manager of the Global Legal Program; Onyema Afulukwe, Senior Counsel for Africa; Paola Salwan Daher, Global Advocacy Adviser; and Nina Sun, Global Advocacy Adviser. Floriane Murphy Borel, Legal Assistant for Global Advocacy and Europe, provided support in editing, fact-checking, and preparing the paper for publication. Anuja Singhal, Graphic Designer, Gabriel Lee, Graphic Designer, and Carveth Martin, Senior Creative and Designer, coordinated the design and layout.

Elizabeth McCullough-Sanden, Legal Fellow, Gretchen Kail, and Chelsea Anelli provided research assistance. Professor Fionnuala Ní Aoláin, Robina Chair in Law, Public Policy, and Society at the University of Minnesota Law School; Madeleine Rees, Secretary-General, Women’s International League for Peace and Freedom (WILPF); and, Catrin Schulte-Hillen, Working Group Reproductive Health and Sexual Violence Care at Médecins Sans Frontières, reviewed draft versions of the briefing paper and provided invaluable input.
I. INTRODUCTION

Conflict and crisis have dire consequences on women and girls’ sexual and reproductive health and rights (SRHR). Women and girls affected by conflict often have limited access to reproductive health care and are particularly vulnerable to sexual violence, human trafficking, and forced marriage. In addition to being serious human rights violations, these abuses contribute to unintended pregnancies, and in turn can lead to high rates of unsafe abortion and maternal mortality. As such, access to sexual and reproductive health information and services is critical in these settings, but disintegrating health systems, unsafe environments, prohibitive costs, lack of information and decision-making power, and fear of further violence for seeking out care all make it difficult for women and girls to access the necessary information and services.

While the provision of sexual and reproductive health services for women and girls affected by conflict has improved in recent years, there remain significant gaps in the comprehensive and systematic delivery of these services. Lack of access to services such as obstetric, prenatal, and postnatal care; contraceptive information and services, including emergency contraception; and safe abortion and post-abortion care, especially for survivors of rape and sexual violence, negatively impact the health and lives of women and girls. Ensuring the provision of sexual and reproductive health information and services and accountability for sexual violence in these settings is central not only to an effective humanitarian response but also to fulfilling fundamental human rights and humanitarian law obligations. International jurisprudence, state practice, and academic literature have consistently affirmed that state obligations under international human rights law (IHRL) apply even during situations of armed conflict, operating complementarily to international humanitarian law (IHL) obligations.
This briefing paper analyzes existing legal standards and principles relevant to protecting the sexual and reproductive health and rights of women and girls affected by conflict. It provides an overview of reproductive rights violations often experienced by women and girls in these settings, including increased maternal mortality, lack of access to contraception, lack of access to safe abortion, and sexual and gender-based violence (SGBV), and concomitant state obligations to address these violations. It focuses on international human rights law and international humanitarian law but also provides brief analyses of other relevant legal regimes as well as key human rights principles relevant to humanitarian actors and other stakeholders. While recognizing that state practice and implementation in conflict and displacement settings often falls far short of these standards, this paper aims in part to raise awareness of the existence and nature of legal obligations and principles with the hope of contributing to their increased operationalization.

This briefing paper is intended to be a resource for advocates, humanitarian agencies and aid workers, service providers, policy-makers, and other key stakeholders working on the health and rights of women and girls affected by conflict to ensure that policies and programs reflect and prioritize human rights obligations and principles.
According to the United Nations High Commissioner for Refugees (UNHCR), there are more than 65 million forcibly displaced people throughout the world, 12.4 million of whom were newly displaced due to conflict or persecution in 2015. The United Nations Population Fund (UNFPA) estimated that 26 million women and girls of reproductive age were in need of humanitarian assistance in 2015. Women and girls affected by conflict include civilians and combatants in situations of armed conflict, internally displaced persons (IDPs), and refugees or asylum-seekers in neighboring or third countries in settings ranging from refugee camps or informal camps to urban and rural settings or in transit.

Armed conflict has significant impacts on the lives of all individuals and particularly women and girls. In addition to the insecurity and risk of physical injury due to combat, armed conflict causes a breakdown of social networks and infrastructure, often leading to displacement or disruption in access to basic services and livelihoods. Moreover, conflict tends to exacerbate existing patterns and structures of discrimination and inequalities, and further undermines access to healthcare, housing, water, sanitation, education, and employment for women and girls in these settings. In addition, women and girls are particularly at risk of sexual violence and exploitation in conflict and displacement settings. Access to obstetric and antenatal care for pregnant women; access to contraceptive
Maternal mortality ratios (MMRs) in countries affected by conflict remain high and have been shown to increase during periods of conflict. Syria's MMR has increased from 49 to 68 per 100,000 live births since the start of the conflict in 2011.ii

While there continues to be a need for more reliable data on maternal mortality in conflict and displacement settings, there is little doubt that conflict exacerbates maternal mortality.16 In 2015, a United Nations (UN) inter-agency report found that in countries designated as fragile states, which include conflict-affected settings, the estimated lifetime risk of maternal mortality is 1 in 54, as compared to 1 in 180 global lifetime risk.17 Moreover, maternal mortality ratios (MMRs) in countries affected by conflict remain high and have been shown to increase during periods of conflict. The Central African Republic has an MMR of 882 per 100,000 live births, which reflects improvement over the past 15 years but a slight increase since the start of the most recent period of unrest in 2013.18 Similarly, Syria’s MMR has increased from 49 to 68 per 100,000 live births since the start of the conflict in 2011.19 Studies have found that MMRs among refugees receiving humanitarian aid tend to be lower than among the host population or country of origin, but that delays in seeking and receiving care are among the most significant factors in maternal deaths20 – factors that are likely exacerbated for asylum seekers in transit.21 A recent study conducted among Syrian refugee women in Lebanon found that many women experienced or perceived challenges in accessing reproductive health services, primarily due to costs, distance or transport to facilities, or fear of mistreatment, with more than 35% reporting problems during pregnancy or complications during labor, delivery, or abortion.22
One of the first things that women refugees ask for upon coming to Lebanon is family planning services.

– Cecilia Chami, Programs Director, Lebanon Family Planning Association for Development & Family Empowerment (LFPADE) – Lebanon
Access to contraceptives is fundamental to women’s ability to exercise the right to decide freely and responsibly the number and spacing of children and is a key intervention for preventing maternal mortality. This access is even more important in conflict and displacement settings, given the increased risks related to pregnancy and delivery due to the unavailability or inaccessibility of maternal health services in these settings. However, according to a global evaluation of the Inter-Agency Working Group on Reproductive Health in Crises (IAWG), the provision of contraception, particularly long-acting methods and emergency contraception, continues to lag behind in reproductive health services in emergencies. Among Syrian refugees in Lebanon, for example, one study found that only 34.5% were using a family planning method, as compared to 58.3% in pre-conflict Syria. The U.S. Centers for Disease Control and Prevention report that only 1 in 3 Syrian women of reproductive age in the Zaatari refugee camp in Jordan are aware of available birth control options. Actual or perceived requirements of third-party authorization also hinder access to contraceptives.

Globally, unsafe abortion accounts for between 8-18% of maternal deaths, almost all of which occur in developing countries. While there continues to be a lack of reliable data on unsafe abortion in humanitarian settings, the need for safe abortion services likely increases in these settings.

Access to contraceptives is fundamental to women's ability to exercise the right to decide freely and responsibly the number and spacing of children and is a key intervention for preventing maternal mortality.

Women and girls affected by conflict may face increased risks of unintended pregnancy and unsafe abortion, due in part to lack of or interrupted access to contraceptives and increased risks of sexual violence and child, early, and forced marriage. However, IAWG’s global evaluation shows little improvement in the availability of safe abortion care in humanitarian settings. For example, more than 200 women and girls rescued by the Nigerian Army from Boko Haram in 2015 were reported to have been pregnant as a result of serial rape or forced marriage; none were offered access to safe abortion, leading some of them to seek out illegal, unsafe abortions.
Finally, women and girls affected by conflict face an increased risk of gender-based violence, including sexual violence and child, early, and forced marriage.³² Sexual violence occurs within all conflict-affected settings, including war or conflict, during displacement, and in transit or refugee settings and is perpetrated by state actors, non-state actor groups, and private individuals.³³ Moreover, in some conflict settings, sexual violence is used as a tactic of war.³⁴ Non-state actor groups, such as the Islamic State, as well as state security forces in Syria have used sexual violence as a tactic of war and repression.³⁵ In some conflict settings, armed groups have created systems of forced marriage and sexual slavery.³⁶

More than 200 women and girls rescued by the Nigerian Army from Boko Haram in 2015 were reported to have been pregnant as a result of serial rape or forced marriage; none were offered access to safe abortion.³³

In Nigeria, systematic sexual and gender-based violence has been a well-documented feature of Boko Haram’s treatment of the women and girls it abducts, but data on the scope and extent of this violence remains difficult to obtain.³⁷ More reliable and comprehensive data on sexual violence in conflict and displacement settings is necessary,³⁸ though it continues to be difficult to collect due to stigma and other barriers associated with reporting these violations.³⁹ There is also a growing body of evidence to suggest rising rates of child, early, and forced marriage in conflict-affected settings due to a lack of economic resources and because families perceive marriage as a way to protect girls from other forms of violence, including sexual violence, the risk of which increases in these settings.⁴⁰ According to UNICEF, the rate of child marriage among Syrian refugee girls in Jordan rose to 32% in 2014, compared to an average of 13% in Syria before the war.⁴¹

In addition to lacking access to health services, survivors of sexual violence and those denied access to sexual and reproductive healthcare are rarely able to seek justice and remedies for the violations they have endured. Disintegrating judicial systems in conflict and displacement settings, discrimination against refugee populations in host countries, fear of reprisals against their families or themselves, and the stigma associated with sexual violence all prevent women and girls from reporting sexual violence and seeking justice and accountability.
The rights of women and girls affected by conflict are protected by multiple, complementary bodies of international law, including international humanitarian law (IHL), international human rights law (IHRL), international criminal law, and refugee law. Developed to regulate and limit the effects of armed conflict, IHL applies only to situations of armed conflict but it does not allow for derogation and its minimum standards are binding on all parties to a conflict (including non-state armed groups). While IHL does not explicitly address women’s reproductive health in any detail or depth, this body of law contains important obligations with respect to medical treatment as well as the treatment of women, and particularly pregnant women. IHRL, on the other hand, has developed detailed and extensive guidance for states with respect to sexual and reproductive health and rights and complements and reinforces IHL obligations in situations of armed conflict. Despite differences in scope and approach, IHL and IHRL share some of the same aims; notably, both aim to protect dignity, life, and health and both prohibit discrimination and torture or cruel treatment. Moreover, where IHL obligations are not spelled out in detail, IHRL and the interpretation of human rights bodies can help clarify analogous principles found in both bodies of law. Human rights bodies have made clear that, with only some limited exceptions, a state’s obligations extend to all individuals in its territory or under its effective control, including refugees and asylum-seekers within its territory. Although IHRL is generally thought to apply only to states (as distinct from IHL which applies to all parties to a conflict, including non-state actors), this view may be evolving. This Part begins by setting out SRHR-related obligations under IHRL, then discusses complementary obligations under IHL, international criminal law, and refugee law.

International Human Rights Law

International legal and political bodies, including the International Court of Justice, have affirmed that fundamental human rights obligations, including economic, social, and cultural rights, continue to apply even during situations of armed conflict. Although IHRL permits states to derogate from certain civil and political rights in times of armed conflict and to limit certain obligations with respect to economic, social, and cultural rights depending on resource availability, human rights treaty bodies have emphasized that such derogations are subject to strict conditions and that certain minimum
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core obligations are non-derogable.54 Even where derogations are permitted, the measures taken cannot involve discrimination based solely on prohibited grounds, including sex.55

Sexual and reproductive health and rights are central to the realization of fundamental human rights, including the rights to life, health, freedom from torture and ill-treatment, privacy, education, and non-discrimination, among others; at the same time, SRHR are grounded in and draw their meaning from fundamental human rights.56 Human rights bodies consistently have emphasized that states’ obligations to guarantee SRHR require not only ensuring women and girls have access to comprehensive reproductive health information and services but also taking affirmative measures to improve reproductive health outcomes and to ensure that women and girls have the opportunity to make fully informed decisions about their sexuality and reproduction, free from violence, discrimination, and coercion.

Fundamental human rights obligations, including economic, social, and cultural rights, continue to apply even during situations of armed conflict.iv

As with other fundamental human rights obligations, obligations related to SRHR continue to apply in situations of armed conflict and displacement. The Committee on Economic, Social, and Cultural Rights (CESCR) interprets the right to sexual and reproductive health as including “the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, over matters concerning one’s body and sexual and reproductive health” as well as “unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health under article 12 of the Covenant.”57 Noting that the Covenant’s obligations continue to apply in situations of armed conflict, CESCR has recommended that states increase efforts to ensure sexual and reproductive health services for populations affected by conflict or displacement.58 Minimum core obligations are obligations with which states are required to comply at all times; those related to the right to health include ensuring non-discriminatory, universal, and equitable access to sexual and reproductive health services and information, particularly for women and marginalized groups; providing essential medicines; and ensuring access to remedies for violations of SRHR.59 Comparable to other non-derogable minimum core obligations is
the obligation to “ensure reproductive, maternal (pre-natal as well as post-natal) and child health care.”

The CEDAW Committee has found that the failure to provide services that only women require to meet their reproductive health needs is a form of discrimination and has emphasized that state obligations under the Convention “are non-derogable and continue to apply during conflict situations.” For women and girls affected by conflict, the CEDAW Committee has recommended that state parties ensure that sexual and reproductive health care includes access to sexual and reproductive health and rights information; psychosocial support; family planning services, including emergency contraception; maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission and emergency obstetric care; safe abortion services; post-abortion care; prevention and treatment of HIV/AIDS and other sexually transmitted infections, including post-exposure prophylaxis; and care to treat injuries such as fistula arising from sexual violence, complications of delivery or other reproductive health complications, among others.

In addition to human rights treaty bodies, the UN Security Council has passed several resolutions in the past 15 years relating to women and armed conflict. Specifically, with regard to SRHR in conflict settings, the Security Council has urged “United Nations entities and donors to provide non-discriminatory and comprehensive health services, including sexual and reproductive health” to survivors of sexual violence. The political body also noted “the need for access to the full range of sexual and reproductive health services, including regarding pregnancies resulting from rape, without discrimination” for women affected by armed conflict. In addition to these specific references to SRHR, these resolutions affirm the applicability of states’ human rights obligations in situations of armed conflict.

The following discussion highlights key human rights obligations related to specific SRHR violations described in Part II.

i. Maternal Health

International human rights law obligates states to ensure that women can survive pregnancy and childbirth, including by ensuring their access to adequate pre- and post-natal care, emergency obstetric services, and skilled birth attendants. Human rights bodies have provided detailed guidance on women and girls’ right to maternal health care, which encompasses the full range of services in connection with pregnancy and the post-natal period and the ability to access these services free from
discrimination, coercion, and violence. These bodies have called on states to address the social and other determinants of health, including the effects of conflict, to enable women and girls to access the maternal health services they need. The CEDAW Committee has recognized that the failure to provide women with quality maternal health services violates the rights to equality and non-discrimination, as these are services that only women need. Treaty bodies have linked high rates of maternal mortality to lack of access to reproductive health services, including contraception; unsafe abortion; adolescent pregnancy; and child marriage.

In conflict-affected settings, the CEDAW Committee has explicitly called on states to ensure access to “maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission and emergency obstetric care . . . complications of delivery or other reproductive health complications, among others.” The Committee has interpreted the Convention to require “women seeking asylum and women refugees be granted, without discrimination, the right to . . . health care and other support, . . . appropriate to their particular needs as women.” In its recommendations to specific states, the CEDAW Committee has noted with concern the effects of armed conflict on SRHR and maternal mortality, in particular, calling on states affected by conflict to “accord priority to the provision of sexual and reproductive health services.” The CEDAW Committee also raised concerns about the restrictions imposed by the Syrian government that have forced women to give birth in unsafe conditions and recommended that the state “prioritize access to maternal health care services, including skilled delivery services for pregnant women irrespective of their area of residence.” As noted above, CESC considers the obligation to ensure reproductive and maternal health care to be comparable to a minimum core obligation with which states must comply at all times. In the context of a military occupation, CESC has recommended “disciplinary action against checkpoint officials who are found responsible for unattended roadside births, miscarriages, and maternal deaths resulting from delays at checkpoints” and urgent measures to ensure “unrestricted access to adequate prenatal, natal and post-natal medical care.”

**ii. Contraception/Emergency Contraception**

International human rights treaty bodies have found that all individuals, including adolescents and youth, have the right to access contraceptive information and services as a means of preventing pregnancy and sexually transmitted infections. All individuals have the right “to decide freely and responsibly on the number, spacing and timing of their children,” which
The situation of the IDP camps in northeast Nigeria leaves much to be desired. The ongoing neglect of major reproductive health needs, if not addressed, will likely escalate Nigeria's negative maternal health record.

— Dr. Abiola Akiyode-Afolabi, Executive Director, Women Advocates Research and Documentation Center (WARDC) - Nigeria
includes the “right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning.” States must ensure that contraceptives are affordable and that a comprehensive range of good quality, modern, efficient contraceptives are available, including emergency contraception, as part of their core obligation under the right to health. Access to contraceptives must not be hindered by legal restrictions or third party authorization requirements. Treaty bodies have called on states not only to ensure access to contraceptive information and services but also to ensure positive contraception-related health outcomes for women and girls. Restrictions on access to emergency contraception, in particular, may violate a number of rights, including the rights to health, non-discrimination, gender equality, and freedom from ill-treatment, particularly for victims of violence, including adolescents.

The CEDAW Committee has recognized that women often experience increased sexual violence in conflict, “which require[s] specific protective and punitive measures,” and has explicitly called on states to ensure access to contraception, including emergency contraception, in conflict-affected settings. Though not legally binding, the ICPD Programme of Action remains an influential political document, and in it states committed to provide refugees with access to health services, “including family planning.” The UN Secretary General has called for humanitarian responses to include access to safe emergency contraception for pregnancies resulting from rape. Although specific language related to access to contraception in conflict-affected settings has been limited to date, human rights and political bodies have consistently affirmed the need to ensure that women and girls affected by conflict have access to the full range of sexual and reproductive health services and information, which includes access to contraception.

iii. Abortion

International human rights treaty bodies and experts have consistently found that denying access to abortion or imposing barriers to access undermines women’s reproductive autonomy and violates the rights to life, health, privacy, equality, and freedom from torture or ill-treatment. At minimum, states must ensure that abortion is both legal and accessible 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 and provide humane, quality post-abortion care to women, regardless of whether abortion is legal. Human rights 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, as per the World Health Organization’s definition of health. The Committee on the Rights of the Child (CRC Committee) has called on states to decriminalize abortion to ensure that adolescent girls have access to safe abortion and post-abortion services, affirming adolescents’ autonomy and decision-making in the context of their SRHR.

The Committee Against Torture (CAT Committee) and Human Rights Committee have found that, in certain circumstances, denial of access to abortion services can lead to physical or mental suffering that amounts to ill-treatment. The CAT Committee has expressed concern that complete bans on abortion may constitute torture or ill-treatment. The CAT Committee also has urged states to ensure access to abortion for women whose health or life is at risk, who are the victims of sexual violence, or who are carrying a nonviable fetus – circumstances where a pregnancy may cause a woman severe physical or mental suffering. Similarly, the Human Rights Committee has found that the denial of access to abortion services can lead to physical or mental suffering amounting to torture or ill-treatment in certain circumstances. Recently, the Human Rights Committee found that by criminalizing abortion and hence denying the petitioner an abortion, the state had violated her right to freedom from cruel, inhuman, or degrading treatment. At the regional level, decisions from the European Court of Human Rights have underscored state obligations to ensure access in contexts where abortion is legal, and the Maputo Protocol obligates states to ensure safe abortion “in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.”

In its general recommendation on women in conflict, the CEDAW Committee urges states to “[e]nsure that sexual and reproductive health care includes access to… safe abortion services” and post-abortion care. Human rights treaty bodies have raised concerns, in particular, about women raped in armed conflict and have found that the denial of safe abortion care to survivors of rape in armed conflict violates the rights to health and privacy and could amount to a violation of the prohibition on ill-treatment. In its recommendations to Syria, the CEDAW Committee urged the state to “[e]xpand the grounds on which abortion is permitted to include, in particular, cases of rape, and prepare guidelines on post-abortion care to ensure that women who are pregnant as a result of rape have free access to safe abortion services.” Non-derogable minimum core obligations related to sexual and reproductive health require states to take steps to prevent unsafe abortion and to provide post-abortion care and counseling; they also require states to “repeal or eliminate laws, policies and practices
that criminalize, obstruct or undermine individual’s or particular group’s access to sexual and reproductive health facilities, services, goods and information.” The UN Secretary General has called for humanitarian responses to include access to safe abortion care for pregnancies resulting from rape, and the UN Security Council has recognized the importance of including “access to the full range of sexual and reproductive health services” for women and girls affected by conflict, “including regarding pregnancies resulting from rape” as part of humanitarian aid and funding.

iv. Sexual and Gender-based Violence

Sexual and gender-based violence (SGBV) impairs or nullifies the enjoyment of a range of human rights, including the rights to life, health, liberty and security of person, equal protection and equality in the family, and freedom from torture and cruel, inhuman, or degrading treatment, among others. The CEDAW Committee has addressed in detail state obligations to prevent and address SGBV, particularly in the areas of domestic violence, sexual violence, and female genital mutilation, as well as other violations of sexual and reproductive health and rights. The Human Rights Committee and the CAT Committee, moreover, have framed forms of gender-based violence, such as restrictions on access to abortion, female genital mutilation, abusive treatment in healthcare settings, and involuntary sterilization, as violations of the prohibition on torture and cruel, inhuman, or degrading treatment. In addition, CESCR, the CRC Committee, and the Committee on the Rights of Persons with Disabilities have made clear that states’ obligations to address gender-based violence fall under their respective treaties. International human rights treaties have recognized the right to be free from harmful traditional practices, finding that child, early, and forced marriage can violate the prohibition on torture or ill-treatment. The CEDAW Committee and the CRC Committee refer to child, early, and forced marriage as a harmful practice that leads to SGBV, due to the increased risk of forced and early pregnancy, maternal mortality, and domestic violence.

With the prevalence of sexual violence in conflict, human rights bodies increasingly have provided recommendations regarding gender-based violence experienced by women and girls. In its general recommendation on women in conflict, the CEDAW Committee urges states to prevent, investigate, and punish all forms of SGBV, particularly sexual violence committed both by state and non-state actors, and to ensure survivors’ access to justice, comprehensive medical treatment, and psychosocial support. The CEDAW Committee has urged states to decriminalize
abortion “more particularly in cases of rape perpetrated in the context of the conflict.” The Committee also calls on states to safeguard refugees and IDPs from SGBV, including child and forced marriage, and to provide them with immediate access to medical services and to create accountability mechanisms for SGBV in all displacement settings.

**International Humanitarian Law**

Non-discrimination is a core principle of IHL, which prohibits adverse distinction based on sex, among other grounds. As one commentator notes, “[t]his is a prohibition on discrimination and not on differentiation,” as IHL also provides for specific protections for women and imposes obligations on parties to an armed conflict to respect women’s specific needs. Current interpretation of these needs encompasses protection from sexual violence as well as the need to ensure that women in conflict receive
medical treatment and adequate health services, including counseling.\textsuperscript{127} The 2016 commentary of the International Committee of the Red Cross (ICRC) notes that this care must take into account “the distinct set of needs of and particular physical and psychological risks facing women, including those arising from social structures” and requires “equal respect, protection and care based on \textit{all} the needs of women.”\textsuperscript{128} Moreover, the Geneva Conventions and Additional Protocol I require that parties to an armed conflict treat pregnant women and nursing mothers with particular care, including with respect to medical assistance.\textsuperscript{129}

IHL establishes an affirmative duty to provide medical care for the wounded.\textsuperscript{130} Additional Protocol I includes in its definition of the wounded and sick “maternity cases” and “other persons who may be in need of immediate medical assistance or care, such as... expectant mothers.”\textsuperscript{131} Victims of sexual violence, including rape, also fall within the protections provided for the wounded and sick in armed conflict situations.\textsuperscript{132} As such,
at minimum, IHL establishes an obligation to provide medical care and attention to pregnant women and victims of sexual violence. The ICRC notes that this is an obligation of means, meaning that parties must make “best efforts” to fulfill it, including by permitting humanitarian organizations to assist.\textsuperscript{133} With regard to the treatment of the sick and wounded, the prohibition on adverse distinction has been interpreted to permit distinction only on the basis of medical need.\textsuperscript{134} The ICRC describes this IHL principle as similar to the human rights principle of non-discrimination,\textsuperscript{135} suggesting that human rights law can provide additional guidance as to how this principle should be interpreted with respect to the medical treatment of women in conflict.

IHL also requires civilians and individuals no longer participating in hostilities (persons \textit{hors de combat}), including the sick and wounded, to be treated humanely in all circumstances.\textsuperscript{136} Although humane treatment is not defined in the Geneva Conventions, Common Article 3, which constitutes the minimum yardstick of treatment during armed conflict, specifically prohibits acts of torture and cruel treatment as well as humiliating and degrading treatment.\textsuperscript{137} While rape and sexual violence are not explicitly prohibited under Common Article 3, other provisions in the Geneva Conventions and the Additional Protocols, as well as customary IHL, make clear that these acts are prohibited and constitute “violence to life and person” or “outrages upon personal dignity” or both and violate the fundamental guarantees of IHL to humane treatment.\textsuperscript{138}

In describing the current interpretation of humane treatment, the ICRC explains that “the detailed rules found in international humanitarian law and human rights law give expression to the meaning of ‘humane treatment.’”\textsuperscript{139} The 2016 commentary notes that “[s]ensitivity to the individual’s inherent status, capacities and needs, including how these differ among men and women due to social, economic, cultural and political structures in society, contributes to the understanding of humane treatment under common Article 3.”\textsuperscript{140} For fundamental IHL guarantees, including humane treatment, human rights law and the interpretation of human rights bodies can clarify analogous IHL principles.\textsuperscript{141} As such, interpretation and guidance from human rights bodies regarding torture and cruel, inhuman, or degrading treatment can help define the contours of humane treatment.\textsuperscript{142} Some human rights treaty bodies have found that the denial of medical treatment, including the denial of access to safe abortion services, may constitute ill-treatment in certain circumstances, including when a woman’s life or health is at risk, in cases of severe or fatal fetal anomalies, and in cases of rape and incest.\textsuperscript{143} More recently,
Human Rights and Non-State Actors

Traditionally applicable only to states, international human rights law is evolving to create obligations for non-state actors. The CEDAW Committee’s General Recommendation No. 30, which sets forth states’ obligations to respect, protect, and fulfill women’s rights and ensure gender equality in times of conflict, explicitly states that the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) remains in effect, before, during, and in the aftermath of conflict. It elaborates on states’ due diligence obligation to hold non-state actors accountable for crimes perpetrated against women. Importantly, it also notes that non-state actors may, in certain circumstances, be obligated to respect international human rights.

The UN Security Council also has recognized the applicability of IHRL to non-state groups by stating that it condemns the human rights violations and acts of violence committed by non-state actors. International fact-finding commissions and inquiries have concluded that non-state armed groups have both IHL and IHRL obligations. The UN Secretary General’s Special Representative on Sexual Violence in Conflict has made a concerted effort to marshal support for holding non-state actors accountable for violations of international law, including international human rights law.

Some political bodies have begun to interpret Common Article 3 to require the provision of abortion services to survivors of rape in armed conflict. Taken together, guidance from human rights bodies and these political bodies suggests increasing support for providing access to abortion for women and girls affected by conflict at least in these circumstances.

IHL also imposes obligations on state parties that are not parties to a conflict. All state parties are obligated to establish universal jurisdiction over grave breaches to the Geneva Conventions, which include torture and inhuman treatment. Moreover, Common Article 1 to the Geneva Conventions obligates all state parties “to undertake to respect and to ensure respect” for the conventions. The 2016 ICRC Commentary states that “[t]his obligation is not limited to stopping ongoing violations but includes an obligation to prevent violations when there is a foreseeable
risk that they will be committed and to prevent further violations in case they have already occurred.”147 As the content of this positive obligation continues to evolve,148 there may be additional avenues to press third states, including donor states, to take affirmative steps to prevent and stop IHL violations, such as acts of torture or inhuman treatment, by parties to an armed conflict.

**International Criminal Law**

International criminal law has also evolved to contain provisions relevant to SRHR for women and girls affected by conflict, specifically with regard to sexual violence. International criminal tribunals have developed a body of law imposing individual criminal responsibility for the commission of sexual violence crimes,149 and the Office of the Prosecutor of the International Criminal Court (ICC) has acknowledged sexual and gender-based crimes as “amongst the gravest under the Statute [of the ICC].”150 Significantly, individuals, including individuals associated with non-state actors, can be prosecuted for international crimes.151 The ICC Statute defines the scope of rape and sexual violence that constitute crimes against humanity or war crimes.152 Sexual violence can also constitute an act of genocide if committed with the specific intent to destroy, in whole or in part, a particular group.153 The jurisprudence of special tribunals continues to evolve in this area. The Statute of the International Criminal Tribunal for Rwanda provides for the prosecution of rape, sexual violence, and torture as genocide, crimes against humanity, or war crimes.154 The Statute of the Special Court for Sierra Leone includes rape, sexual slavery, enforced prostitution, forced pregnancy, and any other form of sexual violence among the constituent elements of crimes against humanity, and the Court also has found forced marriage to constitute a crime against humanity.155 The ICC issued its first conviction for sexual violence crimes in 2016, convicting Jean-Pierre Bemba Gombo for his responsibility as commander-in-chief for rape committed by soldiers under his command in the Central African Republic.156

**Refugee Law**

International refugee law157 also includes protections relevant to women and girls affected by conflict.158 The 1951 Refugee Convention protects the rights of refugees to fundamental human rights, including the right to education, access to justice, and employment.159 As part of the ICPD, states recognized that refugee women and girls are entitled to the same treatment
as nationals with regard to public relief and assistance.160 International
human rights bodies and UNHCR have made clear that economic, social,
and cultural rights obligations extend to refugees.161 UNHCR notes,

Every refugee should have access to medical care. Every adult refugee should
have the right to work. No refugee child should be deprived of schooling. In certain
circumstances, such as large-scale inflows of refugees, asylum states may feel
obliged to restrict certain rights, such as freedom of movement, the freedom to work,
or proper schooling for all children. Such gaps should be filled, wherever possible, by
the international community.162

CEDAW also grants special protection to those who have been displaced or
rendered stateless or have become refugees or asylum seekers.163 Similarly,
CESCR and the CRC Committee have called on states to take into account
the particular health needs of displaced and refugee women and girls.164 As
noted by the Special Rapporteur on the human rights of internally displaced
persons on his most recent mission to Syria, “[f]or internally displaced
persons, access to health care is particularly difficult and challenges
are faced by those who are most vulnerable, including pregnant women,
persons with disabilities or chronic illnesses, older persons, and children.”165
The Guiding Principles on Internal Displacement also call for special
attention to be paid to the health needs of displaced women.166
IV. KEY HUMAN RIGHTS PRINCIPLES

In conflict-affected settings, where state institutions are weakened, overwhelmed, or not functioning, humanitarian organizations play an important role in ensuring the provision of basic services and goods.\textsuperscript{167} In addition to the legal obligations detailed above, human rights principles are critical to ensuring that humanitarian funding, programs, and policies are driven by, benefiting, and accountable to the individuals most directly affected by them. Principles of equality and non-discrimination, participation, transparency, and accountability are foundational to international human rights law and are necessary to guide and inform all aspects of humanitarian service provision to ensure that it reflects and meets the needs of the individuals and communities most directly affected.\textsuperscript{168}

Human rights principles are critical to ensuring that humanitarian funding, programs, and policies are driven by, benefiting, and accountable to the individuals most directly affected by them.

Principles of non-discrimination and equality are central to ensuring that humanitarian programs and policies recognize and address the root causes of sexual violence and SRHR violations in conflict or displacement settings to better prevent and eradicate these practices.\textsuperscript{169} Aid efforts guided by the principles of non-discrimination and equality, moreover, prioritize the needs of marginalized or vulnerable groups or individuals.\textsuperscript{170} To ensure that programs are accessible to the most vulnerable requires agencies and donors to monitor and collect data disaggregated on a number of different grounds, including, but not limited to, gender, age, ethnicity, religion, and geographic location.\textsuperscript{171}

Meaningful participation of women and girls affected by conflict, particularly those from vulnerable or marginalized groups, is a key priority in all stages of humanitarian response, from the development to the implementation, monitoring, and evaluation of service policies and programs. A human-rights based approach recognizes the agency of affected individuals to participate in, shape, and make decisions regarding programs and
policies that are intended to be for their benefit. As part of the ICPD, states acknowledged that reproductive health programming “must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of service,” which the UN Security Council also has affirmed in the context of humanitarian aid programs. As noted by the Special Rapporteur on Health, “[i]nvolve
ment in decision-making processes empowers affected communities and ensures ownership of decisions and resources, which leads to sustainable systems and, potentially, the resolution of conflicts.” Effective and meaningful participation, in turn, rests on the ability of affected individuals to have access to reliable SRHR-related information as well as transparency regarding humanitarian funding decisions and structures.

A human rights-based approach also prioritizes a broad and robust understanding of accountability to ensure that policymakers, decision-makers, and others who have an impact on affected individuals and communities are held responsible for their actions and decisions and that individuals whose rights have been violated have access to remedies. Effective accountability mechanisms require participation and transparency as well as the ability to confer meaningful and effective remedies to victims of violations on a basis of non-discrimination. International human rights and political bodies have recognized that accountability requires prompt investigation into violations and punishment of perpetrators as well as legal and policy shifts in order to prevent future violations. Remedies, moreover, must aim to restore the rights of victims of violations and must include adequate, effective, and prompt reparation, forms of which include restitution, compensation, rehabilitation (e.g. medical or psychological services), satisfaction, and guarantees of non-repetition. As OHCHR has noted in its technical guidance on maternal mortality, human rights accountability entails multiple forms of monitoring, review, and oversight, including administrative, social, political and legal, and accountability for multiple actors within the system. Examples of social accountability include “community-based oversight of finances and quality of care at points of service provision, including ‘community scorecards.”

These fundamental principles must drive and guide all aspects of humanitarian funding, programs, and policies in conflict-affected settings to ensure effectiveness, sustainability, and the fulfillment of the needs and rights of those most directly affected.
Conflicts and displacement have significant consequences for the lives and health of women and girls. Women and girls in these settings often face limited access to reproductive health care and are particularly vulnerable to sexual violence, human trafficking, and forced marriage. Despite some improvements in recent years in some areas, there remain significant gaps in the comprehensive and systematic access to obstetric, prenatal, and post-natal care; contraceptive information and services, including emergency contraception; and to safe abortion and post-abortion care, especially for survivors of rape and sexual violence.

As this briefing paper illustrates, women and girls affected by conflict or displacement are protected by multiple international legal frameworks. Notably, IHRL, which continues to apply in situations of armed conflict and displacement, provides important and detailed protections related to SRHR that complement and reinforce obligations under IHL. Ensuring the provision of comprehensive sexual and reproductive health information and services and accountability for sexual violence is central to an effective humanitarian response as well as to fulfilling fundamental legal obligations, including those under IHRL.

It is critical for states, including those affected by conflict, those hosting refugees, and donor states, to prioritize sexual and reproductive health and rights by ensuring access to maternal health care, contraception, safe abortion care, post-abortion services, and remedies for violations in these settings, including for survivors of sexual violence. Moreover, states, relevant agencies, and humanitarian organizations should work together to allocate adequate resources to gather reliable data on the provision of sexual and reproductive health services and sexual violence to ensure that humanitarian interventions reflect the situation and needs of women and girls affected by conflict or displacement. States should be held accountable for all of their legal obligations, including those under IHRL, and humanitarian service providers should aim to ensure that programs and policies are developed, implemented, and monitored in accordance with human rights principles.
This paper focuses on the rights and needs of women and girls affected by conflict, a category which includes refugees, internally displaced persons, as well as those individuals in or fleeing from active armed conflict settings. See International Committee of the Red Cross (ICRC), Addressing the Needs of Women Affected by Armed Conflict 9 (March 2004), available at https://www.icrc.org/en/assets/files/icrc_002_0840_women_guidance.pdf (emphasizing the need to respond to the specific needs of women and girls affected by conflict regardless of whether they are “combatants, persons deprived of their freedom, refugees, internally displaced persons (IDPs), mothers and/or members of the civilian population”); see also Lauren Schreck, Turning Point: A Special Report on the Refugee Reproductive Health Field, 26:4 INTERNATIONAL FAMILY PLANNING PERSPECTIVES 162 (Dec. 2000), available at https://www.guttmacher.org/sites/default/files/pdfs/fulltext/intergeration.pdf (taking the importance of ensuring reproductive health services across stages of displacement). Not all women and girls in displacement and refugee settings have been affected by conflict, but by no means does the focus of this paper suggest that the obligations applicable to displacement settings, including international human rights law or refugee law, are limited to individuals affected by conflict.


7 While the focus of this paper is on women and girls, men and boys affected by conflict also experience difficulties in accessing health services and information, harm to their reproductive health, and increased risk of sexual violence. See Wynne Russell, Sexual violence against men and boys: a review of the current knowledge, harm to their reproductive health, and increased risk of sexual violence and child, early, or forced marriage, as civilians. The experiences of female combatants reflect “a clear gender dimension to conflict,” and as such, women and boys are also vulnerable to sexual violence and exploitation in conflict or displacement settings. See supra note 7 (collecting sources).

8 UNFPA, Shelter from the Storm, supra note 2, at 43-44, 68.


12 Michelle Hynes, Oshabia Sakani, Paul Spiegel, and Nadine Cornier, A Study of Refugees’ Maternal Mortality in 10 Countries, 2008-2010, 38:4 INTERNATIONAL PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 205, 210 (Dec. 2012) (noting that these rates may be lower for a number of reasons, including as a result of targeted humanitarian care, but that these findings “should be interpreted with caution” as maternal deaths were likely underreported). Moreover, studies noting the correlation between maternal stress, pregnancy-related complications, and fetal development suggest longer-term, intergenerational effects of conflict and displacement. See, e.g., Delan Devakumar, Marion Birch, David Osin, Egbert Sondorp, and Jonathan CK Wells, The intergenerational effects of war on the health of children, 12:5 BMC Medicine (Apr. 2014), available at https://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-12-57; E.J.H Mulder et al., Prenatal maternal stress: effects on pregnancy and the (unborn) child, 70 Early Human Development 3 (June 2002); Lucy Ward, Mother’s stress harms fetus, research shows, THE GUARDIAN (May 31, 2007), https://www.theguardian.com/science/2007/may/31/childresservices.medicineandhealth.


As the Committee on the Elimination of Discrimination Against Women (CEDAW Committee) has acknowledged, “Conflicts exacerbate existing gender inequalities, placing women at a heightened risk of various forms of gender-based violence by both State and non-State actors. Conflict-related violence happens everywhere, such as in homes, detention facilities and camps for internally displaced women and refugees; it happens at any time, for instance, while performing daily activities such as collecting water and firewood or going to school or work.” CEDAW Committee, General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, para. 34, U.N. Doc. CEDAW/Gen/Dec/30 (2013) (hereinafter CEDAW Committee, General Recommendation No. 30).


McGinn and Casey, supra note 27, at 2.

26

Id.


Gender-based violence includes sexual violence, including rape, sexual abuse, sexual exploitation, and forced prostitution; domestic and intimate partner violence; child, early, and forced marriage and other harmful traditional practices such as female genital mutilation/cutting, so-called honor crimes; human trafficking, including sex trafficking, child trafficking, and labor trafficking; denial of resources and lack of opportunities based on gender; harmful traditional practices, for example, female genital mutilation/cutting; and gender-based violence affected by climate change.

See also Inter-Agency Standing Committee, GUIDELINES FOR INTEGRATING GENDER-BASED VIOLENCE INTERVENTIONS IN HUMANITARIAN Action 12 (2015), available at https://gbvguidelines.org/wp-content/uploads/2015/09/UNSC-Gender-based-Violence-Guidelines_lo_ses.pdf. The focus of this paper is on women and girls, but men and boys are also at increased risk of sexual violence in conflict-affected settings. See supra note 26.


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It is now widely accepted that IHL and IHRL are complementary and mutually reinforcing bodies of law in situations of armed conflict. See Legality of the Threat or Use of Nuclear Weapons, Advisory Opinion, 1996 I.C.J., para. 22 (July 8); Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory, Advisory Opinion, 2004 I.C.J., para. 106 (July 9); Human Rights Committee, General Comment No. 31, The Nature of the General Legal Obligation Imposed on States Parties to the Covenant, para. 11, U.N. Doc. CCPR/C/21/ Add.13 (2004) (hereinafter General Legal Obligation Imposed on States Parties to the Covenant).

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3.16 CENTER FOR REPRODUCTIVE RIGHTS, REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS, supra note 45, 5 (2009).


3.23 CEDAW Committee, Gen. Recommendation No. 30, supra note 33, para. 52(c). Notably, the CEDAW Committee's guidance does not condition the provision of safe abortion services to circumstances in which abortion services are legal.


3.25 S.C. Res. 2122, supra note 52, preamble.


3.30 See CEDAW Committee, Gen. Recommendation No. 30, supra note 33, para. 52(c).

3.31 CEDAW Committee, Gen. Recommendation No. 32, supra note 50, paras. 33-34.


CESCR, Gen. Comment No. 22, supra note 52, para. 49.

Report of the Secretary-General, Sexual Violence in Conflict, supra note 88, para. 12.

S.C. Res. 2122


See, e.g., Angela Gonzalez Carreno v. Spain, CEDAW Committee, Commn’s No. 47/2012, para. 9.9, U.N. Doc. CEDAW/C/SWI/CO/47/2012 (2014) (finding that, despite “legislation, awareness-raising, education and capacity-building” around domestic violence, the state had violated its due diligence obligation “to investigate the existence of failures, negligence or omissions on the part of public authorities which may have caused victims to be deprived of protection”).


CESCR, Gen. Comment No. 22, supra note 57, para. 29 (calling on states to prevent and remedy gender-based violence that results in the denial of sexual and reproductive health). CESCR, Gen. Comment No. 14, supra note 54, paras. 21, 35 (linking the article 12 right to health with state obligations to protect women from domestic violence and from harmful practices).

CRC Committee, General Comment No. 13 (2011). The right to the child to freedom from all forms of violence, para. 72(6), U.N. Doc. CRC/GC/13 (2011).

CRPD, supra note 53, art. 16.


Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, paras. 58, 63, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016) (by Jean E. Mendes) (finding that child, cruel, inhuman or degrading treatment or punishment.


CEDAW Committee, Concluding Observations: Democratic Republic of the Congo, paras. 10, 32. U.N. Doc. CEDAW/C/DRC/CO/6-7 (2013); see also CEDAW Committee, Concluding Observations: Central African Republic, para. 40. U.N. Doc. CEDAW/C/CAR/CO/1-5-1 (2014) (recommendng that the state “[e]nsure that women who are victims of rape, including rapes perpetrated during the conflict, have access to health-care, psychological services, including emergency contraception and safe abortion services”).

CEDAW Committee, Gen. Recommendation No. 30, supra note 33, para. 57.

ICRC, 2016 COMMENTARY ON THE FIRST GENEA CONVENTION, supra note 42, art. 12. supra note 192, id. art. 3, para. 578; Jean S. Pettiet et al., COMMENTARY: I GENEA CONVENTION FOR THE AMELIORATION OF THE CONDITION OF THE WOUNDE


Geneva Conventions I-V, art. 1. See also Military and Paramilitary Activities in and against Nicaragua (Nicaragua v. United States of America), Merits, Judgment, I.C.C. Rep. 1986 (June 27), paras. 215-220 (holding that the United States was “under an obligation [...] to encourage persons or groups engaged in the conflict in Nicaragua” to violate common article 3).


The definition of crimes against humanity includes “rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity.” Rome Statute of the International Criminal Court (Rome, 17 July 1998), art. 7(2)(f), entered into force 1 July 2002. War crimes include committing “rape, sexual slavery, enforced prostitution, forced pregnancy, as defined in Article 7(2)(f), enforced sterilization, or any other form of sexual violence also constituting a grave breach of the Geneva conventions.” Id., art. 8(2).


Prosecutor v. Bemba, Case No. ICC-01/05/01-08 ICC (21 Mar. 2016).


1951 Refugee Convention, supra note 157, arts. 13, 16, 22 (noting that with respect to education, refugees shall be treated the same as nationals). It is important to note that obligations under refugee law extend to all refugees, and not only to those affected by conflict. See UNHCR, REFUGEE PROTECTION: A GUIDE TO INTERNATIONAL REFUGEE LAW 8-11 (Dec. 1, 2001), available at http://www.unhcr.org/publications/legal/344aba564/refugee-protection-guide-international-refugee-law-handbook-parliamentarians.html (hereinafter UNHCR, Refugee Protection).

ICPD Programme of Action, supra note 49, para. 10.25.


UNHCR, Refugee Protection, at 46.

CEDAW, supra note 67, arts. 9, 15; CEDAW Committee, Gen. Recommendation No. 28, supra note 50, para. 31; CEDAW Committee, Gen. Recommendation No. 32, supra note 50, para. 8. International refugee and human rights law have recognized the rights of asylum seekers (those whose requests for asylum or sanctuary have yet to be processed), which include the fundamental guarantee of non-refoulment (protection against return to a country where an individual has reason to fear persecution). The International Law Commission recognizes that pressure on an individual to return can be direct or indirect. Rep. of the Int’l Law Comm’n: Draft articles on the expulsion of aliens with commentaries, 66th Sess., U.N. Doc. A/69/15, at art. 4 (Dec. 16, 2015).
Endnotes for Pull Outs and Text Box


Cover photo: Kenya / Somali Refugees / Dadaab / Alima Abdi Abdullahi, 20, carrying her newborn baby Omar and a jerrycan of 5 litres water, comes back from the bush with some firewood she collected. Sometimes she has to stay away all day from her house to collect it. She arrived in the camp in 2008 from Kapsum, near Kismayo, Somalia. May 28, 2010. © UNHCR / Riccardo Gangale

Page 5: Kenya / Ifo 3, an extension to the world’s largest refugee camp complex in Dadaab, Kenya. The camp was created to give shelter and services to the huge influx of refugees to Dadaab refugee camps from Somalia in 2011. October 04, 2011. © Brendan Bannon / IOM / UNHCR

Page 10: Lebanon / Iman is 16 years old and 9 months pregnant. She recently arrived from Syria. March 01, 2013. © UNHCR / Gregory Beals

Page 14: Ukraine / Kristina is a young 20-year-old mother holding her 3-year-old daughter Evelina on her knees. In July 2014, they found temporary shelter in the cellar of the House of Culture in Petrivsky district of Donetsk when their own house had been completely destroyed by artillery fire. Their previous house is only 1 kilometer away from the bomb shelter. “There is nothing left either inside or outside our previous home”, states Kristina. As a young mother she relies on state child and maternity payments to maintain her and her daughter’s lives. The suspension of social payments is one of the major protection concerns for the population. June 16, 2015. © UNHCR / Alexander Khudoteply

Page 18: Nigeria / Malkoli Camp / Women and children form the great majority of Nigerians internally displaced since 2009 by a brutal campaign waged by the Boko Haram organization to form an Islamic government in the west African state. February 20, 2016. © UNHCR / George Ooshi

Page 22-23: Jordan / Za’atari Camp / A general view of Jordan’s Za’atari refugee camp, the largest in the country housing 85,000 Syrians in 2015. March 11, 2015. © UNHCR / Dominic Nahr

Page 30: Democratic Republic of the Congo / A Burundian mother and child sit outside a shelter in the Kamiviria transit centre, October 12, 2016. © UNHCR / Eduardo Soteras Jalil